

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 16 June 2011

PRESENT:

Councillor Simmons (Chairman) Councillors Heaps, Howson, O’Keeffe and Taylor; Councillor Ungar (Eastbourne Borough Council); Councillor Davies (Rother District Council); Councillor Phillips (Wealden District Council); Ms Janet Colvert, East Sussex LINK, Ms Julie Eason, East Sussex Advice Plus, and Mr Maurice Langham, East Sussex Seniors Association.

WITNESSES:

Brighton and Sussex University Hospitals NHS Trust

Joy Churcher, Head of Dietetics

Matthew Hutchinson, Associate Chief Nurse (Quality, Standards and Practice)

East Sussex Healthcare NHS Trust

Darren Grayson, Chief Executive

Dr Amanda Harrison, Director of Strategy

Shotham Kamath, Deputy Chief Nurse

Michelle Clements, Facilities Manager

Lucinda Silva, Acute Lead Dietician

Lesley Houston, Dietetic Services Manager (Community)

Dr James Wilkinson, Divisional Director – Medicine and Emergency Care

Jane Darling, Senior General Manager – Medicine and Emergency Care

NHS Sussex (Primary Care Trust Cluster)

Sarah Blow, Interim Area Director (East Sussex)

Alistair Hoptroff, Programme Lead – Stroke and Long Term Neurological Conditions

East Sussex County Council

Barbara Deacon, Policy Officer

LEAD OFFICER: Claire Lee, Scrutiny Lead Officer

1. APOLOGIES

1.1 Apologies were received from Councillor Rogers OBE (Vice-Chairman) and Councillor Pragnell.

2. MINUTES

2.1 RESOLVED to confirm as a correct record the minutes of the meeting held on 10 March 2011.

3. DISCLOSURE OF INTERESTS

3.1 There were none.

4. REPORTS

4.1 Copies of the reports dealt with in the minutes below are included in the minute book

5. EAST SUSSEX HEALTHCARE NHS TRUST – CARE QUALITY COMMISSION INSPECTION

5.1 The Committee considered a report by the Director of Governance and Community Services which focused on actions being taken by the Trust in response to the inspection.

5.2 Steve Tinton, Interim Chairman of the Trust, speaking on behalf of the Trust Board, outlined the Trust's determination to provide high quality care and meet all necessary standards. He stated that the Trust took the Care Quality Commission (CQC) reports very seriously and would continue to take the necessary action to address the concerns raised by them.

5.3 Darren Grayson, Chief Executive of the Trust, made the following points:

- The CQC inspection in February 2011 was part of the new regulatory framework for NHS providers and had been the first time the Trust had been inspected by CQC.
- The Trust had very recently received a draft report of the Commission's follow-up visit in April 2011 and expected this to be published by CQC in July 2011.
- The CQC inspection had raised significant concerns about a number of areas, some of which the Trust were already acting to address and others where more work is required.
- As Chief Executive he had highlight accident and emergency (A&E) and maternity services to CQC as areas of concern.
- Actions taken to improve A&E services had included:
 - Expansion and reconfiguration of both A&E units.
 - Improved workforce including 24/7 Emergency Nurse Practitioner presence (a substantial increase) and the recruitment of two additional consultants (one recruited to date, the other post covered by locums on an interim basis).
 - Working with staff to address shortcomings in practice and ensure privacy and dignity is maintained at all times.
- In relation to maternity the key issues had been how midwives were working and the escalation policies in place to ensure alternative provision in instances of unexpected staff shortfalls.
- With regard to nursing staff shortages the Trust had taken action prior to the CQC visit to fill vacancies and these were now at a historic low.
- Two outstanding major issues likely to be highlighted in CQC's follow-up report were:
 - Record-keeping – an area requiring significant improvement.
 - Privacy and dignity – the issue of sustaining this consistently in a very busy hospital environment.

5.4 Mr Grayson concluded by reiterating the Trust's commitment to implement the challenging recommendations from CQC. He highlighted that some of the issues raised by CQC were long-standing and required longer-term cultural change which the Trust was determined to achieve.

5.5 Sarah Blow, Interim Area Director for East Sussex from NHS Sussex (the Primary Care Trust (PCT) Cluster) commented that the PCTs as commissioners were supportive of the actions being taken by the Trust and would work closely with the Trust to ensure that progress was maintained.

