Brighton & Hove City Council

Overview & Scrutiny Committee

Title:	**Overview & Scrutiny Committee**
Date:	**9 September 2015**
Time:	**4.00pm**
Venue	**The Ronuk Hall, Portslade Town Hall**
Members:	**Councillors:** Simson (Chair), Allen, Bennett, Cattell, Deane, Marsh, O'Quinn, Page, Peltzer Dunn and Wares **Co-opted Members:** Reuben Brett (Youth Council), Nicky Cambridge (Healthwatch), Sally Polanski (Brighton & Hove Community & Voluntary Sector Forum) and Colin Vincent (Older People's Council)
Contact:	**Cliona May** Assistant Democratic Services Officer 01273 291354 cliona.may@brighton-hove.gov.uk

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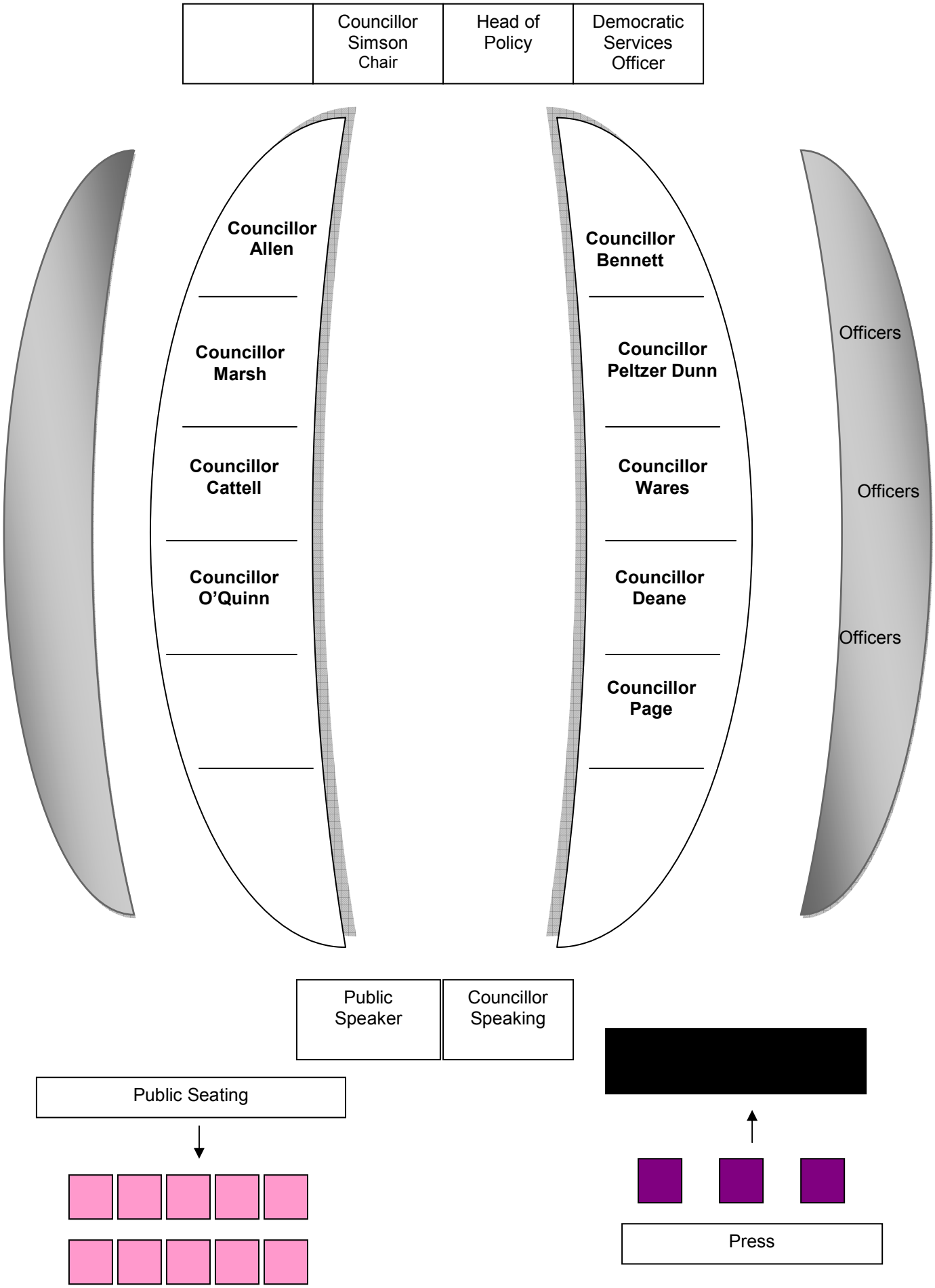
Democratic Services: Overview & Scrutiny Committee



AGENDA

PART ONE **Page**

17 PROCEDURAL BUSINESS

(a) **Declarations of Substitutes:** Where councillors are unable to attend a meeting, a substitute Member from the same political group may attend, speak and vote in their place for that meeting.

(b) **Declarations of Interest:**

(a) Disclosable pecuniary interests;
(b) Any other interests required to be registered under the local code;
(c) Any other general interest as a result of which a decision on the matter might reasonably be regarded as affecting you or a partner more than a majority of other people or businesses in the ward/s affected by the decision.

In each case, you need to declare
(i) the item on the agenda the interest relates to;
(ii) the nature of the interest; and
(iii) whether it is a disclosable pecuniary interest or some other interest.

If unsure, Members should seek advice from the committee lawyer or administrator preferably before the meeting.

(c) **Exclusion of Press and Public:** To consider whether, in view of the nature of the business to be transacted or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

Note: Any item appearing in Part Two of the agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the press and public.

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls and on-line in the Constitution at part 7.1.

18 MINUTES **1 - 8**

To consider the minutes of the meeting held on 22 July 2015 (copy attached).

19 CHAIRS COMMUNICATIONS

20 PUBLIC INVOLVEMENT

To consider the following matters raised by members of the public:

(a) **Petitions:** To receive any petitions presented by members of the public.

(b) **Written Questions:** To receive any questions submitted by the due date of 12 noon on the 2 September 2015.

(c) **Deputations:** To receive any deputations submitted by the due date of 12 noon on the 2 September 2015.

21 MEMBER INVOLVEMENT

To consider the following matters raised by Members:

(d) **Petitions:** To receive any petitions;

(e) **Written Questions:** To consider any written questions;

(f) **Letters:** To consider any letters;

(g) **Notices of Motion:** to consider any Notices of Motion referred from Full Council or submitted directly to the Committee.

22 UPDATE FROM CO-OPTEES

To receive any updates from the non-voting co-optees.

23 SUSSEX PARTNERSHIP FOUNDATION TRUST CQC INSPECTION SUMMARY AND BRIGHTON AND HOVE ACTION PLAN 9 - 26

Report of the Assistant Chief Executive (copy attached).

Contact Officer: *Kath Vlcek* *Tel: 01273 290450*
Ward Affected: *All Wards*

24 CLINICAL COMMISSIONING GROUP PROPOSALS FOR HANOVER CRESCENT 27 - 42

Report of the Assistant Chief Executive (copy attached).

Contact Officer: *Kath Vlcek* *Tel: 01273 290450*
Ward Affected: *All Wards*

25 HOMELESSNESS SCRUTINY PANEL MONITORING REPORT **43 - 70**

Report of the Executive Director for Environment, Development & Housing (copy attached).

Contact Officer: *James Crane* *Tel: 293316*
Ward Affected: *All Wards*

26 BULLYING IN SCHOOLS SCRUTINY PANEL MONITORING **71 - 84**

Report of Executive Director for Children's Services (copy attached).

Contact Officer: *Sam Beal*
Ward Affected: *All Wards*

27 GOODWOOD COURT MEDICAL CENTRE, QUALITY REPORT **85 - 110**

Report attached for information.

28 OVERVIEW & SCRUTINY COMMITTEE DRAFT WORK PLAN/SCRUTINY UPDATE **111 - 116**

(copy attached).

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Date of Publication - Friday, 28 August 2015

BRIGHTON & HOVE CITY COUNCIL

OVERVIEW & SCRUTINY COMMITTEE

4.00pm 22 JULY 2015

THE RONUK HALL, PORTSLADE TOWN HALL

MINUTES

Present: Councillor Simson (Chair)Allen, Bennett, Cattell, Deane, Moonan, O'Quinn, Page, Peltzer Dunn and Wares

Also in attendance: Sally Polanski, Community Works; Nicky Cambridge, Healthwatch Brighton & Hove; Colin Vincent, Older People's Council; Reuben Brett, Youth Council

PART ONE

8 PROCEDURAL BUSINESS

(a) Declarations of Substitutes

8.1 Councillor Moonan was present in substitution for Councillor Marsh.

(b) Declarations of Interest

8.2 Nicky Cambridge, Healthwatch Representative, declared an interest as she was also an employee of Brighton & Hove City Council, on secondment to Healthwatch Brighton and Hove.

(c) Exclusion of Press and Public

8.3 In accordance with Section 100A of the Local Government Act 1972 ("the Act"), the Committee considered whether the public should be excluded from the meeting during consideration of any item of business on the grounds that it is likely in view of the business to be transacted or the nature of the proceedings, that if members of the public were present during it, there would be disclosure to them of confidential information as defined in Section 100A (3) of the Act.

8.4 **RESOLVED** - That the public are not excluded from any item of business on the agenda.

9 MINUTES

9.1 The Older People's Council co-optee raised two queries about the Sussex Community Trust item; the Chair agreed to check and report back after the committee.

9.2 Councillor Peltzer Dunn said that the refererence to Goodwood Court's closure by NHS England was incorrect. It should say that the Care Quality Commission applied to the court, NHS England was a witness to the application. This was confirmed by Sarah MacDonald from NHS England

RESOLVED – That the Chair be authorised to sign the minutes of the meeting held on 10 June 2015 as a correct record subject to the changes above.

10 CHAIRS COMMUNICATIONS

10.1 The Chair gave the following communications:

Councillor Julie Cattell has replaced Councillor Caroline Penn on the committee. There is an official co-optee from Community Works. Sally Polanski, Chief Executive of Community Works, is attending until a permanent representative can be agreed.

We are also joined by Nicky Cambridge, Acting Chief Executive for Healthwatch Brighton and Hove. The Chair thanked Robert Brown for all of the work and dedication that he has put into the scrutiny committees over the years.

Councillors Allen, Peltzer Dunn and Bennett commented that they were unhappy that Mr Brown had been replaced by Ms Cambridge. Their view was that the Healthwatch representative should be a lay volunteer rather than a paid member of staff. They wanted this formally recorded. Councillor Page said that he was aware that Healthwatch Brighton & Hove wanted to strengthen their representation on key committees and welcomed working with Ms Cambridge.

There is a new section on the agenda – 'Co-optee Updates' –to give the co-optees the opportunity to feed back any issues that they have in their organisations which might be relevant to scrutiny so that we can have as full a picture as possible of emerging issues in the city. Councillors are also free to raise issues for the committee's attention; these can be added to the work programme as needed.

11 PUBLIC INVOLVEMENT

11.1 The Chair noted that no items had been submitted for consideration at the meeting by members of the public.

12 MEMBER INVOLVEMENT

12.1 The Chair noted that there were no items for consideration from Members for the current meeting.

13 CO-OPTEE UPDATE

13.1 The representative form the Youth Council updated on two issues, firstly that the Youth Council were planning to produce a leaflet or create an app for information in relation to mental health services for young people and secondly that there will be a Youth Council representative on Buswatch.

