HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee (HOSC) held at County Hall, Lewes on 13 September 2012

PRESENT:

Councillor Simmons (Chairman), Councillors Heaps, Pragnell, and Taylor (all East Sussex County Council); Councillor Ungar (Eastbourne Borough Council); Councillor Cartwright (Hastings Borough Council); Councillor Phillips (Wealden District Council); Councillor Davies (Rother District Council); and Ms Julie Eason, SpeakUp (voluntary sector representative)

WITNESSES:

East Sussex Healthcare NHS Trust
Dr James Wilkinson, Divisional Director – Medicine and Emergency
Dr Mohammed Rahmani, Stroke Consultant and Primary Access Point Clinical Lead
Jenny Darwood, Clinical Service Manager – Stroke
Jayne Boyfield, Associate Director of Integrated Care
Jayne Black, Deputy Director of Strategic Development
Flowie Georgiou, Associate Director of Urgent Care

Sussex Stroke Network
Julia Buck, Stroke Network Manager
Dr David Hargroves, Strategic Health Authority Clinical Lead
Dr Rajen Patel, Network Clinical Lead

Clinical Commissioning Groups (CCGs)
Dr Roger Elias, Chair of Hastings and Rother CCG
Sarah Blow, Interim Chief Operating Officer

NHS Sussex
Alistair Hoptroff, Programme Lead for Stroke and Long Term Neurological Conditions

East Sussex County Council
Imran Yunus, Strategic Commissioning Manager, Adult Social Care (ASC)
Beverley Hone, Assistant Director (Strategy and Commissioning), ASC
Mark Stainton, Assistant Director (Operations), ASC

Voluntary and Community Sector
Alan Keys, Chair – East Sussex Local Involvement Network (LINk)
Sandra Field, Regional Head of Operations – Stroke Association
Kate Davies, Chair – East Sussex Seniors Association (ESSA)
Jennifer Twist, Chief Executive – Care for the Carers

LEAD OFFICER: Claire Lee, Scrutiny Lead Officer

19. APOLOGIES

19.1 Apologies for absence were received from Councillors Howson, Merry, O'Keeffe and Rogers, and from Dave Burke.

19.2 The Chairman announced that Janet Colvert had stepped down as the LINk representative on HOSC. As the LINk is due to be replaced by Healthwatch from April 2013 a replacement LINk HOSC Member would not be nominated, but HOSC will put in place alternative liaison arrangements. The Committee expressed thanks to Ms Colvert for her contribution to HOSC.

20. MINUTES

20.1 RESOLVED to confirm as a correct record the minutes of the meeting held on 26 July 2012.

21. MATTERS ARISING

21.1 RESOLVED to note the three documents attached to supplement discussions at the 26 July 2012 meeting.

22. DISCLOSURE OF INTERESTS

22.1 There were none.

23. REPORTS

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

24. 'SHAPING OUR FUTURE' – HOSC EVIDENCE GATHERING PROCESS

24.1 The Committee considered a report by the Assistant Chief Executive which set out the progress with the Committee's evidence gathering process and highlighted key documentary evidence.

24.2 RESOLVED to:
(1) note the documentary evidence within the appendices; and
(2) note the progress of the evidence gathering process.

25. STROKE CARE – PERSPECTIVE FROM COMMISSIONERS

25.1 The Committee welcomed: Dr Roger Elias, Chair of the Hastings and Rother Clinical Commissioning Group (CCG); Sarah Blow, Interim Chief Operating officer for the East Sussex CCGs; Alistair Hoptroff, Programme Lead for stroke and Long Term Neurological Conditions for NHS Sussex; and Imran Yunus, Strategic Commissioning Manager for East Sussex County Council.

25.2 Dr Elias outlined the reasons why the CCGs supported the proposed consolidation of acute stroke services on a single hospital site in East Sussex. Key points included:

- Stroke had been a low priority in the past and services, despite the efforts of clinicians, had not been good enough or well resourced.

