HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 15 September 2011

PRESENT:

Councillor Simmons (Chairman), Councillors Heaps, Howson, O'Keeffe, Pragnell, Rogers and Taylor; Councillor Ungar (Eastbourne Borough Council); Councillor Merry (Lewes District Council); Councillor Davies (Rother District Council); Councillor Phillips (Wealden District Council); Ms Janet Colvert, East Sussex LINk, Mr Dave Burke, Hastings & Rother Counselling Service, and Mr Maurice Langham, East Sussex Seniors Association

WITNESSES:

East Sussex Healthcare NHS Trust
Stuart Welling, Chairman
Darren Grayson, Chief Executive
Jayne Black, Deputy Director of Strategic Development
Dr David Hughes, Medical Director
Alice Webster, Deputy Director of Nursing

NHS Sussex
Sarah Blow, Interim Chief Operating Officer (East Sussex)

Brighton and Sussex University Hospitals Trust
Duane Passman, Director of 3Ts, Estates and Facilities

Sussex Partnership NHS Foundation Trust
Lorraine Reid, Chief Operating Officer

NHS Sussex/East Sussex County Council
Martin Packwood, Head of Joint Commissioning – Mental Health

GP Representative
Dr Lindsay Hadley

East Sussex County Council
Barbara Deacon, Policy Officer

LEAD OFFICER: Claire Lee, Scrutiny Lead Officer

11. APOLOGIES

11.1 There were none.

12. MINUTES

12.1 RESOLVED to confirm as a correct record the minutes of the meeting held on 16 June 2011.

13. DISCLOSURE OF INTERESTS

13.1 There were none.

14. REPORTS

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

15. EAST SUSSEX HEALTHCARE NHS TRUST CLINICAL STRATEGY

15.1 The Committee considered a report by the Assistant Chief Executive which focussed on the development of the Trust's Strategic Delivery Plan.

15.2 Darren Grayson, Chief Executive of the Trust, made the following points by way of introduction:

- The development of the Strategic Delivery Plan follows on from the agreement of the Trust's Strategic Framework by the Trust Board. These two elements make up the Clinical Strategy.
- The Delivery Plan is based around eight workstreams led by Trust clinicians with the involvement of GPs, the Local Involvement Network (LINk) and other stakeholders.
- A proposed model of care had been developed for each of the workstreams, including a model for maternity and related services which had been developed through the independently-led Maternity Review.
- The next stage of the process would be a two to three month pre-consultation engagement period during which public understanding of the models could be developed and options for delivery could be identified.
- The Trust would then discuss the potential options for delivery with HOSC in order to identify which, if any, constitute substantial change to services which would require consultation with the Committee and associated public consultation.

15.3 The following issues were covered in response to questions from the Committee:

15.4 **Financial basis of the Clinical Strategy**

When asked how the financial circumstances of the Trust had informed the development of the Clinical Strategy, Mr Grayson assured the Committee that the Trust Board had a good understanding of the resources available over the next five years and the pressures on the Trust over that period. Financial modelling had been undertaken which factored in the intentions of commissioners, the downward trend in the national tariff paid to Trusts for the work they undertake, government productivity targets of 4% per year and predicted NHS cost increases such as inflation and increases to the pay bill. This modelling had indicated that the Trust needs to reduce its costs by approximately £100m over the next 5 years on an annual budget of £360m.

Mr Grayson indicated that 30% of the £100m savings required could be achieved through efficiences and 70% would need to be achieved by service redesign through the Clinical Strategy. He acknowledged that the models of care developed by the eight workstreams were to some extent aspirational at this stage and that the delivery options developed through the next stage of the process would need to be fully costed. The Trust Board would then need to take a view on priorities for investment.

15.5 **Staff engagement and morale**

Dr David Hughes, the Trust's Medical Director, acknowledged that staff morale at the Trust could be improved and argued that the development of a clinically led strategy setting out a clear direction for the Trust's services would in itself improve morale. He indicated that there was now a growing recognition within the Trust that the organisation could not be put on a sustainable footing through efficiencies alone and that the opportunity for a more radical redesign of services must be taken.

