Brighton & Hove City Council

Health & Wellbeing Overview & Scrutiny Committee

Title:	**Health & Wellbeing Overview & Scrutiny Committee**
Date:	**5 November 2013**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Rufus (Chair) C Theobald (Deputy Chair), Buckley, Cox, Marsh, Robins, Sykes and Wealls **Co-optees:** Jack Hazelgrove (OPC), Amanda Mortensen (Parent Governor Representative), Marie Ryan, Susan Thompson (Diocese of Chicester), Youth Council and Healthwatch
Contact:	**Kath Vlcek** 01273 290450 kath.vlcek@brighton-hove.gov.uk

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Part One **Page**

97. Procedural Business **1 - 2**

To consider

(a) Declaration of Substitutes

(b) Declaration of Interest

(c) Declaration of Party Whip, and

(d) Exclusion of Press and Public

98. Minutes of Previous Meeting **3 - 10**

99. Chair's Communications

100. Mental Health Beds Update - Final Report **11 - 26**

Additional information was provided by the CCG after the meeting; this has been attached to the document pack.

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

Ward Affected: *All Wards*

101. Musculoskeletal & Dermatology Services in Sussex **27 - 36**

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

Ward Affected: *All Wards*

102. Maternity Services **37 - 42**

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

Ward Affected: *All Wards*

103. PLACE Assessment Results for BSUH **43 - 48**

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

Ward Affected: *All Wards*

104. Homelessness Scrutiny Panel: Verbal Update

Verbal Update from Councillor Andrew Wealls, Chair of the Panel, and Giles Rossington, Acting Head of Scrutiny

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For further details and general enquiries about this meeting email scrutiny@brighton-hove.gov.uk

Date of Publication 29 October 2013

Agenda Item 1

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.

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE

4.00pm 10 SEPTEMBER 2013

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Rufus (Chair)

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

Other Members present: Cooptees Jack Hazelgrove, OPC; Youth Council; Amanda Mortenson, Parent Governor Cooptee

PART ONE

88. PROCEDURAL BUSINESS

88.1 Cllr Barnett was subbing for Cllr Wealls

89. MINUTES OF PREVIOUS MEETING

89.1 Minutes of the previous meeting were agreed.

90. CHAIR'S COMMUNICATIONS

90.1 The Chair had visited Millview and talked to staff. He was pleased to see the service provided. The issue of number of patient beds would be kept 'on the agenda'

90.2 **Public questions**

90.3 Members of the public Mr Rixon and Mr Lee had questions regarding Healthwatch. These would be referred to at item 93. The letter and response are attached to the minutes.

91. A&E SERVICE IMPROVEMENTS- SIX MONTH UPDATE

91.1 Chief Executive BSUH Matthew Kershaw reported significant progress, in addressing problems causing capacity pressure in A&E at Royal Sussex County Hospital since the last updates to Committee in April and June this year. Work was still in progress, as

anticipated; some of the challenges included areas of work with commissioning partners.

91.2 There had been no breaches of the 12 hour national standard (waiting time from decision to admit, to admission). The 4-hour standard, maintained in May, June and July was missed during August with a performance level of 93% of patients. However the service 'feels' very different compared with February and March. Performance levels reflect the fact that the emergency department (ED) is only one part of the process.

91.3 Redesign and reconfiguring was continuing, with the main focus on how best to manage patients, to bring benefits especially before the arrival of winter; eg remove the use of the corridor, do more near the point of arrival at ED, change where people work and get patients to services more quickly.

New appointments were being made in ED and other senior staff including consultants across emergency care.

91.4 Chief Nurse Sherree Fagge told Members that operational technical assistants were now employed to help clear spaces, releasing nurses' time to care, and extra nurses had been brought into 'resuscitation' More resources were being put into managing patient data. The ratio of trained nurses and healthcare assistants had been increased; this change would be reviewed shortly by a Royal College of Nurses colleague for reassurance. Following the CQC visit, privacy/dignity was being improved eg the plaster room and corridor were not now being used as waiting areas. There was more focus on safety and quality. For instance 'comfort rounds' were in place and there were new processes in place to monitor and reduce the number of falls.

91.5 Mr Kershaw pointed out that attendance and admission levels remain high and 'spikes' were challenging. Spikes in both minor and major cases had made early September particularly challenging to manage. A recent flood had also removed the emergency theatre capacity for a whole day which had caused a backup of patients.

Improvements from new rotas being implemented in September/October will start to flow through the hospital shortly, Mr Kershaw said.

91.6 Managing of discharges each day was critical, the aim being to bring forward the time of discharge earlier in the day to benefit not only the patient, but the hospital and partner colleagues. Changes were being introduced in cover between 8pm and midnight to help reduce number of patients waiting for discharge later in the day. Unusually for a UK hospital, the ED does have consultant cover after midnight.

91.7 Dr Christa Beesley, Clinical Accountable Officer, CCG, set out the improvements designed to integrate with these BSUH workstreams. Integrated Primary Care Teams nurses (IPCTs) were being introduced that included using a risk stratification process. This helped identify potential patients/service users who would benefit most from integrated social care and health front-line services. Mental health workers were being recruited to the IPCTs to work with patients eg with dementia, schizophrenia or drug-related issues.

This work would reinforce Primary Care teams and would be shared by up-loading patients' care plans with ambulance services. A Community Rapid Response service was also being introduced to help support patients and families and a rapid access clinic will enable timely diagnostics eg CT scan for older people and the frail, including the homeless and those in hostels.

91.8 In Brighton & Hove, the number of calls for an ambulance is not increasing but an ambulance is very likely to take a caller to hospital. This means that more people are being taken to hospital by ambulance, even if they could be dealt with elsewhere. The 'hear/treat' system for paramedics and ambulance technical crews was working well to help address this issue.

For those who do need admission, treatment and discharge is then important. More patients now go home with rehabilitation in place, so reducing the demand on beds. Dr Beesley affirmed that beds were not being closed; greater use of home care is better for all.

The Urgent Care clinical forum is taking the lead on bolstering services where frontline staff say they are needed.

91.9 A communications campaign is being planned on how to get the best care. This would include how to identify real A&E emergencies such as chest pain, meningitis etc. and promote alternatives for non-A&E services. Everyone wanted to use the right services and all can help by asking – is an urgent need actually an A&E need?

91.10 The speakers answered Members' questions;

- It is the staff supporting patients in hospital who jointly make a decision on the homecare that a person needs on being discharged. The Board round for every patient is one part of this process. Some patients unfortunately do get readmitted.
- The 111 service that locally was 'rocky' initially is now achieving its targets. We need to ensure that all the pathways are appropriate.
- Mental health patients, carers and staff are becoming more aware of dedicated rapid response alternatives to A&E for their urgent care. However it is taking time for increased awareness and changed behaviours.
- Consultants are resident in the ED, though not full-time. At night time 2am or 3am can sometimes be as busy as 3pm. Staffing of ED is a balance between not only providing the right cover for the sickest patients but also not creating an unnecessary dependency in circumstances where treatment is better provided elsewhere. There is more to do to provide a consistent service all through the week. This is not just a case of 'doing more.'
- More GP hours are needed; however this would have to be on a voluntary basis. GPs do work out of hours and are already at the 'front end' of A&E. There are walk-in medical centres; whether one is best sited next to A&E is under discussion.
- Flu vaccinations are being encouraged for hospital staff and made easier to get. There is a plan for staff including night staff and weekend staff, to receive the vaccine as soon as it is available.
- Mr Kershaw receives performance results from A&E at the Royal Alexandra unit. Children were discharged almost entirely within 4 hours and there is generally very positive feedback on children's A&E, from patients and parents.

- There is no single reason for spikes in arrivals at ED. Spikes can be very significant. Around 90 ambulance arrivals would be expected per day, that can be as many as 149. In summer these are driven by surgical rather than medical emergencies; in winter it is the opposite. Surgical emergencies did not initially seem to be problematic. It is not straightforward; there is no single answer.
- Preparations can be made for large festival events, eg directing people to walk-in centres. It's important to ask people not to go to A&E if they don't need to.
- The aim is to discharge patients home in time for lunch. This is good for the patient and good for the future hospital case; arranging transport and prescriptions gets difficult when patients back up towards 8pm. That means staffing levels and processes need very careful management. It was a small factor that some staff were away at times in August and September but the main issues are the fluctuations in demand on the service. The ED is not perfect but it is improving.

91.11 The system had just received an additional £2.3million for health and social care provision this winter. This would enable extra cover including A&E theatre and nursing care.

91.12 HWOSC Members heard that a weekly message from the Chief Executive is published and is available through the following link http://www.bsuh.nhs.uk/about-us/trust-communications/chief-executives-message/

91.13 At the request of the OPC co-optee, HWOSC asked for further information on action on preventing falls on ice following the Winter Service Plan scrutiny review.

91.14 On behalf of HWOSC the Chair Councillor Sven Rufus thanked all the speakers and asked for an update as necessary.

92. B&H WELLBEING SERVICES (MENTAL HEALTH)

92.1 Anna McDevitt, Commissioning Manager, Mental Health CCG (AM); John Ota, Assistant Director Brighton Integrated Care Service; and Dr Helen Curr, Clinical Lead, Consultant Clinical Psychologist, Brighton & Hove Wellbeing Service presented the report on Brighton & Hove Wellbeing Service and answered questions.

92.2 The Service had now been in place for 14 months. The previous service had lacked adequate capacity and had seemed 'disconnected' from primary care services. The service now also included improved links with voluntary sector services. The previous service supported people up to the age of 65. Now around 5% of service users were aged over 65. This was a step in the right direction.