- National efforts to improve stroke care had been spurred on by the 2007 National Stroke Strategy.
- A peer review of acute stroke care at East Sussex Healthcare NHS Trust (ESHT) had been damning and there had been a lack of leadership in driving stroke care forward. Commissioners and the Strategic Health Authority had become involved.
- The Clinical Strategy process had presented an opportunity to look afresh at stroke care and develop a local model based on better management and initial treatment and returning people home more quickly.
- There is a desire to learn from models such as that in London and implement best practice locally by establishing a hyper acute stroke unit.
- It was evident to the CCGs that it would not be feasible to staff two hyper acute units on a 24/7 basis sustainably, hence the preference for one hyper acute unit linked to good quality rehabilitation services. The CCGs fully support this model.
- CCGs understand people's concerns about additional travel but have been assured by the Ambulance Trust that these issues are not insurmountable. There is also acceptance that, with a single unit in the county, some patients will receive acute stroke care at other Trusts, where these are nearer to them.

25.3 The commissioners responded to questions on the following issues:

25.4 **Long-term care/self-care**

In response to concerns about patients' ability to participate in self-care as proposed in the model, Mr Yunus described a long-term support service for stroke survivors which is commissioned to help people make adjustments to their lifestyle. He expected this service to continue. Dr Elias added that there is much which can be done in primary care to ensure effective ongoing care for the patient and this is reflected in the Quality and Outcomes Framework GPs work to. He welcomed the improved dialogue with Adult Social Care which is critical.

Mr Hoptroff commented that in order to get the best result for patients from aftercare it is necessary that they receive the best possible care immediately after the stroke. He advised HOSC that the proposed model represents best practice.

25.5 **Stroke performance on two sites**

When asked to comment on recent improvements in performance on key stroke indicators at both hospital sites and whether these could continue, Ms Blow recognised that ESHT had worked hard to achieve this, but there were concerns about the sustainability of the improvements in light of staffing difficulties.

25.6 **Time to access treatment**

When asked about commissioners expectations regarding access times, Ms Blow described how commissioners make use of a service specification developed across a wider area than East Sussex which covers the standards expected across the whole stroke pathway. Local commissioning intentions are in alignment with this.

25.7 **Access for carers/visitors**

Whilst appreciating that it will be difficult for some visitors to travel further to a single unit, Dr Elias stated that patients prefer a better outcome from more intense initial treatment, followed by an earlier discharge to rehabilitation

services. The creation of a single hyper acute unit should offer better initial therapy support to deliver this. Mr Yunus added that the priority of carers is to get the best outcome for their loved one and this outweighs the travel issue.

Ms Blow clarified that patients would be taken to their nearest acute stroke unit which could be in Kent or Brighton, and that the Ambulance Trust can support patient travel. She added that patients' length of stay in hospital is expected to reduce so there may be additional travel but this would be over a shorter time period.

25.8 **Staff recruitment**
Ms Blow assured the Committee that commissioners had seen evidence of ESHT's recruitment problems and evidence that other areas had found it easier to recruit to a specialist hyper acute unit.

25.9 **Site preference**
Ms Blow stated that commissioners had no preference between Eastbourne and Hastings with regard to the location of the hyper acute unit and that this would need to be assessed using the set criteria. Mr Hoptroff added that commissioners expected best practice standards to be delivered regardless of the location.

25.10 **London model**
Dr Elias acknowledged that data on improved outcomes following the reconfiguration of stroke services in London is preliminary, but he emphasised that the local proposals had not been based on this data. The emphasis locally had been on sustainability. He argued that the change would be to some extent a 'leap of faith' but that early data from London was supportive of the proposed model.

25.11 **Quality of rehabilitation**
Dr Elias emphasised the need for the NHS and social care to work together in delivering effective rehabilitation. He stated the ambition of the CCGs to put East Sussex at the forefront of stroke care. Mr Yunus described ongoing work with providers to integrate health and social care, such as the establishment of Neighbourhood Support Teams linked to GP practice areas. He is confident this will lead to improvements. Ms Blow highlighted the opportunities arising from ESHT being an integrated acute and community Trust. She endorsed the need to work with Adult Social Care and emphasised that commissioning would cover the whole stroke pathway.

25.12 **24/7 Thrombolysis**
Mr Hoptroff confirmed that 24/7 access to thrombolysis is commissioned and any gaps would be addressed.

25.13 **Psychological support**
Dr Elias acknowledged the importance of psychological support for patients and their families in coping with the consequences of stroke and confirmed that this would be part of the package of care commissioned.