5.6 The Trust representatives responded to questions on the following issues:

5.7 **Retention of nursing staff**

Shotham Kamath, Deputy Chief Nurse, assured the Committee that actions were in place to ensure retention of nurses. He outlined a comprehensive programme in place for new nurses joining the Trust in May and September 2011, including a week long induction. He also described an ongoing programme of preceptorship and action learning sets. Mr Grayson added that the Trust's turnover level of 8-9% for nurses was typical of NHS Trusts. In addition to the actions described by Mr Kamath, he highlighted the need to address a dissociation which had developed between front-line staff and management through working differently with staff and ensuring managers and Board members were more visible.

5.8 **Clinical leadership**

In response to a question about the leadership in A&E, Mr Grayson explained that a senior nurse was in charge 24/7 and there were senior doctors present at all times. He stated that a key issue was achieving consistency of care across the Trust for all patients and that a cultural change was needed in order to sustain high standards. Mr Tinton added that the internal reorganisation underway within the Trust aimed to ensure clinical leadership and accountability throughout the organisation.

5.9 **Record keeping**

When asked whether there were appropriate record keeping systems in place Mr Grayson assured the Committee that procedures were in place with a clear requirement that staff must follow these. However, CQC had found examples where these procedures had not been followed at all times which had prompted the Trust to investigate whether there was a wider issue. Mr Kamath added that weekly audits were being undertaken, particularly in relation to risk assessments, to see whether improvements were evident. He also explained that a Trust wide group had been established to oversee record keeping improvements in both the short and longer term.

When asked whether protected time was specifically allocated for record keeping, Mr Grayson explained that there was an expectation that record keeping is an integral part of the care given so there was no a specific period of time allocated at the end of a shift. He added that the group set up to improve record keeping would look at reducing the burden of paperwork and being clear about priorities.

5.10 **Staff training**

In response to a request for assurance regarding mandatory training on Deprivation of Liberty Safeguards (DOLS) and Safeguarding Vulnerable Adults (SVA), Mr Grayson stated that training on the Mental Capacity Act and DOLS was part of the training given to new doctors joining the Trust. Dr Wilkinson confirmed this and added that a mandatory training programme was also in place for other senior staff. He expected CQC to see major improvement in this area.

With regard to SVA, Mr Grayson assured the Committee that this training had been mandatory since 2009. However, there was a challenge in terms of the large number of staff to be trained. The Trust's approach is to ensure all staff are trained in SVA awareness with more detailed training for senior staff. Mr Grayson confirmed that there is an expectation that staff will receive protected time for mandatory training.

5.11 **Staff appraisal**

Mr Grayson assured the Committee that there was appropriate time available to undertake staff appraisals, along with the associated monitoring and training. Dr Harrison explained that the appraisal process had recently been reviewed and improved and, whilst not perfect, was monitored closely. She added there was a need to better explain the process to staff and to improve the accuracy of reporting.

5.12 RESOLVED to:

- (1) request a copy of the external report on privacy and dignity when available.
- (2) request copies of the detailed action plans agreed with CQC when finalised.
- (3) request a copy of the Trust's tool for assessing privacy and dignity.
- (4) liaise with CQC in order to track progress.

6. NUTRITION, HYDRATION AND FEEDING IN HOSPITALS

6.1 The Committee considered a report by the Director of Governance and Community Services which presented an update on the progress of the local hospitals Trusts in implementing HOSC's recommendations.

6.2 The Chairman complimented the best practice outlined in the report from Brighton and Sussex University Hospitals NHS Trust (BSUH) and invited the Trust representatives to introduce their report.

6.3 Joy Churcher, Head of Dietetics and Matthew Hutchinson, Associate Chief Nurse (Quality, Standards and Practice), BSUH, highlighted the following key developments from their progress report:

- A 'spot it and stop it' campaign had been undertaken as part of nutrition awareness month.
- A multi-coloured lid scheme had been introduced to improve patients' hydration. Specific positive impacts on patient outcomes had been seen as a result.
- Audits of MUST (Malnutrition Universal Screening Tool) compliance had shown improvement in screening.
- Inclusion of nutrition information in the discharge checklist was being trialled with a view to rolling out.
- The review of menus at the Princess Royal Hospital had been completed and a review was now underway at the Royal Sussex County Hospital.
- Assisted eating had been subject to monthly surveys and the Trust was now identifying issues from the results with the intention to address these.
- Results from additional audits undertaken at HOSC's request were being examined to identify any action required.
- The concept of 'comfort rounds' had been introduced as a way to ensure consistent delivery of the fundamentals of nursing care. This was a re-introduction of an established nursing routine and had the advantage of clarity for staff as to what is

expected of them. The rounds are led by Healthcare Assistants. A bedside handover process had also been introduced for nursing staff.