92.3 Appendix 1 set out the 4 components of the service and performance and activity levels.

The Hub that received referrals is the key liaison point for information and advice. The Primary Care Health Practitioner Service, usually based in GP surgeries, works alongside GPs to provide the first 'port of call.'

Higher intensity therapy including Cognitive Behavioural Therapy is provided by the Talking Therapy Service. For mild or moderate conditions, the Primary Care Health Support Service provides signposting and self-help.

92.4 Ms McDevitt said the service had inherited a significant backlog. The first year had been very busy. Waiting times were significantly shorter but the waiting list still stood at 900 cases. It was pleasing that response times had improved however some people were still waiting too long. The service was working with partnerships to reduce the waiting list.

Additional funding from the CCG should enable the backlog to be cleared by May 2014. It may also be possible to identify areas where support capacity is underused at present.

92.5 The service had achieved the goal of being available in 30 GP surgeries, 2 voluntary sector venues and 3 community-based sites. Good outcomes were being achieved with recovery rates of around 50% being in the top quartile, nationally.

92.6 The speakers replied to Members' questions:

- Most of the waiting list is for talking therapies, where activity is expected to increase within the existing contract value and where additional investment is being sought. The average waiting time has reduced from around 9 months last year to 5-6 months now. Everyone referred to the service is prioritised and contacted more swiftly. More resources have been put into assessment; the service is now meeting the target of 20 working days for timely assessments.
- Almost all referrals are via GPs though there are a few self-referrals. Referrals are accepted from mental health professionals or other professionals who can help someone to fill in the self-referral form.
- The 7 GP leads are mental health 'champions' supporting other surgeries that are identified in clusters. GPs are aware which part of the service to refer people to and the wellbeing service also does triage.
- The Wellbeing service works in GP surgeries where space is available. People are often more comfortable there although some like to be seen elsewhere.
- Previously the contract was for one year only. The current contract is for 3 years and, if it performs well, can be extended without re- tendering.
- The service is set up for mobile working and can co-locate with community services. It is working with GPs and in collaboration with other organisations including those working with travellers to help increase access to the service, especially for hard to reach populations.
- By being more embedded in local primary care services, it is planned that accessibility to psychological therapies will increase.
- Talking therapies for under-18s are provided via schools counselling, CAMHS or other third sector provision. A service user at age 17-18 would be consulted on their future adult service provision.

92.7 Members noted the report. On behalf of HWOSC, Councillor Sven Rufus, Chair, asked that Members be kept informed on the patient backlog and increased activity levels in the target areas.

93. HEALTHWATCH INTRODUCTION

93.1 Jane Viner, Healthwatch Manager, gave a progress report on Healthwatch. Healthwatch listens to Brighton & Hove citizens regarding their experiences of health and social care services, as set out in Appendix 1 to the report. There had been a Healthwatch Transition Group, carrying forward the work of the former LINk; this had now closed down.

93.2 Referring to a question from the Youth Council co-optee at the previous item, Ms Viner said Healthwatch can work with children and young people but does not have the power to enter or view children's' social care services.

93.3 Information was being gathered on all helpline calls and other sources such as advocacy work, community spokes, community engagement work and letters in the press. Monthly reports on what the public are saying will inform Healthwatch work.

93.4 A Volunteer Co-ordinator and Helpline co-ordinator, Engagement and Communications Co-ordinator and Intelligence and Projects Co-ordinator had been recruited. Ms Viner said that they will ensure that young people and others not traditionally used to having a voice will be involved. Following an open recruitment process a shortlist for an Independent Chair was being drawn up.

93.5 Healthwatch will have its own governing body that will itself decide what type of organisation it will become, e.g. a charity, community interest company etc. This is different from LINk that was supported by CVSF host. Healthwatch will develop its own work programme from intelligence that it has gathered. The public will be asked to help decide on the top themes; there will be an emphasis on community engagement.

93.6 Phase 3, implementation, involves working with the governing body to enable transfer of the contract from CVSF to the new Independent governing body.

93.7 Healthwatch can refer matters to overview and scrutiny. It was important to work together e.g. by informing each other of work programmes, and ensuring work plans are complementary without gaps or duplication.

93.8 Regarding questions about Healthwatch from two members of the public at the start of this meeting; there would be replies, separately from this meeting.

93.9 Ms Viner answered questions:

- The Independent Chair will have a strategic role. This is a paid position of around one day per week.
- Learning from the LINk legacy and from community input is, as planned, taking time.
- There are a range of alternatives for the structure of Healthwatch eg community interest company, charity etc.
- Healthwatch will have a pool of representatives who will attend key strategic meetings eg Health and Wellbeing Board, Trust Boards, HWOSC etc.
- Healthwatch will have a value base to ensure it is representative of the public. It will look at the demographics of Brighton & Hove to work with all sectors.

- Healthwatch engagement worker will be looking at how best to engage with young people. Ofsted monitors children's social services.

93.10 Members commented on the importance of Healthwatch being representative of patients/customers, and not workers in health or care services.

93.11 HWOSC welcomed the enthusiastic work and presentation; the Chair emphasised the importance of developing good working relationships between HWOSC and Healthwatch.

94. INTEGRATED PRIMARY CARE TEAMS

94.1 Geraldine Hoban, Chief Operating Officer CCG, Consultant Nurse Deirdre Power, Clinical Leader IPCT at CCG and Louise Mayer, Head of Service at Sussex Community Trust provided an update on Integrated Primary Care Teams (IPCTs). Members were reminded of the previous update to HWOSC in April 2012.

94.2 Formerly different services, mostly nurses, looked after frail housebound people in the community. This was 'episodic' and task-based, so some people had not been well served and needed more integrated pro-active support.

94.3 The current service model was developed with Public Health based on patient need using demographic data; this helped to increase engagement with GP practices. There were now 11 multi-disciplinary IPCTs focussed around GP hubs (of between 3- 5 practices each) with advanced practitioners, nurse case managers, occupational therapist case managers, physiotherapists and care support workers.

The main aims of the service are preventative care, coordination of care and supporting self-management.

An evaluation at the end of the transitional year, year 1 was carried out against a background of 'huge transformational change,' said Ms Power. Patient satisfaction was found to be high. However feedback from GP practices indicated some good progress though, as expected, some practices were late in engaging with the service.

94.4 Figure 2 showed that on-going work was needed to have all IPCT clusters working well with GP practices all across the city. Increased patient complexity was a factor that had hindered full delivery of pro-active care; therefore the teams were being broadened to bring in mental health and social care support. This is being shown to work very well.

94.5 Ms Hoban told HWOSC that working alongside social care workers enabled pro-active services. However there had been insufficient capacity to be both a responsive and pro-active service. IPCTs wanted to go into carehomes as well as to the housebound. She said the evaluation had been helpful in showing improvements although more work was needed to provide a better quality service.

94.6 Members commented that transition to community-based services can seem 'traumatic' after discharge from hospital for example following a stroke. Ms Power said coordination with secondary care was needed in a 'seamless service' that would anticipate people's

needs. Ms Mayer said the IPCT service works closely with the hospital discharge service and will often track the IPCT's known patients from admission to discharge. IPCTs were also looking to work more closely with the homeless and people living in hostels.

94.7 The speaker replied to queries from Members:

- Learning from the transition year will be used to benefit patients.
- There have been large transitional changes in both primary care and at a community level and 'there have been too many joins in the service that can break down.' Work is continuing including on proactive integrated care.
- More mental health support, especially dementia care is needed for the IPCTs
- Lessons learned on support needed for discharged patients are being captured from 'in-reach' to hospitals and discussion with the hospital discharge teams.

94.8 HWOSC Chair Councillor Sven Rufus thanked the speakers for their progress report. Members noted progress and asked to receive an update as necessary.

95. UPDATE FROM COUNCILLOR MARSH ABOUT THE PPG'S URGENT CARE WORK

95.1 This was postponed until a future meeting.

96. LETTER FROM CCG ABOUT DIABETIC PROVISION CONSULTATION NOTIFICATION

96.1 The letter was noted.

The meeting concluded at 6pm

Signed Chair

Dated this day of

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 100 Brighton & Hove City Council

Subject:		**Mental Health Beds – Final Report**	
Date of Meeting:		**5 November 2013**	
Report of:		**Monitoring Officer**	
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 HWOSC has considered a number of reports since November 2011 regarding the temporary closure of 19 mental health beds.

1.2 The implications of the closure have been closely monitored by a Clinical Review Group including GP leads and Sussex Partnership Foundation Trust staff; regular update reports have been provided to HWOSC members.

1.3 The Clinical Review Group is now in a position to make recommendations about the preferred option for the ongoing model of care for mental health services in Brighton and Hove. They have considered three options and are seeking HWOSC support for securing additional bed capacity, to be funded through release of the funding associated with the empty ward..

2. RECOMMENDATIONS:

2.1 That HWOSC members consider, note and comment on the Clinical Review Group's options, in particular their preferred option to close the ward and secure additional bed capacity as needed.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 Since 2009 health commissioners (formerly Brighton and Hove City PCT and from 1 April 2013 Brighton and Hove Clinical Commissioning Group (CCG)) have been working collaboratively with Sussex Partnership NHS Foundation Trust (SPFT), the main local provider of mental health services, to make system changes to reduce the need for acute beds.

3.2 At the HOSC meeting on 16 November 2011 it was agreed to temporarily reduce the number of beds on a phased basis to test whether the system could safely operate with fewer beds. This agreement was contingent on flexibility to re-open beds should the need arise and the plan being overseen by a Clinical Review Group. The Clinical Review Group is chaired by Dr Becky Jarvis, GP clinical lead

for mental health and with Consultant Psychiatrist representation from SPFT from Brighton & Hove inpatient and community services.