25.14 RESOLVED to:
(1) note the comments of commissioners.

26. STROKE CARE – PERSPECTIVE FROM EAST SUSSEX HEALTHCARE NHS TRUST

26.1 The Committee welcomed: Dr James Wilkinson, Divisional Director – Medicine and Emergency; Dr Mohammed Rahmani, Stroke Consultant and Primary Access Point Clinical Lead; Jenny Darwood, Clinical Service Manager – Stroke; and Jayne Boyfield, Associate Director of Integrated Care all from East Sussex Healthcare NHS Trust (ESHT).

26.2 **Relevance of London model**

When questioned on the reliability of data from London, Dr Wilkinson emphasised that this data is not the main basis of the preferred option for East Sussex and that the drivers for change are much wider. He highlighted sustainability issues related to the current two site model in terms of difficulty recruiting stroke consultants and other specialist staff who provide much of the care. Good quality care can be provided on the two sites but not in a sustainable way, whereas a single unit would provide a depth of staffing support.

Dr Rahmani clarified that the London model had centralised hyper acute care (the initial care for patients who are candidates for thrombolysis), not all acute care. Only 10-15% of patients are suitable for hyper acute care. He acknowledged that the London data had not yet been peer reviewed, but emphasised that the London experience had only been one consideration in developing what is a different service model for East Sussex. Dr Rahmani explained that the local model had been based on the population, required quality standards, safety and efficiency of delivery. Accessibility had also been a consideration but there are two issues to take into account: (i) time dependent pre-hospital care (where the Trust is working with the Ambulance service), and; (ii) post stroke care, which is not time dependent.

Dr Rahmani explained that a single unit had been proposed in order to deliver a range of quality standards, not just access to thrombolysis. The level of therapy available on the ward is also important. He highlighted a key difference from the London model in that all patients (whether eligible for thrombolysis or not) would go to the single unit which will provide acute and hyper acute care. Patients located nearer to stroke units at other Trusts would be taken there instead in order to minimise travel time.

26.3 **Reduction in beds**

Ms Darwood explained that the number of beds required in the proposed hyper acute unit was based on the number of patients (including an anticipated increase as awareness improves), best practice guidance regarding length of stay and early supported discharge and an 85% occupancy level to allow for peaks in activity. She highlighted that the proposed number of beds could not be directly compared with the number of beds in the current two stroke wards as these take non-stroke patients and undertake rehabilitation which would in future be delivered in community settings. Community inpatient rehabilitation beds at the Irvine Unit would be increased by 6 to 18 in total.

When asked about a Royal College of Physicians report which had highlighted the increasing complexity of need amongst hospital patients, Dr Wilkinson clarified that this related to general medical admissions. Stroke units are seeing a stable level of complexity but are treating these patients

more effectively, thus reducing their length of stay. He also reminded the Committee that some stroke patients would be expected to go to other Trusts where nearer to their location, and this reduction in activity at ESHT had also been factored in to bed numbers. Dr Wilkinson assured HOSC that flexibility would be retained as there could always be unexpected levels of demand.

26.4 **Rehabilitation at home**

Ms Boyfield agreed that the proposed acute pathway is reliant on effective rehabilitation being available in the community. She described how rehabilitation services had been expanded over the last two years, for example the development of a Joint Community Rehabilitation Service with social care which includes home care, therapy and nursing, with access to the specialist stroke teams. Commissioners have also invested specifically in stroke through the early supported discharge teams, which are a key enabler of reduced lengths of stay in hospital. These teams in-reach to the acute hospitals and the Irvine Unit. Ms Boyfield also highlighted that rehabilitation outside of hospital is not always undertaken in the patient's home, particularly if this is an inappropriate environment. Services can be provided on an outpatient basis at community hospitals.

26.5 **Staff recruitment**

Ms Boyfield stated that the better services are, the easier it is to recruit specialist staff, as they want to work where services are sustained and standards met. The Joint Community Rehabilitation Service had been able to attract both generic and specialist support workers, such as occupational therapists and neuro- rehabilitation staff. Recruitment of speech and language therapists had been more difficult but posts have been filled, some through agency workers. There is also a need for psychology input and this is currently being assessed. Ms Boyfield clarified that generic support staff are trained across a range of skills to NVQ level 3 and can provide support across all therapy areas.

26.6 **Loss of patients to other Trusts**

Dr Rahmani indicated that the impact of any loss of patients could not be fully assessed until a preferred site had been identified. Further modelling of the financial impact would be undertaken at this stage. Ms Darwood added that the modelling undertaken so far did include isochrones developed with the Ambulance Trust to provide an initial assessment of likely patient flows.