6.4 Shotham Kamath, Deputy Chief Nurse, Michelle Clements, Facilities Manager and Lucinda Silva, Acute Lead Dietician, from East Sussex Healthcare NHS Trust (ESHT) highlighted the following key developments from their progress report:

- MUST screening had been introduced at the Trust in October 2010 and training was included in the induction programmes for all new Healthcare Assistants and newly qualified nurses. An e-learning package was also being introduced to supplement face to face training.
- The nutritional profile aspect of patient documentation had been strengthened.
- The use of assisted cutlery to help patients feed themselves had been successfully trialled and kits had now been provided to 42 wards.
- In terms of discharge, there was a clear expectation that the dietician would refer to the discharging doctor and this had been found to be working well.
- An audit of protected mealtimes had found that 70% of wards were compliant. The Trust recognised there was more to do and had drafted revised guidelines to support a re-launch of the initiative in June-July 2011.
- An extended choice menu had been piloted successfully, resulting in reduced waste and a reduction in the number of referrals to dietetics.
- The Trust acknowledged that it would be beneficial to have a more standardised approach to mealtime routines. Some work had begun on this through the productive ward programme but further work was needed. The Trust would look at the comfort rounds approach being taken by BSUH.

6.5 The Trust representatives responded to questions including the following:

6.6 **Food on the maternity ward - ESHT**

In response to some specific feedback from HOSC Ms Clements agreed to look specifically at the needs of patients on the maternity wards and to consider whether these wards could form part of the next phase of piloting for the extended choice menu.

6.7 **Food production**

Ms Clements explained that ESHT produces all cooked food from its in-house kitchens which enables local produce to be used and quality to be closely monitored. A cook-chill system is used and food is reheated before serving. Ms Clements explained how the Trust regularly monitors patient experience and satisfaction.

Ms Churcher confirmed that BSUH also uses a cook-chill system for its food, which is prepared by an external supplier. She explained that regular patient surveys were carried out by the contractor as well as monthly rounds by the catering team.

6.8 **Food packaging**

Ms Clements assured the Committee that ESHT attempts to source products which are easier for patients to open. However, ward staff were on hand to offer assistance and the training given to housekeeping staff included offering help with packaging.

6.9 **Nursing role at mealtimes**

Mr Hutchinson clarified that BSUH nursing staff are responsible for ensuring patients are fed appropriately. At the Royal Sussex County Hospital nurses supervise the ward

hostess who serves patients. At the Princess Royal Hospital nurses have a direct role in serving food to patients.

6.10 Nil by mouth patients

Ms Silva explained that ESHT had undertaken a pilot audit of nil by mouth patients which had shown that 55% had received nutritional support within 24 hours and the average time taken had been 2.1 days. The Trust would now look to extend the audit further. She also added that 90% of stroke patients had been assessed by Speech and Language Therapy in line with NICE guidelines.

6.11 Comfort Rounds

The Committee commended the 'comfort rounds' approach being taken by the nursing staff at BSUH. Mr Hutchinson indicated that, whilst this was not a new concept, it had been re-introduced as a way to ensure the consistent, routine delivery of basic nursing essentials to all patients at set times each day. He indicated that positive results had been seen since the initiative's introduction.

6.12 Best practice sharing

Both Trusts indicated their willingness to share practice and learn from other Trusts nationally. Mr Kamath indicated that ESHT had been in contact with BSUH regarding specific initiatives such as protected mealtimes and comfort rounds. It was noted that each Trust took a different approach to making changes and improvements to practice.

6.13 RESOLVED to:

- (1) welcome the Trusts' invitations to sample the food provided to patients.
- (2) request a further progress report in March 2012.

7. EAST SUSSEX HEALTHCARE TRUST – CLINICAL STRATEGY

7.1 The Committee considered a report by the Director of Governance and Community Services which gave an update on the development of the Trust's clinical strategy.

