Brighton & Hove City Council

Health & Wellbeing Overview & Scrutiny Committee

Title:	**Health & Wellbeing Overview & Scrutiny Committee**
Date:	**10 September 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, Youth Council and Healthwatch
Contact:	**Kath Vlcek** kath.vlcek@brighton-hove.gov.uk 01273 290450

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88. 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

89. Minutes of Previous Meeting **3 - 12**

90. Chair's Communications

91. A&E Service Improvements- Six Month Update **13 - 30**

Report with updates from Brighton and Sussex University Hospitals Trust and from the Clinical Commissioning Group

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

Ward Affected: *All Wards*

92. B&H Wellbeing Services (Mental Health) **31 - 36**

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

93. Healthwatch Introduction **37 - 48**

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

Ward Affected: *All Wards*

94. Integrated Primary Care Teams **49 - 58**

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

Ward Affected: *All Wards*

95. Update from Councillor Marsh about the PPG's Urgent Care work

Verbal update

96. Letter from CCG about diabetic provision consultation notification **59 - 60**

For noting.

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For further details and general enquiries about this meeting contact 290450 or email scrutiny@brighton-hove.gov.uk

Date of Publication 3 September 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 23 JULY 2013

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Rufus (Chair)

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

Other Members present: Co-optees Jack Hazelgrove (OPC), David Watkins (Healthwatch); Cierney Eddie (Youth Council)

PART ONE

79. PROCEDURAL BUSINESS

79.1 Councillor Alex Phillips was subbing for Councillor Ollie Sykes.

Apologies had been received from co-optees Amanda Mortenson, Marie Ryan and Susan Thompson.

Declarations of Interest - Councillor Cox's wife works for Sussex Community Trust (Agenda item 87)

Declaration of Party Whip – there was none

Exclusion of press and public was as per the agenda.

80. MINUTES OF PREVIOUS MEETING

80.1 Minutes of previous meeting- there was a spelling mistake in 63.1 ('in adequate' rather than 'inadequate').

80.2 Councillor Marsh asked whether members could be involved in the consultation on urgent care; the Chair agreed to look into this further and report back.

81. CHAIR'S COMMUNICATIONS

81.1 The Chair said that he would like to try and theme forthcoming HWOSC meetings around health inequalities as far as possible; this was a key priority for Public Health and the council as a whole. He had held meetings with Tom Scanlon, Director of Public Health, and .Denise D'Souza, Executive Director, Adult Services, to talk about possible work areas for 2013/14

81.2 The Youth Council had some work planning suggestions; the co-opted member would forward these once they had been discussed with the wider Youth Council

81.3 The Chair had attended the regional HOSC Chairs meeting and been to the 111 call centre in Dorking. He was pleased to feed back that, despite a shaky start, he had found the call centre to be responsive and hitting targets much more effectively.

81.4 Some members of HWOSC and other councillors had attended the GP Performance Training, thanks to those who had attended the event. In terms of next steps, the CCG will look again at their commissioning strategy, and HWOSC could feed into that.

Other members who went to the workshop also commented:

- it was clear that there was a lot of work still to be done on appropriate and agreed measurement tools (for instance, the Quality Outcome Framework or other methods)

- the same information had previously come to HOSC in a public meeting; why had this been kept private? The Chair said that this had allowed for a much more in-depth two hour discussion of the subject area, which would not have been possible if it had been a public meeting

- there was a lot of interesting data, although some it had perhaps been pitched at a non lay-person level

81.6 Councillor Marsh gave a brief update on the alcohol scrutiny panel. She and Councillor Deane had attended the Alcohol Programme Board and had been invited to take part in a domain group discussion looking at the night time economy. All three panel members were keen that their work would not duplicate existing workstreams but add value. All three members also sat on the Licensing committee, so it was possible that this was a potential way to add value to the process.

Public Involvement

81.7 Mr Rixson (see previous meeting minutes) returned to raise a question about Healthwatch. He remained concerned that despite Healthwatch being in operation for approximately four months to date, there was still a complete lack of public engagement. Had the HWOSC Chair received a reply from Healthwatch to Mr Rixson's earlier question on the same matter?

The Chair said that he would follow up the response, and reminded Mr Rixson and HWOSC members that Healthwatch was an agenda item for the September HWOSC.

81.8 In terms of public involvement, Mr Watkins spoke on behalf of Healthwatch advising that a response about Healthwatch had been sent to all councillors following the last HWOSC meeting.

With regard to Mr Rixson's specific point, the Healthwatch transition group was due to cease operation at the end of July 2013. A shadow Healthwatch would be formed in September 2013, which would operate until May 2014. At this time, Healthwatch would become a stand alone body, and the CVSF would no longer have involvement, unless Healthwatch specifically asked them to.

81.9 Mr Rixson replied that he had asked to attend a transition group meeting or read the minutes; both requests had been refused. Why was this the case?

Mr Watkins confirmed that they were private meetings and that the transition group was not making policy but merely keeping things ticking over.

82. COUNCILLOR ANDREW WEALLS - VERBAL UPDATE ON HOSPITAL MORTALITY MEETING

82.1 Councillor Wealls reported back on a meeting that he had had with the Patient Safety Team at BSUH following concerning reports about weekend rises in mortality rates.

82.2 Councillor Wealls said that he had been satisfied that there was no statistically significant uptake in mortality at weekends. This remained the same for non-elective admissions, which had been a particular worry.

82.3 Councillor Wealls thanked the Patient Safety Team at the hospital for their assistance.

83. ANNUAL PUBLIC HEALTH REPORT

83.1 Tom Scanlon, Director of Public Health, presented the eighth joint NHS/BHCC annual Public Health report to HWOSC. This year's report centred on happiness.

Members heard that there were close links between happiness and health. A number of citywide policies including One Planet Living and the CCG's approach explicitly addressed happiness.

83.2 Dr Scanlon said that there were already a number of positive stories when looking at public health and happiness; older people were staying healthier for longer, there had been a dramatic drop in drug deaths in the city, young people were drinking and smoking less than in previous years.

83.3 However there were still significant areas of public health that needed to be addressed, including a high level (38%) of people at risk of poor mental health and self harm rates were rising.

There has been a change in the type of drug use in the city, moving toward club drugs rather than more established drugs. People who use club drugs tend to see themselves

as different from users of other drugs such as heroin, so they do not use traditional drug clinics. Therefore a new drug clinic for club drugs is opening in Brighton & Hove.

Dr Scanlon said that work was underway to try and connect drug and alcohol services with sexual health services. There seems to be a lot of connection between the people who use these services, as drug and alcohol use were risk factors for unsafe sexual activity, but the adult services have not been linked up before - this is now taking place.

83.4 Health inequalities are the toughest challenge – HWOSC members heard that there are large health inequalities regarding those at risk of depression, smokers and those with limiting long-term illness, obesity is increasingly associated with deprivation and high risk drinking is now as likely among the affluent.

83.5 Members warmly welcomed the Public Health report and Dr Scanlon's presentation, and asked questions and comments.

83.6 Members asked how Public Health's role had been altered by moving back to becoming part of the council.

Dr Scanlon said that it gave Public Health a much stronger opportunity to tackle health inequalities by strengthening the connection between Public Health and other departments such as Housing, Transport, Education, Benefits and Environmental Services. The connection had existed before but the Public Health team now has greater visibility and a greater scope. Dr Scanlon has already met all of the head teachers in Brighton and Hove to talk to them about a public health programme for schools, looking not just at health but at wider factors including arts and culture.

83.7 Members said that there had been recent media coverage about the change in the drinking habits of women born in or after the 1970s. How was this playing out in Brighton & Hove?

Dr Scanlon said that the distinction between men and women's drinking appears to have been lost. In the past women had tended to drink less than men but this appeared to no longer be the case; women seem now tended to drink at the same level as men now. The health impacts of this can be seen in the higher levels of alcohol related diseases in middle aged women that are now emerging.

83.8 Members said that there was confusion in statistics on young people's happiness. The Public Health report said that most young people are happy but a recent report in the media said that more young people are unhappy. How could this be the case?

Dr Scanlon said that the statistics that were in the Public Health report did show that the vast majority of young people were happy; however there was no trend data so he couldn't say whether this had changed over time or in which direction.

83.9 Members commented that they were glad to see that the serious effects of depression and unhappiness were being recognized.

83.10 Members queried whether the drug death figures included deaths from legal drugs such as paracetamol?

Dr Scanlon said that there were two systems of recording drug related deaths – the ONS system and the St George's np-SAD system which was more influenced by individual coroner's classification of the death. It was unlikely that any of the twenty (np-SAD) reported drug deaths were paracetamol deaths but rather related to illegal drug use.

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83.11 Members concluded by thanking Dr Scanlon for the presentation and report, and agreeing the recommendation to note the report.

84. JOINT HEALTH & WELLBEING STRATEGY

84.1 Giles Rossington, Health and Wellbeing Board Business Manager, presented a report on how the Health and Wellbeing Board (HWB) priorities were set, what the priorities were and how the strategy had been agreed. He then answered members' questions.

84.2 Members asked whether the Public Health annual report on happiness fed into the HWB strategy.

Mr Rossington said that the HWB priorities were based on the same evidence that had been presented in the Public Health annual report so there were very close links between the work areas. In addition, Dr Scanlon and Denise D'Souza also sat on the HWB so they could ensure that the priorities were shared.

84.3 Members asked how reactive the HWB would be to new priorities that might emerge over the next few years.

Mr Rossington said that the HWB was a very high level strategy but that each of the five priorities had more detailed work plans attached to them. It is likely that the objectives would stay the same but that the action plan could be amended where needed.