26.7 **Scanning capacity**

Dr Wilkinson acknowledged that there would be greater demand on CT scanning at the site hosting the hyper acute unit. He outlined the Trust's planned expansion of CT scanning on both sites to serve a range of 24/7 needs, not just stroke. Ms Boyfield explained that a second CT scanner is due to come on line at the Conquest Hospital in November and a business case is in development for a second scanner at Eastbourne Hospital. She added that the extra demand being on one site would make it easier to manage in relation to other priorities.

With regard to MRI scanning, Dr Wilkinson explained that this is primarily used for transient ischaemic attacks (TIAs) which are less urgent. There is no lack of capacity in terms of carotid Doppler scanning.

26.8 **Access to thrombolysis**

Dr Rahmani emphasised that thrombolysis is only one aspect of acute stroke treatment. Currently national levels are at c4-5% against an expectation of 10-15% set out in the National Stroke Strategy. ESHT now reflects the national picture with a rate of 4-5% on average. Dr Rahmani explained the need for properly trained staff to be available to administer thrombolysis safely and he suggested that a concentration of staff on one site would provide a better basis for delivery of thrombolysis.

26.9 **Community services**
Ms Boyfield assured the Committee that the development of the community services which would be needed to support the proposed model had already begun and there are few vacancies left to be filled, but there would be an ongoing need for review and flexibility. Dr Rahmani also gave an assurance that the commitment has been made and it is a case of getting the right people in place. Ms Darwood highlighted the importance of getting the right skill mix in the hyper acute unit to provide therapies seven days a week, since this is one of the most significant changes under the proposed model.

26.10 RESOLVED to:
(1) note the comments of the East Sussex Healthcare NHS Trust.

27. STOKE CARE – PERSPECTIVE FROM THE SUSSEX STROKE NETWORK

27.1 The Committee welcomed Julia Buck, Sussex Stroke Network Manager, Dr Rajen Patel, Network Clinical Lead and Dr David Hargroves, Strategic Health Authority Clinical Lead.

27.2 The Network representatives responded to questions on the following issues:

27.3 **Access times**
When asked to clarify the optimum time within which patients should access thrombolysis or acute stroke care, Dr Hargroves emphasised that the best possible care is as quick as possible, whether the patient is suitable for thrombolysis or not. However, although the chances of recovery decrease the longer it takes to access treatment, the quality of care available also has a significant impact, therefore the configuration of services must reflect a balance of these two factors.

Dr Hargroves stated that thrombolysis can be administered up to 4.5 hours from the onset of symptoms and evidence is currently suggesting this could be extended to 6 hours, with many units already working to the extended timescale. He clarified that the Ambulance Trust may have referred to a time of 5.5 hours because this is the window specified for their purposes by the Strategic Health Authority. Stroke should be treated as a category A call.

Dr Hargroves indicated that modelling had identified a 10 minute variation in access times depending on which site was chosen as the location of a single hyper acute unit. Dr Patel clarified that the modelling was based on Ambulance Trust data showing a current average travel time of 30 minutes which would increase by 15 minutes if the unit was located at the Conquest Hospital and 5 minutes if the unit was located at Eastbourne Hospital.

Dr Patel advised the Committee that a slight increase in average journey times had to be set against an increase in the quality of care. He indicated that if the quality of care is better, there will be better outcomes for patients.

27.4 **End of life care**

Ms Buck confirmed that the Integrated Service Specification for stroke included a section on end of life care and that the network would expect the proposed ESHT model of care to meet these standards.

27.5 **Examples of reconfigured services**

Dr Hargroves told the Committee that there are numerous examples where stroke services have been reconfigured recently, but there is little data available from these as it can take several years to collect and peer review data. He cited an example in the Bournemouth area where two sites had been consolidated onto one and reductions in mortality had been achieved. However, he cautioned that it is difficult to compare different areas due to the different geography and case mix.

27.6 **Hyper acute unit standards**

Dr Hargroves confirmed that the Integrated Service Specification sets out the standards required of a hyper acute stroke unit. He clarified that on site access to endovascular and neurosurgery is not required, but a protocol must be in place with regard to their access. Dr Hargroves indicated that approximately 2% of patients would require transfer to access these services and that transfer should ideally be within 1 hour or as near as possible to this. If transfer is achievable within an acceptable time the location of the local hyper acute unit is irrelevant, in his view.