7.2 Mr Grayson made the following points by way of introduction:

- The Clinical Strategy will define the reshaping of the Trust in terms of its services, workforce and estate.
- The Trust still intends to apply for Foundation Trust status in 2013, with a view to achieving it by 2014, despite the recent relaxation of the national timeframe.
- The work undertaken to date indicates that a range of services will need to change in some way, including acute medicine, cardiology, stroke, trauma and orthopaedics and maternity.
- The integration of community and acute services within the Trust means that change will be needed across the patient pathway.
- A range of 'cases for change' are currently in development and these would be discussed with HOSC and the public.
- Three levels of potential change were anticipated:
 - Operational efficiencies
 - Redesign of care pathways – for example, patients spending less time in hospital, better management of long term conditions to prevent admission.
 - A small number of major service reconfigurations, i.e. changing the location of a service or not providing a service in the future.

- The Maternity Review is an example of the work currently underway.
- There has been some involvement of local people in the work to date but the Trust intends to do more to engage people.
- The Trust has not broken even financially for the past five years – the strategy must deliver financial as well as clinical sustainability and the two are intrinsically linked.

7.3 Sarah Blow, Interim Area Director for East Sussex from NHS Sussex indicated that the success of the clinical strategy was crucial for the whole local health economy, not just the Trust itself. She explained that commissioners also require services to be sustainable. Ms Blow assured the Committee that the PCTs and GP Commissioners had been involved in local meetings and were taking a joint approach, with the Trust, to the future commissioning and provision of services in East Sussex. She described three local networks which had been set up – covering planned, urgent and integrated care – which each included clinicians, providers and patient representatives.

7.4 Issues covered in questions and discussion included the following:

7.5 **Maternity Review**

Mr Grayson stated that he understood the strong views which had been expressed in relation to maternity services, particularly from the Eastbourne area, but that the Trust had to provide the best possible care for the whole of East Sussex.

Dr Harrison outlined the review process which was being led by an independent senior midwife and independent Chairman with no maternity background. External consultant obstetrician advice was being provided to the review and external paediatric advice was also being sought. Dr Harrison assured the Committee that a process was in place to ensure day to day safety of care but the review related to the Trust's ability to continue to do this in the long term. She added that the review was working on the basis of the recommendations made by the Independent Reconfiguration Panel.

Dr Harrison highlighted that over 50% of women give birth with no intervention from doctors and that midwife practice was key. She explained that a consultation being carried out with staff related to best practice in this respect. She assured the Committee that this consultation on midwifery practice would have been undertaken regardless of the maternity review outcome and it would support the Trust's ability to sustain safe care.

7.6 **GP involvement**

When asked to clarify how GPs were involved in the clinical strategy development Mr Grayson assured HOSC that the Trust had involved the leaders of the emerging Clinical Commissioning Groups. Dr Greg Wilcox, Chair of the Transitional Clinical Executive, was on the steering group. He added that the various workstreams also involved GP commissioning leads.

7.7 **Recruitment of doctors**

When asked whether the Trust could do more to recruit permanent doctors in order to reduce the cost of locums, Mr Grayson described how the challenges varied from specialty to specialty. In some areas, such as A&E, there were national shortages which made local recruitment difficult. However, Mr Grayson argued that candidates would also look at the long term sustainability of services such as A&E when making decisions as to

where they wish to work. The clinical strategy was therefore important in setting out a clear future for the Trust and its services.

7.8 **Parallels with local authority challenges**

Mr Grayson agreed that there were some similarities between the challenges faced by the Trust and those faced by local authorities. He compared the scale of change seen in adult social care services in recent years with the scale of change required of the Trust.

7.9 RESOLVED to request a further progress report in September 2011.

8. **STROKE CARE IN EAST SUSSEX**

8.1 The Committee considered a report by the Director of Governance and Community Services which presented an update on progress with the East Sussex Stroke Strategy and HOSC's recommendations with regard to stroke care.

8.2 Alistair Hoptroff, Programme Lead for Stroke and Long Term Neurological Conditions, NHS Sussex introduced the report. Dr James Wilkinson, Divisional Director and Jane Darling, Senior General Manager, Medicine and Emergency Care, East Sussex Healthcare NHS Trust were in attendance.

8.3 The following points were made in response to questions:

8.4 **Increase in stroke consultants**

Dr Wilkinson clarified that ESHT had identified funding to implement its commitment to increase consultant numbers from two to four. One post for the Conquest Hospital was to be advertised imminently. The other post at Eastbourne DGH would be recruited to following the retirement of another (non-stroke) consultant. This was expected to be within the next few months.