3.3 The 19 beds have been temporarily closed since January 2012 which has provided an opportunity to test the system and make further improvements and investment in community services.

3.4 The temporary closure of the beds has enabled funding to be released from the "variable costs" associated with a ward (for example staff, drugs, equipment). This funding has been used to make further improvements to the community services.

3.5 The total annual costs associated with the 19 beds that have been temporarily closed is £1.6 million. This is made up of variable costs (approximately 50%) and fixed costs (building and overhead costs) approximately 50%. Whilst the beds have temporarily been closed the ward has been kept empty in case of the need to re-open. This has prevented alternative usage of the ward and is an opportunity cost.

3.6 The variable costs associated with the beds have been re-invested into community mental health services including a Crisis Resolution Home Team, additional Care Coordinators, an enhanced Brighton Urgent Response Service, new Accommodation Support Services and a new day centre for people with Personality Disorder. More information can be found in **Section 3, Appendix One.**

3.7 Decisions about the capacity of acute mental health beds in the city are the joint responsibility of NHS commissioners (Brighton & Hove CCG) and providers (Sussex Partnership NHS Foundation Trust). These are not local authority services and no Council responsibilities are directly discharged via them.

3.8 However, acute mental health beds are only one aspect of the totality of mental health provision, as **Appendix 1** makes clear. Also of key importance are NHS community and social care mental health services; and, more broadly still, support services provided by statutory agencies, including the city council, and by a range of other providers, including the voluntary and community sector. Whilst there is no direct local authority interest in these plans therefore, there are indirect interests in terms of Adult Social Care services, and more broadly a range of services such as housing (e.g. landlord functions), homelessness, and community safety. All of these services could potentially benefit from improved local NHS mental health provision; but might also be impacted by a reduction in the effectiveness of these services.

3.9 Potential BHCC 'interests' notwithstanding, the main role of the HWOSC here is to determine whether the committee believes that the proposals will deliver improved healthcare services to local people. This is not an abstract judgement: it is important to bear in mind the financial context for these proposals and to be aware that 'perfect' solutions are unlikely to be affordable.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The Clinical Review Group considered three options including retaining the status quo, re-opening the beds and securing additional capacity in the city to be funded through releasing the funds associated with the empty ward.

4.2 More information on all three options can be found at **Figure 6, Appendix One**.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 There was public consultation in 2010; further information was provided to HWOSC in previous meetings.

6. CONCLUSION

6.1 The Clinical Review Group has been meeting regularly since 2012 to oversee changes to the system and monitor performance, in particular the ability to access a local bed. Through analysis of the data it has been identified that at times more beds are needed than we have locally, but there has never been an occasion when there has been a need for 19 more beds in Brighton and Hove.

6.2 The recommendation of the Clinical Review Group at option 3 is the preferred option and they will support the plans for alternative use of the current empty ward on the condition:

- All funding associated with the 19 beds that has not already been invested in community services is ring fenced specifically for further investment in local mental health services.

- The Clinical Review Group will continue to have responsibility for overseeing the next phase of the plan; the membership and terms of reference of this group is reviewed to ensure they are fit for purpose.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 All financial implications for the CCG have been covered in Appendix One.

Legal Implications:

7.2 Section 244 of the National Health Service Act 2006 and associated regulations (The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013) permit the council to review and scrutinise any matter relating to the planning, provision and operation of the health service in its area. The council has arranged for these functions to be discharged by its Health & Wellbeing Overview & Scrutiny Committee.

In exercise of that power, the Committee is permitted to make reports and recommendations to a relevant NHS body, a relevant health service provider, or the council itself, on any matter it has reviewed or scrutinised.

Lawyer Consulted: Oliver Dixon *Date: 23/10/13*

Equalities Implications:

7.3 There are no additional equalities implications identified.

Sustainability Implications:

7.4 There are no sustainability implications.

Any Other Significant Implications:

7.5 The mental health service provision has implications for public health and for Brighton and Hove residents generally. These have been considered throughout the temporary closure process.

SUPPORTING DOCUMENTATION

Appendices:

1 Mental Health Services in Brighton and Hove, Model of Care, CCG

Mental Health Services in Brighton and Hove

Model of Care

1. Summary

1.1 Around 1 in 4 people experience some form of mental health problem in the course of a year. Anxiety and depression are the most common forms of mental health problems and over the last 20 years there has been a significant increase in the number of people supported by mental health services and the vast majority of care is now provided outside hospital.

1.2 Where care is provided in hospitals there has been a trend towards shorter stays. Many mental health problems are chronic conditions and inpatient care is often part of an overall package of ongoing care and support taking a life-course approach.

1.3 There is significant variation in hospital bed usage across the country and recent investigation by Community Care has highlighted concerns that some parts of the country have reduced hospital bed numbers too far without reinvesting sufficient resources in community services.

1.4 Whole system modelling work undertaken in 2009 highlighted Brighton and Hove as an outlier with higher than average bed usage[1] and scope to shift the balance of care to provide more care in the community and less in hospital.

1.5 This paper provides recommendations for the ongoing model of mental health care in Brighton and Hove for adults with functional need e.g. depression, psychosis. The model for dementia care is excluded from this paper.

[1] The bed usage figures have been adjusted for population need e.g. Brighton and Hove has on average higher mental health need than other parts of Sussex but when data is adjusted to reflect need; the data shows higher than expected bed usage.

2. Background

2.1 In 2009 a whole system review was undertaken of the demand and capacity for acute mental health beds in Sussex. The key findings for Brighton and Hove were:

- Higher than average lengths of stay when compared nationally
- Delayed discharges

2.2 The review highlighted opportunities to redesign mental health services and provide better quality care by providing more services in the community to:

- help prevent admission in the first place; and
- facilitate earlier discharge from hospital.

2.3 The key recommendation of the review was that if services could be redesigned the overall number of acute mental health beds for the Brighton and Hove population could be reduced from 95 to 76; a reduction of 19 beds.

2.4 Since 2009 health commissioners (formally Brighton and Hove City PCT) and from 1 April 2013 Brighton and Hove Clinical Commissioning Group (CCG) have been working collaboratively with Sussex Partnership NHS Foundation Trust (SPFT) the main local provider of mental health services to make the system changes to reduce the need for acute beds.

2.5 At the HOSC meeting on 16 November 2011 it was agreed to temporarily reduce the number of beds on a phased basis to test out whether the system could safely operate with fewer beds. This agreement was contingent on:

- flexibility to re-open beds should the need arise[2] and
- the plan being overseen clinically by a Clinical Review Group chaired by Dr Becky Jarvis, GP clinical lead for mental health and with Consultant Psychiatrist representation from SPFT from Brighton & Hove inpatient and community services.

2

Link to minutes attached http://present.brighton-hove.gov.uk/mgConvert2PDF.aspx?ID=37574

2.6 The 19 beds have been temporarily closed since January 2012 which has provided an opportunity to test the system and make further improvements and investment in community services.

2.7 The key consideration for the Clinical Review Group has been the need to ensure that wherever possible a local bed is made available for anyone that needs one. It is recognized that there will be periods where demand for access to beds surges, both within Brighton and Hove and across Sussex and therefore the standard set for access to a bed within Brighton and Hove is 95% of all admissions. A small number of people also choose not to receive care locally and it may also not be clinically appropriate for some to be admitted to the local hospital.

2.8 The Clinical Review Group is now in a position to make recommendations about the preferred option for the ongoing model of care for mental health services in Brighton and Hove.

2.9 This paper provides a summary of:

- The improvements & changes that have been made to services and pathways since January 2012
- The performance against key metrics, in particular the ability to access a local bed.
- The recommendations for the ongoing model of care for mental health services in Brighton and Hove.

3. Improvements to Community Mental Health Services

3.1 The temporary closure of the beds has enabled funding to be released from the "variable costs" associated with a ward (for example staff, drugs, equipment). This funding has been invested to make further improvements to the community services.

3.2 The total annual costs associated with the 19 beds that have been temporarily closed are £1.6 million. This is made up of variable costs (approximately 50%) and fixed costs (building and overhead costs) approximately 50%. Whilst the beds have temporarily been closed; the ward has been kept empty in case of the need to re-open. This has prevented alternative usage of the ward and is an opportunity cost.

3.3 The variable costs associated with the beds have been re-invested into community mental health services. Specific improvements that have been made from this funding source as well as additional CCG funding in mental health services is detailed in sections 3.4 to 3.9.

3.4 Crisis Resolution Home Treatment Team (CRHT). This team provides intensive crisis support to people living in the community who may otherwise be likely to be admitted to inpatient care and also facilitate early discharge from hospital. The service is provided 7 days a week and is a national evidence based model of care. An additional six nursing posts have been recruited to increase capacity and support more care at home. This investment has enabled the team to provide care for 100 more people at home in a year. The CRHT Team target has increased from 724 to 824 completed treatment episodes.

3.5 **Additional Care Co-ordinators.** An additional seven care co-ordinators have been funded to help reduce case loads and enable more preventative pro-active care. Five out of the seven additional posts have been recruited to substantively and the remaining two posts have been filled by temporary staff. This has enabled the average Care Co-ordinator caseload to decrease from 38 to 28. The posts that are still vacant have now been advertised.

