HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 64 Brighton & Hove City Council

Subject:		**A&E and Capacity Pressures at the Royal Sussex County Hospital**	
Date of Meeting:		**23 April 2013**	
Report of:		**Head of Law (Monitoring Officer)**	
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Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The Royal Sussex County Hospital (RSCH) has for some time been experiencing severe and prolonged pressure on the capacity of its Emergency Department and overall unscheduled care services. This pressure has led to breaches in the four-hour A&E wait targets. In February this year the situation became more acute so the trust declared an 'Internal Major Incident' in order to best focus its resources. The Department of Health Emergency Care Intensive Support Team (ECIST) has also been asked to visit RSCH and to produce an independent report on A&E services. Copies of this report have been circulated electronically to HWOSC members for reference.

1.2 The issue of A&E capacity at RSCH (and of its twin hospital, the Princess Royal in Hayward's Heath) has been of concern to local Health Overview & Scrutiny Committees (HOSCs), which have a statutory duty to monitor local NHS-funded health services to ensure that they are fit for purpose. In consequence, the Chairs of the three Sussex HOSCs recently wrote a letter to the interim Chief Executive of Brighton & Sussex University Hospitals Trust (BSUH) seeking assurances that patient safety and service quality had not been compromised. (This letter and the BSUH interim Chief Executive's response are included as **Appendix 1** to this report.)

1.3 Separately, the Chair of the Brighton & Hove HWOSC contacted Brighton & Hove Clinical Commissioning Group (CCG) to better understand the CCG's perspective on the situation. The CCG commissions emergency (A&E) care from BSUH on behalf of city residents. (A letter from the CCG's Clinical Accountable Officer, Dr Christa Beesley, is included as **Appendix 2** to this report.)

1.4 Whilst the correspondence included in the appendices to this report provides some assurances around the safety and quality of services at the RSCH,it was thought important that HWOSC members should have the opportunity to hear a statement on the current state of affairs at the RSCH from the new BSUH Chief Executive, Mr Matthew Kershaw, and also to question directly Mr Kershaw and his officers, the CCG, and other bodies with a significant interest in RSCH

unscheduled care services - e.g. the city council's Adult Social Care department (ASC) and Sussex NHS Community Trust (SCT). ASC and SCT have an important role to play in managing transfers of care from acute hospital care into community settings.

2. RECOMMENDATIONS:

2.1 That HWOSC members consider and comment on the information included in this report and its appendices, and on any additional information presented verbally at the HWOSC committee meeting;

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Hospitals across England are currently experiencing unprecedented demands upon their A&E services, with many A&E departments experiencing similar pressures to the RSCH. However, the fact that this is a widely experienced problem does nothing to lessen its gravity. It is clearly important that the Local Health Economy works together to understand and better manage the underlying factors which are responsible for the capacity pressures on RSCH A&E.

3.2 There are a number of possible reasons for the capacity problems currently being faced by A&E units. These include:

- Changing demographics – as the population becomes older it is anticipated that there will be more pressure on a range of NHS services, potentially including A&E. In general, the older the person, the poorer their health can be expected to be, and therefore the greater the likelihood that they may need to use A&E services (and that they will present with a complicated condition requiring admission to hospital). In addition, older people tend, on average, to be less likely to be suitable for early discharge from hospital, and more likely to require a community care package on discharge, potentially increasing average lengths of bed stay and the risk of delays in transfers to community settings. Since the ability of an A&E department to admit patients to hospital beds depends on the availability of these beds elsewhere in the hospital, the length of time patients spend in hospital is a critical factor in A&E performance – even in terms of patients who were not admitted via A&E. Therefore, as the population ages, the number of people presenting at A&E and the actuity of their conditions may also increase. Although Brighton & Hove is not experiencing the same pressures as many areas in terms of an ageing population, we are seeing a significant increase in very old and frail people – the group most likely to require hospital services.

- Problems accessing GP services – people unable to book a timely appointment with their GP are more likely to present for treatment at A&E – but A&E is intended as a last rather than a first resort. Therefore areas where people struggle to access regular GP services may see particular spikes in A&E attendance.

- Problems accessing GP Out Of Hours (OOH) services – people who receive a poor service from, or do not understand how to access, OOH services are more likely to present for treatment at A&E. Again, A&E is not intended to be an alternative to OOH, but an escalation should OOH be unable to cope. (Similarly, NHS advice services such as NHS Direct/111 are intended to divert non-emergencies from A&E, but will only do so if they work properly and if people use them as intended.)

- Unregistered patients – people who have not registered with a GP (or who are registered with a GP practice in another part of the country) are more likely to present directly at A&E for treatment, since they may feel that they have no obvious alternative recourse (although there is in fact a walk-in GP surgery at near Brighton station that accepts unregistered patients). The groups of people most likely to fall into this category include students, recent immigrants, tourists, and people living chaotic lives who cannot cope with the challenge of registering with a GP (e.g. homeless people etc). Once again, the intended pathway to services is via a GP, not attending A&E directly except in cases of genuine emergency.