Mr Grayson added that the Trust was undertaking an organisational restructure which would put clinicians in positions of responsibility and accountability. This would contribute to cultural change within the Trust and address the gap between ward and Board. Mr Grayson indicated that the Trust would be undertaking a survey of all staff in 2011 (rather than the more usual annual sample) in order to get a very good understanding of their views.

15.6 **Maternity workstream – role of Crowborough Birthing Unit**

Mr Grayson explained that a draft model of care for maternity had been developed and would be considered by the Maternity Review Board on 19th September. The model includes midwifery-led care. He indicated that the Crowborough Unit is highly valued but the number of women choosing to give birth there had declined by a third over the last two years. This decline raised issues about the clinical, and to some extent financial, viability of the unit. Mr Grayson stated that the Trust was committed to providing the Crowborough service as long as it was commissioned by local GPs.

15.7 **Cardiology workstream – provision of primary angioplasty**

When asked to clarify the Trust's intentions regarding the provision of primary angioplasty treatment for heart attacks Mr Grayson informed the Committee that NHS Sussex and GP commissioners had indicated that they wish to move to a 24/7 service in Hastings by 1 April 2012, with 'in-hours' provision in Eastbourne. Out of hours patients would be transferred to Hastings or Brighton. Commissioners had put forward the clinical evidence base to support their intention and the Trust would need to consider the implications as part of the pre-consultation phase of the Clinical Strategy development. HOSC would need to consider whether the proposed model represented a substantial change to the service requiring consultation.

Sarah Blow, Interim Chief Operating Officer (East Sussex) for NHS Sussex, confirmed that commissioners had agreed their preferred model in late 2010 following lengthy discussion, based on clinical evidence and best practice.

15.8 **A&E workstream – model of care**

In response to questions on why aspects of the proposed A&E service model were not already in place, Mr Grayson acknowledged that part of the Clinical Strategy process was to bring East Sussex into line with best practice already seen elsewhere. However, he highlighted that the Trust routinely met the

national target to treat 95% of patients within 4 hours and less than 5% of patients left A&E without being treated, below the national average.

Jayne Black, Deputy Director of Strategic Development, added that the Trust had struggled to recruit to some clinical roles in A&E. However, Emergency Nurse Practitioner capacity had been increased in order to provide rapid assessment. She highlighted that the proposed service model was based on good evidence that early assessment by a senior decision maker helps patients get the right treatment quickly. Mr Grayson explained that the challenges differed in Eastbourne and Hastings. The A&E department at the Conquest Hospital has good clinical staffing but requires improvements to the space and layout of the building whereas the Eastbourne department has adequate space but requires additional senior clinicians.

15.9 **Stroke workstream – provision of 24/7 services and early supported discharge**

Mr Grayson agreed that stroke services require additional investment and indicated that it would be possible to make significant changes across the patient pathway within the existing configuration. For example, the Trust had recently implemented direct access to the stroke units at both acute hospital sites. Dr Hughes added that 24/7 thrombolysis was now available, but that the Trust was still lacking in specialist stroke support. This was being addressed through recruitment and obtaining support from neurologists for the thrombolysis service. Dr Hughes indicated that access to scans was improving but that it would be challenging to deliver increasing standards. The Trust was intending to increase capacity to two MRI scanners and two CT scanners per acute site over the next few years.

In relation to early supported discharge, Ms Black explained that this was being piloted in the Eastbourne area which was generating significant learning about how stroke patients could be supported in a holistic way by staff from acute, community and social care teams.

Mr Grayson indicated that the options for the future delivery of stroke services would be considered as part of the pre-consultation process. The Trust currently operates two acute stroke units and the question would be whether the proposed higher standard of care could be best delivered from two units or one unit.