3.6 Enhanced Brighton Urgent Response Service. This enhanced service provides a 24/7 urgent response service to patients at high risk. It was established on 14 January 2013, initially on a pilot basis (until 31 March 2014) to test out the model of care and make any necessary adjustments. It aims to provide a streamlined urgent response to crisis with care provided in community settings wherever possible. An interim evaluation has been undertaken in August 2013 which shows that more patients are being provided with an immediate response when in crisis. Further work is being planned to ensure greater awareness of the service and maximize the opportunity for individuals to benefit from the service. A full evaluation is in progress and this will be considered by the CCG in December 2013 to inform ongoing commissioning of the service from April 2014 onwards.

3.7 **New Accommodation Support Services**

The CCG and Brighton and Hove City Council (BHCC) undertook a joint procurement process to increase capacity for mental health accommodation support for a range of different needs from high intensity complex needs to tenancy support for individuals in rented accommodation. It is anticipated that this increased capacity will help prevent unnecessary delays in terms of discharge from hospital. The total capacity is to support 120 individuals (20 replacing an existing contract with SPFT) and additional capacity to 100 individuals. The

contracts that have been awarded are and are due to start in February 2014. The full detail is contained in a paper to the HWOSC in December 2012.[3]

3.8 **New Day Centre for People with Personality Disorder**. The Lighthouse Day Centre based in Hove opened on 20 May 2013. This new day centre provides intensive 7 day a week support in the community targeting support to people with a diagnosis of personality disorder who have had admissions to hospital. It is not unusual for people with this diagnosis to have multiple admissions over a period of time. The Lighthouse is aiming to provide community based support and reduce admissions and length of stay in hospital. The service has already proving to be successful in terms of numbers attending and plans are under consideration to develop the service to provide an enhanced level of crisis support

3.9 **Summary of Service Developments**

A summary of community developments are detailed in Figure 1 below. The total investment value is £2.6 million per annum. £2.1m has been funded through redesign of existing mental health resources with £0.5 million of new resources.

Figure 1: Summary of Service Developments

	Annual CCG Investment	Start Date	Notes
CRHT	£429,000	April 2013	Funded through release of variable costs associated with temporary bed closure
Care Co-ordinators	£329,000	April 2013	Funded through release of variable costs associated with temporary bed closure
Personality Disorder Development	£715,000	May 2013	Funded through redesign of services plus £142,000 of additional funding
Brighton and Hove Urgent Response Service	£391,000	January 2013	New CCG funding
Accommodation Support Contracts	£718,000	February 2014	Funded through redesign of existing resources. Additional capacity for 100 individuals.
Total	**£2,582,000**		

[3] Link to the Paper is at the attached http://present.brighton-hove.gov.uk/Published/C00000728/M00004126/AI00029442/$Item45app1MHAccomwithsupport.docA.ps.pdf

4 Update on Performance

4.1 Access to Acute Mental Health Beds.

The Clinical Review Group set a target of at least 95% of patients being able to access a bed in Brighton and Hove. The demand for acute beds is variable with relatively small numbers of patients requiring admission at any one time. In 2012-13 there were 752 acute mental health admissions related to Brighton and Hove residents which relates to approximately 2 admissions per day. Since January 2012 when the beds temporarily closed, **93%** of people have been able to access a bed within the City. Performance has not significantly changed from the preceding period when the beds were open but the target of 95% has not been achieved. Due to the relatively small numbers of admissions, fluctuations in terms of numbers of Brighton and Hove residents admitted out of area occur on a weekly basis. In addition there are distinct patterns of seasonable fluctuation in demand with greatest demand for beds from April to June a second peak in December/January. Over the last two years the number of residents admitted to a bed outside of the City has ranged from zero to 16. Figure 2 shows the ability to access acute mental health beds in Brighton and Hove and Figure 3 shows the location where Brighton and Hove residents have accessed a bed when one has not been available in the City.

Figure 2: Access to Acute Mental Health Beds in Brighton and Hove

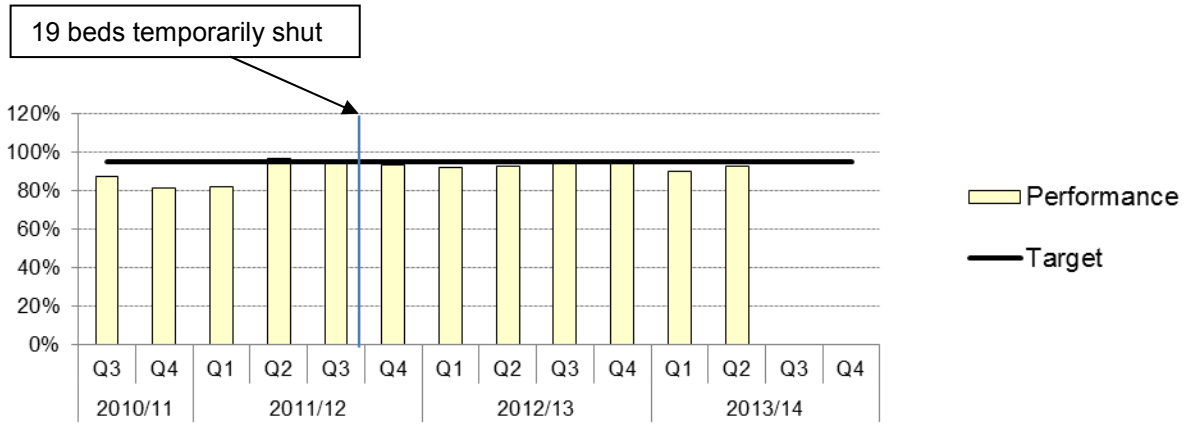
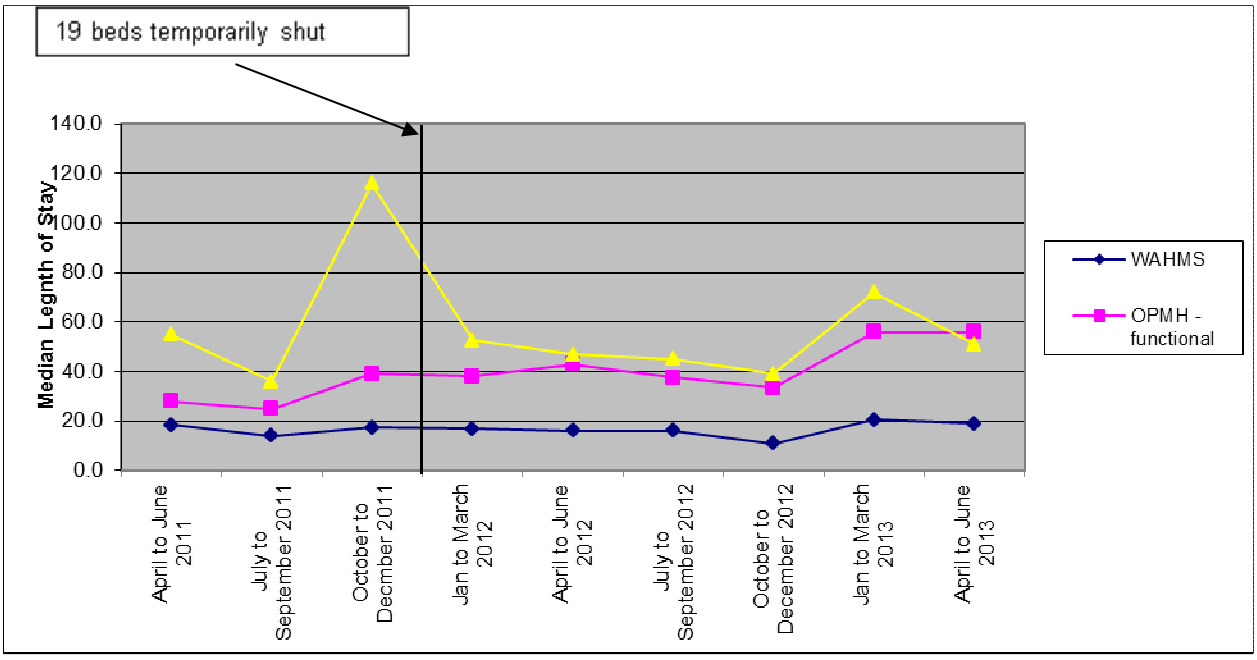


Figure 3: Location of Acute Mental Health Admission for Brighton and Hove Residents (January 2012 until September 2013)

Location of Hospital	Usage (% of Total Bed Days)
Brighton and Hove Hospital	92.6%
Other NHS Hospital in Sussex (Eastbourne, Crawley, Worthing, Hastings)	7.0%
Hospital Outside Sussex	0.4%
Total	**100%**

4.2 **Length of Stay.** Delayed transfers of care were highlighted as a significant issue in the original 2009 whole system modeling. Median length of stay has not altered significantly since the beds have been temporarily been shut and it is anticipated that the additional accommodation support described in section 3.7 will enable people to move on from hospital when they are ready and prevent any unnecessary delays. Figure 4 details the median length of stay.