27.7 **Staff recruitment**

Dr Hargroves indicated that, anecdotally, it is known that highly trained professionals prefer to work at larger sites as they are working alongside a wider range of highly trained colleagues and see more patients. Ms Buck, who herself has a clinical background, supported the view that a consolidated hyper acute unit would attract staff.

27.8 **Length of stay**

When asked whether the Trust's estimated reductions in length of stay are realistic, Dr Patel indicated that this is based on better care, early supported discharge and patients being able to leave acute care sooner. He stated that the number of acute beds proposed by the Trust should be sufficient to accommodate the number of patients based on a reduction in average length of stay from 15 to 10 days. He also noted the proposed increase from 12 to 18 stroke rehabilitation beds at the Irvine Unit.

Dr Patel advised that ESHT is ahead of some other areas with regard to early supported discharge. Nationally it is estimated that 40% of patients could be suitable for this approach, but the elderly population in East Sussex means this could be ambitious. Ms Darwood confirmed that the calculation of bed numbers had been based on significantly less than the 40% target, recognising the local population make up. She also confirmed that an increased number of side rooms and single sex bays had been built into the proposals to ensure flexibility in deployment of beds.

27.9 **Improvements on two sites**

Ms Buck recognised that ESHT had worked hard to achieve recent improvements in performance against key targets at the two hospitals, but she did not regard these as sustainable in the current circumstances. She described the measures taken as a 'sticking plaster' and advised the Committee that there are a range of other targets the Trust would struggle to meet without change.

27.10 RESOLVED to:
(1) note the comments of the Sussex Stroke Network.

28. COMMUNITY SERVICES – NHS PERSPECTIVE

28.1 The Committee welcomed Jayne Black, Deputy Director of Strategic Development; Flowie Georgie, Associate Director of Urgent Care and Jayne Boyfield, Associate Director of Integrated Care from East Sussex Healthcare NHS Trust (ESHT) and considered the report attached to the agenda.

28.2 The ESHT representatives responded to questions as follows:

28.3 **Timing of changes**
Ms Georgiou assured HOSC that many of the planned developments in community services, which would support delivery of the Clinical Strategy, are already starting. For example, phase one of the Neighbourhood Support Teams initiative with social care went live on 1 April 2012 and more teams would be transferred into this model in further phases. She added that some acute staff are starting to migrate into community roles and this would continue as changes are made.

28.4 **Rapid response service**
When asked what services will be available when patients require a rapid response, Ms Georgiou explained that part of the Neighbourhood Support Team model is a rapid response capacity. Other initiatives include data sharing with the Ambulance Trust in relation to frequent users of services to enable paramedics to contact ESHT when called to these patients and enable an alternative to hospital admission to be arranged where appropriate. This scheme will be extended to other patients in due course.

When patients do arrive at hospital, the Hospital Intervention Team are in place to facilitate rapid turnaround of patients – this team works with both frequent users and other patients. Ms Boyfield explained that their aim is to return patients home, or to an alternative community location in conjunction with social care, on the same day. This is currently being achieved for 60% of patients seen by the team, showing a good return on investment.

28.5 **Input from relatives/carers**
Ms Boyfield indicated that the need for input from relatives and carers would depend on the individual. If appropriate support is not available some patients may not be able to return home or will require extra support. She suggested that society increasingly depends on carers but as the population ages this may be less feasible. Ms Boyfield highlighted the increasing ability of services to respond on the same day without relying on carers.

28.6 **Source of investment**

When asked how investment could be made in community services before savings had been achieved from changes to acute services, Ms Black explained that specific reablement funding had been used to develop the new services discussed. ESHT has also discussed with commissioners making an investment of £10m over a period of years as part of the strategy to shift activity to the community and disinvest in acute services. Ms Black highlighted the importance of key services such as Neighbourhood Support Teams in underpinning all parts of the clinical strategy, particularly primary access points such as acute medicine and cardiology.

28.7 **Engagement of partners**

Ms Black highlighted good engagement from patients, carers and partners throughout the development of the clinical strategy. Feedback on community services had contributed to the establishment of a community redesign group which looked at the requirements of all the primary access points and commissioners' intentions.

