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

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