13.2 The representative from Community Works updated that the Community Works had met with 150 members to discuss developing safeguarding further and received training on the Care Act.

13.3 Healthwatch Brighton and Hove said that they had a concern about the strategic position of GP provision in the city, with members of the public regularly contacting them about primary care and whether it can meet the needs of the city population.

14 EMERGENCY CARE UPDATE- BRIGHTON & SUSSEX UNIVERSITY HOSPITALS TRUST

14.1 The Committee received a presentation from Matthew Kershaw, Chief Executive of Brighton & Sussex University Hospitals Trust (BSUH) in relation to an update on emergency care, focussing on the hospital's current performance, achievements and challenges.

14.2 Mr Kershaw explained in more detail the areas that needed improving, highlighting that the quality of care given to patients, including waiting times, and their experience was essential. The Trust's performance against the four hour national standard had fallen; there had been a number of incidents of 12-hour trolley breaches, ambulance handover delays and very high demands for unscheduled care. There have also been concerns raised by the coroner in relation to the Acute Medical Unit.
Mr Kershaw said that there were a number of reasons for this and that the hospital remained at very high capacity. Independent consultants had assessed the hospital as needing 127 more beds in order to meet the demand effectively.
The focus on the next six months would be on patient flow and patient experience, capacity and process.

14.3 Matthew Kershaw and Dr Mark Smith, Chief Operating Officer, BSUH, explained to the Committee that departments were particularly under pressure due to the hospital design and the types of patients that they attracted due to their position as a trauma centre. The 3T development will be progressed over the next few years.

14.4 Dr Smith explained that once the hospital expanded, and had additional capacity, the intention was to employ more specialists to treat significant injuries and illnesses. He explained that usually patients would travel to the hospital where there was greater specialism in their specific area of care, rather than simply go to the closest hospital. Dr Smith believed this would help improve the waiting time for patients.

14.5 In response to Councillor Allen's question about the number of Care Quality Commission inspections, Mr Kershaw said that there had been an announced inspection in May 2014, with 45 inspectors looking at 64 performance areas. They have

recently had an unannounced inspection, with ten inspectors focussing on Emergency Care and AMU. BSUH was still waiting for the formal assessment results.

14.6 Ms Fagge said that she was responsible for delivering the action plan brought into place following the May 2014 inspection. Unfortunately the actions for the Emergency Care department had not moved forward as much as had been hoped.

14.7 In response to Councillor Wares, Mr Kershaw answered queries regarding the ambulance turnaround time by explaining that the paramedics were now assessing the patients before bringing them to hospital or taking them to an alternative provider. This was improving the turnaround time, but ongoing work was needed to progress this upward trend further.

14.8 In response to Councillor Peltzer Dunn, Mr Kershaw clarified that the target for 999 emergency telephone pick up times was within one minute; however, approximately 93% had an average of being answered in 33 seconds. Mr Kershaw recognised the concerns of the Committee that there was still further work to be undertaken to improve in this area.

14.9 In response to Councillor Cattell, Ms Fagge clarified that the "dump the junk" programme was in place to dispose of items that were broken or not of any use. This helped with infection control. Ms Fagge went on to explain that the remaining "clutter" was predominately equipment that was used regularly, but needed to be more productively organised.

14.10 In response to a further query from Councillor Cattell, Mr Kershaw outlined that a proportion of the staff in the hospital, such as caterers and cleaners, were external agency but the service was being brought inhouse. This should be completed by the beginning of September 2015. Mr Kershaw was confident that this would show improvements, as staff would feel part of the same team with the rest of the hospital staff. They would have to decide the long term plan for the service in due course.

14.11 Ms Polanski asked whether the hospital had noticed any increases in attendance due to the closure of Eaton Place practice. Mr Kershaw said that they had not noticed any dramatic increase thanks to the work of the CCG and NHS England to transfer the patient lists.

14.12 In response to a query from Councillor Page about the Risk Summit that had recently taken place, Mr Kershaw said that the Summit had discussed similar issues about unannounced care. The Trust would be returning to the Summit in October to check progress against the actions that have been agreed.

14.13 Ms Cambridge stated that Healthwatch had visited the Accident & Emergency department last week and had agreed to undertake more Enter and View visits in the future to monitor the situation. She also commented on how friendly and engaging the staff were, and reminded the Committee that the main causes for concern were in relation to patients' basic care which needed further improvement.

14.14 Ms Cambridge said that she was aware that the independent Ombudsman was leaving the Trust; what was the proposal to cover her role as independent advocate? Mr

Kershaw said that there was a national drive for 'Freedom to Speak' champions in healthcare and they would be replacing the Ombudsman's post. In the interim, the Safety and Quality Team would be picking up issues raised.

14.15 In response to the Youth Council representative about international recruitment, Ms Fagge explained that there was local advertising to recruit nurses and GPs as well as on going work with local universities in this area but that it was necessary to recruit internationally to meet the demand.

14.16 In response to a query from Councillor Moonan about the link between BSUH and Adult Social Care, Mr Kershaw said that the two organisations worked very closely together with positive results, particularly in Brighton and Hove.

14.17 The Committee agreed a further progress update to the November meeting of the Committee.

14.18 **RESOLVED –** That the Committee note the contents of the presentation and the response to their questions.

15 UPDATE ON GP PROVISION IN THE CITY

15.1 The Committee received a presentation from Sarah MacDonald, Director of Commissioning, NHS England South, and Kirsty Sibandze GP Contract Manager, Operational, NHS England South, , in relation to update on GP provision in the city.

15.2 Geraldine Hoban, Chief Executive, Clinical Commissioning Group for Brighton and Hove, explained to the Committee that the city had a high level of primary care need compared to other areas. This related to the significant number of people in the workforce nearing retirement, and the ongoing difficulty of recruiting new GPs. There was work underway to 'cluster' GP practices together geographically so that they could support one another if a practice was struggling and share resources and back office functions.

15.3 Ms Hoban also advised that all CCGs had been asked if they wanted to take on direct responsibility for commissioning GPs, but Brighton & Hove CCG had not taken up the opportunity at this stage. This may change in the future.

15.4 The NHS England representatives explained that NHS England and the Care Quality Commission (CQC) worked alongside each other; as they have different roles between NHS England, the CQC and the regulator, with NHS England being the contract managers; any action that they take has to be linked to contractual issues,. She highlighted that NHS England and the CQC had monthly meetings to discuss possible issues that needed improvement.

15.5 With regard to Goodwood Court, NHS England had met with the practice on a number of occasions in 2014 to raise concerns and had been assured that action would be taken. Information came to light in June 2015 that had not been known before, which meant that a different course of action had to be taken and led to the closure of the practice.

15.6 The Committee expressed concerns that a similar situation could arise in other GPs surgeries in the city. To provide assurance Ms Hoban offered to update the Committee at a future meeting with the criteria considered by NHS England in relation to the oversight and monitoring of GPs surgeries. It was also agreed that Officers could work alongside NHS England and the CCG to bring this information in the appropriate format to the Committee.

15.7 Nicky Cambridge, Healthwatch Brighton and Hove representative, expressed concern about patients being temporarily registered for Charter Medical Centre and said that there were a number of lessons and challenges for NHS England to take forward about communication. Healthwatch Brighton and Hove had been contacted by very distressed patients from Goodwood Court, some of whom still did not feel that they had a permanent GP placement, Ms Cambridge suggested that the local CCG might be better placed to cascade information urgently.
NHS England acknowledged they needed to communicate more with patients, and were looking into using social media more.

15.8 Ms MacDonald confirmed patients had been informed the arrangements were temporary, and work was being progressed to arrange an engagement session in September which would brief them on the next steps.

15.9 In response to the Committee, the Practice Manager and one of the partners from Charter Medical Centre explained that since Goodwood Court had closed, Charter medical centre were working towards continuity in the quality of service. They were looking into opening on Saturdays and holding additional clinical surgeries. Charter had retained one member of the Goodwood Court staff which had been very helpful in building knowledge of vulnerable patients on the Goodwood Court lists.
The Chair thanked the staff of Charter Medical Centre on behalf of the committee, for their work in taking on the additional patients so speedily and successfully.

15.10 In response to the Chair, Ms MacDonald provided assurance to the Committee that, at this time, there were no any other GPs practices in the city with the same level of concerns as had been identified at Goodwood Court.

15.11 Ms Cambridge commented that Healthwatch Brighton and Hove had been carrying out a number of Enter and View visits to GPs in the city and would be happy to share this data when results were known.

15.12 Following a question from Councillor Deane, Ms Hoban stated that the GPs who worked at Goodwood Court were still practicing but they were currently the subject of investigation from the General Medical Council (GMC).

15.13 Members said that they felt were a number of issues outstanding with regard to their concerns about GP provision in the city. It was agreed to continue the discussion at a later stage.

15.14 **RESOLVED –** That the Committee note the contents of the presentation and the response to their questions.

16 OSC WORK PLAN - UPDATE

16.1 In general discussion of the work plan the Committee agreed the following:

- Consider offering scrutiny training to all Members as part of phase two of the 2015/16 Member Induction Programme.
- Scope for some Members of the Committees to focus on specific areas of the work plan.

The meeting concluded at 6.55pm

Signed Chair

Dated this day of

OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 23 Brighton & Hove City Council

Subject:		**Sussex Partnership NHS Foundation Trust CQC inspection summary for Brighton and Hove**	
Date of Meeting:		**9 September 2015**	
Report of:		**Assistant Chief Executive**	
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The Care Quality Commission (CQC) held a planned week long inspection of services provided by Sussex Partnership NHS Foundation in January 2015. The CQC rated Sussex Partnership as an organisation which 'requires improvement.'

1.2 The report details the findings of the report and the actions that the Trust has planned.

2. RECOMMENDATIONS:

2.1 That OSC members note the findings of the CQC report and actions that the Trust is taking.

2.2 That OSC members ask the Trust to report back in six months on progress against the actions.

3. CONTEXT

3.1 In January 2015 the Care Quality Commission (CQC) held a planned, week long inspection of services provided by Sussex Partnership NHS Foundation. In the report of this inspection, published on 27 May 2015, the CQC rated Sussex Partnership as an organisation which 'requires improvement.'

3.2 Overall ratings were:

Overall rating for mental health services	Requires Improvement	🟡
Are mental health services safe?	Requires Improvement	🟡
Are mental health services effective?	Requires Improvement	🟡
Are mental health services caring?	Good	🟢
Are mental health services responsive?	Requires Improvement	🟡
Are mental health services well-led?	Requires Improvement	🟡

3.3 Overall, the CQC rated the Trust as requires improvement, in relation to

- Two core services were rated as inadequate under the 'safe' domain.
- The Trust had no plan in place to tackle the high rate of suicide.
- There were significant gaps in the flow of information, particularly around learning from serious untoward incidents.
- There were significant gaps in training, appraisal and supervision for some staff.
- The quality of care planning was inconsistent and did not always demonstrate how people were involved in their care.
- The Trust lacked strategic direction.
- The Trust had gaps in relation to providing the board with assurance.

However, 'caring' was rated as good or outstanding in all but one service and the Trust was considered to be a place of innovation and ideas, aspiring to best practice in many parts of the services provided.