84.4 Members said that there were other priorities for the city that were not reflected in the HWB, for example alcohol – where was this work being covered?

Mr Rossington said that the HWB had actively chosen not to prioritise work that was being covered by partnerships elsewhere. In the case of alcohol, the Alcohol Programme Board had been set up following the intelligent commissioning pilot. It was hard to see what added value the HWB would be able to add to this existing partnership work.

84.5 Members thanked Mr Rossington for his update, commenting that they looked forward to hearing more about the work of the HWB in due course.

85. DUAL DIAGNOSIS

85.1 Linda Harrington, Commissioning Manager, NHS Brighton & Hove City, and Kathy Caley, Lead Commissioner for Alcohol & Substance Misuse, presented a joint report and update on the dual diagnosis work.

85.2 Ms Harrington said that the work was in the context of the Overview and Scrutiny panel report in 2009 that looked at services for people with a dual diagnosis. The scrutiny

panel recommended a joint strategic needs assessment was carried out; this was completed in 2012. Other updates included introducing a universal screening tool, new accommodation services and greater service integration.

85.3 Ms Caley said that the alcohol and substance misuse services were currently in the process of being retendered; at present they were consulting with service users to see what they would want to see in the service.

85.4 Ms Harrington and Ms Caley then answered members' comments and questions.

85.5 Mr Watkins said that he had been on the scrutiny panel that had looked at dual diagnosis in 2009. It had been a very harrowing process and they had heard from service users who had had a terrible experience. Mr Watkins found it unbelievable that four years on from the panel, the recommendations had still not been carried out. It was very sad that those people who needed specialist services were still not able to access them. He anticipated that Healthwatch would want to look at dual diagnosis when it was operating.

Ms Caley said that she fully appreciated Mr Watkins' comments but it was the case that a range of work had already been carried out. Sussex Partnership Trust had taken the dual diagnosis workstream forward, dual diagnosis champions were now in place and training was in place for more generic staff. However it was true that there was still a lot of work that needed to be completed.

Ms Harrington added that this was the second update on dual diagnosis, so they had not included all of the updates that had happened since 2009. Another positive change was an increase in bed spaces at the West Pier Project. However there was a recognition that services still needed to be more integrated.

85.6 Members asked for more information about the new accommodation provision. They heard that there were different levels of accommodation support, with a specific focus on dual diagnosis at every level.

85.7 Members thanked Ms Harrington and Ms Caley for their presentation and looked forward to being kept informed of developments in service provision.

86. INTEGRATED FAMILIES: UPDATE

86.1 Mr Barton presented an update to HWOSC members on the Stronger Families, Stronger Communities (SFSC) work that was taking place. He gave a summary of the SFSC work, explaining the priorities that the project worked with. Mr Barton said that the team was now fully staffed. It was also working closely with the community and voluntary sector, commissioning the CRi project to work with 45 families.

SFSC was working with 232 families at present (although there had been an anticipated 292 families). They had closed down 19 family interventions, mainly due to the work having had a positive impact on the family.

86.2 Mr Barton said that the project was working to try and improve the links between Children's Services and Adult Social Care as these had been fractured in the past. He

and his team were learning a lot about the different thresholds in the various services which meant that they could understand the decisions better.

86.3 There were cost savings attached to every family in the project, looking at costs that are not being spent by those services not being needed, eg less police call outs.

86.4 Mr Barton then answered members' questions.

86.5 Members asked why the project had not engaged with the predicted level of families so far.

Mr Barton said that there had been a challenge in establishing an effective team and working well with the voluntary sector. They now have a very committed and energetic team of staff. It was key that the project worked appropriately with the families rather than promising easy solutions. He was confident that they would catch up on the numbers in due course.

86.6 Members asked how often family coaches saw the families that they were working with. Mr Barton said that it varied for each family, but the most intensive programme was for a worker to be with the family for nine hours per week.

86.7 Members asked whether 'managed moves' were included in the school exclusion statistics as many schools chose not to exclude pupils. Mr Barton said that the nationally set criteria could not be formally adjusted but they were able to include pupils who had treatment 'equivalent to exclusion' as determined by the head teacher.

86.8 Members queried how the projected savings could be turned into cashable savings. Mr Barton agreed that this was a very hard part of the project but that the figures were a combination of those set nationally and some set locally.

86.9 The Chair concluded that it was clear that there was a general level of support for the SFSC work and thanked Mr Barton for his frank approach to the challenges that the team faced.

87. SUSSEX COMMUNITY TRUST: FOUNDATION TRUST APPLICATION

87.1 Paula Head, Chief Executive, Sussex Community Trust and Sue Sjuve, Chair, Sussex Community Trust, attended HWOSC as part of the consultation for the Trust's (SCT) Foundation Trust (FT) application process. They appreciated the support that HWOSC had given them to date and hoped that this could be continued.

87.2 Ms Head and Ms Sjuve gave a presentation on SCT's work and explained the reasons that they wanted to be approved as a Foundation Trust and then answered members' questions.

87.3 Members said that the FT application was a long and involved process; how could SCT ensure that their other priorities were being covered as well.

Ms Head said that the FT application helped the core part of their business, it focused on the Trust's ability to deliver excellent care. It was necessary to demonstrate very high quality care in order to take the FT application further.

Ms Sjuve added that she had had numerous years' experience of working in the private sector. The level of scrutiny that SCT faced for their FT application was much higher than she had seen in the private sector, members should feel reassured that services were being closely inspected and were delivering well.

87.4 Members asked how staff governors would be elected and how having one union governor would enable fair representation.

Ms Head said that all staff automatically became members of the trust; they were able to put themselves forward to stand as a governor and other staff members would then vote for their preferred governors. With regard to Trade Unions, she expected that the unions would work together and nominate a governor collectively. They would be on the Board in order to shape the FT rather than other union matters.

Ms Sjuve gave a bit more information about how anybody could become involved in the FT. There were effectively three layers of membership and indiviuals pick which level they would prefer to be. The first level is merely to have information about SCT and have a level of awareness about their work. The second level would be to take part in focus groups etc, and the third level is for people who would like to be a governor. All HWOSC members were invited to become members.

87.5 Members asked what SCT would like from HWOSC members at this stage. Ms Sjuve said that they would like HWOSC's formal support for becoming an FT. It would also be useful to have any comments on the proposed governance arrangements; these would be taken into account as part of the consultation process.

87.6 Ms Head said that it was true that SCT had to become a FT. If this did not happen, they cannot stay as they are and they would have to merge with another FT. If the SCT's plans are approved, this will give staff and patients a much greater level of stability for the future.

87.7 The Chair said that HWOSC members would be asked for their feedback. This would be fed back to SCT as part of their consultation.

The meeting concluded at 6.30

Signed Chair

Dated this day of

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 91 Brighton & Hove City Council

Subject:		**A&E Service Improvements at the Royal Sussex County Hospital – Six Month Update**
Date of Meeting:		**10 September 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. SUMMARY AND POLICY CONTEXT:

1.1 The April and June 2013 HWOSCs heard reports and updates from Brighton &Sussex University Hospital (BSUH) NHS Trust on the various workstreams that had been organised to address the problems causing capacity pressures in A&E at Royal Sussex County Hospital.

1.2 HWOSC members asked for a six month update to come to the September committee meeting so that they could assess progress against the workstreams.

2. RECOMMENDATIONS:

2.1 That HWOSC members note progress on the different workstreams and

2.2 That HWOSC members ask for further progress updates as necessary.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Following severe and prolonged pressures on A&E services and breaches of the four hour waiting time target, BSUH invited the Department of Health's Emergency Care Intensive Support Team to assess services and produce a report. After the report was received, the Hospital Board compiled and committed to an action plan that addressed all of the issues that had been raised.

3.2 The work programme is due to last for six months, with a period of eight weeks gaining immediate improvements and then a further 18 weeks embedding the changes. It has been in place since April 2013, and is now approaching the six month point.

3.3 There are two appendices to this cover report, the first from BSUH with an update on the work programme (**Appendix 1**) and the second from the Clinical Commissioning Group, which updates on work to support improvements in the urgent care system (**Appendix 2**). The two appendices are designed to complement one another.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 None to this cover report for information.

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.

Crime & Disorder Implications:

5.5 None to this cover report.

Risk and Opportunity Management Implications:

5.6 None to this cover report.

Public Health Implications:

5.7 The emergency department and the hospital as a whole is a key public health service for the city and it is vital that it is running as effectively and efficiently as possible.

Corporate / Citywide Implications:

5.8 The emergency department and the hospital as a whole is a key service for the city and it is vital that it is running as effectively and efficiently as possible.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 None to this update report.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 To keep HWOSC members aware of the situation with regard to the Emergency Department at Royal Sussex County Hospital and allow them to query the arrangements as necessary.