28.8 **Impact on most vulnerable**

The Committee expressed concerns as to whether the shift of activity into the community could have a disproportionate impact on more vulnerable or isolated groups and potentially exacerbate health inequalities. Ms Georgiou explained how population needs had been profiled and resources for Neighbourhood Support Teams had been allocated on this basis, coupled with risk stratification of known service users. In this way an attempt was being made to tailor the level of care to the level of need in different areas. Ms Georgiou also argued that better local access to care would be likely to keep people healthier at home for longer rather than being frequently admitted to acute units.

Ms Boyfield added that ESHT is unusual as an integrated Trust, in that it provides a range of public health services such as health trainers and smoking cessation which are important for both primary and secondary prevention in relation to conditions such as stroke. These services are focused in the areas of highest need and can also be brought to patients on the ward.

Ms Black acknowledged that carers had raised the issue of isolation if patients receive more care at home. She highlighted that community based care is not always at home, but also in other settings such as community hospitals or health centres.

28.9 **Assumptions**

Ms Boyfield advised the Committee that assumptions regarding reduced admissions are based on commissioning intentions which, although based on the best available evidence, are also a leap of faith. The introduction of a triage type function enables alternatives to be identified where possible but there will always be people who require admission. She indicated that data is collected to measure the effectiveness of new approaches, such as the Hospital Intervention Team, and if a service is not having the desired impact the approach will be changed.

28.10 **Generic teams**

Ms Georgiou assured HOSC that the use of generic support teams is about having a more flexible approach which is more able to support patients with a

number of health conditions, rather than being a compromise. Best practice is now to focus on needs rather than a specific medical diagnosis.

28.11 **Alignment of resources to need**
Ms Georgiou confirmed that Sussex Partnership NHS Foundation Trust and Adult Social Care are involved jointly with the Trust in discussing the next phase of Neighbourhood Support Teams and services are being realigned across partners in anticipation. She expressed confidence that this would lead to a more responsive approach.

28.12 **Patients of other Trusts**
Ms Black confirmed that the ESHT community services which had been discussed would be available to East Sussex residents discharged from other Trusts.

28.13 RESOLVED to:
(1) note the comments of the ESHT representatives.

29. COMMUNITY SERVICES – ADULT SOCIAL CARE PERSPECTIVE

29.1 The Committee welcomed Beverly Hone, Assistant Director – Strategy and Commissioning and Mark Stainton, Assistant Director – Operations, of East Sussex County Council's Adult Social Care department, and considered the report attached to the agenda.

29.2 **Cultural differences**
Mr Stainton acknowledged that there are cultural and practical differences between the NHS and social care but highlighted the inextricable link between the two and how essential it is to take the integrated approach being pursued in East Sussex. Experience from establishment of the Joint Community Rehabilitation Team from April 2012 had identified issues regarding different IT systems, policies/procedures, culture and terms and conditions of staff. However, these issues are not presenting significant problems at this stage and the focus is on delivering an integrated, patient centred pathway across all disciplines.

29.3 **Individual budgets**
Ms Hone explained that where patients require a discrete element of social care in their package they are able to use their allocated personal budget. The NHS is developing personal budgets for long term conditions which could present opportunities in the future to design individual packages of care, but this is some way off.

29.4 **Support for carers**
Ms Hone agreed that carers are a critical part of the picture in moving towards more care provided closer to home. She confirmed that Adult Social Care has a responsibility to assess carers' needs and provide appropriate support and respite. The Department of Health has recognised the NHS responsibility towards carers and funding will be transferred from the health service to expand support for carers.

When asked about the identification of carers Ms Hone agreed that it would be a positive step to identify more carers, and the links to GP surgeries through the Neighbourhood Support Team model may help with this. It will be

important to ensure there is a clear pathway within this model for carers to access the available support. An increase in demand, as more carers are identified, will be challenging given financial constraints. However, the additional NHS funding will potentially increase what is available and Adult Social Care is working with carers to ensure resources address their priorities.

29.5 **Market development**

Ms Hone assured the Committee that Adult Social Care recognised the added value which could be brought to services by voluntary sector organisations through their local links, and that this had been reflected in the investments made through the Commissioning Grants Prospectus. It is possible that more services will be commissioned through this route in the future. Ms Hone also highlighted the Support with Confidence scheme which aims to support increased choice and diversity of providers, both voluntary and independent sector. The development of an on-line resource directory also aims to support choice through better information.