More information on the results of the Sussex-wide inspection can be found in **Appendix 1.**

Brighton and Hove services

3.4 Services inspected in Brighton and Hove

Type of service	**Where**
Acute Inpatient service - Female	Caburn Ward, Millview Hospital
Acute inpatient service - Male	Regency Ward, Millview Hospital
Acute Inpatient service – Integrated – Mixed sex	Meridian Ward, Millview Hospital
Psychiatric Intensive Care Unit - Male	Pavillion Ward, Millview Hospital
SMS - Inpatient	Promenade Ward – Millview Hospital
CRHT	Millview Hospital
Brighton Urgent Response, Mental Health Liaison Team and Hospital Based Place of Safety	Millview Hospital + Royal Sussex County Hospital
Dementia Care – Mixed sex	Brunswick Ward
Adult Community mental health services	Brighton and Hove- East Brighton
Rehabilitation service	Hanover Crescent, Brighton
Rehabilitation service	Rutland Gardens

Compliance

3.5 The Trust closed Hanover Crescent (part of Brighton and Hove rehabilitation services) to admissions following feedback as to the CQC's concerns in relation to shortcomings within the building and the lack of clarity regarding the service model. We subsequently took the decision to support patients to move on from Hanover Crescent and relocated the staff within local adult community services. In order to review the service model and for a final decision to be made with partners about its future the Trust is working closely with commissioners to formulate a proposal for a new service model within the supported accommodation pathway in Brighton & Hove recognising the existing system pressures.

3.6 At Rutland Gardens the CQC reported that there was not an effective system around infection prevention and control and therefore people were not adequately protected against the risk of infection. Following the inspection an Infection control audit was completed in June 2015 and the service scored 99% which would indicate that the actions that they have implemented have significantly improved standards. The audit will be repeated on an annual basis.

It was clear that the Trust recognised that some areas are facing particular challenges and the CQC found managers and directors of the service responsive to their challenge and acting swiftly to put things right.

3.7 Concerns were raised about a number of standards of care within Older Age Adult services across the Trust which included Brunswick and Meridian Ward. These included:

- Ligature risks that hadn't previously been identified
- Gender separation
- Inadequate care planning
- Lack of access to physical health care
- Medicines management – poorly controlled drugs
- Lack of suitable arrangements in place to ensure that staff had received appropriate training, professional development, supervision and appraisal

3.8 The Selden Centre In-Patient Learning Disability Service is located in West Sussex but is used by patients from Brighton and Hove rated as 'Requires Improvement'. A number of issues were highlighted, more detail can be found in Appendix 1.

3.9 There were some Trust wide issues that apply to Brighton and Hove

- Caseloads in community teams
- Mandatory training compliance
- Learning from incidents/SIs
- Holistic, personalised care planning

3.10 The Trust has developed a comprehensive action plan in response to the CQC inspection which includes areas of specific action for the Brighton and Hove division. The action plans are available at: www.sussexpartnership.nhs.uk/cqc

3.11 There were a number of examples of good practice highlighted in Brighton and Hove inpatient and community services. These have been grouped under the five headings used by the CQC.

Safe

- The modified early warning system (MEWS) to help monitor a patient's physical health care needs was fully implemented for all patients.
- The inspection team found evidence that Pavilion ward was represented at the Mill View site safety meeting, held regularly to ensure optimum safety of the entire hospital site.
- All staff the inspection team spoke to said there were sufficient staff to deliver care to a good standard.

- Staff carried out a range of environmental and health and safety audits and risk assessments, including checks on any ligature points and standards of cleanliness.
- The inspection team found evidence that Pavilion ward participated in the monthly health and safety meeting, membership across all acute and urgent care teams, chaired by the service director.
- The inspection team was told by the ward manager that senior managers were flexible and responded well if the needs of the patients' increased and additional staff were required.
- The inspection team found the risk formulations were good and used a recognised risk assessment tool (The five Ps) which all staff we spoke to had been trained to use. The team also saw evidence that risk assessments were reviewed as part of the multi-disciplinary care review process as detailed in the acute inpatient service operational policy.
- Staff conducted regular audits of infection control and prevention, and staff hand hygiene to ensure that patients, visitors and staff were protected against the risks of infection.
- Community teams used a "zoning" risk assessment tool to identify risks for people on their caseloads. In East Brighton this was updated daily in response to changing needs. This identified changes to the person's risk levels and either the duty staff or care coordinator could call upon extra support to enable any increased risks to be safely dealt with.

Effective

- There was multi-disciplinary working and integration.
- There was a rolling recruitment drive incorporating a full assessment centre involving patients.
- The inspection team found the risk formulations were good and used a recognised risk assessment tool (The five Ps) which all staff we spoke to had been trained to use. We saw evidence that risk assessments were reviewed as part of the multi-disciplinary care review process as detailed in t
- The inspection team was told by the ward managers that lessons learnt from incidents were shared at the regular ward managers meetings facilitated by the matron and general manager for Mill View Hospital. We found the systems and processes regarding incidents, particularly strong and robust at Mill View hospital acute inpatient service operational policy.
- The inspection team saw evidence which demonstrated that community services were involved in the monitoring and measurements of quality and outcomes for people who use the service. The teams used a range of multi-disciplinary assessment tools to measure the outcomes for the people using the services and promote their recovery, such as Health of the Nation Outcome Scale (HoNoS). The homeless service in Brighton used a range of qualitative outcomes which they had devised to measure the effectiveness of the service. This included areas such as; finding accommodation, medication reviewed, help with benefits, and psychiatric review.
- The Mental Health Liaison team based at the Royal Sussex County Hospital were able to assess and accept patients on behalf of the Crisis Home Treatment Team from Millview Hospital. This meant that people did not have to be assessed twice to access crisis team services.

Caring

- Consistent evidence of comfortable environments which optimised privacy and dignity at Mill View hospital.
- Brighton and Hove recovery college prospectus was available to all patients.
- Mill View art project exhibition was advertised and all patients encouraged either participating in or enjoying the artwork on show.
- Pavilion ward was bright, clean, comfortably and well-furnished and decorated to a high standard.
- One patient the inspection team spoke to said, “I can honestly say I have never been treated with such kindness as I have here. It’s not just a couple of nice staff but all of them.” Another patient said, “One week ago I was a complete wreck and the staff have helped me turn myself around. They are wonderful, I’m not exaggerating when I say they are the best, fantastic and so very well led by the manager.”
- One family member said, “The staff have looked after my relative as well as I would have done myself; just like it was one of their own family members. They have supported me so well. They have gone beyond the call of duty and at a time of extreme crisis in my relative’s life.”
- The inspection team saw a lot of positive interaction between staff and patients on the ward. Staff spoke to patients in a friendly, professional and respectful manner and responded promptly to any requests made for assistance or time.

Responsive

- Mill View hospital, patients’ needs were assessed and care was delivered in line with their individual care plans.
- At Mill View hospital the system for managing and responding to complaints was well embedded and learning from such events was routine.
- The experience-based co-design project at Mill View hospital involved patients in directing environmental design of ward areas and quiet areas.
- The CQC inspection team found a rich and diverse selection of therapeutic activities available for patients at Mill View hospital.
- In Brighton there are diverse ethnic groups of people, some areas of high deprivation, drug and alcohol problems, and homelessness. In the other areas the inspection team was told of how increasing numbers of people with enduring mental health problems were re-locating into new care homes which were opening up on a regular basis. Managers from each team showed the inspection team how they had developed the team models in response to the changing demographics and needing to target the resources to those with greatest need.

Well led

- The CQC inspection team found a particularly strong senior management team at Mill View hospital which included consultant psychiatrists and other senior representatives from the multi-disciplinary team who were fully involved in all aspects of the service.
- Pavilion ward had been accredited and was a member of the National Association of Psychiatric Intensive Care units (NAPICU) as well as having

obtained the Royal College of Psychiatry accreditation for inpatient mental health services (AIMS).

- The Pavilion ward student nurse placement initiate had been shortlisted for the Nursing Times student placement of the month award.

3.12 SPFT has developed action plans which describe what they are doing in relation to the compliance actions raised by the CQC. These were submitted to the CQC on 30 June 2015 and published on their website www.sussexpartnership.nhs.uk/cqc.

4 COMMUNITY ENGAGEMENT & CONSULTATION

4.1 The CQC findings have been incorporated into Sussex Partnership Foundation Trust's 2020 vision.

4.2 The engagement strategy to develop the 2020 Vision involved:

- six public events in January 2015 which were attended by patients, carers, staff, partner agencies and public.
- discussions with staff.
- discussions with Board and the Council of Governors, the latter of which includes patient, carer and public representation.
- sharing the draft strategy with stakeholders and adapting it in response to feedback.
- a further round of six public events in June / July 2015 where the Trust demonstrated how they have used feedback to develop the strategy and invited people to be involved in discussion about how we implement it.

The Trust is planning further engagement activity to continue the conversation with stakeholders.

5. CONCLUSION

5.1 Sussex Partnership Foundation Trust provides vital mental health services for residents across Sussex including Brighton and Hove. OSC members should be assured that the Trust is working to develop and improve these services for the benefit of all residents.

5.2 OSC members should monitor the progress of actions against the plans drawn up by the Trust and seek further information as necessary.

6. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

6.1 SPFT and the CCG will fully consider all financial implications in their future proposals. The proposals will be reflected in Adult Services 4 year service and financial plans.

Finance Officer Consulted: Anne Silley *Date: 26/08/15*

Legal Implications:

6.1 The Council has certain health scrutiny functions under the National Health Service Act 2006 (as detailed in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013). The authority may review and scrutinise any matter relating to the planning, provision and operation of the health service in our area. The subject matter within this report falls within this remit and the Overview and Scrutiny Committee is the correct committee to consider this report.

Lawyer Consulted: Sarita Arthur-Crow *Date: 26/08/15*

Equalities Implications:

6.2 None to this cover report for information.

Sustainability Implications:

6.3 None to this cover report for information.

Any Other Significant Implications:

6.4 None to this cover report for information.

SUPPORTING DOCUMENTATION

Appendices:

1. Sussex Partnership Foundation Trust CQC Inspection Summary

Sussex Partnership NHS Foundation Trust
CQC inspection summary for Brighton and Hove

Overview

In January 2015 the Care Quality Commission (CQC) held a planned, week long inspection of services provided by Sussex Partnership NHS Foundation. In the report of this inspection, published on 27 May 2015, the CQC rated Sussex Partnership as an organisation which 'requires improvement.'

We have developed action plans which describe what we are doing in relation to the compliance actions raised by the CQC. These were submitted to the CQC on 30 June 2015 and published on our website www.sussexpartnership.nhs.uk/cqc

As well as specific issues that we need to address, the CQC report highlights issues which require a wider healthcare systems response such as how we deal with delayed transfers of care and respond to pressure upon our services. We will be inviting partner organisations to work with us on a Quality Improvement Programme to explore these issues, building on the Quality Summit hosted by the CQC on 22 May 2015 to share their report on our services.

1. Overall Ratings

Overall rating for mental health services	Requires Improvement	
Are mental health services safe?	Requires Improvement	
Are mental health services effective?	Requires Improvement	
Are mental health services caring?	Good	
Are mental health services responsive?	Requires Improvement	
Are mental health services well-led?	Requires Improvement	

	Safe	Effective	Caring	Responsive	Well-Led	Overall
1. Community Based Mental Health Services for Adults of Working Age	Good	Good	Good	Good	Good	Good
2. Child and Adolescent Mental Health Wards	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
3. Wards for people with learning disabilities	Requires Improvement	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
4. Long Stay/Rehabilitation Mental Health Wards for Working Age Adults	Inadequate	Requires Improvement	Good	Good	Good	Requires Improvement
5. Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
6. Forensic Inpatient/secure wards	Good	Good	Outstanding	Good	Good	Good
7. Community based Mental Health Services for Older People	Good	Good	Good	Good	Good	Good
8. Community Mental Health Services for people with Learning Disabilities	Good	Good	Good	Good	Good	Good
9. Wards for Older People with Mental Health Problems	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
10. Adult Acute	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
11. Community based Mental Health Services for Child and Adolescents	Requires Improvement	Requires Improvement	Outstanding	Requires Improvement	Good	Requires Improvement
12. Overall Provider Report	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

2. Summary of findings

This section summarises the CQC findings at the time of the inspection.