SUPPORTING DOCUMENTATION

Appendices:

1. BSUH September update

2. CCG September update

Documents in Members' Rooms

1. None

Brighton and Sussex University Hospitals NHS Trust

Emergency Care Pathways - Right patient, right place, first time

Briefing paper for HWOSC

1. Purpose of the Paper

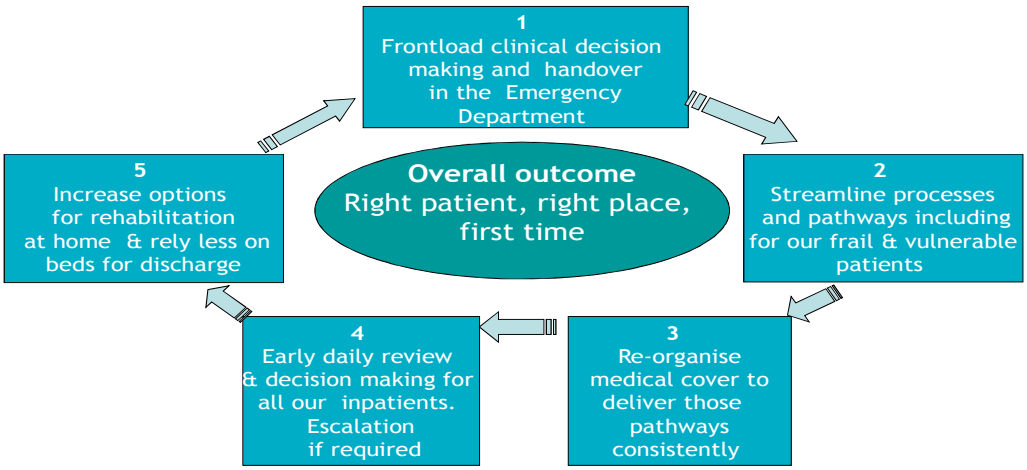
1.1. This paper provides a further update to the HWOSC regarding work currently underway on emergency care pathways. This is our third briefing paper.

1.2. Following a marked increase in the time patients were spending in our Emergency Department last winter at the Royal Sussex County Hospital (RSCH), BSUH invited the Emergency Care Intensive Support Team (ECIST) to review our emergency care pathways. Their report and our own assessment confirmed that our deterioration in performance could not be put down to one issue but we could be sending more patients home from the Emergency Department (ED) with the right support, our patients needing admission were waiting too long for a bed and our patients stayed too long in hospital.

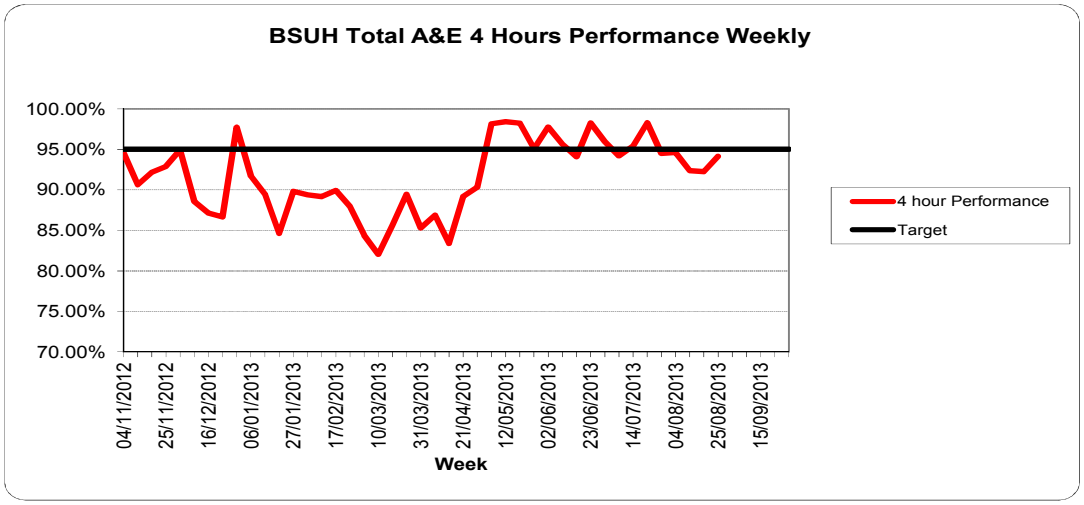
1.3. This paper updates on progress since the start of our improvement programme and work to follow within BSUH. It should be read in conjunction with the CCG/Partner update. Our work streams are designed to integrate with the wider systems work. Without this integration BSUH will be unable to deliver and sustain the safety and quality of service required.

2. Programme of work

2.1. We developed a work programme with 5 key work streams:



2.2. Overall we have seen a sustained improvement in waiting times in ED since April and Zero breaches of the 12 hour standard (no patient to wait more than 12 hours from decision to admit to admission). Performance against the 4 hour standard was achieved in May, June and July but has been more difficult to maintain in August and overall performance was at 93.3% for the month. Our focus is now to address this in September and onwards for the coming winter:

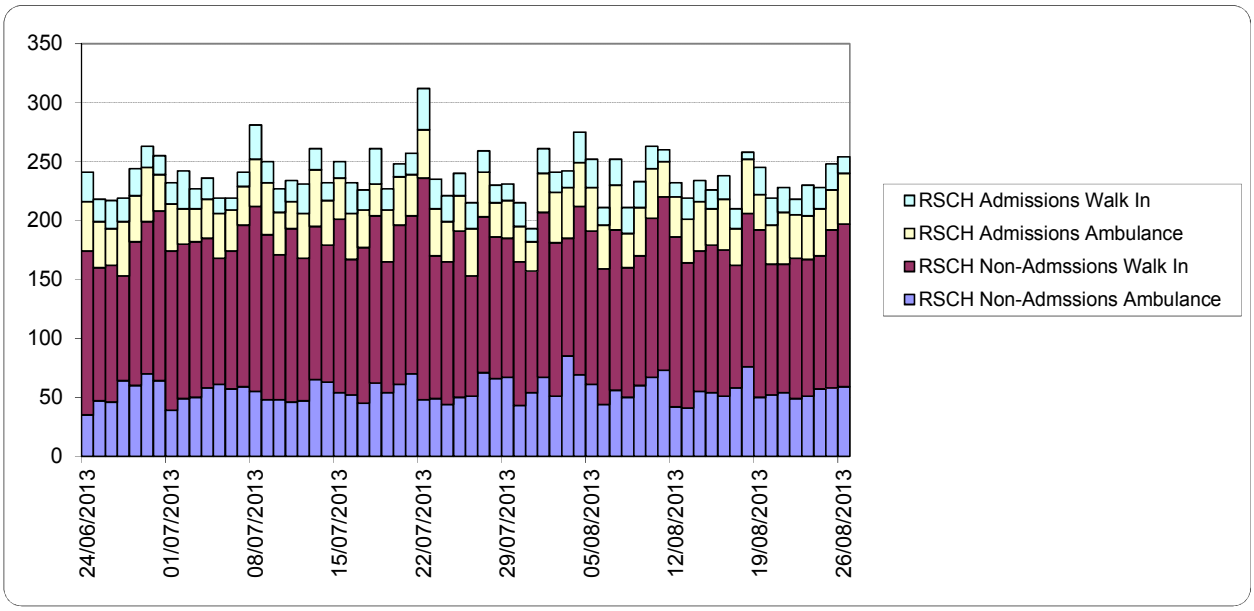


2.3. There are two reasons main reasons for this:

2.3.1. A large part of our programme of work was around changing doctors rotas and referral practices and this required new consultant appointments and new ways of working. Whilst these appointments have

now been made we will not see the full benefit until October this year. We have also identified that we have more to do in surgery and around the time of day and number of discharges particularly at the weekends.

2.3.2. RSCH remains with consistently high ED attendances and a significant daily variation in the number of patients passing through the Emergency Department:

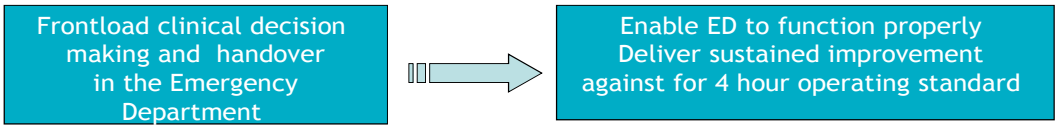


Within this there is a significant daily variation in ambulance conveyances (from 69 to 128 each day in July and August) and the associated admissions. This is important because between 40 and 45% of the patients who come to us by ambulance will need admission to hospital. The more we can understand this variation the better we can influence it through the work that CCG and partners are doing so admission to hospital becomes the exception.

We also remain with a significant number of patients who make their own way to ED who do not need to be seen in hospital.

2.4. The rest of this section updates on our programme of work.

2.5. WORK STREAM ONE



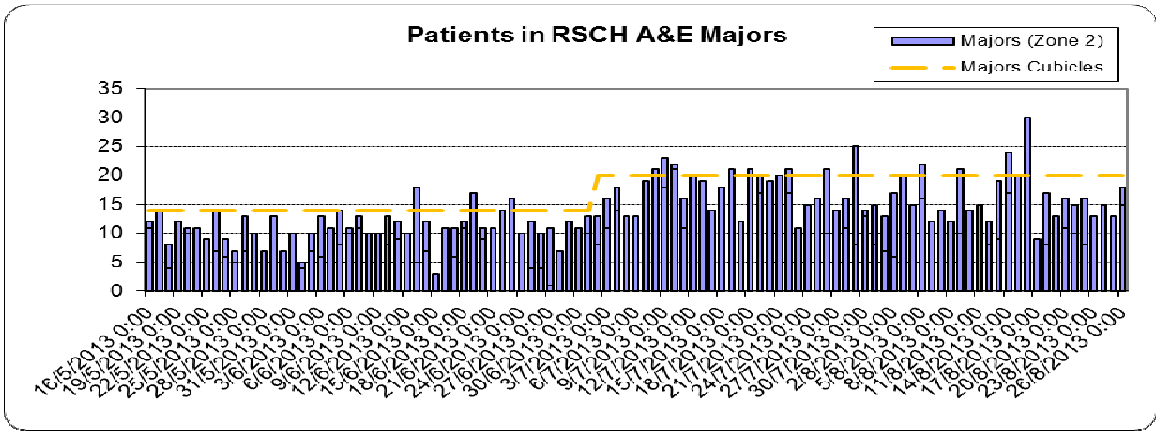
We have made three key changes:

- Introduction of a Patient Assessment Team (PAT) in ED to improve the patient journey through our emergency department through:
  Early identification of the sickest patients
  Early instigation of treatment including analgesia
  Early and appropriate ordering of investigations
  Early signposting of the patient's journey through urgent care

- Improved use of space in ED for patients with more serious injury or illness, providing two cubicles dedicated to PAT and 9 additional cubicles which is making it easier to ensure a smoother flow of patients when the department is at its busiest

- Improved the area for 'minors' (patients who are less poorly but still require ED care and treatment). These patients are now all seen in consulting rooms and no longer require cubicle space.