15.10 **Bed management**

Mr Grayson acknowledged that beds at the acute hospitals were often under pressure for a range of reasons including demand, management of A&E and Medical Assessment Units, ward operation and discharge arrangements. He indicated that the Clinical Strategy aims to address every aspect of this patient journey and should reduce the number of patients staying in hospital for more than seven days to 20%, based on good evidence that shorter stays in hospital where possible benefit patient outcomes.

15.11 **Review of vascular services**

Mr Grayson confirmed that a review of vascular services across Sussex had been undertaken by the Vascular Society and the recommendations were being considered by the Trust. If the recommendations were taken forward they would need to be integrated into the wider Clinical Strategy and delivery options developed in the same way as for other workstreams. He indicated

that there was strong clinical evidence to support different models for complex vascular surgery.

15.12 **Public engagement**

When asked how the Trust was preparing for a public debate over potentially significant change to services, Mr Grayson acknowledged that change to health services can be an emotive issue and that it could be challenging to ensure the focus remained on what was best for patients. He assured the Committee that the Trust would ensure any proposals for change had a good evidence base and had been developed by clinically-led working groups. Mr Grayson acknowledged that a strong process of engagement would be needed which encompassed all stakeholders. He argued that the debate should focus on the health and wellbeing of local people rather than specific buildings.

Stuart Welling, the Trust's Chairman, assured HOSC that the Trust Board was very clear about the need for the Clinical Strategy to be developed with stakeholders and understood by patients and the public. He did not expect universal support for proposals for change but argued that the debate should focus on the provision of high quality, evidence based services. Mr Welling also highlighted that the consequences of not delivering the Clinical Strategy successfully would be very significant.

15.13 RESOLVED to:

(1) welcome the addition of a pre-consultation engagement period to the Clinical Strategy development process.
(2) request a further report to HOSC on the proposed delivery options across the eight workstreams in due course.
(3) establish a working group to provide additional HOSC input during the pre-consultation period, particularly in relation to the engagement process.

16. <u>BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS TRUST – 3TS</u>

16.1 The Committee considered a report by the Assistant Chief Executive which presented an update on progress with the 3Ts (Teaching, Trauma and Tertiary Care) programme.

16.2 Duane Passman, Director of 3Ts, Estates and Facilities, gave a presentation (included in the minute book) on progress. The following issues were covered in response to questions from the Committee:

16.3 **Funding**

Mr Passman confirmed that Treasury funding of the 3Ts redevelopment at the Royal Sussex County Hospital site had government support. This was subject to planning consent being obtained. The Trust were about to submit the planning application to Brighton and Hove City Council with a decision anticipated by Christmas.

16.4 **Provision of information for East Sussex residents**

Mr Passman acknowledged the need to provide information in non-digital formats for patients who would be affected by the redevelopment. He indicated that he would be very happy to receive advice on local information sharing avenues. Mr Passman also assured the Committee that, where services were relocated as part of the decanting process, patients would receive specific information with their appointment letters.

16.5 **Parking capacity**

Mr Passman acknowledged that parking availability at the Royal Sussex County Hospital site is a key concern of patients. He advised the Committee that the revised plans had replaced the proposed multi-storey car park with underground car parking and that this had enabled further car parking spaces to be included. The redevelopment would now include 350 extra spaces (over and above current parking capacity) as opposed to the 200 extra spaces in the previous plans.

16.6 **Construction issues**

Mr Passman informed the Committee that as much of the new build as possible would be pre-fabricated off site due to the constrained nature of the development site. This would also reduce the number of deliveries required, although it was inevitable that there would be construction traffic during the redevelopment. Roadworks on Eastern Road would also be required during the redevelopment.

16.7 **Impact of design on Royal Alexandra Children's Hospital**

Mr Passman assured the Committee that the impact of the new development on surrounding buildings, including the children's hospital, had been a key area of focus. He explained that original plans had not blocked any views from the children's hospital. However, following essential changes to the shape of the new build, there would be an impact on some rooms. Although this was regrettable, it was the only way to get the required accommodation onto the site in an efficient way. This had required the Trust to strike a balance between different priorities.

