HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee (HOSC) held at County Hall, Lewes on 12 September 2013

PRESENT:

Councillor Ensor (Chair), Councillors O'Keeffe (Vice-Chair), Standley and St Pierre (all East Sussex County Council); Councillor Ungar (Eastbourne Borough Council); Councillor Phillips (Wealden District Council); Councillor Merry (Lewes District Council); and Julie Eason (SpeakUp)

WITNESSES:

Urgent Care Network
Dr Susan Rae, Co-Chair

Clinical Commissioning Groups (CCGs)/East Sussex County Council
Nicky Young, Whole Systems Programme Manager

Hastings and Rother CCG/Eastbourne, Hailsham and Seaford CCG
Amanda Philpott, Joint Chief Operating Officer and Accountable Officer
Catherine Ashton, Associate Director of Strategy and Whole Systems Working

East Sussex Healthcare NHS Trust (ESHT)
Stuart Welling, Chairman
Darren Grayson, Chief Executive
Dr Andy Slater, Medical Director (Strategy)
Pauline Butterworth, Deputy Chief Operating Officer (Operational)
Jayne Phoenix, Director of Community Services
Lindsey Stevens, Head of Midwifery

South East Coast Ambulance Service NHS Foundation Trust
Geraint Davies, Director of Commercial Services
Dr Jane Pateman, Medical Director
Anouska Adamson-Parks, NHS111 Programme Director

East Sussex County Council - Adult Social Care
Beverley Hone, Assistant Director (Strategy and Commissioning)
Mark Stainton, Assistant Director (Operations)

Sussex Partnership NHS Foundation Trust
Ian Watling, Service Director for Older People's Mental Health

LEAD OFFICER: Claire Lee, Scrutiny Lead Officer

11. APOLOGIES

11.1 Councillors Carstairs, Pragnell and Wincott (East Sussex County Council), Councillor Davies (Rother District Council), Councillor Poole (Hastings Borough Council), Dave Burke (SpeakUp).

12. MINUTES

12.1 RESOLVED to confirm as a correct record the minutes of the meeting held on 20 June 2013.

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. URGENT CARE

15.1 The Committee considered a report by the Assistant Chief Executive which set out some of the issues and challenges faced by health and social care partners in improving the way the healthcare system responds to urgent needs.

15.2 Dr Susan Rae, a GP and Co-Chair of the East Sussex Urgent Care Network, gave a presentation on the role of the network and the workstreams it is focusing on in order to improve the effectiveness of the urgent care response. Representatives of the East Sussex Clinical Commissioning Groups (CCGs), East Sussex Healthcare NHS Trust, South East Coast Ambulance Service NHS Foundation Trust and East Sussex County Council (as listed above) were also present to explain their roles.

15.3 The representatives responded to questions from the Committee covering the following issues:

15.4 **System complexity**
Dr Rae agreed that the system is complex for patients to understand. She emphasised that GPs remain the first point of contact for patients in working hours, unless it is an emergency. If the patient requires help out of hours, their GP practice will have an answerphone message with instructions on what to do. NHS 111 is now the main point of contact out of hours and Dr Rae indicated that there has been a decrease in the use of GP out of hours services, Accident and Emergency (A&E) departments and ambulance conveyances to hospital since the introduction of the 111 telephone number in April 2013.

Amanda Philpott indicated that East Sussex is typical of all areas of the country and that it has been recognised nationally that urgent care is too complex. She emphasised that urgent care starts in the community but, if the pathways are not clear, patients will end up in the acute sector even if this is not clinically necessary or appropriate. Ms Philpott assured HOSC that the CCGs will be reviewing the urgent care system, are clear on what it needs to do and on the need to ensure primary care services are a key part of the patient pathway.

15.5 **Awareness of NHS 111**
Anouska Adamson-Parks advised HOSC that there had been no national marketing of the NHS 111 service as yet, due to regional variation in the readiness of the service. Locally, marketing had been delayed to allow additional

time for the service to bed in. Ms Adamson-Parks acknowledged that this may have been confusing for patients who could have been redirected to NHS 111 without having sufficient information about what the service does.

The launch of 111 locally is now underway, with thousands of leaflets distributed via CCGs, coupled with advertisements in bus shelters and on local radio. This local promotion is seen as an interim approach pending the national launch which will include TV advertising.