The chart below shows the initial benefit that we have seen from this work:



All 3 changes are improving patient flow through ED but we need work streams 2-5 to be complete in order to maximise the benefit.

We are also working with CCG, SECAMB and other partners to reduce the daily variation in attendances. It may be that we will need to re-introduce GP cover into ED if attempts to reduce the number of ED attendances for patients who could be seen in primary care do not bring any real benefit. Princess Royal Hospital similarly remains with consistently high ED attendances and daily variation in ambulance conveyances.

2.6. WORK STREAMS TWO AND THREE

Streamline processes and pathways, including for frail elderly patients and re-organise medical cover to best support	→	Deliver right patient, right place, first time so patients are discharged at the optimal time. Medical cover in place to deliver these pathways 7/7

Having recruited to additional consultant posts, we will be changing the medical cover rotas in October so we ensure early senior clinical review and maximise the number of patients who can be safely managed without admission or admitted and discharged within 2-3 days.

In the meantime the clinical teams are working closely with the Hospital Rapid Discharge Team (HRDT) in order to maximise the number of patients who can be managed without admission (see 2.8 below).

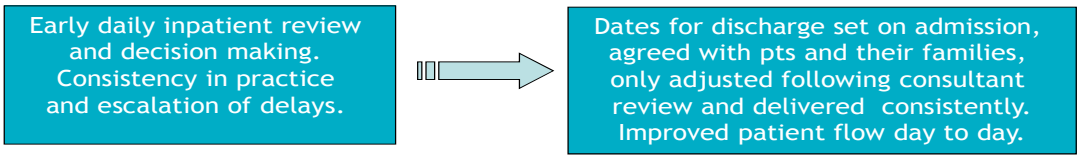
Work is also well underway on:

- the frailty pathways and other internal processes.

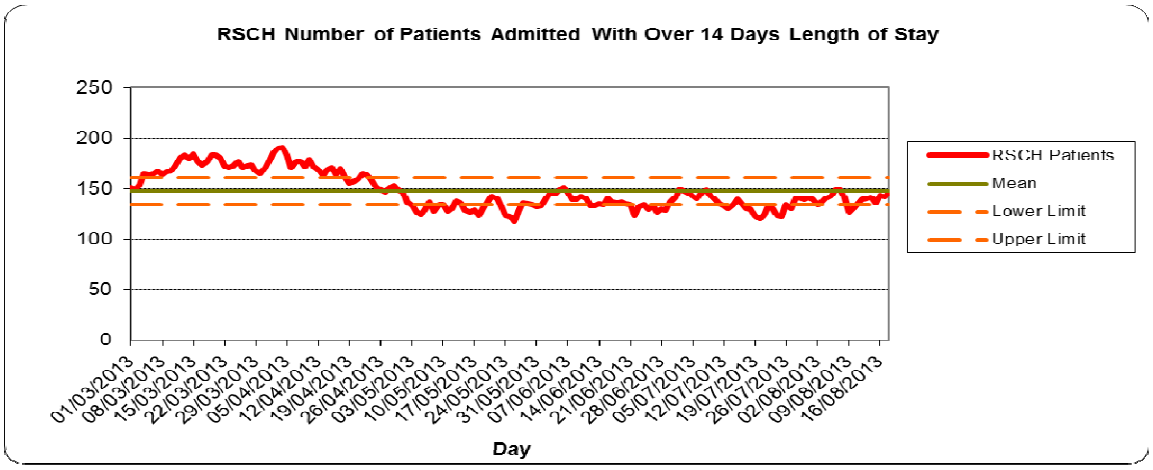
- surgical services including a virtual surgical assessment unit with nurse team leader, additional lists for emergency surgery and a reduced pre and post operative length of stay.

-

2.7. WORK STREAM FOUR



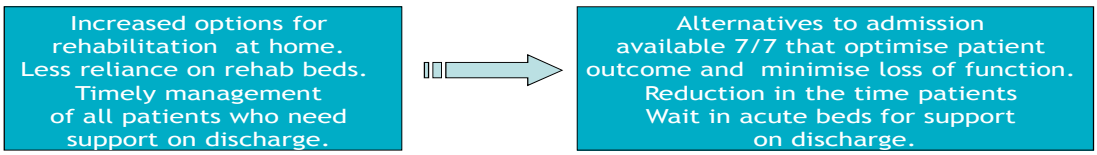
Care of the elderly wards at the Royal Sussex County Hospital (RSCH) all now have daily 'board rounds' along with planning meetings to ensure all arrangements are in place for patients who are scheduled for discharge the next day. They also complete a weekly review of all patients who have been in hospital for more than 14 days to ensure that everything is being done to ensure their safe and timely discharge. This is working very well and we have seen an overall decrease in the number of patients:



Our digestive diseases ward (58 beds) at RSCH has daily multi-disciplinary meetings to ensure medication required on discharge is ordered well ahead and to escalate other issues as required. The vascular team at RSCH is also running daily 'board rounds' and again planning ahead for safe discharge of patients including those who need onward care at a neighbouring hospital.

Electronic whiteboards on all our wards are proving invaluable, enabling us to see at a glance where each patient is on their pathway and identify and deal with potential delays.

2.8. WORK STREAM FIVE



We continue to see significant benefits from this work stream:

- The Hospital Rapid Response Discharge team continues to deliver a 3/4 fold increase in number of patients discharged from ED directly home with support, managing between 55 and 80 safe discharges home from RSCH. We are now preparing a further case for the development of this service.

- Ad hoc funded placements can be made for patients who will need placement but have still to make a final choice.

- East Sussex has assigned 2 full time social workers for Princess Royal Hospital to enable timely intervention for patients who will need support on discharge.

- We have also seen a significant rise in patients attending with mental health issues and work is underway with Sussex Partnership NHS Foundation Trust in order to enable us to enhance our current response so that we do not have patients waiting many hours for assessment and treatment within ED.

3. **Next steps**

3.1. BSUH indicated at the outset that this would not be a 'quick fix'. We will see further benefit from our work in September and October but without a reduction in ED attendances it will be very difficult to sustain required performance.

3.2. BSUH clinicians are engaged in the Urgent Care Clinical Forum led by the CCG Chair Dr Xavier Nalletamby and the Chief of Clinical Leadership, Dr Naz Khan.

3.3. Discussions are underway with SECAMB as to how they can help reduce the variation the number of patients who are brought to ED each day. There is also work underway across the local health economy in relation to anticipatory care, reducing ambulance conveyances to ED and prevention of admission in a crisis (see CCG report) which should start to deliver a reduction in the overall volume of attendances through ED.

3.4. We are also very concerned about the timeliness of service that we can offer to patients with mental health issues and as referenced, this is being reviewed with Sussex Partnership NHS Foundation Trust.

3.5. We also need to see a further rapid expansion of the Hospital Rapid Response Discharge Team both for winter and in the longer term and this has been included as part of the winter planning investment requests. The team has proved its worth and needs to be fully developed as an immediate priority.

3.6. In terms of winter planning, we are working with key stakeholders in the system to ensure a robust plan for the forthcoming winter. This will draw on experience from previous years and ensure that we have plans in place to meet the expected levels of demand.

3.7. A dashboard of performance and process measures is in place and in use to provide assurance around our progress to the wider system. The dashboard looks at both key performance and safety and quality indicators.

3.8. This work will continue at pace and alongside our other initiatives to improve quality, safety and dignity. notably:

- COMFORT rounds

The principal of comfort rounds in wards areas is to provide a holistic approach to care, enhancing each patient's sense of well being, generally improving their experience in hospital. We are also trying to prevent falls, reduce the risk of pressure damage and develop a more focused approach to nutrition and hydration through:

Choice, clean, comfort, cared for, conversation
Oral care, observation of bed area
Meal time preparation
Falls prevention
Offering drinks
Repositioning and pressure damage prevention
Toileting and bathroom assistance

- Quality review visits on all wards
- Nursing metrics and Friends and family test
- Patient Voice.

3.9. There is still a lot of work for BSUH to do but this is in hand. Our Implementation Board met weekly for the first 8 weeks but now meets fortnightly to give more time to implement the required changes and we continue to meet regularly with CCG and partner organisations also.