- Delayed transfers of care – many patients discharged from hospital are able to return home and live independently immediately, but for some people, particularly the frail and elderly, this is not possible. For these people, timely and effective discharge will depend on the availability of medical and/or social care at home, or of intermediate/short term community beds, or of a place in a residential care or nursing home. Delays in the transfer of patients from acute to community settings are a long term problem for many areas, and effective management of this area typically involves several agencies working together productively. In Brighton & Hove this includes BSUH, ASC, the CCG, SCT and a number of other community care providers. Where there are delays in the system, it may be due to community care providers/commissioners not putting community care in place in a timely manner; but it may also be due to the acute provider for not alerting the community care system at an early enough stage that an in-patient is likely to need an assessment for/the provision of community care.

- Delayed transfers from tertiary care – the RSCH is increasingly taking on tertiary (specialist) hospital activity for patients who live outside the BSUH catchment area of Brighton & Hove and Mid Sussex. Transferring these patients into local (to them) community services may be more complicated than transferring local patients, because there is unlikely to be the same level of understanding between hospital and community services as exists locally.

- A&E attendances due to behaviour – people may end up having accidents due to their own risky behaviour, particularly in terms of behaviour related to heavy drinking. Clearly this is likely to be an issue in Brighton & Hove given the orientation of our economy. Management of risk in this instance is a multi-partner affair, involving the police, health services, community safety, public health, licensing etc.

- A general inclination to use A&E as a first recourse – this is not wholly understood, but it does appear that a greater proportion of the population, even those who are registered with and able to access GP services, have been using A&E as a first recourse in recent years.

- Inefficient practices within unscheduled care within a hospital – this could include poor triage of people presenting for treatment at A&E, issues for patients admitted to an inpatient bed whose care does not then progress as quickly as possible. This could be due to a number of factors including how consultant input is provided but might also include delays in getting prescriptions to patients ready for discharge, meaning that a patient who could have been discharged in the morning is still tying-up a bed in the afternoon when the hospital is able to deal with them (this specific issue was flagged up by the BHLINk in its recent report on prescribing problems). In short, anything that complicates or delays the timely processing of patients through the hospital system may impact on A&E capacity.

3.3 The above represent some of the main reasons why hospital A&E services may be experiencing increased pressures. These are essentially generic issues, and some may not be locally relevant. However, members may be interested in ascertaining whether they do apply locally, and if so, what steps are being taken to counter them.

3.4 Issues around A&E capacity are clearly very complex. It is unlikely that problems with capacity at an A&E unit will be solely due to inefficiencies at that unit – indeed it is entirely possible that an A&E could be very efficient yet still experience severe capacity problems. Any 'solution' to A&E capacity problems clearly involves the whole of the local health economy, including the acute provider (in terms of the entirety of hospital services not just the A&E department), the commissioners of emergency care (CCG), the commissioners of local GP services and of very specialist hospital care (The NHS Commissioning Board Area Team), the provision of primary care (the GPs) community care commissioners and providers, local ambulance services, and potentially other partners such as the police, community safety and licensing.

3.5 It is unlikely that HWOSC can add much in the way of value to this professionally driven process, but HOSCs do need to be assured that the professional leaders of the local health economy are taking issues of A&E capacity seriously and have agreed a multi-partner approach to dealing with problems. If HWOSC members are assured that this is the case locally, they may choose to take no further action at this stage, other than perhaps of requesting update report(s) on the situation. However, if members are not satisfied with the approach being taken they may wish to consider involving other agencies – e.g. writing to the Care Quality Commission expressing their concerns.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 None at this point

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 None directly – there is no decision here which has financial implications for the city council.

Legal Implications:

5.2 None to this report for information

Equalities Implications:

5.3 None directly

Sustainability Implications:

5.4 None directly

Crime & Disorder Implications:

5.5 None directly

Risk and Opportunity Management Implications:

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5.6 Members may wish to enquire as to how BSUH (and potentially the CCG, ASC etc) is quantifying risk in relation to A&E pressures and what its mitigatory approach to this risk entails.

Public Health Implications:

5.7 Timely access to A&E services is a key part of healthcare.

Corporate / Citywide Implications:

5.8 None directly

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 This report is for information

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 This report is for information

SUPPORTING DOCUMENTATION

Appendices:

1. Letter from Sussex HOSC Chairs to Chris Adcock, interim CE of BSUH, and response from Mr Adcock

2. Letter from Dr Christa Beesley to Cllr Sven Rufus

Documents in Members' Rooms

None

Background Documents

None