15.6 **Role of NHS 111**

Ms Adamson-Parks clarified that NHS 111 can route people to the most appropriate service for their needs and in some cases can make an electronic referral to the relevant service. With regard to repeat callers, Ms Parks advised that the system has a frequent user process which flags up the patient's potential complexity and ensures they are spoken to by a GP. In addition, a special note can be added to the patient's record to provide additional details on their condition or care plan, where this is appropriate.

15.7 **Information systems**

Geraint Davies acknowledged the complexities of joining up different information systems. He described how the ambulance service is working successfully with GPs in East Sussex on risk stratification, i.e. identifying higher risk patients with multiple co-morbidities. These patients can be added to an IBIS database, together with details of their conditions and care plan, which enables the Ambulance Service to provide the most appropriate response when called out to them. This can include avoiding hospital admission by helping the patient access alternative services in primary/community care or through the Ambulance Trust's own staff. The system has reduced conveyances to hospital.

Mr Davies advised HOSC of national evidence suggesting that 5% of the population are the heaviest users of health services and that IBIS is intended to focus on this cohort first. He acknowledged that it is a pragmatic solution developed locally pending the development of a whole system electronic patient record.

15.8 **Role of walk-in centres**

Nicky Young clarified that the original aim of NHS walk-in centres, such as those provided in East Sussex at Eastbourne and Hastings stations, was to address the needs of the more transient or mobile populations such as students, visitors and commuters. However, experience locally is that they have also been used by local populations who are less likely to have registered with a GP, such as homeless people, those with chaotic lifestyles or younger people of working age. They do not tend to be used by older people, who generally prefer their own GP and are able to access their practice in working hours.

Ms Young indicated that the centres are part of a complex picture of urgent care services which had grown up over many years, all offering slightly different services at different times. She advised that the walk in centres, along with similar services such as minor injury units, will form part of the wider review or access points to urgent care which will focus on patient needs and why patients choose different services.

15.9 '**Take home and settle' service**

Ms Young confirmed that this service, provided by Age UK at the Conquest and Eastbourne Hospitals, is jointly funded by Adult Social Care and the CCGs. It works closely with the social care and therapy team located at the front of the

hospitals to identify patients who require additional support and reassurance to return home. The service can accompany a patient home, undertake basic tasks such as urgent shopping, and ensure the patient is back in touch with their own local support networks. If further problems emerge on returning home, the service will stay with the patient until they are in touch with appropriate services.

15.10 **Access to social care services**

Mark Stainton confirmed that patients can access social care services through a variety of routes and do not have to be admitted to hospital in order to do so. Adult Social Care teams undertake assessments in the community and are able to do this rapidly in order to prevent unnecessary admissions to hospital.

Mr Stainton described the role of the Hospital Intervention Team (HIT), a joint social care and nursing team working seven days a week on the 'gateway' hospital areas – A&E and Medical Assessment Unit – to organise packages of care and support in the community which will enable patients to return home without being admitted to an inpatient ward.

Mr Stainton explained that reablement, provided by the Joint Community Rehabilitation Service (JCRS), is a non-means tested short-term intervention of up to 6 weeks to help people regain independence. In the first year of the JCRS (2012/13) over 1000 hospital admissions had been avoided and 60% of the team's referrals come from the community rather than acute hospitals.

15.11 **Winter preparedness**

When asked whether ESHT had confidence that the wider system developments would adequately support the hospitals during the winter peak period, Pauline Butterworth agreed that a number of avenues have been created to help patients access alternative services outside of hospitals. She acknowledged that a side-effect of this range of services is potential confusion amongst patients.

In terms of the impact to date, Ms Butterworth indicated that a decrease in A&E attendances had been seen at Eastbourne Hospital. However, there had been an increase at the Conquest Hospital and further analysis is underway to understand the reasons behind this.

With regard to the Trust's own preparations for winter, Ms Butterworth advised that plans include boosting staffing, opening additional ward capacity from December and reviewing the skill mix to bring senior decision makers into the pathway at an earlier stage. Changes to skill mix are being supported by additional winter pressure funding being made available to the Trust and its partners by the Department of Health. Ms Butterworth emphasised that plans did not only relate to A&E and that the Trust is also looking to expand intermediate care services for patients who do not need an emergency service.

Ms Butterworth assured HOSC that escalation plans are in place for peak times and that the Trust is working with the Urgent Care Network, Integrated Care Network and Local Resilience Forum to identify options if a hospital site comes under particular pressure.