1 September 2013

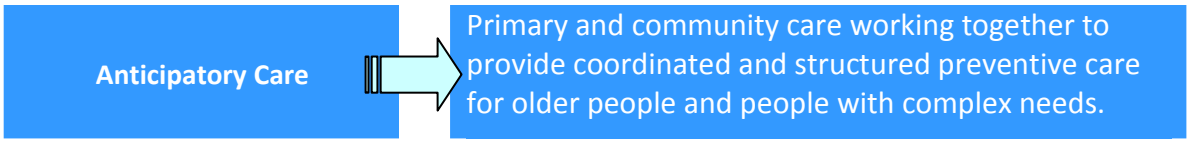
Appendix Two

Brighton and Hove
Clinical Commissioning Group

Update for HWOSC – September 2013

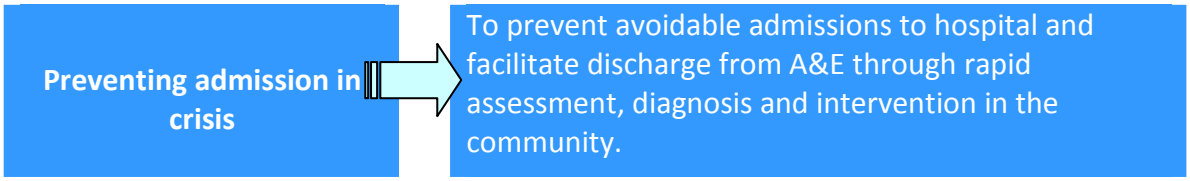
The purpose of this paper is to provide an update to the HWOSC regarding work currently underway to support improvements in the local urgent care system. In particular, it describes progress in the work streams delivered by the wider system partners and is intended to be complimentary to the update provided by BSUH.

The wider system work streams focus on 4 key areas:

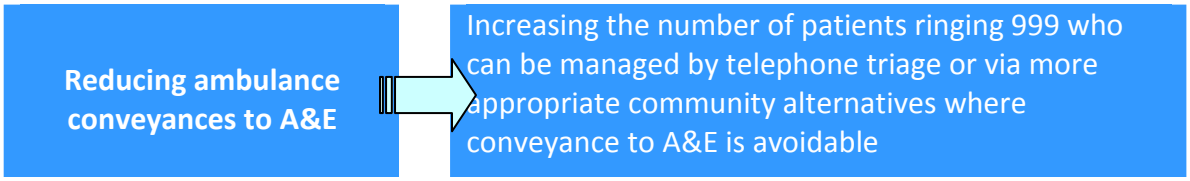


- The Integrated Primary Care Teams (IPCTs) which provide care for older people and those with long term conditions within the city will soon have dedicated social workers working across the three localities.
- Mental health nurses are also being recruited to work with IPCTs in the west locality and central Brighton.
- GP practices are now having regular meetings with their IPCTs using a computer based risk stratification tool to review their top 10% of patients who are at the highest risk of admission to hospital
- A plan has now been agreed with Sussex Community Trust and Sussex Partnership Trust to upload care plans for patients with dementia, nearing end of life, with continence issues or on the caseload of the IPCTs onto a computer system known as IBIS. This enables the ambulance service to see and support their care plans should they phone 999.

Appendix Two

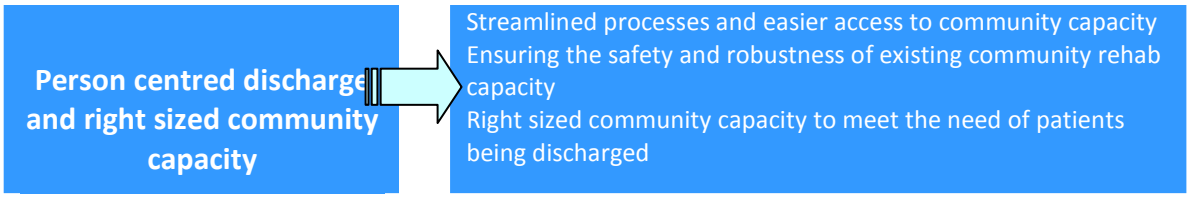


- More people are using community services that prevent admission e.g. Community Rapid Response Service (CRRS) and Rapid Access Clinic for Older People and we will create additional capacity in both services over the winter period
- Recruitment has started for the additional staff to enable the CRRS team to look after people who need intravenous therapy or catheter care.
- We will be piloting new services aligned to Integrated Primary Care Teams across the city to prevent avoidable admissions in specific patient groups including:
    - Coordinated support for patients in care homes
    - In-reach nursing to hostels.



- The number of patients being managed by telephone triage e.g. hear and treat are above expected levels at 12%
- Overall ambulance service activity in Brighton and Hove is lower than the same time last year however more patients than expected are still being conveyed to hospital
- We are working with SECAMB on a supported conveyance pilot which provides ambulance crews with advice and support to help them use community services as an alternative to A&E.
- The local NHS 111 service was passed by NHS England for full 'go live' on the 13th August 2013. The two main performance targets, calls answered within 60 seconds and abandoned calls, are being met on a daily basis. Both the Sussex and Brighton and Hove CCG NHS 111 clinical governance groups continue to monitor provider performance and clinical risks, healthcare professional and patient feedback

Appendix Two



- The number of patients whose discharge is delayed from BSUH remains very low (currently 4 patients) and the main reason for delay seems to be patients waiting for long term care home placements.
- A team of clinicians are about to undertake an audit of need for patients either waiting to go into or already in our community rehabilitation beds. The outputs of this audit will inform the future size and scope of bed based rehabilitation services within the city and ensures we have the right mix of services available in time for winter.
- A task and finish group has been set up to streamline access to and from bed based services.
- We have seen an increased number of patients going home with support rather than to bed based rehabilitation. There are currently no patients waiting to go to a community rehabilitation bed.
- Knoll House, one of sites from which community rehabilitation beds are delivered, remains partially closed but an improvement plan is well underway and the beds are likely to reopen at the end of August

The Urgent Care Clinical Forum led by the CCG Chair Dr Xavier Nalletamby and the Chief of Clinical Leadership, Dr Naz Khan has met again and discussions focused on how we can work together to improve urgent care services for frail and older people. The forum identified a number of key areas to prioritise over the winter period.

We are also working with key stakeholders in the system to develop a robust plan for the forthcoming winter which will include extra resource in key services including primary care and an escalation plan to more effectively manage peaks in demand.

The CCG is planning a comprehensive communications campaign around urgent care services informed by our learning from the recent public engagement event and the findings of the Healthwatch review of A&E. This will include a mobile phone app for the public on how to access urgent care services locally.

# HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	**Agenda Item 92** Brighton & Hove City Council

Subject:		**Brighton and Hove Wellbeing Service**	
Date of Meeting:		**10 September 2013**	
Report of:		**Monitoring Officer**	
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel: 290450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report provides an update to the HWOSC on the Wellbeing Service which has now been in place for 14 months. The Wellbeing Service provides a range of services and therapies to support people over 18 who are experiencing common mental health conditions including anxiety and depression.

2. RECOMMENDATIONS:

2.1 That HWOSC members note the information on the Wellbeing Service.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Until June 2012 Sussex Partnership Foundation Trust (SPFT) was the main provider of services to people experiencing common mental health conditions such as anxiety and depression in Brighton and Hove.

3.2 Following a tender exercise, the Mental Health Partnership began a three year contract to provide the Brighton and Hove Wellbeing Service. The Partnership is made up of the Brighton and Hove Integrated Care Service (BICS), 7 GP practices in Brighton and Hove, SPFT, MIND and Turning Point.

3.3 The service has four components, primary care health support; primary care health practitioner; talking therapies and the Hub (back office support).

3.4 The first year of the contract has been a challenging year for the service. The service started with a backlog of cases and whilst this has reduced significantly, there is still a large waiting list for the talking therapy service. Meanwhile there has been under performance in both the practitioner and support services. The CCG is working closely with the Mental Health Partnership to develop management strategies and to ensure that all parts of the service are utilised effectively.

3.5 The service has achieved some good outcomes but further work is needed to ensure that all parts of the service are meeting the performance measures set out in the contract

3.6 More information about the service and performance against targets can be found at **Appendix One**.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 There was extensive community engagement at the start of the process and there is ongoing user engagement in the service as it continues to develop . More information can be found in **Appendix One**.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are no financial implications attached to this report

Legal Implications:

5.2 There are no legal implications attached to this report

Equalities Implications:

5.3 The provider is expected to complete an equalities impact assessment

Sustainability Implications:

5.4 There are no sustainability implications

Crime & Disorder Implications:

5.5 There are no crime and disorder implications.

Risk and Opportunity Management Implications:

5.6 The provider manages the current risks to the service

Public Health Implications:

5.7 This Wellbeing Service supports the higher than average rate of people who are experiencing mental health problems, as set out in the Joint Strategic Needs Assessment.

Corporate / Citywide Implications:

5.8 There are no relevant implications for this report.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Not relevant for this report.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 This report is for noting and no recommendations are being made

SUPPORTING DOCUMENTATION

Appendices:

1. Appendix One from the CCG

2.

Brighton and Hove Wellbeing Service – update for the HWOSC 10 September

Summary and policy context

This report provides an update to the HWOSC on the Wellbeing Service which has now been in place for 14 months. The Wellbeing Service provides a range of services and therapies to support people over 18 who are experiencing common mental health conditions including anxiety and depression.

Relevant background information/ chronology

GPs told us that we needed to improve the organisation and delivery of "primary care mental health services" for people with common mental health conditions who did not necessarily need the expertise of secondary mental health services. Until June 2012 these services were primarily provided by the Sussex Partnership Foundation Trust (SPFT) - however GPs were concerned about the long waiting times, felt that the service was disconnected from them A tender was advertised to secure a service that would

- offer more capacity
- offer earlier intervention for users
- provider greater connection with GP practices, community and voluntary mental health support services
- provide more services in the community and in primary care settings helping to reduce stigma

A 3 year contract was awarded to the Mental Health Partnership which is made up of The Brighton and Hove Integrated Care Service (BICS), 7 GP Practices in Brighton and Hove, SpFT, MIND and Turning Point and the service started on 1 June 2012. One of the attractions to this bid was that it was a multi-agency partnership which included SpFT and the voluntary sector, therefore ensuring that there would be connections with secondary care as well as the voluntary sector.