Overall, the CQC rated the Trust as requires improvement, in relation to;

- Two core services were rated as inadequate under the 'safe' domain.
- The Trust had no plan in place to tackle the high rate of suicide.
- There were significant gaps in the flow of information, particularly around learning from serious untoward incidents.
- There were significant gaps in training, appraisal and supervision for some staff.
- The quality of care planning was inconsistent and did not always demonstrate how people were involved in their care.
- The Trust lacked strategic direction.
- The Trust had gaps in relation to providing the board with assurance.

However, 'caring' was rated as good or outstanding in all but one service and the Trust was considered to be a place of innovation and ideas, aspiring to best practice in many parts of the services provided.

The inspection team found that some areas of care in learning disability and older people's inpatient services were inadequate. The Trust closed Hanover Crescent (part of Brighton and Hove rehabilitation services) to new admissions following feedback the CQC's concerns in relation to shortcomings within the building and the lack of clarity regarding the service model. Subsequently all residents were supported to move elsewhere and the Trust is working with commissioners to develop a new service model.

The CQC recommended a number of requirement notices to be put into force. These relate to ensuring that standards of hygiene are maintained, that staff are properly supported to receive their mandatory training, that risks are properly identified and people are involved in planning their own care.

The CQC found an elevated risk of people self-harming or committing suicide. Many of these deaths happened whilst people were in receipt of services in the community. The CQC found an elevated risk of suicide within 3 days of discharge and within 3 days of being admitted to an acute setting. In total there were 80 deaths in the period from 1 November to 31 October 2014. Whilst the CQC recognise that it is not just the Trust's responsibility to develop a suicide prevention plan, they have urged the Trust to initiate urgent work with public health and community agencies to address this. More specifically in Brighton, Sussex Partnership is part of the plan being led by public health which predates the CQC inspection.

The CQC were concerned that staff were not receiving timely feedback in relation to serious untoward incidents. The CQC therefore asked the Trust to supply them with details of length of time it took from notification of a serious untoward incident to time the report and action was completed and circulated. The data supplied suggested that the Trust was struggling to meet timescales, with some investigations having exceeded the time period stated in the policy. They concluded that this may impact on the ability to close the loop on serious incidents and ensure that learning to avoid / prevent similar incidents from emerging is shared.

The staff survey identified that there was an elevated risk to staff working extra hours and feeling stressed. The Trust had a clear action plan to address this which included reviewing the staffing levels and skills mix on inpatient units and re-introducing a three shift rota.

At the time of the inspection, the Trust acknowledged that there was not a system in place to identify clearly where agency staff were used. The Trust raised this with CQC prior to the inspection.

Overall, caring was rated as good, the trust achieved outstanding ratings in community child and adolescent services and forensic services. Staff were found to be compassionate, kind and motivated to go an extra mile for the people they served. Community services for adults, older people, dementia and people with a

learning disability were inspected in West Sussex and rated as good. Community services in Brighton were rated as good. They found a multidisciplinary approach was used to support people effectively, national guidance and best practice was used to provide care and risk assessments were comprehensive.

Good solid evidence demonstrated that the Trust was sensitive to individual needs, taking cultural, religious and spiritual needs into account. The Trust also provided good information to people and this was available in a variety of languages and formats.

The CQC found that the Trust is a place where innovation is given priority and this enables them to seek new ways of working and bring about change to service delivery. They commented that there is much creativity at a senior level. They recommended that the Trust continues to ensure that the quality of more traditional services is maintained and that the desire to seek new and innovative ways of working is not at the expense of those services.

The inspection found that the senior management team were very positive about the new Chief Executive Officer (CEO). They felt that having been through a difficult and challenging period and that the culture of the board had changed for the better. The senior team came over as open and transparent in their interviews and discussions. The CEO was able to describe the challenges facing Sussex.

The report concluded that the Trust was in a period of some significant change, including a cultural change. Staff and stakeholders said that relationships with the Trust had been difficult to manage at times but that this was becoming more positive. Many felt that the new CEO was responsible for bringing in a more visible and open approach. The Trust did not have a clear strategic direction that was written down and understood by staff at the time of the inspection and also lacked a framework to ensure that the Board was clear about and understood the more detailed risks and challenges facing the organisation. It had identified the principal risks faced by the organisation.

3. Examples of immediate actions the Trust has taken

- Held a CQC improvement plan event with staff from clinical and corporate services.
- Reviewed ligature risks based on the needs of different client groups and took action where appropriate to reduce risk.
- Taken action to improve the fabric of environments in older people's services
- Closed Hanover Crescent to new admissions.
- Started developing Trust-wide principles and a plan for gender separation to promote dignity and privacy.
- Completed infection control audits of all inpatient services, including Rutland Gardens.
- Became a partner in Sign up to Safety, a national initiative to help the NHS improve patient safety.
- Introduced a 3 shift system within adult services. Staffing and skill mix has been reviewed and is in line with national guidance (staffing on our acute wards in Brighton and Hove was uplifted)
- Held a Brighton and Hove specific CQC feedback event with staff in acute and urgent care services.

Ongoing actions

- 'My Learning' an electronic system for recording training and providing e-learning has been implemented and already used by around 2,00 staff.
- 'Carenotes' electronic patient record is being implemented in CAMHS and is scheduled to be implemented in adult services later this year.
- A review of governance has been commissioned.
- An Executive Assurance Committee has been introduced to ensure risk is appropriately triangulated.
- We developed and launched a five year strategy, Our 2020 Vision, following an engagement process involving staff, patients, carers, partner agencies and public. In our most recent series of public events, held in June / July 2015, we highlighted how people's feedback has been used to shape the strategy and involved them in discussions about what we need to do to achieve it.

4. Services inspected in Brighton and Hove

Type of service	Where
Acute Inpatient service - Female	Caburn Ward, Millview Hospital
Acute inpatient service - Male	Regency Ward, Millview Hospital
Acute Inpatient service – Integrated – Mixed sex	Meridian Ward, Millview Hospital
Psychiatric Intensive Care Unit - Male	Pavillion Ward, Millview Hospital
SMS - Inpatient	Promenade Ward – Millview Hospital
CRHT	Millview Hospital
Brighton Urgent Response, Mental Health Liaison Team and Hospital Based Place of Safety	Millview Hospital + Royal Sussex County Hospital
Dementia Care – Mixed sex	Brunswick Ward
Adult Community mental health services	Brighton and Hove- East Brighton
Rehabilitation service	Hanover Crescent, Brighton
Rehabilitation service	Rutland Gardens

5. Compliance

The Trust closed Hanover Crescent (part of Brighton and Hove rehabilitation services) to admissions following feedback as to the CQC's concerns in relation to shortcomings within the building and the lack of clarity regarding the service model. We subsequently took the decision to support patients to move on from Hanover Crescent and relocated the staff within local adult community services. In order to review the service model and for a final decision to be made with partners about its future the Trust is working closely with commissioners to formulate a proposal for a new service model within the supported accommodation pathway in Brighton & Hove recognising the existing system pressures.

At Rutland Gardens the CQC reported that there was not an effective system around infection prevention and control and therefore people were not adequately protected against the risk of infection. Following the inspection an Infection control audit was completed in June 2015 and the service scored 99% which would indicate that the actions that they have implemented have significantly improved standards. The audit will be repeated on an annual basis.

It was clear that the Trust recognised that some areas are facing particular challenges and the CQC found managers and directors of the service responsive to their challenge and acting swiftly to put things right.

Concerns were raised about a number of standards of care within Older Age Adult services across the Trust which included Brunswick and Meridian Ward. These included:

- Ligature risks that hadn't previously been identified
- Gender separation
- Inadequate care planning
- Lack of access to physical health care
- Medicines management – poorly controlled drugs
- Lack of suitable arrangements in place to ensure that staff had received appropriate training, professional development, supervision and appraisal

The Selden Centre In-Patient Learning Disability Service is located in West Sussex but is used by patients from Brighton and Hove rated as 'Requires Improvement'. A number of issues were highlighted:

- Lack of capacity assessments
- Seclusion rooms not fit for purpose
- Use of seclusion

- Lack of physical health action plans
- Privacy – lack of proper gender separation
- Blanket restrictions on the use of the garden, access to hot drinks and choice of meals

There were some Trust wide issues that apply to Brighton and Hove

- Caseloads in community teams
- Mandatory training compliance
- Learning from incidents/SIs
- Holistic, personalised care planning

We have developed a comprehensive action plan in response to the CQC inspection which includes areas of specific action for the Brighton and Hove division. The action plans are available at: www.sussexpartnership.nhs.uk/cqc

6. Good Practice

6.1 Examples of good practice highlighted in Brighton and Hove inpatient and community services

Safe

- The modified early warning system (MEWS) to help monitor a patient's physical health care needs was fully implemented for all patients.
- The inspection team found evidence that Pavilion ward was represented at the Mill View site safety meeting, held regularly to ensure optimum safety of the entire hospital site.
- All staff the inspection team spoke to said there were sufficient staff to deliver care to a good standard.
- Staff carried out a range of environmental and health and safety audits and risk assessments, including checks on any ligature points and standards of cleanliness.
- The inspection team found evidence that Pavilion ward participated in the monthly health and safety meeting, membership across all acute and urgent care teams, chaired by the service director.
- The inspection team was told by the ward manager that senior managers were flexible and responded well if the needs of the patients' increased and additional staff were required.
- The inspection team found the risk formulations were good and used a recognised risk assessment tool (The five Ps) which all staff we spoke to had been trained to use. The team also saw evidence that risk assessments were reviewed as part of the multi-disciplinary care review process as detailed in the acute inpatient service operational policy.
- Staff conducted regular audits of infection control and prevention, and staff hand hygiene to ensure that patients, visitors and staff were protected against the risks of infection.
- Community teams used a "zoning" risk assessment tool to identify risks for people on their caseloads. In East Brighton this was updated daily in response to changing needs. This identified changes to the person's risk levels and either the duty staff or care coordinator could call upon extra support to enable any increased risks to be safely dealt with.

Effective

- There was multi-disciplinary working and integration.
- There was a rolling recruitment drive incorporating a full assessment centre involving patients.
- The inspection team found the risk formulations were good and used a recognised risk assessment tool (The five Ps) which all staff we spoke to had been trained to use. We saw evidence that risk assessments were reviewed as part of the multi-disciplinary care review process as detailed in t
- The inspection team was told by the ward managers that lessons learnt from incidents were shared at the regular ward managers meetings facilitated by the matron and general manager for Mill

View Hospital. We found the systems and processes regarding incidents, particularly strong and robust at Mill View hospital acute inpatient service operational policy.

- The inspection team saw evidence which demonstrated that community services were involved in the monitoring and measurements of quality and outcomes for people who use the service. The teams used a range of multi-disciplinary assessment tools to measure the outcomes for the people using the services and promote their recovery, such as Health of the Nation Outcome Scale (HoNoS). The homeless service in Brighton used a range of qualitative outcomes which they had devised to measure the effectiveness of the service. This included areas such as; finding accommodation, medication reviewed, help with benefits, and psychiatric review.
- The Mental Health Liaison team based at the Royal Sussex County Hospital were able to assess and accept patients on behalf of the Crisis Home Treatment Team from Millview Hospital. This meant that people did not have to be assessed twice to access crisis team services.