16.8 **Impact of prevailing winds**

Mr Passman advised that the Trust was aware of the wind tunnel effect experienced in the existing northern service road. The new development includes a southern service road which will be crossed by link bridges. These bridges would provide some mitigation to the wind tunnel effect and further mitigation measures would be considered as part of the environmental impact assessment.

16.9 **Helipad**

Mr Passman advised HOSC that dialogue with local planners had led the Trust to locate the helipad on the existing Thomas Kemp tower rather than the new development. English Heritage were supportive of this approach. The helipad would be large enough to take a coastguard helicopter if required.

16.10 **Impact of decanting process**

In response to questions about the impact on services from the decanting process, Mr Passman assured the Committee that no services would move until their decant facility was available. He also confirmed that clinical leaders from affected areas had been engaged in designing decanting arrangements.

16.11 **Links to Foundation Trust application**

When asked how the 3Ts development related to the Trust's Foundation Trust application, Mr Passman assured HOSC that the 3Ts programme and all other service plans formed part of the business plan which supports the Trust's Foundation Trust application.

16.12 RESOLVED to:

(1) request that the Trust inform HOSC of the outcome of the planning application and progress towards Foundation Trust status.
(2) request a further report at the start of the decanting process.
(3) arrange a visit to the Royal Alexandra Children's Hospital.

17. IMPROVING MENTAL HEALTH SERVICES – PROGRESS REPORT

17.1 The Committee considered a report by the Assistant Chief Executive which presented an update on the progress with the implementation of changes to adult mental health services which had previously been considered by HOSC.

17.2 Lorraine Reid, Chief Operating Officer at Sussex Partnership NHS Foundation Trust informed the Committee that service performance had continued as expected and that 20 inpatient beds at the Department of Psychiatry in Eastbourne had closed as agreed over the summer. As part of the next stage of implementation, the Trust proposed a slight change to bed configuration in the creation of three, 18 bedded wards in Eastbourne. To enable the refurbishment of the Department of Psychiatry it was also proposed to decant one ward to Brighton and Hove for approximately 23 weeks.

17.3 Martin Packwood, Head of Joint Commissioning (Mental Health), advised the Committee that various permutations for the configuration of beds had been considered and that in his view as commissioner, the proposed three, 18 bedded wards in Eastbourne most closely aligned with population needs.

17.4 The following issues were covered in response to questions:

17.5 **Management of decanting process**
Ms Reid indicated that the decanting of a single ward was the safest option clinically to achieve the refurbishment. She advised HOSC that decanting mental health wards was more difficult than general wards due to the specific safety requirements. The Trust was therefore proposing to use a ward in Brighton and Hove which is designed for similar use. Ms Reid agreed that it would be important to provide appropriate information and travel support for service users and carers affected by the relocation and indicated that the Trust would draw on its previous experience of a similar process in Mid Sussex.

17.6 **Feedback from service users**
In response to a question about service user feedback during the process of change, Ms Reid advised the Committee that the Trust obtained feedback via the Patient's Councils at the inpatient units and a postcard comments scheme. She indicated that the development of integrated care pathways and the changes to service structures were particularly significant to service users.

17.7 RESOLVED to:
(1) support the proposed bed configuration due to its alignment with population needs.
(2) support the temporary relocation of a ward from Eastbourne to Brighton and Hove to enable the refurbishment of the Department of Psychiatry.
(3) request further informal updates as implementation progresses, particularly in relation to the decanting process.

18. DEMENTIA STRATEGY

18.1 The Committee considered a report by the Assistant Chief Executive which presented an update on progress with the local dementia strategy.