8.5 **Access to scans**

Ms Darling highlighted that both ESHT sites had been compliant with the target for access to scans for stroke patients over the last three months. Weekly monitoring continued in conjunction with radiology.

8.6 **A&E bay for stroke patients**

Dr Wilkinson explained that the Trust had considered HOSC's suggestion that a dedicated A&E bay could be designated for stroke patients. He indicated that there were some practical difficulties with this approach but that the work to improve the whole patient pathway would obviate the need for a dedicated bay.

8.7 **Availability of stroke unit beds**

When asked whether it would be feasible to ringfence the stroke unit beds in order to avoid them being used by non-stroke patients, Dr Wilkinson suggested that although this approach may have some merit it would not be an ideal solution since there were always likely to be unforeseen instances where there was an urgent need for a bed. He suggested that access to stroke beds was more likely to be improved through changes to the whole stroke pathway. This would mean that acute and community services were working in harmony and patients could move on from the acute wards more quickly, thus creating more capacity. Dr Wilkinson indicated that some progress had been made, such

as an increase in patients transferred to the Irvine Unit in Bexhill for rehabilitation, but that there was some way still to go.

8.8 **Challenges in improving stroke care**

Mr Grayson emphasised the Trust's commitment to improving stroke care and his desire to be open about the challenges. Dr Wilkinson highlighted that there had been progress in recent months towards the target of 80% of stroke patients spending at least 90% of their hospital stay on the stroke unit, and on the issue of all stroke patients being allocated a named stroke consultant. Dr Wilkinson also indicated that progress was being made towards equitable care out of normal hours and work towards this was continuing.

8.9 RESOLVED to:

- (1) request further information on the roll out of the new Sussex-wide primary care pathway for atrial fibrillation.
- (2) request a further progress report in March 2012.

9. EAST SUSSEX HEALTH AND WELLBEING BOARD

9.1 The Committee considered a report by the Chief Executive which outlined proposals for the establishment of a shadow Health and Wellbeing Board (HWB) for East Sussex.

9.2 Barbara Deacon, Policy Officer, East Sussex County Council made the following points by way of introduction:

- The County Council had looked at HWB models emerging around the country to inform the proposals which were now being put forward.
- Not all HWBs have a voting model but it was felt that this would be better for East Sussex.
- The Council wanted to ensure wide involvement in the work of the HWB. Some HWBs are anticipating a membership of 50-60 which was felt to be unworkable. The local proposals have therefore drawn on the East Sussex Strategic Partnership model of a core partnership and a wider 'assembly' group.
- The recent report of the NHS Future Forum and the Government's response to this did not significantly change the original proposals for HWBs. However there was now a duty for Boards to undertake patient and public involvement, something which was already reflected in the proposal to take an assembly approach in East Sussex.
- A three month consultation was being undertaken to ensure compliance with the Compact. This would end on 12th September 2011. All interested parties were invited to respond.

9.3 The following points were covered in response to questions:

9.4 **Voting rights**

Ms Deacon explained that the proposed model gave voting rights to the HWB Members who were democratically accountable. However the issue of voting rights would be looked at through the consultation and legal advice would be obtained.

9.5 **Provider representation**

Ms Deacon confirmed that the proposed model did envisage non-voting representation on the HWB from provider organisations.

9.6 **Relationship with scrutiny**

Ms Deacon confirmed that the separate role of scrutiny, and its role in holding the HWB to account, was now clearly recognised by Government. This was reflected in its response to the NHS Future Forum report.

9.7 RESOLVED to:

- (1) recommend that the HOSC Chairman be given a standing invitation and speaking rights in relation to the HWB.
- (2) request a report on the outcomes of the consultation in September 2011.

10. HOSC ACTIVITY UPDATE

10.1 Individual HOSC Members' activities included:

10.2 **Cllr Rupert Simmons**

- **26th May** – Introductory meeting with Darren Grayson, Chief Executive, ESHT.
- **6th June** – Centre for Public Scrutiny national event for HOSCs which looked at the progress of the national listening exercise and potential changes to the NHS reforms.

10.3 **Cllr Davies**

- Attended meetings of the Stroke Programme Board

10.4 **Cllr Carolyn Heaps**

- Attended a conference on the ageing population.

10.5 RESOLVED to note and update the HOSC work programme.

The Chairman declared the meeting closed at 1.10pm