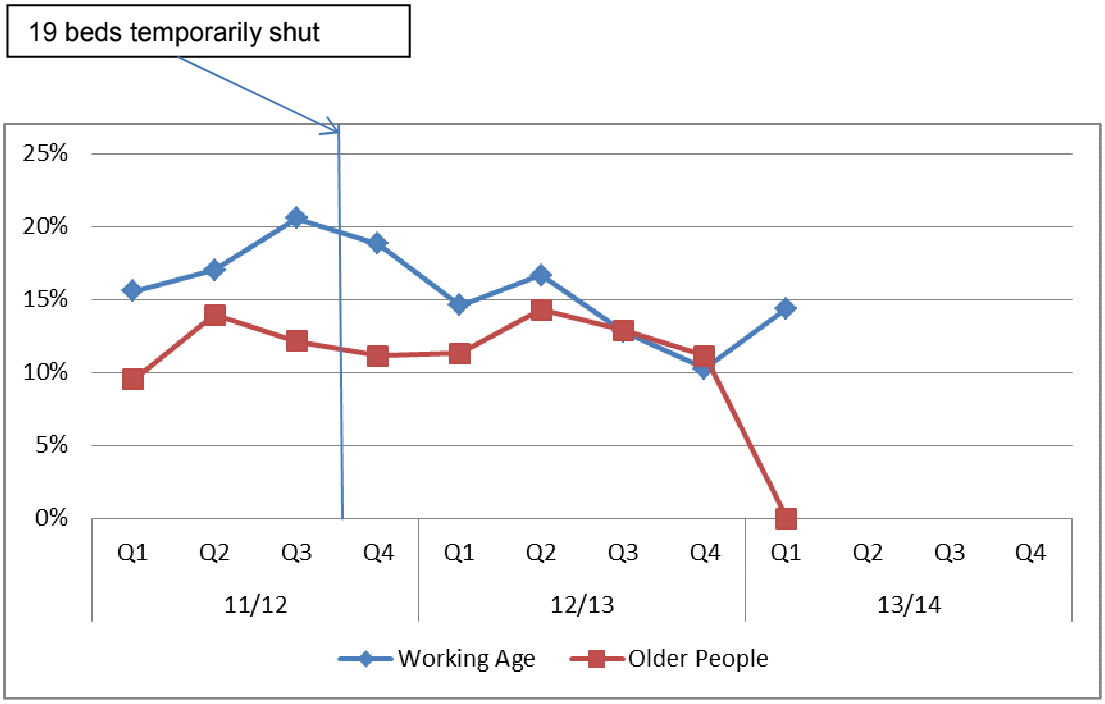
Figure 4: Median Length of Stay



Key
WAHMS: Working Age Service - patients aged18-64
OPMH - functional: Patients aged 65 and over a functional mental illness
PPMH – organic : Patients with dementia

4.3 **Re-admission Rates**. One of the potential risks of reducing length of stay is that patients are discharged too early and end up needing to be re-admitted. The Clinical Review Group have also been monitoring re-admission rates and these have slightly decreased since the beds have been temporarily been shut. Figure 5 shows the trends in re-admission rates.

Figure 5: Re-admission Rates



4.4 In addition to monitoring the performance metrics the Clinical Review Group have also considered a range of soft intelligence from health and social care practitioners delivering mental health care. Issues that have been identified include:

- Approved Mental Health Professionals [4] in Brighton and Hove have highlighted that where a local bed is not available, the assessment process can take longer and patients have at time been detained without an identified bed.

[4] AMHPs are responsible for organising, co-ordinating and contributing to Mental Health Act assessments. It is the AMHP's duty, when two medical recommendations have been made, to decide whether or not to make an application to a named hospital for the detention of the person who has been assessed.

- The consolidating of clinical expertise on the Millview site that has been created through the temporary closure of the ward at the Neville Hospital is seen as beneficial in terms of delivery of high quality clinical quality.

5. Analysis & Discussion

5.1 The decision to temporarily close the 19 beds has provided an opportunity to test the system. Ongoing investment has been made in community services; that aims to provide as much early intervention as possible closer to home and this is the desired overall model of care for mental health. In addition to early intervention community care provides intensive support before and after discharge from hospital to ensure a co-ordinated and safe care pathway.

5.2 Within a community focused model of care, when an acute mental health bed is needed then it is essential that one is made available. It is also desirable that wherever possible this bed should be available locally. The experience since January 2012 is that for over 9 out of 10 Brighton and Hove residents requiring an acute inpatient admission a local bed has been found. However due to the fluctuation in demand there are times but this isn't happening frequently enough.

5.3 In addition is the demand for particular type of beds are not predictable on occasions there are greater demand for male beds and at other times the pressure is for female beds.

5.4 Admission to an acute mental health bed outside the local area has disadvantages from a number of perspectives. Firstly there is the inconvenience for the patient and their carers/families and friends in terms of transport and visiting. There is also a risk that patients who not formally detained under the mental health act chose not to be admitted unless it is to a local bed. There is also evidence that patients admitted out of area end up having a longer length of admission as there can sometimes be difficulties ensuring streamlined continuity of care with local community services when a patient is ready for discharge. Finally there is cost of administrative time spent sourcing beds and the increased financial costs of paying for beds outside the NHS.

5.5 Pressures on acute mental health beds have been noted across the country. The recent Community Care investigation raised concerns at a national level about mental health beds being closed without making further investment in community services. Within Brighton and Hove, senior psychiatrists through the Clinical Review Group have overseen the process of bed closures to ensure that it is clinically safe and to develop sufficient community services as alternatives to hospital admission.

5.6 The Clinical Review Group has been meeting regularly since 2012 to oversee changes to the system and monitor performance in particular the ability to access a local bed. Through analysis of the data it has been identified that at times more beds are needed

than we have locally, but there has never been an occasion when there has been need for 19 more beds in Brighton and Hove.

5.7 The Clinical Review Group has considered a range of options to address this. Figure 6 shows a summary option appraisal.

Figure 6 Option Appraisal

Option	Advantages	Disadvantages
1) Retain Status Quo – with Beds Temporarily Closed	• Flexibility to open beds retained	• Opportunity costs associated with the empty ward • Patients will continue to be admitted outside Brighton and Hove
2) Re-open the Beds	• Additional bed capacity will be made available locally	• Cost associated with opening whole ward • The ward could only be single sex and therefore not always accommodate the demand, which can fluctuate between male and females • Investment from community services will need to be diverted to pay to re-open the ward. • No guarantee that beds will all be used for Brighton and Hove residents given similar system pressures in Sussex
3) Secure additional bed capacity in Brighton Hove (to be funded through release of the funding associated with the empty ward)	• More local beds then are currently available • More cost effective than opening a whole ward • Flexibility in terms of access to male and female beds • Maintains recent investment made in community services • Enables further evaluation of the model of care • Flexibility to cover seasonal pressures	• Not always able to guarantee that Brighton and Hove residents will be able to access a local bed

5.8 The clinical review groups view is that option 1 is not viable on an ongoing basis as there is sufficient intelligence to demonstrate that at times more local beds are needed. In addition there is a financial cost associated with keeping the ward temporarily closed. The funds could be spent more productively to invest in additional bed capacity and/or making further investment in community services.

5.9 Options 2 and 3 are to increase local bed capacity and of these two options the Clinical Review Group is recommending option 3 as the preferred option as it allows for greater flexibility to respond to the variation in demand and also crucially allows maintenance of the recent investment in community services.

5.10 In summary, the recommendation of the clinical review group is option 3 is the preferred option and they will support the plans for alternative use of the current empty ward on the condition:

- All funding associated with the 19 beds that has not already been invested in community services is ring fenced specifically for further investment in local mental health services.
- The Clinical Review Group continue to have responsibility for overseeing the next phase of the plans and that the membership and terms of reference of this group is reviewed to ensure they are fit for purpose.

5.11 The CCG and SPFT have formally agreed to the ring fencing of the funds to pay for:

- Additional bed capacity that will be secured from the Priory Hospital in Hove – initially for a three month trial period from November 2013 and
- Additional investment in community mental health services in Brighton and Hove.

6. Recommendation

6.1 The HWOSC is asked to note the recommendation of the clinical review group to release the funds associated with the ward that has been empty since January 2012 to:

- secure additional local acute mental health bed capacity and
- invest further in local community mental health services.

Subject:		**Musculoskeletal and Dermatology Services in Sussex**
Date of Meeting:		**5 November 2013**
Report of:		**Monitoring Officer**
Contact Officer:	**Name:**	**Kath Vlcek** **Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 Brighton and Hove Clinical Commissioning Group (the CCG) is currently working with Horsham and Mid Sussex and Crawley CCGs to re-procure Musculoskeletal services (MSK) across the area of the three CCGs. The CCG is also working to re-procure dermatology services.

1.2 This paper covers the procurement process for both services,

2. RECOMMENDATIONS:

2.1 That HWOSC members consider and comment on the reports and procurement processes for both services.

3. CONTEXT/ BACKGROUND INFORMATION

Musculoskeletal Services

3.1 The current service in Brighton and Hove is provided by Brighton and Sussex University Hospital NHS Trust (BSUH) who subcontract to two other providers to deliver the service: Sussex Community Trust (SCT) and Brighton Integrated Care Services (BICS). It covers all services in the areas of Orthopaedics (bones and joints), Podiatry (feet and ankles), Rheumatology, Pain Management and Physiotherapy. More information on services that are provided can be found in **Appendix One**

3.2 The original scheme was a pilot and now has to be re-tendered. The procurement process is laid out in **Appendix One,** this also contains information on how social value will be taken into account.

3.3 The CCG is hoping to go out to tender in October leading to signature of a contract in six months' time. A period of a further six months will be allowed for the new provider to mobilise and organise their services, leading to a service start in October 2014

Dermatology Services

3.4 At present, the Integrated Dermatology Service is provided under contract with BICS (Brighton Integrated Care Services, as prime provider, who then subcontract to BSUH (Brighton and Sussex University Hospital Trust) for consultant input. The current service includes the management of Enhanced Minor Surgery and Dermatology services in Primary Care, Community services run by General Practitioners with Specialist Interests (GSWIs) and Nurses and all adult elective outpatient activity. It also includes patient triage.