18.2 Martin Packwood, Head of Joint Commissioning (Mental Health), made the following points by way of introduction:

- The dementia action plan continued to be implemented.
- The engagement of GPs had been strengthened.
- A partnership approach to developing services continued to be taken across the NHS and social care.
- The introduction of a new Memory Assessment Service had been deferred to April 2012. It had not been possible to reach agreement with Sussex Partnership NHS Foundation Trust regarding the terms for offering the new service, but the opportunity had been taken to develop a new, primary-care based approach with GPs. There is potential for this to be a primary care delivered service which would be innovative and has potential to offer improved value for money. Because this would be a new model it was taking additional time to work through the associated issues.
- The focus of the strategy is on service redesign to ensure financially sustainable services, rather than relying on non-recurrent funding from regional transformation funds.
- One aspect of service redesign was to make alternative provision for people currently receiving social care type services through NHS facilities. The intention is to disinvest on some services in order to release funds to invest in new models of care.

18.3 Dr Lindsay Hadley, a local GP lead for dementia, described a national shift towards increasing provision of dementia care through community or primary care services, as opposed to specialist mental health services. She highlighted the increasing emphasis on early diagnosis and finding better ways to care for people locally. Dr Hadley also indicated that potential advantages of a primary care based model were to increase expertise amongst GPs in managing an increasingly common condition, and also to reduce the stigma associated with dementia.

18.4 The following issues were covered in response to questions:

18.5 **Engagement of the GP community**

When asked how the wider GP community could be engaged in delivering the dementia strategy Dr Hadley indicated that, although most GPs are familiar with managing care of dementia, there is a demand for additional training, given that they are often faced with patients or carers in a crisis situation. She added that the development of a Local Enhanced Scheme was being considered which would enable GPs to receive additional payment for taking on an increased role in dementia care.

Mr Packwood added that any new model would be phased in gradually, initially working through groups of GP practices with one practice taking the lead. The lead practice would receive additional training in order to provide care which had previously required a referral to specialist services. Further development could then follow as more GPs received the additional training.

18.6 **Patient pathways**

When asked how patients with both dementia and 'functional' mental health needs (such as depression) would experience a suitable pathway of care, Dr Hadley responded that this could be an additional benefit of a primary care based service which could take a more holistic approach than that which could be taken by services which specialise in one type of condition or the other. She added that the link between dementia and depression is recognised and that GPs are currently encouraged to screen for depression before making a referral to specialist dementia services.

Mr Packwood added that specialist mental health services in Sussex had moved to an 'ageless' model where services are grouped according to functional or organic (dementia) needs rather than being grouped according to the age of the service user. This ensured that people could access the most appropriate service for their need, regardless of which age group they fall into. Mr Packwood explained that this reflected a national move towards recognising the need for specific dementia services and the fact that organic and functional conditions have very different causes and care requirements. Mr Packwood assured the Committee that additional training for GPs would include this distinction and that the importance of the interface between the two types of specialist service was recognised.

18.7 **Patient registers**

Dr Hadley advised the committee that GPs do hold registers of patients referred to specialist services due to dementia as part of their current systems. However, as many people either do not come forward for diagnosis or are living in care homes, these registers are not comprehensive. It is hoped that the introduction of a community based service would lessen stigma, encourage more and earlier diagnosis, and therefore enable registers to be expanded.

18.8 RESOLVED to request that the HOSC Mental Health Task Group reconvenes to consider service redesign in dementia services in more detail, particularly the development of a primary care based model.

19. <u>HEALTH AND WELLBEING BOARD</u>

19.1 Barbara Deacon, Policy Officer at East Sussex County Council, provided an oral update on progress with the formation of a Health and Wellbeing Board which included the following points:

- The consultation period had ended on 7th September 2011 and there had been a good response. East Sussex County Council had been one of few local authorities nationally to consult on its approach to establishing the new Board.
- It was clear through the consultation that there is widespread interest in the NHS changes and a desire that people be kept informed of developments locally.
- 72% of respondents agreed that the Health and Wellbeing Board should be the 'guardian of the health and social care system'. There was not universal support for the term 'guardian' but the majority agreed with the principle.
- There was strong support for the proposed 'assembly' model which was viewed as a good route for engaging the large number of individuals and organisations who wish to be involved with the Board's work.