15.12 **A&E staffing**

Darren Grayson confirmed that ESHT reflects the national picture in terms of A&E medical staffing. He indicated that recruitment to A&E consultant posts is challenging and the reasons for this have been explored in a recent report by the College of Emergency Medicine. The Trust has 10 consultant posts, of which 2.5 are currently vacant. On-call arrangements are initially led by junior and middle

grade doctors, with a consultant available on-call to provide senior input. Mr Grayson suggested that national media coverage highlighting a very small number of hospitals with a consultant on duty in A&E at night probably reflected the fact that most district general hospitals operated a similar on-call arrangement to ESHT and it is likely that only large hospitals with major trauma units would have a consultant on duty around the clock.

15.13 **Child safeguarding**
Dr Andy Slater assured HOSC that ESHT is very aware of safeguarding and has ensured that it has a high profile, including providing staff with additional information on how to recognise a child who is being abused. He acknowledged that it is far more challenging to join up information across organisations, particularly if an abuser is wilfully deceiving services, for example by using multiple access points to avoid detection. Work to improve communication is led by the Local Safeguarding Children Board.

15.14 **Implementation**
Ms Young assured HOSC that the Urgent Care Network has a delivery plan which is monitored. This is based on the identification of risks and barriers, with mitigating measures forming the agreed actions.

15.15 RESOLVED:
(1) Welcome the co-ordinated approach being taken through the Urgent Care Network.
(2) Request that HOSC is kept informed of the CCG review of access to urgent care.
(3) Write to the Chair of the Local Safeguarding Children Board to request further information on work being undertaken by the Board to improve information sharing between services, with particular reference to children accessing urgent care in multiple locations.

16. <u>MATERNITY AND PAEDIATRICS</u>

16.1 The Committee considered a report by the Assistant Chief Executive which provided updates on two aspects of maternity and paediatric services: the performance of East Sussex Healthcare NHS Trust (ESHT) services following temporary changes to their configuration; and the development of future commissioning plans for these services across East Sussex by the Clinical Commissioning Groups (CCGs).

16.2 Darren Grayson, Chief Executive and Lindsey Stevens, Head of Midwifery presented the ESHT update. Mr Grayson indicated that the temporary changes had yielded a positive impact, in the Trust's view. The following points were made in response to the Committee's questions:

16.3 **Complaints**
Mr Grayson agreed that complaints are a valuable source of learning and he assured the Committee that the Trust has a system in place which enables this to happen. He acknowledged that there had been an increase in complaints relating to paediatric services since the temporary reconfiguration but advised that many of these related to the move of location rather than the quality of the service.

16.4 **Flexibility in peak periods**
Mr Grayson clarified that gynaecology patients can, on occasion, be redirected between hospitals for planned care during busy periods, and that this is part of the Trust's flexible use of the two main hospitals to manage demand.

Ms Stevens highlighted the innate unpredictability of demand for maternity services and outlined how the Trust manages the provision of post-natal support in busy periods, for example sometimes transferring women to the midwifery-led units after the birth. She also highlighted the role of community midwives in providing post natal support and the fact that women may transfer to the care of this team at home rather than being discharged from the service. Notwithstanding these arrangements, there may be very busy periods where some women are asked to return home sooner than usual due to high pressure on ward space, but women are not discharged inappropriately at night.

16.5 **Midwifery staffing**

Ms Stevens indicated that the Trust uses the Birthrate Plus methodology to calculate the ideal staffing based on the number and acuity of women using the service. The Trust is very close to this level, which Ms Stevens described as a 'gold standard', and is one of the better staffed services in the South East Coast area. Ms Stevens advised that seven newly qualified midwives had recently been appointed to full time posts which brings the Trust up to full establishment levels, although there will always be times of staff sickness or other absence.

16.6 **Consultant staffing**

Mr Grayson indicated that the Trust's number of obstetrics/gynaecology consultants (11) is quite high for the population served. He suggested that Royal College representatives, who had recently visited the Trust, may make some comment on the medical skill mix in their report.

16.7 **Care Quality Commission – Paediatrics**

Mr Grayson confirmed that the Care Quality Commission had found no basis for concerns raised by Eastbourne paediatricians about the temporary service configuration. He clarified that the temporary changes were driven by safety issues in obstetric services, not paediatrics, but that due to the close links between the services, inpatient paediatrics and neonatal services had also needed to temporarily reconfigure.

16.8 **Serious incidents**

Mr Grayson acknowledged HOSC's view that it is too early to gain a reliable picture of the impact of the changes on the level of serious incidents and agreed that the figures will need to be reviewed over a longer period. However, Ms Stevens advised that staff in the service had reported a decrease in incidents.