3.5 The original scheme was a pilot and now has to be re-tendered. The procurement process is laid out in **Appendix Two.**

3.6 The CCG Board have approved a formal competitive tender process starting in October. Market engagement has demonstrated that there are a range of providers that are capable and interested in providing an integrated dermatology service.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 There is no alternative to formally procuring the services as they have both been run as pilot schemes to date.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 Patient engagement for both MSK and dermatology service users took place in April 2013 and their feedback informed the process. More information can be found in **Appendices One and Two.**

6. CONCLUSION

6.1 The service has to be procured as the current provision is a pilot service. Social value will be considered as part of the procurement process.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this cover report; the procurement process will take account of this in due course.

Legal Implications:

7.2 None to this cover report; the procurement process will take account of this in due course. Both services legally have to go through the procurement process as they have been operated under a pilot scheme to date.

Equalities Implications:

7.3 None to this cover report; the procurement process will take account of this in due course.

Sustainability Implications:

7.4 None to this cover report.

Any Other Significant Implications:

7.5 Both services are key public health services and so their procurement and provision is a vital part of the health service.

SUPPORTING DOCUMENTATION

Appendices:

1. Musculoskeletal services in Brighton and Hove, CCG report

2. Procurement of a Dermatology Service, CCG report

Brighton and Hove
Clinical Commissioning Group

Report to Brighton and Hove HWOSC
Tuesday 5th November 2013
Author: Alison Dean – CCG Commissioning Manager for Planned Care
4th October 2013

Musculoskeletal services in Brighton and Hove

Introduction

1. Brighton and Hove Clinical Commissioning Group (the CCG) is currently working with Horsham and Mid Sussex and Crawley CCGs to re-procure Musculoskeletal services (MSK) across the area of the three CCGs. This is a long term project that has gradually come to fruition.

Current services

2. The current service in Brighton and Hove (B+H) is provided by our local acute hospital trust, Brighton and Sussex University Hospital NHS Trust (BSUH) who subcontract to two other providers to deliver the service: Sussex Community Trust (SCT) and Brighton Integrated Care Services (BICS).

   The current service was commissioned as an integrated service by negotiation with the existing providers as a pilot to provide all services in the areas of Orthopaedics (bones and joints), Podiatry (feet and ankles), Rheumatology, Pain Management and Physiotherapy. A review in 2012 found that this had been partly successful but that there were barriers to complete integration. Pain management, Physiotherapy and Rheumatology had not been integrated into the service but continued to be provided separately by BSUH. There had been improvements in quality of care and more streamlined pathways in some specialties but lack of complete integration had stopped this being achieved in the others. There were still duplicate appointments taking place on the interface between community and secondary care. In addition patients sometimes experienced waiting times longer than had been commissioned (assessment, diagnosis and start of treatment within four weeks of receipt of referral). This has been a particular problem in Pain Management which is now being addressed by extra CCG funding.

   In 2012-13 the CCG spent approximately £22m on these services. This included approximately:

   - 4.7 thousand inpatient spells
   - 73 thousand new outpatient appointments
   - 23 thousand follow-up outpatient appointments
   - 60 outpatient procedures

Re-provision

3. This contract has been in place since 2010 and we are currently running under a contract extension to allow time for re-provision. Under national rules we have to tender this service as it originally was considered to be a pilot and this cannot continue; there are a range of other potential providers. Also with the value of this service we have to be able to prove good value for money. Tendering provides an opportunity to write a new specification that includes full integration to reduce duplication and introduce new technology and other benefits.

4. The Public Services (Social Value) Act 2012 requires the procurement of services to consider how the proposed procurement might improve the economic, social and environmental wellbeing of the relevant area. Consequently we will include questions in the second part of our procurement process to ask bidders how they propose to do this. We will also ask for detail of how bidders plan to deliver the service in an environmentally sustainable way.

5. A key part of any clinical service is how it is monitored to see if it is achieving the desired performance. The key performance indicators for this service will be based on proven clinical outcome measures where these are available rather than only counting activity.

6. The first stage of the procurement aims to exclude any clearly unsuitable bidders such as those who are not financially stable or who have no track record in delivering clinical services. The initial documentation will include mention of key subjects which will examined in more detail at the second stage of procurement known as Invitation to Tender (ITT).

   The ITT will be constructed as a series of questions grouped under a range of weighted headings such as Service Delivery, Workforce, Integration, IT, Finance and Business, Mobilisation, Governance, Equality, Sustainability and Social Value. A panel of trained evaluators score the bidders' responses against agreed criteria and if needed, a moderation meeting will examine and resolve any conflicting scores. This process enables a balanced decision to be made on a range of factors.

The new service

7. The main aims of re-provision are to improve the clinical outcomes for patients, to improve patient experience and to improve value for money. These will be achieved by:
   7.1. Development of patient information and education to support patient self-care and empowerment
   7.2. Use of nationally developed aids for patients to make decisions about their care jointly with healthcare professionals
   7.3. Implementation of 'one-stop shops' where possible to reduce the number of appointments
   7.4. Ensuring that all assessment and treatment is based on best medical evidence
   7.5. Clinicians working together in multidisciplinary teams to promote learning and to ensure the best use of the range of skills available

7.6. Use of good information systems to streamline decision making and reduce paper based working and encouraging the use of new technology to support innovation
7.7. Rapid patient access to the services that they need, provided in a holistic way, with signposting to other services in the community
7.8. Improved access including longer opening hours, to promote equality of access
7.9. Inclusion of the management of patients' transfer into and out of secondary care for surgery

8. The specification describes services delivered in a hub and spoke model with one of the hubs mandated to be in B+H. Each site will have adequate parking facilities including those for the disabled, accessibility for hospital transport and public transport stops within a five minute walk.

9. Delivery of the service will depend on the contract holder having the right staff with good competencies and opportunity to train and develop. We are seeking to ensure that the contract holder will be a good employer.

Patient and public involvement

10. The CCG held a MSK patient engagement event on 16th April 2013, in conjunction with colleagues working on a Dermatology project. This was widely advertised through the current service, via primary care Patient Groups in GP practices and through LINKs. Fifteen members of the public were involved in the MSK session. This involved presentations about what we had intended to commission, how well the current service was working and what improvements could be made. There were round table discussion groups where participants raised what was important to patients and members of the public and what suggestions they had for improvements. Discussion and comments were clustered around five main themes:
    - Better information for patients
    - Quality of appointment
    - Public transport and parking, choice of location
    - Long term conditions
    - Good data

    A summary of the day has been reported to the participants. The detail of these discussions has been fed back to the project team and has been used to strengthen the service specification. A newsletter on progress on the project including how the specification has been improved because of the participation is planned to go out to the participants and others in October. In the newsletter we will also ask for volunteers who may be interested in supporting the procurement process from drafting questions through to evaluating bids.

11. An Equality and Human Rights Analysis is being carried out.

12. A Sustainability and Social Needs Assessment is being carried out. This is already indicating some clear benefits of the new service such as the reduction in the number of needed appointments reducing the number of patient journeys, and improved information systems cutting down on the use of paper based recording and communications. Reducing costs of duplication will release resource that can be used to improve services.

Next steps

13. The CCG is hoping to go out to tender in October leading to signature of a contract in six months' time. A period of a further six months will be allowed for the new provider to mobilise and organise their services, leading to a service start in October 2014.

Procurement of an Integrated Dermatology Service

1. Introduction

1.1 Brighton and Hove PCT / CCG have been running a pilot for an Integrated Dermatology Service for the last three years. An extension to this contract has recently been granted until July 2014 to allow for an evaluation of the service and a thorough consideration of the commissioning process to be taken forward to secure an improved service on a more robust contracting basis.

1.2 At present, the Integrated Dermatology Service is provided under contract with BICS (Brighton Integrated Care Services, as prime provider, who then subcontract to BSUH (Brighton and Sussex University Hospital Trust) for consultant input. The current service includes the management of Enhanced Minor Surgery and Dermatology services in Primary Care, Community services run by General Practitioners with Specialist Interests (GSWIs) and Nurses and all adult elective outpatient activity. It also includes patient triage.

2. The Case for Change

2.1 The need for change is driven by a number of factors, most significantly that the service has been running on a pilot basis for the last 3 years. It does not currently include all of paediatric out-patient activity and there are pathway efficiencies to be gained by including this. Psychdermatological approaches were not specified in the current service specification and there are no incentives to improve quality, develop innovative solutions or manage activity and costs more appropriately within the current contract.

2.2 There is strategic fit with national and local policy direction to deliver a model that provides more flexible and accessible care to patients via an integrated model.

2.3 National needs assessment work indicates an on- going increase in the dermatology workload and the need to improve self-care and the role of primary care. We need to develop a model that manages increasing activity whilst delivering high standards of care and patient satisfaction within an affordable budget.

3. Patient and Public Engagement and Consultation

3.1 An engagement event held in April 2013 provided valuable feedback both on how the service has been running and what patients and public value in terms of future developments. This has fed into the aims and objectives written into the revised service specification. The following summary statement was agreed:
Patients tell us that they would like local services which are timely and convenient and have good response times. Location of service is less important than being seen by the right professional team and receiving a reliable and high quality service. They also want their communication needs to be understood and to be empowered and supported to manage their condition.

3.2 Patient and clinical engagement has emphasised that the current service is valued and they do not perceive the need for significant change. The areas that required strengthening were around patient education and communications and similarly with GPs to receive improved support and education. The steer was to continue with an integrated model of care. The procurement method going forward has taken this into account.

The public and patient group will also be continuing their involvement in helping to frame quality indicators around engagement and patient satisfaction.

4. Options Appraisal

4.1 The option appraisals presented to the CCG Board in September 2013 concluded that a competitive tender process for a Prime Contractor or Accountable Lead Provider model would provide the most effective route to develop further the integrated service. As the name suggests *The Accountable Lead Provider* is a provider of care from within the pathway of care and therefore has the power and insight to make changes along the whole pathway and hold all of the providers within this to account.