29.6 **Integrating health and social care services**

Mr Stainton explained that, as the Joint Community Rehabilitation scheme is in its early stages, only initial findings on performance and feedback are available, but these are very positive. Early benefits are being seen in terms of avoiding admissions and more people requiring reduced or no ongoing support, thus increasing their independence. Mr Stainton added that the development of this service had generated learning in relation to bringing services from different organisations together. The importance of a clear vision and objectives is evident in helping people work together, as is strong staff engagement.

29.7 **Impact of reconfiguration on Adult Social Care**

Ms Hone assured HOSC that the impact of any NHS service reconfiguration would be closely monitored in terms of quality, performance and budget and that Adult Social Care has good information on costs which enables tracking over time. It would be important to distinguish between an initial peak in demand and ongoing pressures. She added that there had been a specific allocation of NHS funds to social care to recognise the impact of the NHS direction of travel, i.e. shifting more care into community settings, on social care services.

Ms Hone advised the Committee that some services are already jointly funded, such as the provision of equipment, and both partners will need to recognise that additional resources will be needed to support more people in their own homes. Mr Stainton indicated that the way resources are deployed will change in the future, for example increased focus on short term rehabilitation and a preventative approach to long term conditions via the Neighbourhood Support Teams.

29.8 **Means testing of social care**

HOSC questioned how integrated services such as Neighbourhood Support Teams are affected by the different funding arrangements – the free at point of use NHS model versus the means tested social care model. Mr Stainton explained that the Teams provide an assessment and care management function from a social care perspective, and there remains a clear distinction in terms of provision of services. If a patient is assessed as having a social care need, this element of their care will be means tested.

29.9 **Sustainability**
Mr Stainton acknowledged that both social care and the NHS have to make savings and address demographic pressures. He indicated that the integrated approach will offer both parties greater efficiency and therefore release resources to address these pressures. He emphasised that integration is the right approach to take, and it needs to be accompanied by a shift of NHS resources from acute to community settings which will enable savings to be made alongside investment in community services.

Ms Hone advised HOSC that the community services models being established in East Sussex are based on the best available national evidence and represent the best opportunity to achieve a sustainable position. There is not an obvious alternative approach. She highlighted the need to recognise the demand avoided through the new approaches (i.e. the difference from making no change).

29.10 RESOLVED to:
(1) note the comments of the Adult Social Care representatives.

30. 'SHAPING OUR FUTURE' – PERSPECTIVES FROM THE VOLUNTARY AND COMMUNITY SECTOR

30.1 The Committee welcomed: Alan Keys, Chair – East Sussex Local Involvement Network; Sandra Field, Regional Head of Operations – Stroke Association; Kate Davies, Chair – East Sussex Seniors Association; and Jennifer Twist, Chief Executive – Care for the Carers. Written submissions had been provided by the first three organisations and attached to the agenda.

30.2 The voluntary sector representatives initially commented on the NHS proposals and consultation process from a patient/carer perspective:

30.3 **East Sussex Local Involvement Network (LINk)**
Mr Keys welcomed the improved openness and engagement with patients by East Sussex Healthcare NHS Trust (ESHT), and he applauded the engagement with Adult Social Care. He indicated that the community services redesign work has potentially big benefits but also carries considerable risk, given that it is a large shift taking place in a relatively short time whilst organisations are under financial pressures. It is a large undertaking with practical issues, such as different IT systems, to resolve.

In terms of the specific proposals for change, Mr Keys stated that the intentions behind them are excellent. However, there are concerns regarding the savings required at ESHT over the next few years. The LINk sees its role as protecting patients and carers in order to prevent gaps in services, particularly in rural areas, as pressures increase.

30.4 **Stroke Association**
Ms Field informed HOSC that the Association is a campaigning organisation in relation to stroke care, as well as a provider of services in East Sussex. The Association wants to see excellent care which is accessible for all. It is hoped that the new model for stroke care developed though the Clinical Strategy review will provide excellence. Ms Field indicated that research is

positive about the benefits of community rehabilitation, suggesting that the sooner patients can be discharged from the acute hospital the better. However, it is essential that adequate community provision is in place, including support for carers.