Caring

- The CQC inspection team found consistent evidence of comfortable environments which optimised privacy and dignity at Mill View hospital.
- Brighton and Hove recovery college prospectus was available to all patients.
- Mill View art project exhibition was advertised and all patients encouraged either participating in or enjoying the artwork on show.
- Pavillion ward was bright, clean, comfortably and well-furnished and decorated to a high standard.
- One patient the inspection team spoke to said, “I can honestly say I have never been treated with such kindness as I have here. It’s not just a couple of nice staff but all of them.” Another patient said, “One week ago I was a complete wreck and the staff have helped me turn myself around. They are wonderful, I’m not exaggerating when I say they are the best, fantastic and so very well led by the manager.”
- One family member of a patient on the ward said, “The staff have looked after my relative as well as I would have done myself; just like it was one of their own family members. They have supported me so well. They have gone beyond the call of duty and at a time of extreme crisis in my relative’s life.”
- The inspection team saw a lot of positive interaction between staff and patients on the ward. Staff spoke to patients in a friendly, professional and respectful manner and responded promptly to any requests made for assistance or time.

Responsive

- Mill View hospital, patients’ needs were assessed and care was delivered in line with their individual care plans.
- At Mill View hospital the system for managing and responding to complaints was well embedded and learning from such events was routine.
- The experience-based co-design project at Mill View hospital involved patients in directing environmental design of ward areas and quiet areas.
- The CQC inspection team found a rich and diverse selection of therapeutic activities available for patients at Mill View hospital.
- In Brighton there are diverse ethnic groups of people, some areas of high deprivation, drug and alcohol problems, and homelessness. In the other areas the inspection team was told of how increasing numbers of people with enduring mental health problems were re-locating into new care homes which were opening up on a regular basis. Managers from each team showed the inspection team how they had developed the team models in response to the changing demographics and needing to target the resources to those with greatest need.

Well led

- The CQC inspection team found a particularly strong senior management team at Mill View hospital which included consultant psychiatrists and other senior representatives from the multi-disciplinary team who were fully involved in all aspects of the service.

- Pavilion ward had been accredited and was a member of the National Association of Psychiatric Intensive Care units (NAPICU) as well as having obtained the Royal College of Psychiatry accreditation for inpatient mental health services (AIMS).
- The Pavilion ward student nurse placement initiate had been shortlisted for the Nursing Times student placement of the month award.

6.2 Examples of good practice identified more generally

Safe
There were services the CQC inspected which they found to be good under the 'safe' domain. This was because they had good systems in place to monitor risk; for instance a 'zoning' system in community services. Staff were able to articulate how to identify abuse and how to implement safeguarding procedures. Our Psychiatric Intensive Care Unit at Mill View Hospital had successfully reduced seclusion through implementing a reducing restrictive practices strategy.

Effective
The Trust consistently demonstrated a good awareness of best practice. Staff were able to articulate how NICE guidelines were used. The Trust is clearly committed to using audit as a measure of how services were performing. The Trust has participated in seven national audits and have undertaken a number of local audits. The Trust is creative and keen to innovate and are taking part in national pilots. They are currently participating in the 'Street Triage' pilot, which aims to reduce the number of people detained inappropriately under S136 of the Mental Health Act 1983.

The Trust is also expanding their forensic and secure services. These services were noted for the initiatives they have implemented on patient involvement and improving patient experience.

The Harold Kidd Unit and the electroconvulsive therapy department are all accredited by the Royal College of Psychiatry which is used by Brighton and Hove patients

CAMHS and forensic services belong to the Quality Network for Inpatient Care (QNIC) The network aims to demonstrate and improve the quality of inpatient care through a system of review against the QNIC service standard. The CQC saw that forensic services had implemented changes based on recommendations from the QNIC peer review.

Caring
Caring was rated as good. This was because staff were found to be compassionate, kind and motivated to make a difference. Caring was rated as good across all core services. In some areas this was rated as outstanding.

The inspection team received positive feedback from patients and their carers and observed many instances where staff were kind and compassionate.

Responsive
Positively, the proportion of patients followed up within 7 days of discharge was in line with the England average of 97%.

Well Led
It was clear that there have been some significant changes at a senior level of the organisation. Work has been started to ensure that the Trust is open and transparent. The CEO was in the process of developing his team.

The Trust has a set of values and these were set out in the 'better by experience' booklet that lists and describes the five values: We welcome you. We hear you. We work with you. We are helpful. We are hopeful for you.

There was good financial management in place and the Trust had devolved budgets to the level of the clinical team.

Staff overall were very positive about their managers and most core services were rated as good.

7. Areas for Improvement:

Action the provider MUST take to improve

The CQC identified the following areas where the Trust must improve services across the organisation and specifically in Brighton and Hove. The Trust has now developed action plans to address each of the following areas:

- Mandatory training.
- Standards of hygiene and cleanliness.
- Supervision and reflective practice.
- Recording and analysis of incidents and complaints, and how lessons are learnt from this.
- Effectiveness of the links between the corporate and local governance processes.
- Provision of gender segregated facilities.
- Safe staffing with appropriately qualified staff on the child and adolescent unit.
- Remove blanket restrictions in some areas.
- Meet requirements the Fit and Proper Person Test.
- Bring the seclusion rooms up to required standard in the inpatient unit for people with a learning disability and address use of seclusion in the inpatient unit for people with a learning disability.

Action the provider SHOULD take to improve

- Ensure that young people at risk to themselves or others were not nursed in de-escalation areas.
- The Trust should ensure consistent use of the Fraser Guidelines.
- The care plans on the child and adolescent ward should demonstrate the active involvement of young people in identifying their needs and goals for treatment.
- Discharge planning should be carried out as part of the assessment and care planning of the young people.
- Ensure all Section 17 leave forms are completed correctly and specify the frequency and duration of leave.
- In rehabilitation services the provider should ensure that all patients are seen and reviewed by a consultant psychiatrist regularly (Hanover Crescent issue).
- Ensure that the controlled drugs storage facility meets with legal requirements.
- Ensure that patients taking care of their own medicines can safely secure and store medicines in their bedrooms.
- Ensure that an Independent Mental Health Advocacy service is put in place promptly and that all detained patients have access to an Independent Mental Health Advocate.
- Ensure that patients are not held in the Section 136 suites for longer than necessary.
- Monitor of the use of the 136 suites to ensure no untimely delays
- Ensure all incidents of restraint are appropriately recorded.
- Ensure that staff are clear about what constitutes seclusion.
- The Trust should ensure that the induction programme prepares people adequately for their role.
- Improve the quality of assessment and care planning
- Improve patient flow in acute services to improve local access to inpatient beds.
- Reduce the number of transfers between inpatient units.
- Work actively with stakeholders to improve access to accommodation.

- Enable privacy to allow patients to make private telephone calls.
- Ensure that staff receive feedback from complaints on some wards.
- Care record documentation should reflect a holistic, person centred, recovery approach highlighting strengths of patients.
- Resolve staff shortages.
- The Trust should review staff understanding and monitoring of the Modified Early Warning Score (MEWS) records, where routine physical records, where routine physical observations of patients are recorded (such as blood pressure and pulse).
- Review access to psychology within the service.
- Ensure staff are confident regarding the location of ligature cutters and that this location is consistent across wards.
- Consider arrangements for parking on the site as it was reported that people attending appointments had to wait for up to an hour to find a suitable parking space that would allow parking of a converted vehicle.
- All hospital staff should undergo breakaway and de-escalation of violence training to make sure that they are aware of the latest guidance and techniques to keep them and patients safe.
- Slips, trips and falls training should be cascaded across all older adult wards to support the pilot project on falls reduction.
- Introduce an electronic patient record system.
- Fire evacuation timetable at Mill View Hospital for 2015 to be planned and executed.
- Training at Mill View Hospital to be implemented for all wards on slips, trips and falls.
- Mandatory training should be compliant to 100% across all wards at Mill View Hospital.
- Care record documentation at Mill View Hospital to reflect a holistic, person centred, recovery approach highlighting strengths of patients.

As above the Trust took immediate action to ensure the safety of patients, services and staff following feedback from the CQC. In addition to the decision to close Hanover Crescent to new admissions and instigate an infection control audit at Rutland Gardens further actions taken within Brighton & Hove services included: an immediate quality & safety action plan for Hanover Crescent, a new care plan format was introduced at Rutland Gardens on the 1st June with an audit plan to ensure compliance, deep cleaning of kitchen area and bedrooms at Rutland Gardens with additional cleaning resource diverted on permanent basis with improved cleaning schedules. Management of ligature risks had been raised as an issue and on Brunswick Ward evidence was provided to show that ligature risk assessments were completed during the recent refurbishment and two rooms have enhance anti-ligature equipment and door furniture. Guidance on the use of these rooms and the criteria to identify patients at increased risk of ligatures has been provided to the nursing staff.

Following a concern around monitoring of storage of medication on Brunswick Ward several actions were completed in response including immediate support from pharmacy services. All nursing staff are aware of covert medicines procedures, compliance around reporting and return of controlled drugs has been reviewed and completed, both medical management update and medication competency training has been completed.

Brunswick Ward have instigated a pilot to ensure that care plans are more appropriate for patients with a cognitive impairment and that next of kin / relatives are routinely involved in the development of care plans especially for patients without capacity to fully represent themselves.

Within inpatient learning disability services immediate environmental changes were in response to feedback regarding the use of quiet rooms, mixed sex accommodation and access to the kitchen and an improvement plan was implemented.

Quality Improvement Planning: The Trust is currently working closely with Clinical Commissioning Groups, Local Authorities and broader stakeholders across the City and Sussex to produce a Quality Improvement

plan for local services which will inform the transformation of care delivered by our services over the next 12-18 months. This plan will include some of the aspects of the CQC feedback which require changes across the Trust and the involvement of partner agencies.

8. Our 2020 Vision: Outstanding care and treatment you can be confident in

We have taken the CQC's findings into account when in developing our strategy for the next five years: Our 2020 Vision. Is overarching vision is to provide 'outstanding care and treatment you can be confident'. To achieve this, we have developed five strategic goals which will steer us towards where we want to be:

1. Safe, effective, quality patient care
2. Local, joined up patient care
3. Put research, innovation and learning into practice
4. Be the provider, employer and partner of choice
5. Live within our means

Our 2020 Vision describes what we will do over the next five years to improve the services we provide to patients. To help us plan this we've spoken to people about what they think of our services, the care we provide and what they would like us to do in future.

We've looked long and hard at where we know we need to improve. Carers and people who have used our services have told us, for example, that they can find it hard to know where to get help and sometimes feel like they are being passed around 'the system'. Whilst the way mental health services are provided is complex and involves a lot of organisations, this is something patients and carers shouldn't need to worry about. They shouldn't even notice. Our job is to work so well with our partners that people only notice the quality of care and support they are receiving. At the same time, it should be clear about where people should go if they have concerns or complaints at any time about their care.

Many of our services have developed new ideas to improve services for patients, but we are not as good as we should be at learning from these positive examples and putting them into practice elsewhere. More broadly, it can take up to 20 years in the UK for the learning from healthcare research to be used to benefit patients. We want to help reduce that gap. The mind and body continue to be treated separately, whereas it would be better for patients if physical and mental health care were brought more closely together.