4.2 A Programme budget will provide a further drive to integrated pathways and is an effective method of aligning financial accountability and clinical responsibility. It forces providers to consider the entire population and to develop models that deliver better value outcomes. A programme budget has been calculated using 2012/13 activity and costs and modelling savings on this by shifting further activity into the community. This approach with allow for reinvestment in service gaps, the predicted growth in skin damage cases and enable an allocation for a quality incentive scheme.

5. Summary of Next Steps

5.1 The CCG Board have approved a formal competitive tender process starting in October. Market engagement has demonstrated that there are a range of providers that are capable and interested in providing an integrated dermatology service.

5.2 The principle aim of the service, going forward, will be to improve integration ensuring an seamless care pathways across primary and secondary care, working in partnership with GPs, Nurses, Consultant Dermatologists, Pharmacists and Patients and provide improved value for money.

Subject:		**Maternity Services**	
Date of Meeting:		**5 November 2013**	
Report of:		**Monitoring Officer**	
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The paper highlights a range of issues identified as of interest to the HWOSC and is intended to provide assurances on the following areas, in particular:

1 Home births
2 C –sections
3 Implications of activity transferring due to the temporary closure at Eastbourne
4 Patient and user engagement

2. RECOMMENDATION:

2.1 That HWOSC members note and comment on the information, asking for updates as necessary.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 Maternity Services in Brighton and Hove are provided by Brighton and Sussex University Hospitals Trust (BSUH). There is an Obstetric Led Unit (OLU) at the Royal Sussex County Hospital site (RSCH). Women can also choose to have a home birth and locally these currently account for about 5% of births. In 2012/13 there were a total of 3,366 deliveries in Brighton and Hove.

3.2 BSUH closely monitor the performance of all their maternity services; details of performance can be found in **Appendix One**. Performance is reported to have improved steadily in the last two years.

3.3 There are three Trusts across Sussex providing maternity services across eight locations; more information on all of these can be found in **Appendix One.**

3.4 The Eastbourne Unit has been temporarily closed, and plans developed to accommodate patients at BSUH instead. This is closely monitored to ensure that there is adequate provision.

4. COMMUNITY ENGAGEMENT & CONSULTATION

4.1 There is a user – led Maternity Service Liaison Committee (MSLC) funded by the CCG. It works closely with local parents, maternity staff and commissioners to ensure that

there is continuous feedback and dialogue about maternity services. There are also a number of mechanisms to collect patient feedback.

4.2 Maternity is an area where user feedback and engagement works really well and provides a rich source of intelligence that is constantly fed in to the system, providing dialogue.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this cover report.

Legal Implications:

5.2 None to this cover report.

Equalities Implications:

5.3 None to this cover report.

Sustainability Implications:

5.4 None to this cover report.

SUPPORTING DOCUMENTATION

Appendices:

1. Maternity Services in Brighton and Hove, CCG report

2.

Maternity Services in Brighton and Hove

1. Purpose of this Paper

This paper highlights a range of issues identified as of interest to the HWOSC and is intended to provide assurances on the following areas, in particular:

- Home births
- C –sections
- Implications of activity transferring due to the temporary closure at Eastbourne
- Patient and user engagement

2. Introduction to Brighton and Hove Maternity Services

In 2012/13 there were a total of 3,366 deliveries in Brighton and Hove. The number of births per year in the city is projected to be relatively stable over the next decade at 3,300 births.[1] This compares with a projected increase of 3% in England but a projected fall in the South East of 3%.[2]

Maternity Services in Brighton and Hove are provided by Brighton and Sussex University Hospitals Trust (BSUH). There is an Obstetric Led Unit (OLU) at the Royal Sussex County Hospital site (RSCH). There are plans for a Midwife Led Unit (MLU) or Birth Centre to be co-located with the OLU but this is not likely to be available until 2015. Women can also choose to have a Home Birth and locally these currently account for about 5% of births.

3. Performance and Activity Highlights at Brighton RSCH Site

Table 1 – Data from BSUH Maternity Dashboard Averages April – Sept 2013

Area	Description	Local Performance	National Standard / Target
Workforce	Midwife / Birth ratio	1:32	1:30
	1:1 Midwife care in labour	98%	100%
	Consultant presence	60 hrs	60 hrs
Deliveries	Home Births	5.2%	2.3%*
	C – Section Emergency	14.6%	13%
	C – Section Elective	12.8%	10%
	C- Section Total	27.3%	23%
Public Health	Breast Feeding Initiation	87%	85%
	Smoking at Birth as a % of births	6.5%	12.7%*

* Current available averages for England

BSUH complete a monthly Dashboard that provides a comprehensive range of indicators on Maternity Care. The above is a sub set of these for the first half of 2013/14. Please note that averages are presented and that this can hide a significant month by month variation particularly in c –sections.

[1] ONS registered birth figures for 2010 & projections for 2020
[2] ONS sub national population projections (2010 based) http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Sub-national+Population+Projections

Performance has improved steadily in the last 2 years against the Key Performance Indicators highlighted above. A recent extra investment in Midwifery posts by BSUH has seen an improvement in the Midwife: birth ratio, bringing it down from the previous level of 1:34 to 1:30 in the last 3 months. It will also impact on the homebirth rate as a 24/7 Home Birth Service has been implemented. The proportion of home births has consistently been higher than the national average but has seen a gradual decline from it's highest at 9% (2010) to 3.3% (2012). The new model of care introduced in May 2013 has already seen an increase and its' peak month so far was up to 6%.

In addition, capital investment to improve the environment has just been completed to provide en suite facilities in the Labour ward.

4. Caesarean section rates (C- Sections)

C sections births are the most complex type of delivery and represent the largest drain on resource, both financial and personnel.

C-section rates in England have increased considerably in the past two decades. In 1989, the caesarean section rate in England was 5% by 2004/5 it was 22.7% (RCOG 2001; NS 2006).

Individual Maternity Units' C-section rates vary enormously across England. In 2007, the average rate in England was around 24% but the range was between 14 – 33%. Respected studies have found that just over one third of all of this variation can be explained by case mix differences of mother's age, ethnicity, number of previous caesarean sections and vaginal deliveries, gestation, mode of onset of labour, presentation and birth weight. It is not clear whether the rise is due to changes in practice, demography or patient choice.

Brighton and Hove has had a higher than average c- section rate for a number of years, peaking at 32% a number of years ago, it has very gradually reduced to its' current average of 27% (compared to the England average of 25%).

The Normalising Birth Programme was launched across the South East Coast in 2010 with an aim to reduce the c -section rate to 23%. The methodology was to encourage multi professional, collaborative working and optimise the opportunities to increase the normal birth rate, through identifying, adopting and promoting best practice. The focus was on Women in their first pregnancy and labour and Women who have had a previous C-section. These two groups contribute the largest proportion of patients to overall c -section rates.

The CCG have identified as a priority in 2014 to undertake an audit of the c- section rates at RSCH, working with clinicians and parent representatives from the MSLC to understand in further detail the choices women are making for elective c- sections.

5. Public and Patient Engagement and Feedback

There is a very dynamic user – led Maternity Service Liaison Committee (MSLC) funded by the CCG. It works closely with local parents, maternity staff and commissioners to ensure that there is continuous feedback and dialogue about maternity services. A work plan is agreed and monitored at bi monthly meetings with around 20 members, where a crèche is provided. However, much of the work of the MSLC continues outside of the official meetings:

- parents' feedback is collected through the 'Walk the Patch' programme on the postnatal ward, antenatal clinics and in the community;
- via the website: www.brightonandhovemslc.com;

- and via parent representatives meetings.

The MSLC Chair passes feedback immediately onto service providers / commissioners and meets regularly with the head midwifes and obstetricians.

BSUH also collate patient feedback through *Patient Voice* which is a questionnaire handed to women on the post natal ward. Birth stories, is a service offered by specially trained Midwives to meet with women who want to discuss their birthing experience. The Friends and Family Test is about to be introduced throughout the maternity pathway.

Maternity is an area where user feedback and engagement works really well and provides a rich source of intelligence that is constantly fed in to the system, providing a 2-way dialogue.

A recent exercise across Sussex collating all of the forms of user feedback illustrated seven common themes: *continuity of midwife; relationships with midwives; concerns about postnatal care; poor practice in sharing information; consistency of information; concerns about privacy; Choice.*

In addition to these broad themes user engagement continues to highlight specific concerns, ranging from poor quality food and issues with cleanliness.

6. The Sussex Context

There are three Trusts across Sussex providing maternity services across 8 locations:

Table 2: Trusts and Sites across Sussex

Trust Maternity Site	Deliveries 2011/12
West Sussex Health Trust	
• St. Richards	*2771*
• Worthing	*2851*
Brighton &Sussex University Hospitals Trust	
• Princess Royal	*2422*
• RSCH	*3587*
East Sussex Hospitals Trust	
• Eastbourne	*1949*
• Conquest	*1804*
• Crowborough	Data not available

Sussex wide work to consider the long term sustainability of obstetric units in the light of Royal College standards with regards to consultant presence and midwife ratios was initiated by NHS Sussex in 2012. Clinical leads across Sussex have recently agreed the following consensus statement:

There is a threshold of 2500 births per year, below which the sustainability of the service should be scrutinised more closely due to the additional challenges of maintaining safety and quality. The most efficient size unit is in the region of 4000 to 5000 births per year.