16.9 **Babies born before arrival of assistance**

Ms Stevens assured HOSC that the number of babies born before the arrival of assistance is closely monitored and that she is aware of concerns, particularly in the Eastbourne area, regarding additional travel time. She advised that there have always been babies born very quickly, before arrival at a maternity unit, and the average numbers are currently three per month, which is no different to the previous year. An increase during July was reviewed and it was found that the majority of these women were from the Hastings area rather than Eastbourne.

16.10 **Access to caesarean sections**

In relation to women's access to caesarean section when giving birth at a midwifery-led unit, Ms Stevens explained that it is very unusual for there to be a sudden need for the procedure. In general, the need for it can be identified well in advance and a timely transfer can be arranged from a birthing unit or home birth to the obstetric unit. Data from the Eastbourne midwifery-led unit shows that most women transferred to the Conquest had been on the labour-ward for 4

hours before their birth. Ms Stevens clarified that being in a midwifery-led unit does not change the threshold for needing an unexpected emergency caesarean section but there is evidence that the need is reduced as the birth is more likely to stay 'normal' in this environment.

16.11 **Safety of midwifery-led units**
Ms Stevens assured HOSC that there is no national or international evidence to suggest any danger for low risk women in giving birth in a midwife-led environment (including home birth). There is also no evidence of any difference in outcomes related to the distance to an obstetric unit. She explained that the decision on place of birth is taken jointly by the woman and her midwife, and that the discussion includes a conversation about the potential need for a transfer.

16.12 Amanda Philpott, Joint Chief Operating Officer and Accountable Officer, Eastbourne, Hailsham and Seaford/Hastings and Rother CCGs, presented the update on development of commissioning plans. She was also speaking on behalf of High Weald Lewes Havens CCG and highlighted that CCGs commission services for the entire population from a range of providers. Ms Philpott made the following points by way of introduction:

- The CCG Boards receive monthly reports on the safety of maternity services and the CCG lead nurse works closely with ESHT to monitor the temporary arrangements.
- When the temporary changes were agreed, an 18 month timeframe was set for reaching a decision on the long term future of the services.
- The process for reaching a decision on the long term will learn from the previous process in 2007/8.
- The CCGs began an engagement phase in July, focused on discussing the case for change, which closes in mid-September.
- The process will now move into a discussion on the pros and cons of different options and the criteria for appraising options.
- The CCGs want to undertake further engagement with the public and clinicians on the development of options during the autumn and therefore plan to begin a formal consultation process in January 2014.
- Following consultation the CCGs would be expected to reach decisions by July 2014, and they will engage with partners, including providers, to inform their decision.

16.13 The following points were made in response to questions:

16.14 **Paediatrics case for change**
Ms Philpott indicated that the case for change is based on the advice of the Royal College of Paediatrics and Child Health with regard to networking of paediatric services, for example the potential use of local ambulatory care units to provide access, rather than inpatient wards. She confirmed that the CCGs are engaged with the Children and Young People's Board and that commissioners are aware of the need to look at the provision of consultant paediatrician support for looked after children.

16.15 **Engagement process**
Ms Philpott welcomed advice on maximising engagement with affected groups, as well as the public at large, and recognised that there can be a perception that decisions have already been made which discourages engagement. The CCGs were disappointed to have to cancel some focus groups due to lack of attendance, but have replaced these with different ways to reach target

audiences through other events and groups, for example working with children's centres and with local Healthwatch.

HOSC recommended working with local voluntary and community sector organisations, particularly in Hastings where some innovative consultations have been undertaken. The Committee also noted the lack of take up of focus groups in the west of the county and suggested this area should be targeted. Ms Philpott specifically agreed to contact the East Sussex Foster Care Association. She also clarified that comments and suggestions can continue to be submitted throughout the next phase of engagement and that the website, survey and newsletters would remain active.

16.16 **Proposals – level of detail**
Ms Philpott supported the principle of providing the best possible evidence and information to support consultation and decision making. She assured HOSC that a range of data would be made available, without overloading people, and that the CCGs want the process to be as transparent as possible.

16.17 RESOLVED to:
(1) welcome the additional period of public and clinical engagement.
(2) arrange an additional HOSC meeting in early January 2014 to consider CCG proposals for maternity and paediatric services.
(3) request a further report on the progress of the engagement and options development process in November 2013.