8.1 Engagement

The engagement strategy to develop Our 2020 Vision involved:

- six public events in January 2015 which were attended by patients, carers, staff, partner agencies and public.
- discussions with staff.
- discussions with our Board and Our Council of Governors, the latter of which includes patient, carer and public representation.
- sharing the draft strategy with stakeholders and adapting it in response to feedback.
- a further round of six public events in June / July 2015 where we demonstrated how we have used feedback to develop the strategy and invited people to be involved in discussion about how we implement it.

We are planning further engagement activity to continue the conversation with stakeholders how we achieve our vision to provide outstanding care and treatment you can be confident. Our 2020 Vision is available on our public website: www.sussexpartnership.nhs.uk/our-strategy

John Child, Service Director, Adult Services Brighton Division
August 2015

OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 24 Brighton & Hove City Council

Subject:		**Clinical Commissioning Group Proposals for Hanover Crescent**	
Date of Meeting:		**9 September 2015**	
Report of:		**Assistant Chief Executive**	
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 In January 2015 the Care Quality Commission (CQC) undertook an inspection of Sussex Partnership Foundation Trust's (SPFT) services, including the supported accommodation at Hanover Crescent, Brighton.

1.2 The CQC asked SPFT to take immediate action about the Hanover Crescent property, due to concerns about the poor physical environment and lack of clarity about the role of the service. The property was closed to new admissions and existing residents moved into alternative accommodation.

1.3 The CCG, in partnership with SPFT, are proposing a permanent closure of Hanover Crescent and a re-investment of resources released from this in a new rehabilitation model.

1.4 This paper provides a summary of actions taken and proposals for the future model of care.

2. RECOMMENDATIONS:

2.1 That OSC members consider the proposals and comment on them.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 Hanover Crescent is a 9-bed unit providing short term (3 months maximum) supported housing predominantly staffed by non-qualified support staff. Hanover Crescent receives referrals primarily from the acute wards at Millview Hospital and the usual onward discharge pathway is to an individual's own home or longer term supported accommodation.

3.2 It is a Grade 2 listed building and presents challenges with regard to observation, ligature anchor point reduction and communal living. In addition to this, the lack of clarity regarding the service model and the investment that would be needed

both in material costs for renovation and additional staffing costs would make the service disproportionally expensive.

3.3 The concerns raised by CQC inspectors, and the immediate actions undertaken by SPFT are listed below:

- Patient Safety – risk assessments and care planning. A comprehensive review of each person was undertaken following the CQC inspection and SPFT were assured that each resident had a comprehensive care plan and risk assessment in place.

- Gender Separation – privacy and dignity was compromised due to shared bathroom and toilet facilities. During the transition of residents to other provision, SPFT put in an additional staff member in order to manage this risk.

- Ligature risk – the fabric and configuration of the building increased the risk around ligature points. SPFT reviewed the Ligature Anchor Point assessment and scoped the acceleration of remedial works in order to manage the risk.

- Safeguarding and Incident Management – issues were raised around the way safeguarding was undertaken and how incidents are raised. A system of on call management support was immediately strengthened

- Staffing Establishment and medical cover – the model of care lacked clarity and the staff mix was felt to be inappropriate to meet the needs of the residents. SPFT put in additional temporary staffing and identified a Consultant Psychiatrist to take an overview of Hanover Crescent.

- Medicines Management – management of controlled drugs and administration of PRN medications as well as appropriate record keeping were highlighted. SPFT reviewed the operational policy and a clinical pharmacist immediately reviewed the systems around medicines management.

- Cleanliness and hygiene – standards of cleanliness and infection control were poor. SPFT took immediate action to improve these standards.

- Training records showed that not all staff were up to date with their risk assessment and PMVA breakaway training, or with their basic life support training. SPFT have an action plan with regard to statutory and mandatory training.

- A Hanover Crescent Steering Group was immediately convened to monitor the above actions and improvement plan. The CCG were invited to attend this group.

- Upon closure of Hanover staff were temporarily redeployed elsewhere across the Brighton & Hove Division of the Mental Health Trust

3.4 The CQC recognised that in some areas standards were good. The CQC found that staff were kind and respectful towards patients and were positive when planning their care and support. Patients were involved in developing their own care plans. Staff recognised patients' individual needs and understood how to care for them. Patients gave feedback about the service and this was listened to by staff and managers.

3.5 It also found that rehabilitation services were recovery oriented and promoted social inclusion and community involvement.

3.6 Services were aware of patients' cultural and religious needs and supported people in meeting these. The services encouraged positive risk-taking and supported patients towards achieving independence.

4. The Future of Hanover Crescent

4.1 Hanover Crescent is currently temporarily closed. This was done in light of the CQC inspection findings and in agreement with the CCG.

4.2 The proposal is to permanently close Hanover Crescent and re-invest the annual running costs into a new model of rehabilitation care and support which is community based.

4.3 There are a number of reasons to support the permanent closure of Hanover Crescent including staffing levels and extensive works needed to make the building fit for purpose.

4.4 Instead, the permanent closure of Hanover Crescent would release the resource needed to pursue more innovative community based models of rehabilitation support and care. A new model would give an opportunity to develop a clear pathway for rehabilitation which is person centred and flexible to meet individual's needs in a range of accommodation settings.

5. Transitions Team

5.1 The Transitions Team are responsible for care coordinating those individuals with mental health needs who are living in registered adult mental health residential and nursing care provision. The Transitions Team functions have not been reviewed for some time.

5.1 SPFT and the CCG are keen to review the functions and re-deploy the resource to have more of an impact on reducing admissions to psychiatric in-patient units, to facilitate earlier discharge, and to ensure people are supported in a range of environments in their recovery journey.

6. Proposed new models of care

6.1 There are two proposals for re-investment of the resource released from the permanent closure of Hanover Crescent, subject to formal approval, and the running costs of the Transitions Team. More information on both can be found in **Appendix 1**.

- Community based recovery multi-disciplinary team
- Respite support to provide step-up and step-down care along the acute/recovery pathway

7. Community Based Recovery Team

7.1 Demand remains high for acute in-patient beds and supported accommodation placements. Brighton and Hove CCG has invested significantly in community services over the last two years, such as the Crisis Resolution Home Treatment Team, additional care co-ordinators to reduce demand on acute services and to provide more care in the community.

7.2 This additional capacity is now fully operational and working well to facilitate discharge from the acute and to support individuals in their recovery.

7.3 A community based recovery team would support the timely discharge from acute in-patient units and would increase the flow of individuals through the mental health tiered supported accommodation pathway. The team would be clinically led but would have a staff mix to reflect the needs of the individuals under its care. It would link in to support discharge from in-patient units, and link out to offer support into recovery and independence.

7.4 Outcomes for the team would include:

- Reduced admissions to acute in-patient units
- Reduced tenancy breakdown
- More timely discharge from acute care
- Increased support for individuals in their own homes in order to maintain independence and quality of life
- Reduced social care and specialist placement costs

8. Respite Support

8.1 If there are sufficient resources available, and subject to approval, the CCG would like to explore the opportunity of developing a respite support model in the city. There is currently a gap for this type of provision within Brighton and Hove and it is a recurrent theme of feedback from patients, their families and carers that this type of provision should be offered within mental health services in the city.

8.2 The respite model could offer step-up care from community settings (own home, supported accommodation) for individuals experiencing, or at risk, of crisis and would provide an alternative to hospital admission. This is particularly important for individuals experiencing social crisis and/or need 'time out' from their usual environments. This would help to reduce demand for in-patient beds.

8.3 The service could also offer step-down care from acute in-patient units for those individuals who need additional time to recover from their acute mental health episode and who needed further assessment and planning around discharge. This would help to reduce the length of stay and delayed transfers of care which would have an additional benefit of freeing up capacity within acute units.

9. CONCLUSION

9.1 The temporary closure of Hanover Crescent has provided SPFT and the CCG with an opportunity to re-consider how the resources involved in the accommodation are best used, and how residents are best supported.

9.2 OSC members should consider the proposals for alternative service provision and determine whether they feel that this would be a preferable use of resources for patients.

10. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

10.1 SPFT and the CCG will fully consider all financial implications in their future proposals.

Legal Implications:

10.2 The Council has certain health scrutiny functions under the National Health Service Act 2006 (as detailed in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013).

The authority may review and scrutinise any matter relating to planning, provision and operation of the health service in our area. In addition, certain health bodies must consult the authority before implementing a proposal for a substantial development of the health service in the area of the local authority or for a substantial variation in the provision of such a service. In terms of the decision to temporarily close the Hanover Crescent accommodation, although that decision has already been taken, it falls within an exemption to the duty to consult as the Care Quality Commission required immediate action based on the risk to safety or welfare of patients.

The legal requirements have therefore been complied with, the subject matter of the report falls within the Council's functions and the Overview and Scrutiny Committee is the correct committee to consider this report.

Lawyer Consulted: Sarita Arthur-Crow *Date: 26/08/15*

SUPPORTING DOCUMENTATION

Appendices:

1. Information from the CCG about Hanover Crescent

Mental Health Services in Brighton and Hove

Report on the outcomes of the Care Quality Commission Inspection of Hanover Crescent and the Future Model of Care

July 2015

1. Background

1.1. In January 2015, the Care Quality Commission (CQC) conducted a Trust wide inspection of services provided by Sussex Partnership NHS Foundation Trust (SPFT). As part of this inspection, the rehabilitation unit at Hanover Crescent was visited.

1.2. Hanover Crescent is a 9-bed unit providing short term (3 months maximum) supported housing predominantly staffed by non-qualified support staff. Hanover Crescent receives referrals primarily from the acute wards at Millview Hospital and the usual onward discharge pathway is to an individual's own home or longer term supported accommodation.

1.3. The CQC were seriously concerned about the standards of hygiene and cleanliness at Hanover Crescent, the poor physical environment and the lack of clarity around a model of care. There were also concerns about the staffing mix given that the majority of the individuals placed there had complex mental health needs and this was directly linked to the lack of clarity around the purpose of the service

1.4. In light of these concerns the CQC asked SPFT to take immediate action and it was agreed that Hanover Crescent would be voluntarily closed to new admissions with immediate effect, an immediate improvement plan put in place and that move on plans for all current residents there would be actioned. These actions were supported by Brighton & Hove CCG. The last resident moved on from Hanover Crescent in March 2015.

1.5. Hanover Crescent is a Grade 2 listed building and presents challenges with regard to observation, ligature anchor point reduction and communal living. In addition to this, the lack of clarity regarding the service model and the investment that would be needed both in material costs for renovation and additional staffing costs would make the service disproportionally expensive.

1.6. In the summer of 2014 SPFT completed an internal process reviewing care pathways in each locality area including Brighton & Hove. One of these was the rehabilitation pathway. The drivers for change included the

on-going pressure on acute services, the changing patient presentation to include greater numbers of patients presenting with dual diagnosis-psychosis and substance misuse issues, pressure on accommodation across the City and looking to reduce the number of failed tenancies resulting in hospital readmissions. This generated discussions between the CCG and SPFT which started in the autumn of 2014 around the future of Hanover Crescent, the rehabilitation pathway, the interface with the newly commissioned supported accommodation pathway and how best to meet the needs of service users across rehabilitation provision in general. Prior to the CQC inspection actions were underway to complete an audit of discharge destinations from Hanover Crescent, reviewing the unit costs and considering the impact of the newly commissioned supported pathway. These discussions were accelerated following the CQC inspection.