7. Temporary Closure of the Eastbourne Unit

East Sussex Healthcare NHS Trust (ESHT) confirmed that following a visit by the NHS Clinical Advisory Team a number of co- dependent services in women and children's health would be reconfigured in May 2013. For Maternity this meant the

removal of Obstetric-led care in labour from Eastbourne District General Hospital (EDGH) and the institution of a midwife-led birthing unit. Given the consensus statement above, there has been clinical support for this action.

BSUH and ESHT have worked very closely together to anticipate the activity flows in relation to this temporary closure and develop robust plans to ensure women are safely transferred and supported during this change. BSUH have based their plans on the upper end of the anticipated activity range to ensure the activity can be accommodated should it materialise. This has included a phased recruitment of additional midwives and advancing design work to expand the physical capacity of both the RSCH and PRH sites.

There are high level monthly conversations across the local health economies in East Sussex and Brighton and Hove to discuss any new issues that arise and anticipate any further mitigating actions that may be required. Monthly data reports allow us to monitor actual activity against anticipated. To date, whilst the number of births are not as high as anticipated (April – August 50 extra compared to the same period in 2012) the number of women booking with BSUH at 12 weeks is steadily increasing. Close monitoring will continue to ensure that women are cared for safely and capacity is in place to manage this. Choice is such an important issue in maternity that close monitoring will be crucial to ensuring responsiveness.

Brighton and Hove CCG will also continue to monitor all maternity key performance indicators for our local population and work with our MSLC to ensure that local women continue to have a positive and safe experience of maternity services.

Kathy Felton 23/10/2013

Subject:		**PLACE Assessment Results**
Date of Meeting:		**5 November 2013**
Report of:		**Monitoring Officer**
Contact Officer:	**Name:**	**Kath Vlcek** **Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 All NHS Hospital Trusts are required to carry out an annual audit of their hospital environments called PLACE (Patient Led Assessments of the Care Environment).

1.2 The assessments took place between April and July 2013; members of HWOSC were invited to take part. The report provides detail of BSUH's results across the Trust and how they compare with the national average.

2. RECOMMENDATIONS:

2.1 That HWOSC members note and comment on the results.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 All NHS Hospital Trusts are required to carry out an annual audit of their hospital environments called PLACE (Patient Led Assessments of the Care Environment). The PLACE assessment falls into four broad categories:

- How clean the hospital environment is;
- Buildings and facilities - inside and outside of the building, fixtures and fittings, signage and car parking;
- Food and Hydration, the quality and availability of food and drinks; (the meal service to patients is observed and the assessors have an opportunity to taste the food);
- Privacy and Dignity, how well the environment supports this;

3.2 PLACE is not a patient survey. PLACE assessors are required, as a team, to reach joint decisions based on what they see on the day of the assessment. In certain circumstances (for example ascertaining whether an individual received the meal they ordered) then they can speak to the patients. Assessors gather information on their findings following a clearly defined checklist.

3.3 The results of the assessments are shared with the Care Quality Commission, who will use the information in their monitoring of provider compliance with the essential standards of quality and safety, and to inform inspection of relevant standards.

3.4 The patient assessors who conducted this year's assessments will be invited back towards the end of November 2013 to re-visit the areas that they assessed to see if they consider that improvements have been made.

4. COMMUNITY ENGAGEMENT & CONSULTATION

4.1 Assessments are undertaken by patient assessors. The term patient assessor covers all people whose experience of the hospital is as a user rather than a provider. It encompasses relatives, carers, friends, patient advocates, and volunteers. The local Healthwatch and HOSC members were also invited to participate; some members were able to take part.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this cover report.

Legal Implications:

5.2 None to this cover report.

Equalities Implications:

5.3 None to this cover report.

Sustainability Implications:

5.4 None to this cover report.

Any Other Significant Implications:

5.5 None to this cover report.

SUPPORTING DOCUMENTATION

Appendices:

1. PLACE Summary 2013; BSUH

Brighton and Sussex NHS
University Hospitals
NHS Trust

PLACE 2013.

Introduction

All NHS Hospital Trusts are required to carry out an annual audit of their hospital environments called PLACE (Patient Led Assessments of the Care Environment). PLACE has superseded the previous hospital environment audit called PEAT (Patient Environment Action Team).

The key change between PEAT and PLACE was to increase the number of patient assessors on the audit team so that they now make up half of the audit group. There should always be at least two patient assessors, even in smaller sub-teams, whereas previously it was generally a single patient assessor working with the Trust staff. The exact number of assessors required depends on how the Trust wants to organise the assessment – for example whether or not they want several smaller teams or one large one. Hospitals involved in the pilot assessments generally found it easier to split into smaller teams, each checking two or three wards or departments (as we did at BSUH). This also allows the use of a wider range of patient assessors, including those who might not be physically fit enough to assess a whole site.

The term patient assessor covers all people whose experience of the hospital is as a user rather than a provider. It encompasses relatives, carers, friends, patient advocates, and volunteers. The local Healthwatch and HOSC members were also invited to participate although some of the dates of the audits that BSUH were given did not coincide with the availability of some members. The PLACE audit teams at BSUH are divided equally according to the size of the hospital/unit being audited.

The Assessment

The PLACE assessment falls into four broad categories:

How clean the hospital environment is;
Buildings and facilities - inside and outside of the building, fixtures and fittings, signage and car parking;
Food and Hydration, the quality and availability of food and drinks; (the meal service to patients is observed and the assessors have an opportunity to taste the food);
Privacy and Dignity, how well the environment supports this;

Final decisions on which wards or areas of the hospital are to be assessed are not made until the day of the assessment. They are a joint decision by the assessment team, although the hospital staff have an important role to play in ensuring that the wards or areas chosen are reflective of the range of services and, where appropriate, the buildings and wings that make up the hospital.
In each year, different areas should be selected (with the exception of A&E) so that over a period all areas of the hospital are assessed.

Scoring

PLACE is not a patient survey. PLACE assessors are required, as a team, to reach joint decisions based on what they see on the day of the assessment. In certain circumstances (for example

ascertaining whether an individual received the meal they ordered) then they can speak to the patients. Assessors gather information on their findings following a clearly defined checklist.

To achieve a pass, all aspects of all items must meet the definition/guidance as set out in the assessment form. There is no margin whereby an item can fail to meet the required standard and still pass.

The scores should be agreed by each team as the team walk round each area. Final scores should be agreed at the conclusion of the assessment of that ward/department before moving on to the next. Once the whole of the site has been audited, all of the patient assessors (Trust staff are not included) meet to complete a final summary sheet which should accurately reflect the hospital as a whole.

The results of the assessments are shared with the Care Quality Commission, who will use the information in their monitoring of provider compliance with the essential standards of quality and safety, and to inform inspection of relevant standards. Other organisations such as the NHS Commissioning Board and the National Institute for Health and Clinical Excellence may also use the data in support of their own objectives. The results also enable us as a Trust to identify what we are doing right and improve on things that we are not.

The Assessments

PLACE assessments took place between April and July 2013. The results for BSUH and how they compare with the national average is set out in the following table.

BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST

Hospital	Cleanliness	Food/Hydration	Privacy/Dignity	Cond/Appearance
Hurstwood Park	99.82%	87.82%	80.63%	94.31%
Royal Alexandra Childrens Hospital	95.52%	87.27%	97.25%	92.51%
Princess Royal Hospital	99.41%	87.93%	91.03%	94.86%
Sussex Eye Hospital	97.80%	89.09%	80.12%	83.94%
Royal Sussex County Hospital	97.00%	83.52%	86.78%	80.81%
Sussex Orthopaedic Centre	100%	89.62%	86.84%	92.17%
National Average	***95.74%***	***84.98%***	***88.87%***	***88.75%***

BSUH scores were mostly better than average in cleanliness and food/hydration, but in several of the Trust's older buildings which are earmarked for refurbishment or redevelopment the

privacy/dignity and condition/appearance scores were lower than average. The detailed PLACE reports for the areas audited have been shared with the Clinical teams, Infection Control, Estates and the Trust's external soft FM services provider (Sodexo). The reports have been used to identify and rectify specific issues in patient catering, cleaning and the environment. Some long standing environmental issues which are impacting on the privacy and dignity scores in particular in the Barry Building and Sussex Eye Hospital at RSCH and at Hurstwood Park are such things as spacing between beds, large enough reception areas in departments, sufficient space at reception desks so that conversations cannot be overheard, and also patients leaving consulting rooms without having to return through the general waiting area. This is all dependent on Trust's 3Ts redevelopment programme to achieve a permanent solution.

Our Estates team continues to maintain the buildings within the Trust. The Estates and Facilities department along with our Infection Control and Risk Management teams have recently undertaken an audit on problematic floor areas and have risk rated them, prioritising the work to be carried out.

Food and Hydration were rated slightly below average at the Royal Sussex County Hospital. Meetings have already taken place with the dietetic team to review menus and service standards of meals to our patients. Patient satisfaction surveys in relation to food are also undertaken with the patients on a weekly basis to gain feedback.

The Trust liaises daily with Sodexo (the service provider), and holds weekly operational meetings to discuss any concerns and how they will be resolved. The Trust in conjunction with Sodexo undertakes mini PLACE audits in each area regularly to identify any non conformities which can be rectified as soon as possible.

The patient assessors who conducted this year's assessments will be invited back towards the end of November 2013 to re-visit the areas that they assessed to see if they consider that improvements have been made.

PLACE 2014

Healthwatch and HOSC assessors will also be invited to attend an initial planning meeting with the Trust early next year (date to be confirmed) to commence planning the 2014 PLACE audits. The Trust's PLACE lead is Karon Goodman, Facilities Compliance Manager.

Author: Karon Goodman, Facilities Compliance Manager
October 2013