17. <u>EAST SUSSEX HEALTHCARE TRUST (ESHT) CLINICAL STRATEGY</u>

17.1 The Committee considered a report by the Assistant Chief Executive which included an update from East Sussex Healthcare NHS Trust (ESHT) on progress with implementing reconfiguration of stroke, orthopaedic and general surgery services.

17.2 Darren Grayson, Chief Executive, Stuart Welling, Chairman and Dr Andy Slater, Medical Director (Strategy) from ESHT presented the report. Amanda Philpott, represented the Clinical Commissioning Groups (CCGs).

17.3 Mr Welling informed HOSC that the ESHT Board had informally undertaken an initial review of the draft Full Business Case (FBC) for the Clinical Strategy and had decided to hold an additional dedicated Board meeting in October at which it would be formally considered. This will not cause any further delay to the NHS Trust Development Authority (TDA) decision, which is planned for their January 2014 Board meeting, but will enable ESHT further time to ensure the FBC meets the TDA requirements.

17.4 With regard to the status of the three services subject to reconfiguration, Mr Grayson summarised as follows:

- Stroke services were successfully centralised in Eastbourne in late July. This is the first phase of the reconfiguration which brings the acute service onto one site. The FBC contains a detailed plan to get the service to a gold standard.
- Emergency and higher risk planned general surgery services are planned for consolidation at the Conquest Hospital in November, subject to a detailed internal assurance process including equipment and estates considerations. The clinical pressures in this service are driving the move before the winter peak.
- Orthopaedic services will not move until spring 2014, after the outcome of the FBC process.

17.5 Mr Grayson indicated that the changes to stroke and general surgery are interim, in that FBC approval is needed to implement the full plan for each service. However, the FBC is significantly wider than the three reconfigured services, incorporating plans for all eight primary access points covered by the Clinical Strategy. The FBC itself is a very detailed document which will support the entire strategy implementation process, not just the ESHT and TDA Board approval processes.

17.6 **FBC approval**

Mr Grayson acknowledged that ESHT and TDA Board approval for the FBC cannot be assumed and he recognised that the TDA would want to consider the overall financial situation of the Trust and its ability to repay a large capital loan with interest. He expressed confidence that the FBC would present a strong case. When asked about the consequences if the TDA did not grant ESHT access to the capital funding, Mr Grayson indicated that the Trust would not be able to implement its plans and would have to discuss a way forward with its commissioners, the CCGs. He stressed that the issues the Clinical Strategy is designed to address would remain and a new solution would be needed, rather than simply retaining the status quo.

17.7 **Patient experience benefits**

Dr Slater emphasised that the Clinical Strategy is based on achieving timely, safe care for patients. He described the Trust's detailed benefits realisation framework which is monitored weekly. With regard to monitoring patient experience, he drew attention to the national friends and family test, a survey of patient experience which the Trust has introduced as an early adopter. Mr Grayson added that this test forms one element of the Trust's wider patient experience strategy which includes other feedback mechanisms such as complaints and compliments. The FBC sets out measures of this type which will be monitored as part of benefits realisation.

17.8 **Stroke performance**

When challenged on certain Accelerating Stroke Improvement (ASI) metrics where the Trust's performance receives a red rating, Dr Slater indicated that there is a time lag of around two months in the availability of performance data. The data in the Trust's report relates to the period before the service move and further data from after the consolidation is expected to be available by the end of September. Dr Slater advised HOSC that, based on anecdotal evidence, he expects to see improved performance on indicators such as direct admission to the stroke unit. He agreed that early supported discharge is a vital element of the pathway and improvement is needed, but also highlighted that FBC approval is required to fully implement planned changes to the service which are designed to maximise performance and quality.

Ms Philpott indicated that anticipated improvements in stroke performance were a key factor in the CCGs' support for reconfiguration and they look forward to seeing improvements in the ASI metrics when data becomes available. She added that High Weald Lewes Havens CCG does not currently commission stroke early supported discharge services for its population which would impact on this performance target. It was noted that HOSC had written to the CCG on this issue and the Chief Operating Officer had confirmed that there are plans to address it. It was also noted that the HOSC Clinical Strategy Task Group will continue to monitor stroke performance.

17.9 **Stroke consultant recruitment**

Mr Grayson expressed disappointment that the Trust's attempts to recruit an additional stroke consultant had so far been unsuccessful. He indicated that ESHT is in discussion with Brighton and Sussex Medical School about including an academic element to the role which would make it more attractive. There is a national shortage of consultants specialising in stroke, and Mr Grayson emphasised that the Trust is seeking leadership qualities and will only appoint a high calibre candidate.