There are 4 components to the service.

The **Primary Care Health Support Service** offers low intensity Cognitive Behavioural Therapy, guided self help workshops, signposting and offers support to people with work and learning needs

The **Primary Care Health Practitioner Service** supports patients who are higher risk and have more complex needs. This service offers patients assessments including medication reviews.

The **Talking Therapies Service** provides high intensity psychological therapy including CBT and psychotherapeutic counselling

And the **Hub** provides the back office support that enable the whole service to function eg taking referrals, making appointments etc. In addition this part of the service includes 7 GP leads who provide support to practices to help them understand the different parts of the service and helps them refer to the most appropriate part of the service.

The demand for the Support and Practitioner Services was below the contract activity target and we are working with the Mental Health Partnership to increase demand for these services by raising awareness, working with specific groups of potential users. Conversely

demand for the Talking Therapies Service is over plan and at the end of year 1 there was waiting list of over 900 for this service (this compares with a waiting list of 1500 when the service started). The CCG has approved additional funding to enable the service to clear the backlog and the expectation is that this is done by end of May 2014.

Performance and activity headlines

The performance headlines about the service to date are that

- in year 1 the service completed 7106 treatments– the target is 9000

Service	Activity Target	Year 1 Performance
Talking Therapy	2400	2409
Support Service	3600	2140
Practitioner Service	3000	2557

- waiting times are down and the waiting list is shorter
- operational bases for the service have been established in 28 surgeries, 2 large voluntary sector organisations and 3 community based SpFT sites
- recovery rates are in excess of 50% - compared to 20% before service started
- the service consistently exceeding the target for the numbers of patients it supports to come off ill health benefits
- service offers extended opening hours and includes weekend appointments too
- service supports adults of all ages and currently about 5% of users are over 65 – previous service supported people up to 65
- the service is offering support with employment issues and accessing vocational learning

Community engagement/ consultation

There was extensive user and stakeholder engagement in the design and procurement phases. Feedback about the service is systematically collected and analysed by BICs and we will be organising a user event with MIND to secure further feedback. The service has also established the Peer Support Service, which has engaged volunteers in the service, many of whom have lived experiences of mental health problems, and is working with current service users to engage them in community activities and offer alternative ways of accessing support.

Recommendations

There are no recommendations - this paper is for noting only.

Conclusion

The service has achieved some good outcomes to date. However further work needs to be done to both manage the waiting lists in talking therapies and to ensure that all parts of the service are used in line with projected activity levels. We are also keen to explore how the service can support people with long term conditions and a mental health problem. Ongoing performance will continue to be monitored closely at the quarterly contract meetings and a further report can be submitted to the HWOSC once we have seen the impact of the actions taken to address both of these issues.

Anna McDevitt, Commissioning manager, Brighton and Hove CCG , 20 August 2013

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 93 Brighton & Hove City Council

Subject:		**Healthwatch Update**	
Date of Meeting:		**10 September 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. SUMMARY AND POLICY CONTEXT:

1.1 The purpose of this report is to give members background information about Healthwatch, an update regarding the development of Healthwatch Brighton and Hove and to highlight the relationship between Overview and Scrutiny and Healthwatch.

2. RECOMMENDATIONS:

2.1 That HWOSC members note the Healthwatch information and how to best utilise the relationship between Healthwatch and HWOSC.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Healthwatch Brighton and Hove was established in April 2013. It replaces the Local Involvement Network (LINk) established in 2008 and will carry on its work, with the addition of new functions and powers.

3.2 Nationally, Healthwatch's remit is to influence, signpost and advise service users on health services locally. Healthwatch has a range of statutory powers. More information on their role and their powers can be found in **Appendix One (Healthwatch Brighton and Hove)**.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 Part of Healthwatch's key function is to consult and engage with the community. From April to July 2013 they worked with volunteers formerly from LINk, in order to provide some continuity.

4.2 From August – October 2013 Healthwatch is focussed on recruiting volunteers and its Shadow Governing Body. More detail of this can be found in **Appendix One (Healthwatch Brighton and Hove).**

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this cover report.

Legal Implications:

5.2 None to this cover report although it should be noted that Healthwatch was set up due to the Health and Social Care Act 2013. From April 2014 Healthwatch Brighton and Hove will be an independent entity with its own legal form.

Equalities Implications:

5.3 Healthwatch's role is to give communities a stronger voice to challenge service providers, aiming to improve the experience for service users throughout the city. It is likely that some of the protected equality groups have had differing, perhaps more negative, experiences of the local health service to date; Healthwatch's remit will be to reflect and challenge this where possible.

Sustainability Implications:

5.4 None to this cover report.

Crime & Disorder Implications:

5.5 None to this cover report

Risk and Opportunity Management Implications:

5.6 None to this cover report.

Public Health Implications:

5.7 Healthwatch is a key figure in gauging public opinion of health service provision locally, and will be well placed to provide patient experience of different services. Unlike LINk, it has a remit which covers both children and adults and so it can represent all service user groups.

Corporate / Citywide Implications:

5.8 None to this cover report.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 There is a legal obligation to establish Healthwatch under the Health and Social Care Act 2013. Therefore there is no alternative to establishing a local Healthwatch.

SUPPORTING DOCUMENTATION

Appendices:

1. Healthwatch Brighton and Hove.

2.

HEALTHWATCH BRIGHTON AND HOVE

Date: 10th September 2013

Meeting: Health & Wellbeing Overview & Committee

Healthwatch Lead: Jane Viner – Healthwatch Manager (Maternity Cover)
Tel: 01273 810234 Email: jane@cvsetorforum.org.uk

Title/Subject Matter: Healthwatch Update

Purpose of the Report

The purpose of this report is to give members an update regarding the development of Healthwatch Brighton and Hove and to highlight the relationship between Overview and Scrutiny and Healthwatch.

Healthwatch Brighton and Hove

Healthwatch Brighton and Hove, in line with national guidance, undertakes the following functions:

Influencing

To shape the planning and delivery of NHS, public health and adult and children's care services. This includes scrutinising the quality of services, particularly in response to public concern, holding them to account, representing the voice of the public and patients, contributing to the work of the Health and Wellbeing Board, contributing to the Joint Strategic Needs Assessment (JSNA) and working in partnership with commissioners of NHS, public health and adult and children's social care services.

Local Healthwatch can escalate matters to the overview and scrutiny committee of a local authority where they feel it necessary to do so. The overview and scrutiny committee must acknowledge receipt and keep Healthwatch informed of any action they take.

Signposting

To help people to make choices about their care by providing evidence based information about local services and supporting patients and the public to choose the most appropriate service.

Advising

To empower and enable individuals to speak out, including supporting them to access NHS complaints advocacy services.

Powers

Local Healthwatch has:

- powers to request information from commissioners and providers of health and social care and expect a response within 20 working days.
- make reports and recommendations and expect a response within 20 working days.
- enter and view premises where publically funded health or social care is provided with the exception of children's social care services.
- have a seat on the local statutory health and wellbeing board, actively participating in local decision making.
- refer matters to the local Health Scrutiny Committee.

Further information can be found here:

Healthwatch England www.healthwatch.co.uk

Healthwatch Brighton and Hove www.healthwatchbrightonandhove.co.uk

healthwatch
Brighton and Hove

Development Phases 2013 - 2014

Phase 1> Transition - April - July 2013

- Helpline set-up
- Monthly Magazine established
- Healthwatch website development
- Intelligence data base developed
- Hospital Pilot project launched
- Transition project work undertaken
- Interim Representation
- Public Engagement work undertaken
- Volunteer Strategy developed
- Relationships established with Community Spokes
- Relationships established with Commissioners and Providers

As part of its approach to setting up Healthwatch Brighton and Hove CVSF committed to continuing to work closely with the volunteers involved in the Brighton and Hove LINk to ensure that their experience and expertise informed the work undertaken by Healthwatch Brighton and Hove during the set up period whilst new mechanisms for engaging with and involving patients, residents and new volunteers were being developed. The Healthwatch Transition Group stopped operating on 31st July 2013.

Phase 2> Mobilisation - August – October 2013

- Staff and Volunteer recruitment
- Paid Independent Chairperson (open recruitment process)
- Shadow Governing Body Member recruitment (open recruitment process)
- Healthwatch Representative's recruitment
- Launching Healthwatch Brighton and Hove
- Developing the Work Programme
- Developing a Communication and Engagement Strategy
- Establishing engagement mechanisms with Community Spokes
- Agreeing a Memorandum of Understanding for work with commissioners and providers

Healthwatch Brighton and Hove will be recruiting an Independent Chairperson and Members to a Shadow Governing Body. The shadow governing body will be responsible for deciding the type of independent organisation that Healthwatch will become.

As well as undertaking its core functions, Healthwatch Brighton and Hove will be implementing the volunteering strategy, volunteer support programme, and volunteering roles. We aim to start recruiting to these roles in September 2013.

Healthwatch Brighton and Hove will be formerly launched, and this will be an opportunity for the public, Healthwatch volunteers and associates to engage in prioritising the feed-back received about local health and social care services in the development of the new work plan.