1.7. The CCG, in partnership with SPFT, are proposing a permanent closure of Hanover Crescent and a re-investment of resources released from this in a new rehabilitation model.

1.8. This paper provides a summary of:

- The proposal for permanent closure of Hanover Crescent
- Proposals for the future models of care

2. Hanover Crescent

2.1. The CQC inspectors visited Hanover Crescent on the 15th January; during this inspection a number of concerns were raised. The key concerns and immediate actions undertaken by SPFT are listed below:

- Patient Safety – risk assessments and care planning. A comprehensive review of each person was undertaken following the CQC inspection and SPFT were assured that each resident had a comprehensive care plan and risk assessment in place.

- Gender Separation – privacy and dignity was compromised due to shared bathroom and toilet facilities. During the transition of residents to other provision, SPFT put in an additional staff member in order to manage this risk.

- Ligature risk – the fabric and configuration of the building increased the risk around ligature points. SPFT reviewed the Ligature Anchor Point assessment and scoped the acceleration of remedial works in order to manage the risk.

- Safeguarding and Incident Management – issues were raised around the way safeguarding was undertaken and how incidents are raised. A system of on call management support was immediately strengthened

- Staffing Establishment and medical cover – the model of care lacked clarity and the staff mix was felt to be inappropriate to meet the needs of the residents. SPFT put in additional temporary staffing and identified a Consultant Psychiatrist to take an overview of Hanover Crescent.

- Medicines Management – management of controlled drugs and administration of PRN medications as well as appropriate record keeping were highlighted. SPFT reviewed the operational policy and a clinical pharmacist immediately reviewed the systems around medicines management.

- Cleanliness and hygiene – standards of cleanliness and infection control were poor. SPFT took immediate action to improve these standards.

- Training records showed that not all staff were up to date with their risk assessment and Prevention and Management of Violence and Aggression (PMVA) breakaway training, or with their basic life support training. SPFT have an action plan with regard to statutory and mandatory training.

- A Hanover Crescent Steering Group was immediately convened to monitor the above actions and improvement plan. The CCG were invited to attend this group.

- Upon closure of Hanover staff were temporarily redeployed elsewhere across the Brighton & Hove Division of the Mental Health Trust

2.2. The CQC recognised that in some areas standards were good.

2.3. The CQC found that staff were kind and respectful towards patients and were positive when planning their care and support. Patients were involved in developing their own care plans. Staff recognised patients' individual needs and understood how to care for them. Patients gave feedback about the service and this was listened to by staff and managers.

2.4. It also found that rehabilitation services were recovery oriented and promoted social inclusion and community involvement.

2.5. Services received few complaints from patients and carers but when they did they responded promptly and implemented learning from complaints.

2.6. Patients had discharge plans in place and most were well informed about and supported to move forward. There were some delays in discharging patients because of difficulties identifying suitable accommodation.

2.7. Services were aware of patients' cultural and religious needs and supported people in meeting these. The services encouraged positive risk-taking and supported patients towards achieving independence.

3. The Future of Hanover Crescent

3.1. Hanover Crescent is currently temporarily closed. This was done in light of the CQC inspection findings and in agreement with the CCG.

3.2. The proposal is to permanently close Hanover Crescent and re-invest the annual running costs into a new model of rehabilitation care and support which is community based.

3.3. There are a number of compelling reasons to support the permanent closure of Hanover Crescent.

3.4. Although immediate concerns were addressed and governance and focus strengthened, there remains a need to be constantly vigilant to clinical risk.

3.5. Risk assessment and management is a dynamic process and while staffing levels can be adjusted in line with need, Hanover Crescent does not afford the flexibilities that would otherwise be available to contain risk outside of a hospital setting.

3.6. The ambiguity of the service model and the risks within the environment led the CQC to formulate their view and have prompted SPFT and the CCG to look closely at the future of Hanover Crescent.

3.7. Increasing the staffing into Hanover Crescent would improve the safety but the cost of this would mean the service becomes disproportionately expensive and the addition of qualified nursing staff makes the model increasingly unclear.

3.8. The physical building would need extensive work to make it fit for purpose to support a new model of rehabilitation support and care which would not represent value for money.

3.9. New and more innovative community based models of rehabilitation support and care are emerging and the permanent closure of Hanover

Crescent would release the resource needed to pursue these models. The needs of the cohort of people placed in Hanover Crescent are changing with more dual diagnosis, forensic issues and complex psychosis. A new model would give an opportunity to develop a clear pathway for rehabilitation which is person centred and flexible to meet individual's needs in a range of accommodation settings.

4. Transitions Team

4.1. The Transitions Team are responsible for care coordinating those individuals with mental health needs who are living in registered adult mental health residential and nursing care provision.

4.2. They also have a role providing short term support to people leaving hospital, accommodation transitions or where accommodation is at risk.

4.3. The team have the following staff:

- Nurse band 7 – 1wte
- Nurse band 6 – 2.60wte
- Healthcare assistant band 4 – 2.13wte
- Healthcare assistant band 3 – 1.91wte

4.4. The Transitions Team functions have not been reviewed for some time.

4.5. SPFT and the CCG are keen to review the functions and re-deploy the resource to have more of an impact on reducing admissions to psychiatric in-patient units, to facilitate earlier discharge, and to ensure people are supported in a range of environments in their recovery journey.

5. Proposed new models of care

5.1. There are two proposals for re-investment of the resource released from the permanent closure of Hanover Crescent, subject to formal approval, and the running costs of the Transitions Team.

- Community based recovery multi-disciplinary team
- Respite support to provide step-up and step-down care along the acute/recovery pathway

6. Community Based Recovery Team

6.1 Demand remains high for acute in-patient beds and supported accommodation placements. Brighton and Hove CCG has invested significantly in community services over the last two years, such as the Crisis Resolution Home Treatment Team, additional care co-ordinators to reduce demand on acute services and to provide more care in the community.

6.2 Following a multi-agency review of mental health accommodation support the CCG jointly with the Local Authority redesigned the mental health accommodation pathway and commissioned additional units of accommodation with support from third sector providers. This additional capacity is now fully operational and working well to facilitate discharge from the acute and to support individuals in their recovery.

6.3 Included within the recommissioned mental health tiered pathway are 120 accommodation support units, of which 101 are new. The pathway has : 25 hostel style accommodation units for people with mental health needs, 20 units of accommodation with support for people with high support needs, 30 units of accommodation with support for people with medium support needs, 40 floating support units and 30 tenancy support services. Providers have been working together since the start of these new services to support individual's recovery journey and move on between support services.

6.4 Plans are already in place, subject to approval, to develop and implement the community based recovery team.

6.5 A community based recovery team would support the timely discharge from acute in-patient units and would increase the flow of individuals through the mental health tiered supported accommodation pathway.

6.6 The team would provide flexible and personalised care to individuals whose needs are complex and where other community based services are not able to meet the need for more intensive support.

6.7 The team would be clinically led but would have a staff mix to reflect the needs of the individuals under its care. The key elements of the team would be:

- Nurse Prescriber
- Community Psychiatric Nurse
- Psychologist
- Occupational Therapist(s)

- Support Workers (possibly 3rd sector)
- Peer mentors/supporters

6.8 The team would provide in-reach to support discharge from in-patient units and residential care and support transition and move on to more independent living working closely with a range of providers including :

- West Pier Project (homeless hostel)
- Shore House (high support accommodation)
- Star Project (medium support accommodation)
- Adult mental health residential placements

6.9 The team would outreach support into any environment where individuals under the care of the team are living to support recovery and maximise opportunities for independence.

6.10 The team would link to a range of existing community based teams including the Crisis Resolution Home Treatment Team (CRHT), Assessment and Treatment Services (ATS) and Assertive Outreach team (AOT). Further consideration would need to be given as to where is most appropriate for the Consultant psychiatric cover to be available.

6.11 Assessment and Treatment Service (ATS) and Assertive Outreach team (AOT) would provide a link to social care support where needed and potentially the medical cover (see above).

6.12 Robust links with substance misuse services in the city, Pavilions, would be established to enable joint working with people with dual diagnosis.

6.13 The model and service specification need to be further developed and modelling around the potential demand for the service which will influence the staffing compliment needed.

6.14 The team would have a role in developing relationships with providers of supported accommodation services, building on the well-established links between mental health and housing to provide additional reassurance and risk management.

6.15 Outcomes for the team would include:

- Reduced admissions to acute in-patient units
- Reduced tenancy breakdown
- More timely discharge from acute care
- Increased support for individuals in their own homes in order to maintain independence and quality of life
- Reduced social care and specialist placement costs

7 Respite Support

7.1 If there are sufficient resources available, and subject to approval, the CCG would like to explore the opportunity of developing a respite support model in the city.

7.2 There is currently a gap for this type of provision within Brighton and Hove and it is a recurrent theme of feedback from patients, their families and carers that this type of provision should be offered within mental health services in the city.

7.3 The respite model to offer step-up care from community settings (own home, supported accommodation) for individuals experiencing, or at risk, of crisis and would provide an alternative to hospital admission will be explored. This is particularly important for individuals experiencing social crisis and/or need 'time out' from their usual environments. This would help to reduce demand for in-patient beds.

7.4 The service could also offer step-down care from acute in-patient units for those individuals who need additional time to recover from their acute mental health episode and who needed further assessment and planning around discharge. This would help to reduce the length of stay and delayed transfers of care which would have an additional benefit of freeing up capacity within acute units.

7.5 The service may also be able to offer respite on a planned basis for those individuals where this would be of clinical and social benefit.

7.6 Further work needs to be undertaken to develop the model and service specification for a respite placements, and it is likely that a procurement exercise would need to be undertaken to secure this provision.

8. Finance Summary

8.1. The CCG and SPFT are still working through the level of resource that will be available to re-invest into the new model of care and support.

9. Summary

9.1. There are compelling reasons for a permanent closure of Hanover Crescent and the re-investment of resource to be used to develop a new and innovative model for community based rehabilitation provision.

9.2. Brighton & Hove CCG would like to develop, in partnership with Sussex Partnership NHS Foundation Trust, a community based recovery team which will provide intensive, flexible and personalised care and support to individuals wherever they reside. The team would be clinically led with a staff mix that reflected the needs of the individuals under its care.

9.3. Brighton & Hove CCG would also like to pursue the development of a respite/crisis house in the city as it recognises that this is a current gap and would support the effective management of demand for acute in-patient beds.

9.4. The services will ensure that there is an integrated approach to mental and physical health and wellbeing, and have appropriate links to social care and support in the community and voluntary sector.

9.5. The service would meet the needs of individuals with functional mental health needs aged 18yrs and over.

10. Future Plans

10.1. Moving forward Brighton & Hove City Council and Brighton & Hove Clinical Commissioning Group have developed plans as part of their Better Care Programme to integrate care across the city.

10.2. Programmes of work focused on Frailty and Homeless have been established and mental health is integral to both of these programmes. The development of multi-disciplinary care teams based around GP practices will provide the opportunity to ensure people with mental illness can receive more support in the community and have better coordinated holistic care that addresses both their physical and mental health needs. The new Substance Misuse services from April 2015 include an integrated model of care for those with dual diagnosis, and have both mental health and substance misuse needs. The new model of care includes the co-location of substance misuse and mental health staff, to strengthen the delivery of an integrated care model. Further updates on the progress of the Better Care Programme will be provided to the HWOSC at regular intervals.