- There was some debate over the precise membership of the core Board, beyond that specified in legislation. The Chief Executive would be taking further soundings on this with a decision expected within the next two weeks.

19.2 **Involvement of District and Borough Councils**
Ms Deacon confirmed that District and Borough Councils had been involved in the consultation process. The original proposal had been for two places to be allocated on the core Board to District and Borough representatives in order to keep the Board to a manageable size and to reflect arrangements on some other county wide bodies. However, their responses had indicated a preference for all five Councils to be represented and further consideration was being given to the final arrangements.

19.3 **Role of Health and Wellbeing Board**
Ms Deacon confirmed that a key role of the Board would be to oversee a refreshed and expanded Joint Strategic Needs Assessment. This would need to be adjusted to reflect Clinical Commissioning Group boundaries, some of which extend beyond the county boundary as they reflect GP practices' registered populations. The Board would also lead the production of a Health and Wellbeing Strategy.

Sarah Blow, Interim Chief Operating Officer (East Sussex) for NHS Sussex, advised the committee that two Clinical Commissioning Groups had been established in East Sussex, with a further two in development, but that all were committed to working together across East Sussex on strategic matters affecting the whole county.

19.4 RESOLVED to request a written update when the final details of Board membership are confirmed.

20. HOSC ACTIVITY UPDATE

20.1 Individual HOSC Members' activities included:

20.2 **Councillor Rupert Simmons**

- 15th July – attended regional HOSCs event which looked at the implications of the NHS reforms for scrutiny. The HOSCs in the region also met with the Strategic Health Authority on 7th September which again focused on NHS reforms and transition.
- Introductory meetings with the Chief Executives of NHS Sussex, Sussex Partnership NHS Foundation Trust and Brighton & Sussex University Hospitals NHS Trust, the Director of Corporate Affairs at South East Coast Ambulance Service NHS Foundation Trust and the Director of Public Health.
- 10th August - visited Pembury Hospital to see the new A&E department and wards opening this autumn.
- 8th September – attended East Sussex Healthcare Trust's Clinical Strategy stakeholder event on behalf of HOSC.

20.3 **Janet Colvert**
Ms Colvert gave an update on Local Involvement Network (LINk) activities which included:

- Preparation for the transition to Healthwatch by reviewing the LINk's own structures.

- Engagement with East Sussex Healthcare Trust in areas including the Clinical Strategy development, Maternity Review Board and action planning in response to the Care Quality Commission inspection.
- Work on dementia outcomes for challenging patients.

20.4 **Councillor Carolyn Heaps**

- Due to attend a stroke awareness event in Eastbourne.

20.5 **Councillor John Ungar**

- Due to attend the stroke awareness event in Eastbourne.
- Received research information from Save the DGH campaign group.

20.6 **Councillor Angharad Davies**

- Attended the regional HOSCs event on 15th July.
- Visited Pembury Hospital on 10th August and undertook a separate visit to the hospitals women's and children's department.

20.7 **Councillor Diane Phillips**

- Attended a meeting of the High Weald area Clinical Commissioning Group.
- Visited Pembury Hospital on two occasions.

20.8 **Maurice Langham**

- Visited Pembury Hospital.

20.9 **Councillor Philip Howson**

- Activities related to role as Trustee of Age UK.

20.10 **Councillor Elayne Merry**

- Attended HOSC induction session.

20.11 **Councillor Peter Pragnell**

- Chaired Adult Social Care Scrutiny Committee meeting on 8th September.
- Activity as local Member for the Conquest Hospital area related to a planning decision on the provision of additional staff car parking on the hospital site.

20.12 **Dave Burke**

- Leading LINk group on mental health and primary care. The group is due to meet with Sussex Partnership NHS Foundation Trust.

20.13 **Councillor Barry Taylor**

- Attended regional HOSCs event on 15th July.

20.14 **Councillor Ruth O'Keeffe**

- Undertaking research on alcohol abuse services and due to attend training relating to alcohol interventions.

The Chairman declared the meeting closed at 12.50pm