Phase 3> Implementation – November – March 2014

- Developing the Legal Structure for the new Independent Governing Body.
- Influencing the key health and social care commissioners and providers.
- Providing information to help people make choices about the services they use.
- Listening to people views, concerns and suggestions about services and using that information to help shape and improve them.
- Researching, carrying out Enter and View, writing reports and making recommendations.
- Producing an Annual Report.

During this phase the new Shadow Governing Body will agree its legal form, this will be an open and transparent structure for making decisions and Enabling local people to influence what it does (e.g. internal processes, work prioritisation, recommendations, impact analysis) and acts in accordance with the Nolan principles of standards in public life.

Phase 4> Independence- April 2014 – Onwards

- April 2014 – Healthwatch Contract Transferred from CVSF to the new Independent Governing Body.

From April 2014 Healthwatch Brighton and Hove will be an independent entity with its own legal form. The final form will have governance structures in place including: a membership, a governing body or board or management committee, a chair of the governing body or board, an annual report (which the Health and Social Care Act 2012 requires to be sent to the NHS England, relevant Clinical Commissioning Groups and Healthwatch England) and annual accounts.

Health & Wellbeing Overview and Scrutiny and Healthwatch

Working together for better outcomes

Listening and responding to communities and people who use services is fundamental to the functions of Healthwatch and Health and wellbeing Overview and Scrutiny, but each have different ways to gather views and experiences.

It is therefore vital that Healthwatch and Health and Wellbeing Overview and Scrutiny work together, both structures focus on the fundamental principle of improving outcomes for local people, there are opportunities for us to better work together and add value to each other's work.

The Centre for public Scrutiny document 'Local Healthwatch, Health and Wellbeing Boards and Health Scrutiny Roles, relationships and adding value', suggests the importance of:

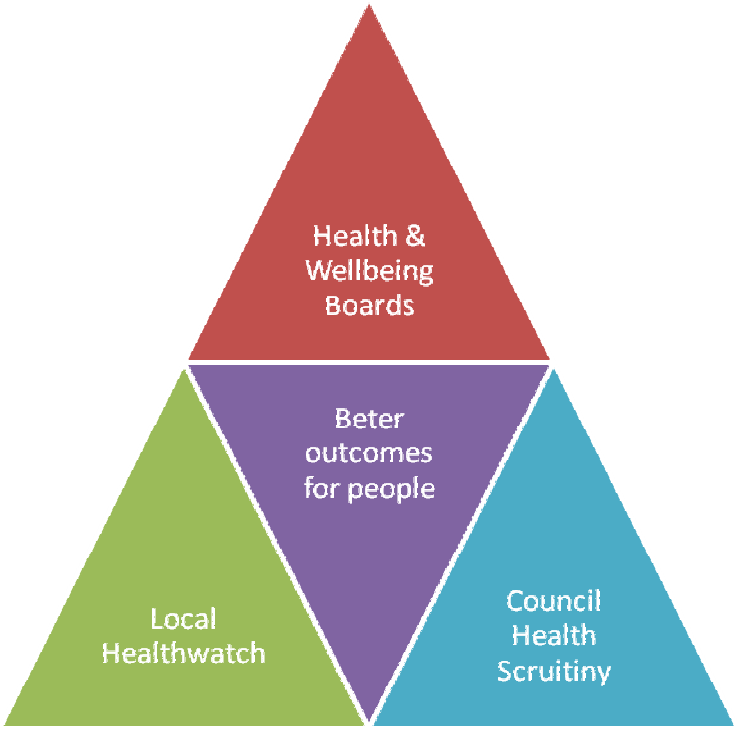
- Understanding each other's roles and responsibilities – at different parts of the commissioning cycle.
- Building relationships - gaining trust and credibility.
- Valuing independence and difference - build on powers.
- Understanding that all have common goal – work out how to do it together.
- Knowing what each other are doing – by receiving agendas, attending each other's meetings, sharing work plans etc.
- Ensuring that we complement not duplicate other's work.
- Making sure we work together in transparent, inclusive and accountable ways.
- Co-ordinating engagement activity.

Further information can be found here:

The Centre for Public Scrutiny
'Local Healthwatch, Health and Wellbeing Boards and Health Scrutiny Roles, relationships and adding value'

www.cfps.org.uk

- **Bring together individual and organisational knowledge, expertise and experience**
- **Develop area wide view of Health and Social Care.**
- **Agree area wide strategy**
- **Facilitate shared awareness of information to improve outcomes and decision making**



- **Understand patient and public experience**
- **Share information from VSC networks**
- **Influence the JSNA**
- **Have a seat on the Health & Wellbeing board**
- **Highlight Concerns**
- **Cascade information to the public**

- **Be a bridge between professionals and people who use services**
- **Bring a collective memory of public engagement, policy development and local knowledge about community needs and assets**
- **Be a valuable 'critical friend'**
- **Evaluate polices, actions and impact.**
- **Carry out pro-active qualitative reviews that can inform and enhance policy and services**

The Centre for Public Scrutiny
'Local Healthwatch, Health and Wellbeing Boards and Health Scrutiny Roles, relationships and adding value'

# HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	**Agenda Item 94** Brighton & Hove City Council

Subject:		**Integrated Primary Care Teams**	
Date of Meeting:		**Health and Wellbeing Overview & Scrutiny Committee**	
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. SUMMARY AND POLICY CONTEXT:

1.1 This paper is to update the HWOSC on key themes from the year 1 evaluation of the Integrated Primary Care Teams and the work that has is progressing to continue to develop these teams.

2. RECOMMENDATIONS:

2.1 That HWOSC members note the progress of the Integrated Primary Care Teams and suggest any improvements for future work.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The HWOSC was last provided with an update on the Integrated Primary Care Teams in March 2012.

3.2 Historically a range of different community teams have provided support and care for people in the community. There is a range of national and international evidence that integrated, coordinated and preventative care system for people with long term conditions can provides better outcomes and better use of resources. Delivering care with a single point of coordination can improve patient and carer experience, supports care at home and may prevent avoidable hospital admissions

3.3 In Brighton and Hove, the Integrated Primary Care Teams (IPCT) went live in January 2012. They operate seven days a week, providing care between 8am and 8pm. The GP practice remains the hub of care for the IPCT and the team includes nurses, occupational therapists, physiotherapists, pharmacist & carers support. Approximately 6,000 patients were cared for and supported in one year.

3.4 The first year's work has been assessed and evaluated, finding a variable performance across the city. More detail of the evaluation can be found in **Appendix One.**

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 Service users and patients have given feedback on their views of the first year's work. Staff feedback has also been sought through focus groups. Detail can be found in **Appendix One.**

4.2 The ongoing Project Board includes a member of Healthwatch who will be able to provide more service user experience and information as needed.

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

Crime & Disorder Implications:

5.5 None to this cover report.

Risk and Opportunity Management Implications:

5.6 None to this cover report,

Public Health Implications:

5.7 The IPCTs are aimed at improving the service user experience for health service users, by restructuring services in a more joined up way.

Corporate / Citywide Implications:

5.8 None to this cover report.

Brighton and Hove Integrated Primary Care Teams (IPCTs)
Update Report – September 2013

1. Summary and context

This paper is to update the HWOSC on key themes from the year 1 evaluation of the Integrated Primary Care Teams and the work that has is progressing to continue to develop these teams.

2. Relevant background information

2.1 The HWOSC were last provided with an update on the Integrated Primary Care Teams in March 2012.

2.2 Historically a range of different (predominantly uni-professional) community teams provided support and care for people in the community. Whilst these services individually provided a high quality care, in terms of an overall care system it tended to be reactive, episodic and fragmented rather than being co-ordinated around the needs of the individual patient. There was also a relatively high rate of emergency hospital admissions for acute conditions that should not usually require hospital admission indicating scope to improve community based preventative care.

2.3 Alongside this the local population is growing and complexity of need and the prevalence of long term conditions is increasing[1]

3. Service Model

3.1 There is a range of national and international evidence that integrated, coordinated and preventative care system for people with long term conditions can provides better outcomes and better use of resources. Delivering care with a single point of coordination can improve patient and carer experience, supports care at home and may prevent avoidable hospital admissions.

3.2 Holistic assessments and user and carer participation is the first step in developing appropriate care and support plans. Regular discussions at multi-disciplinary team (MDT) meetings within GP practices enable health and social care practitioners to reassess individual care plans, address any gaps in a collaborative way and make more effective use of local services. Instead of reactive or crisis care, people and their carers will receive an improved service through a more proactive assessment and care planning approach.

3.3 In light of evidence and best practice as well as the growing needs of the population, multidisciplinary teams (MDT's) aligned to small clusters of GP Practices - the Integrated Primary Care Teams were developed in Brighton and Hove to provide pro-active care & support to the frail housebound

[1] Long-term conditions are defined on the Department of health website as "those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies. The life of a person with a LTC is forever altered – there is no return to 'normal'." Among the most common of these conditions are hypertension, asthma, diabetes, coronary heart disease, chronic kidney disease, stroke and transient ischaemic attack, chronic obstructive pulmonary disease, heart failure, severe mental health conditions and epilepsy.

population with long term conditions. The IPCT service is provided by Sussex Community NHS Trust and the organisation has worked collaboratively with the Clinical Commissioning Group and other partners to deliver the model.