30.5 **East Sussex Seniors Association (ESSA)**
Ms Davies indicated that ESSA wishes to see excellent, infection-free, care in any hospital used by East Sussex residents. ESSA members had some concerns regarding the need to transfer between hospitals and the reduction in choice associated with the creation of specialist units. As a number of hospitals serving East Sussex are based outside the county, Ms Davies stated that ESSA had found it hard to say where such units should be based.

30.6 **Care for the Carers (CftC)**
Ms Twist informed the Committee that CftC had been engaged from the start of the Clinical Strategy process, supporting the involvement of carers and the overall engagement had been good. She indicated that carers have some concern about the volume and speed of change, particularly as carers often pick up the pieces if services fail. There are also some concerns about the future financial situation.

Ms Twist highlighted several issues which had been raised by carers:

- The importance of quality and safe care which meets best practice – this was the main issue raised.
- The desire of carers to be involved as partners in care.
- The importance of community services working smoothly. The development of Neighbourhood Support Teams is welcomed and must include access to carers' services.
- The importance of transport if the cared for person or carer is in hospital.
- The need for health and social care to work together, especially in relation to discharge.
- Cutting through bureaucracy – it is felt there is more to do here.
- The importance of a preventative approach, stepping in early to prevent breakdown – it is hoped that the additional NHS carers' funding will support this.

30.7 The voluntary sector representatives responded to questions as follows:

30.8 **Staff morale and engagement**
Mr Keys elaborated on his written comments regarding poor staff morale within ESHT. He informed HOSC that recent relatively poor staff survey results had been recognised by the Trust as an issue to address. He acknowledged that change does inevitably impact on staff morale, but staff need to be highly motivated in order to deliver the right care. Mr Keys highlighted the potential risk of an impact on patient care if staff are not well motivated. This is why the LINk wants to see the issues raised by staff addressed.

In relation to the Clinical Strategy process, Mr Keys advised HOSC that staff workshops had been offered to staff at all levels and had been well run. The Trust had not expressed a view at these events and had started with the intention of working with staff to design the best model of care. Mr Keys' impression was that staff had been able to contribute openly without a heavy management hand at play, although there is an inevitable hierarchy in large organisations.

30.9 **Overall view of patients/carers**

When asked for a picture of patient/carer views on the specific proposals, Ms Twist indicated that there is worry, primarily based on people's current experience, but also recognition that change is needed. Carers have to trust that the promised improvements will be delivered. It is felt that more attention is needed on the underpinning elements of the strategy such as supporting carers at end of life, liaison in GP surgeries and hospitals, and better community services. There will be a need for more services for carers as more are identified. CftC will be engaging further with carers before submitting a formal response to the consultation and has no firm view yet.

Ms Davies indicated that there are too many changes happening too quickly for many older people to understand, such as changes to staff job titles which leave people unsure if the service itself has changed. There had also been some concern regarding the difficulty of explaining the implications of the proposals and whether the 'glossy' consultation document was helpful.

Ms Field indicated that the consultation had been good and the Association's Stroke Co-ordinators had raised awareness amongst patients. However, current patients are most interested in their immediate experience of services rather than future configuration. Research shows that people want care from a stroke expert and to be involved in their care. Psychological support has been identified as a gap locally.

Mr Keys was of the view that meaningful consultation with all residents of East Sussex is virtually impossible given the complexity of the issues and the general lack of interest unless people are directly affected by service change. LINk representatives have therefore tried to look at proposals from a patient viewpoint and have sought wider opinions where possible, recognising this will be limited. There had been a generally positive response to the proposals, particularly on stroke care, where the need to improve is widely recognised. However, others, such as the Save the DGH campaign, have opposed the plans so there is not unanimity of opinion.

30.10 **Clinical leadership**

Mr Keys expanded his written comments about the failure of the consultant committees at the Conquest and Eastbourne Hospitals to integrate by suggesting that consultants were failing to provide the necessary clinical leadership and support to management in developing a first class Trust. He indicated that consultants from the two hospitals needed to work together and his impression was that there was more openness to this at the Conquest than at Eastbourne. Mr Keys said that there could be practical issues with implementation of changes if consultants were to refuse to work at the other hospital site, but that it should be possible to resolve this with management action.

30.11 RESOLVED to:

(1) note the comments of the voluntary and community sector representatives.

The Chairman declared the meeting closed at 1.48pm