17.10 RESOLVED:
(1) Request that the Clinical Strategy Task Group continues to scrutinise progress.
(2) Request a further update, particularly on plans for general surgery and the progress of the FBC, in November 2013.

18. DEMENTIA SERVICE REDESIGN

18.1 The Committee considered a report by the Assistant Chief Executive which provided an update on the outcome of a review of dementia assessment beds by the Clinical Commissioning Groups (CCGs) and outlined a range of options for the future which are currently subject to consultation.

18.2 Catherine Ashton, Associate Director of Strategy and Whole Systems Working and Amanda Philpott, Joint Chief Operating Officer and Accountable Officer, Eastbourne, Hailsham and Seaford/Hastings and Rother CGGs presented the report. Ian Watling, Service Director for Older People's Mental Health, Sussex Partnership NHS Foundation Trust was also in attendance.

18.3 Ms Ashton provided an update on the consultation process as follows:

- Consultation is running for 12 weeks, ending on 25 October.
- The consultation document has been circulated widely to stakeholders including MPs, Older People's Forums, Alzheimer's Society, carers' groups, NHS organisations and Healthwatch. It is also available on the CCG websites.
- 3VA and Hastings Voluntary Action (HVA) are organising focus groups as part of the consultation process.
- Presentations are being given to key groups including the Carers' Partnership Board and East Sussex Seniors Association.
- There has been a range of media coverage, including radio interviews.
- An audit of recent bed usage is being undertaken in parallel to the consultation – the findings of this will add to the evidence base for decision making.

18.4 The following points were covered in response to questions:

18.5 **Demand for dementia services**
Ms Ashton explained that the CCGs use the Joint Strategic Needs Assessment to identify future need for services. Although there is expected to be an increase in the prevalence of dementia, there remains a need to ensure the right services are available to meet demand in the best way. She advised that options for the future of the assessment beds should be seen in the context of the wider dementia strategy which is about making best use of resources to deliver dementia services in the most appropriate way.

18.6 **Beechwood – temporary closure to admissions**
Ms Ashton acknowledged that the temporary closure of the Beechwood Unit to new admissions at the same time as the start of a consultation on its future was unfortunate in terms of managing communications. The decision to temporarily

restrict access to the unit was made by the provider, Sussex Partnership NHS Foundation Trust, on the grounds of safety. Ms Ashton advised that commissioners are engaging with the Trust to encourage the reopening of the unit as soon as it is safe to do so. She stressed that no decisions have been made on its long term future and that the consultation is a separate process. Ms Philpott reiterated that providers must make decisions about the safety of services and commissioners will support this.

Mr Watling explained that the closure to new admissions had been necessary due to the presence of a number of service users with high needs at the same time as some staff left the unit. He indicated that the Trust is seeing an increased number of patients requiring intensive observation and an increasing number of younger people with dementia, who are more physically active and strong.

18.7 **Staff recruitment - Beechwood**

Mr Watling clarified that the departing staff had not left as a result of the consultation process and assured HOSC that the Trust is recruiting new staff, initially on six month contracts, so that the unit can reopen to admissions. In the meantime, it had been possible to transfer some patients to Beechwood from other units they had been admitted to during the closure. Mr Watling welcomed the consultation process but accepted that it made recruitment more complicated. The Trust had advised applicants that there may be other opportunities within the organisation if Beechwood was to close and recruitment had not been difficult so far, as staff are familiar with the need for flexibility.

18.8 **Access for families**

Ms Philpott agreed that contact with family and friends is important for people with dementia and stated that the basis of local dementia strategy is to care for people appropriately within communities as far as possible. The consultation relates to defining the role of specialist NHS bed based provision and ensuring the level of this provision reflects changes to the rest of the pathway such as increasing early diagnosis and support. She highlighted that the proposals include reinvestment in alternative models.

18.9 RESOLVED to:

(1) note the outcome of the CCGs' review of dementia assessment beds and the options currently subject to consultation;

(2) support the proposed approach of the Mental Health Task Group to reviewing these proposals on behalf of HOSC; and

(3) request that the Task Group consider: (i) likely future demand for the beds in light of forecast increases in dementia prevalence and (ii) access for family and friends, during its review.

19. <u>WORK PROGRAMME</u>

19.1 RESOLVED to note and update the Work Programme.

<u>The Chair declared the meeting closed at 12.55pm</u>