3.4 The IPCT's went live in January 2012. Key features of the new model:

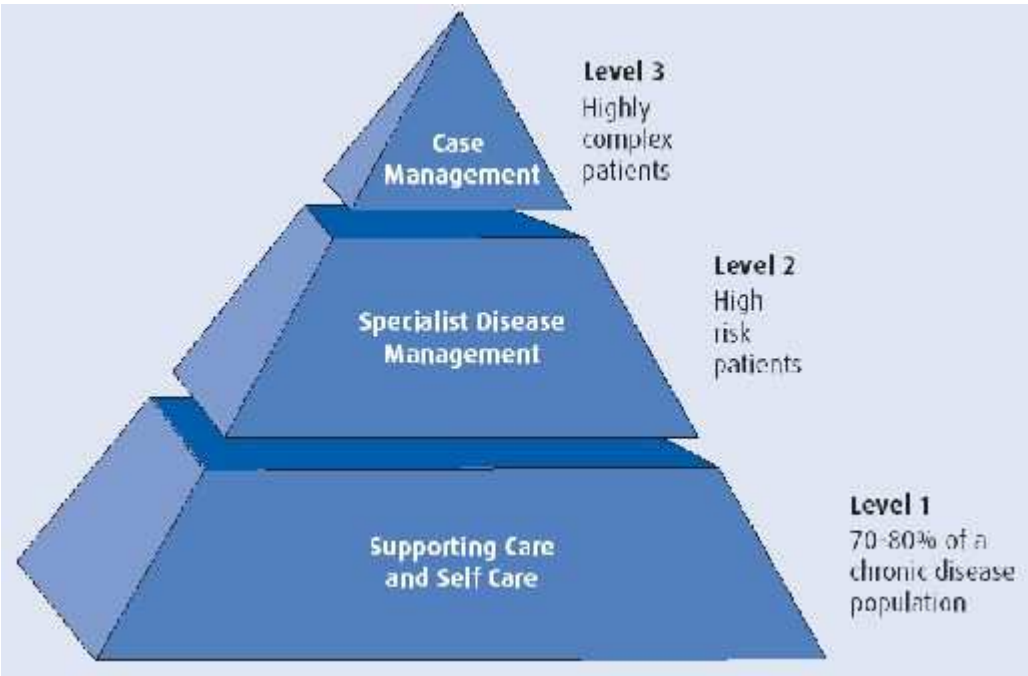
- The teams operate 7 days a week, providing care between 8am and 8pm.
- The GP practice remain the hub of care for the IPCT's
- The IPCT's consist of nurses, occupational therapists, physiotherapists, pharmacist & carers support.
- There is a pilot social care worker in the East Locality .
- Approximately 6,000 patients were cared for and supported in one year

3.5 Key principles of IPCT's

1. Planned and proactive preventative care intended to keep people as well as possible in the community
2. Co-ordinated care using team based approaches
3. Support for self -management
4. Increased support to carers
5. Case management for high risk patients.
6. Reduce avoidable demands on acute health care

The IPCT model of care is shown diagrammatically in Figure 1.

Figure 1: IPCT Model of Care



4. Key Themes From the Year 1 Evaluation

4.1 An evaluation of the first year of the IPCT service delivery was completed in April 2013. The overall key theme from the evaluation was variability in the success of the model. In some parts of the City it was working well but in others the benefits had not been fully realised and pro-active care is not yet being delivered consistently across the City.

4.2 The evaluation included structured feedback from stakeholders. There was wide

variation between different stakeholders with patients being most positive, and GP practices identifying the most need for further improvement of the service.

4.3 A patient survey (with 159 responses) was conducted in September 2012 which showed positive results:

- **91%** felt treated with dignity and respect
- **85%** agreed there was sufficient time to discuss their problems
- **87%** felt they received clear explanations of their treatment
- **88%** satisfied with standard of care

4.4 The GP practice survey conducted in October 2012 (with 105 responses) showed that the pro-active care model was not yet being delivered as intended as there was room for improvement:

- **61%** reported that they had frequent MDT meetings.
- **Over half** felt the teams were too busy or not adequately resourced to meet demand.
- **70%** did not feel there had not been an improvement in management of housebound.

4.5 IPCT staff feedback was obtained via focus groups which showed a more mixed views. Positive comments included: "*Significant benefits working in an integrated team with shared learning, better access to therapy and better patient care*". Staff also highlighted areas of variability. Comments included:

- GP engagement is variable
- Case manager role is variable and further development is needed.

4.6 Key themes from the evaluation and the actions agreed as part of the subsequent Development Plan are detailed in Figure 2

Figure 2: Key Themes and Development Plan Actions

	Issue	Action
1	**Variable GP engagement and MDT Working.** MDTs have been a success in some areas but in other's meetings had not taken place. Regular discussions is essential to enable care to be planned for patients in a collaborative way and is fundamental to the model of IPCT care.	• An "Enhanced Service" for Risk Profiling and Case Management has been launched which provides funding and a consistent framework for General Practice to work with their IPCT's • Service delivery started from July 2013 and 91% of Brighton and Hove GP Practices have signed up to deliver this new Enhanced Service. • Progress will continue to be closely monitored.
2	**Increasing Patient Complexity coupled with Insufficient Staff Resources & high levels of staff turnover in the IPCT's has hindered full delivery of Pro-active Care**	• Funding for 12 additional nursing and therapy posts has been agreed. Recruitment has been undertaken and most posts have been recruited to. These additional new staff will start in post form from September 2013 • Pilot funding for occupational therapy to IPCT's in Year 1 has now been made permanent • A plan has been agreed to transfer some "re-active" activity from the IPCT's to the Community Rapid Response Service – freeing up the IPCT's to concentrate on pro-active care • The impact of the additional resources will be closely monitored.
3	**Gaps in Service Model**. The IPCT model has integrated a range of physical health care services and two key gaps were identified in the model of care through the evaluation: • Mental health • Social Care	**Mental Health** • Plans are in place for Sussex Partnership Foundation Trust (the main local provider of mental health services) to provide training for IPCT's on the range of mental health services available and to ensure streamlined referral routes. • A pilot has been agreed for two mental health workers to be embedded within two IPCT's one focusing on mental health and one on dementia) to test out whether this enhances the model of delivery. The pilot will commence in Autumn of 2013 and will be evaluated in 2014. **Social Care** • The pilot Social Worker in the East Locality has provide successful and this been extended to Central and West localities increasing the amount of social care support available across the City. Recruitment to these additional posts is underway.

4.	**Scope to Improve Self-Care**	• A plan is being developed to introduce volunteers into the IPCT's providing increased support with practical tasks to support frail people at home and to enable independence. • The Public Health Promotion Team has delivered health promotion training sessions in May & June 2013. The training includes details of services they could refer on to promote self-care. • Further plans are being developed to ensure opportunities for IPCT's to promote self- care are maximised
5	**Lack of clarity about Support Available to Care Homes with Nursing**	• Discussions are taking place between the Clinical Commissioning Group, IPCT's, and Nursing Home Managers to ensure: o Clarity about role and support available from IPCT's o Clarity about responsibilities of Care Homes with Nursing Homes • Written information about support available from IPCT (and other specialist community services) is being produced to share with Care Homes • A networking event is being organised by Sussex Community NHS Trust and Care Homes with Nursing to promote IPCT's and other more specialist community services

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5. Summary

5.1 The development of IPCT's has been a large scale change and in common with any transformational change programme it takes time for the full benefits to be delivered. The evaluation and feedback from stakeholders is that the IPCT model of care is about right but there are gaps and it could be developed further. Ability to successful delivery of model in first year has been affected by Increasing patient complexity and difficulties in recruitment and retention of IPCT staff.

5.2 A Development Plan has been produced following the Evaluation and Brighton and Hove Clinical Commissioning Group meet on a monthly basis with SCT to oversee the delivery of the plan. In addition there is an IPCT Project Board which includes representation from stakeholders including other care providers and Healthwatch meet to ensure that the IPCT's develops with reference to the overall system of care.

Brighton and Hove
Clinical Commissioning Group

HWOSC agenda item 96

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Cllr Sven Rufus
HWOSC Chair
Brighton & Hove City Council
Kings House
Grand Avenue
Hove
BN3 2LS

20 August 2013

Dear Cllr Rufus

Briefing for HWOSC – Diabetes Care

I am writing to let you know that the Brighton and Hove Clinical Commissioning Group has highlighted care for people with diabetes as a key strategic priority in it's 2013-2014 Annual Operating Plan. We have identified that there is scope to develop more holistic care for diabetic patients that improves both outcomes and also make better use of resources.

With the prevalence of diabetes in Brighton and Hove expected to increase by 37% by 2030, the CCG is planning now to ensure that a comprehensive range of services and support are developed for people with diabetes; in line the latest evidence base and national best practice.

The Brighton and Hove Joint Strategic Needs Assessment for Diabetes (2012) highlights that one in two people with diabetes in the City are undiagnosed so there is scope to raise awareness of the disease and ensure more people get a diagnosis. Obtaining a diagnosis offers individuals the opportunity to be offered support, education and care at the earliest opportunity.

There is also scope to increase the range of services that are offered for diabetic patients for example through a one stop shop model of service that could improve outcomes and as well as patient experience.

The CCG is currently undertaking an initial phase of planning & scoping work. We have had discussions with our GP practices at the Local Member Group meeting in July 2013,

and they highlighted the need for an integrated system with services better coordinated around patients.

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We intend to have further discussions in September and subject to formal approval at the September Local Member Group meeting, Brighton and Hove CCG will be undertaking a consultation process in the Autumn 2013 seeking views on improvements to diabetic care.

We are writing to give you early notification of our plans and will write to you again prior to any formal consultation beginning. If you would like any further information at this stage then please do not hesitate to get in contact.

Yours sincerely

Anne Foster

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