Renée Padfield
Head of Commissioning – Mental Health and Children's Services
Brighton & Hove CCG

John Child – Service Director, Sussex partnership NHS Foundation Trust

July 2015

OVERVIEW AND SCRUTINY COMMITTEE	Agenda Item 25 Brighton & Hove City Council

Subject:		**Annual Update on the Scrutiny Panel on Homelessness**
Date of Meeting:		**9 September 2015**
Report of:		**Acting Executive Director Environment for Development & Housing**
Contact Officer:	**Name:**	**James Crane** **Tel: 29-3316**
	Email:	**James.crane@brighton-hove.gcsx.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The Scrutiny Panel on Homelessness was set up in January 2013 to look at and highlight the issues of homelessness in the city in light of increased levels of homeless including the number of accepted households in temporary accommodation (statutory homeless) and rising numbers of rough sleepers. It set out to look at the provision of services across the city and to see if all that could be done was being carried out by services across the city and to make recommendations on what it feels needs to be done in relation to this increasing problem.

1.2 The Members on the cross party Panel were Councillors Andrew Wealls (Chair), Alan Robins and Ollie Sykes. The Panel took evidence from a range of Council departments, other statutory bodies and a number of community and voluntary organisations including Housing, Adult Social Care, Sussex Partnership NHS Foundation Trust, Community Safety Partnership, Friends First, Sanctuary Support Living, Off the Fence, CRI, Shore, Homeless Link and importantly Homeless Service Users.

1.3 The Council's Health & Wellbeing Overview & Scrutiny Committee of 4th February 2014 agreed and endorsed the scrutiny panel report without any amendments. Contained within the Homelessness Scrutiny Panel Report 2014 were 17 recommendations.

1.4 The Housing Committee received a report on the12 November 2014 outlining the 17 recommendations made by the panel along with its response to those recommendations. This report was also considered by full Council on the 11th December 2014.

1.5 This report now looks at the progress and has been made since the original recommendations were made in February 2014. The action plan is contained at appendix 1.

2. RECOMMENDATIONS:

2.1 That committee notes the progress made against the action plan in appendix 1 by the relevant council departments.

2.2 That the following actions are considered to be completed members are requested that this actions are therefore discharged. Action No 7 No 9 No 11 No 13 No 15 No 16

2.3 That members decide if the remaining actions that are now embedded in within service directorates may also be discharged

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The Homelessness Scrutiny Panel was established in January 2013 in response to the growing number of people housed in temporary accommodation by the City Council and the rising numbers of people that are found to be sleeping rough of the streets of Brighton & Hove over the past four years.

3.2 The panel took evidence from a range of Council departments, other statutory, voluntary and charity sector organisations, both funded and non-funded. In addition the panel listened to the voices of people who had had experience of homelessness themselves. The panel noted the complexity of the issues that face the city from those that may need some advice to resolve their housing situation to others that can face sleeping rough through either being unable to find accommodation or those that, for various reasons are unable to accept accommodation.

3.3 After taking evidence from a range of professionals and service users the Scrutiny Panel produced a report with 17 recommendations. These recommendations cover a range of topics many of which have been incorporated into the development of the Council's Homelessness Strategy 2014. Appendix one contains the recommendation and progress against each of them since the report was accepted by the Health and Wellbeing Overview and Scrutiny Committee in February 2014.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 There is not analysis or consideration of any alternative options contained in this report. It is customary for an up date on the recommendations to be presented to the overview and scrutiny committee on an annual basis so that members can be advised of the progress, or otherwise, that has been made.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 This report is an update of the action plan that was agreed following the scrutiny panel's recommendation in February 2014. During this time the Council has consulted on both the Homelessness Strategy 2014 and the Housing Strategy 2015. These consultations included community engagement city wide along with some targeted engagement that was the subject of recommendations within the Scrutiny Panel report.

6. CONCLUSION

6.1 Levels of homelessness remain as a cause of concern in the City. The number of households accepted under a statutory duty has fallen slightly in the past financial year. The number of households who are accommodated in temporary accommodation remains at high levels and the number of rough sleepers are estimated to in the region on 130 people on any given night.

6.2 A number of the actions in appendix 1 relate to the development of the Council's Housing and Homelessness strategies. Both of these strategies have now been signed of and are therefore concluded. The actions that are therefore considered as completed are Nos 7,9,11,13,15 and 16

6.3 The council continues to looks at new and innovative approaches to deal with homelessness as reflected in appendix 1. The council has a number of work streams across directorates dealing with homelessness in its many forms across the city. This includes a rough sleeper strategy that will be presented to the Housing and New Homes Committee in 2016. Partnership working has also increased with the development of the Homeless Integrated Health and Care Board. This board seeks to integrate service health and social case for homeless people and will also report to the Wellbeing & Wellbeing in 2016. In addition there is a Rough Sleeper Review Steering group established that will organise a stakeholder summit and objective setting in November 2105.

7. FINANCIAL & OTHER IMPLICATIONS:

This report sets out the progress made to date on the action plan to address the recommendations made by the Scrutiny Panel on Homelessness in the City. There are no financial implications of this report but any financial implications arising from the implementation of the recommendations made will be reported either as part of the in-year budget monitoring process or through separate reports as necessary.

Finance Officer Consulted: Monica Brooks *Date:12th August 2015*

Legal Implications:

There are no significant legal implications attached to this report. Legal support will be available as and when necessary to take projects forward.

Lawyer Consulted: *Liz Woodley* *Date: 14/08/15*

Equalities Implications:

7.1 None

Sustainability Implications:

7.2 None

Any Other Significant Implications:

7.3 None

SUPPORTING DOCUMENTATION

Background Documents

1. Report of Homelessness Scrutiny Panel February 2014

Scrutiny Report Recommendation No. 1 (February 2014)	**Service Lead**	**ELT Lead**
Given the significance of homeless people in terms of city health inequalities, we welcome the fact that the Health & Wellbeing Board is taking an active interest in the health and social care needs of this group. We are very interested in the progression of this work, and request that the HWB's plans for homeless healthcare be presented to the HWOSC for comment within the next 12 months.	Alistair Hill – Public Health	Tom Scanlon
Council Response (December 2014)		
Recommendation Accepted Recommendation accepted. Homeless health has been adopted as a key element of the Brighton and Hove Better Care Plan. A Homeless Integrated Health and Care Board has been established to improve the health and wellbeing of homeless people by providing integrated and responsive services that place people at the centre of their own care, promote independence and support them to fulfil their potential. An extended multidisciplinary team approach will be implemented. The Board is also overseeing the delivery of projects currently in place including the newly established hostel nursing team and Pathway Plus (focusing on hospital discharge and A&E attendances). A stakeholder event took place in July 2014 and a user involvement work-stream has been established. In line with the Better Care timetable the full model will be introduced in April 2016. An update for the HWOSC can be presented in early 2015.		
Progress at June 15 – short commentary by service lead: **Programme remains a priority work stream in Better Care as described above. Extended multidisciplinary team approach to improve health and wellbeing needs is currently being piloted.** **To meet this recommendation a full update was presented to HWOSC in March 2015. Minutes available at**	**Status - (note status indicates progress by June 2015)** **Green** 	

Scrutiny Report Recommendation No. 1 (February 2014)	Service Lead	ELT Lead
http://present.brighton-hove.gov.uk/ieListDocuments.aspx?CId=728&MId=5423&Ver=4		

Scrutiny Report Recommendation No. 2 (February 2014)	Service Lead	ELT Lead
A senior BHCC officer should be appointed as 'homelessness services integration champion' across statutory services and other sectors.	Sylvia Peckham	Geoff Raw
Council Response (December 2014)		
Recommendation Accepted in Principle The Council provides a range of services across the City for both statutory and non statutory homelessness. Due to the complex nature of homelessness there are a number of officers at senior levels who already have responsibilities to ensure that the services provided are those that meet the needs of homeless people. There is no single officer post in existence that covers the whole homelessness agenda.		
Progress at June 15 – short commentary by service lead: There are several initiatives set up to draw together integration of internal services and external sectors to focus on services provided for homeless households and considering how best to prevent homelessness. To facilitate joint working across the council we have held joint workshops with Housing, Children's services and Adult Social Care an agreed aims of much earlier interventions to try and prevent homelessness at a much earlier stage and where this is not possible, to provide joined up approaches support and move people through to settled accommodation.	**Status - (note status indicates progress by June 2015)** **Green**  Completed June 2015. Action plan agreed with timelines through to the end of 2015.Led by Interim Head of Housing, Patrick Odling-Smee Set up and operating Led by Alistair Hill, Public health.	

Scrutiny Report Recommendation No. 2 (February 2014)	Service Lead	ELT Lead
The Homeless Integrated Care Board includes representatives from different sectors and was set up for the purpose to oversee the work taking place to improve the health and wellbeing of homeless people. This is will be by ensuring that integrated and responsive services are in place which place people at the centre of their own care, promote independence and support them to fulfil their potential Rough Sleeper Review Steering group is being set up to develop a new approach to the operational management of street homelessness and reduce the levels of rough sleeping in the city. This will cover the measures to prevent people sleeping rough, services provided to support people on the streets and approaches to help people move on from rough sleeping. The project will be initiated through a stakeholder Summit – this will establish the objectives for the review and agree the process leading to completion.	Initial Steering Group meeting end June 2015 led by Denise D'Souza, Executive Director of Adult Social Care Stakeholder Summit and objective setting November 2015 Delivery of new approach to Rough Sleeping April 2016	

Scrutiny Report Recommendation No. 3 (February 2014)	Service Lead	ELT Lead
The council needs to take action to diversify its 'stock' of hostel accommodation, seeking to spread hostels more evenly across the city, and to offer a range of accommodation options in terms of hostel size and the level of support on offer.	Brian Doughty	Denise de Souza
Council Response (December 2014)		

Scrutiny Report Recommendation No. 3 (February 2014)	Service Lead	ELT Lead
Recommendation accepted In Autumn 2014 the Council is embarked on a review of its Integrated Support Pathway services, including hostels, which will inform future commissioning from April 2015 onwards. The review will consider the O&S Report and the Single Homelessness Needs Analysis published in 2013 as well as the recently published Homelessness Strategy 2014-19, feedback from partner organisations and from commissioners of Housing, Adult Social Care and Health services.		
Progress at June 2015 – short commentary by service lead: The Council is currently in the design and Commissioning process for accommodation and housing related support services. Tenders have been issued for the Rough Sleepers Team and Floating Support contracts. This will be followed by the tender for a Housing First service following Brighton & Hove's successful pilot of this intensive support accommodation model. A woman only accommodation and support service will also be tendered in the coming months. This is a homeless service for clients who have trauma associated with DV, sex work, violent family histories, and children taken into care. These services meet the gaps which have been identified within the city. Tenders will follow later in the year for hostel accommodation and supported accommodation.	**Status - (note status indicates progress by January 2015)** **Green**  Award Tender for Rough Sleepers contract June 2015 Award Floating Support contract End July 2015 Award Housing First contract End Sept 2015 Award Women only accommodation and support service contract by November 2015 Tenders for Hostel Accommodation out in November 2015 Tenders of Supported Accommodation out in November 2015	

Scrutiny Report Recommendation No. 4 (February 2014)	Service Lead	ELT Lead
We need a more diverse range of supported accommodation available to house single homeless people, particularly those with very complex needs. Whilst this is clearly not going to happen overnight, we would welcome a commitment to move to a model of greater diversity coupled with at least some practical action in the short term.	Brian Doughty	Denise De Souza
Council Response (December 2014)		
Recommendation Accepted The Council continues to review services to ensure that they meet the needs of homeless people. Recent developments include the complex needs project looking at single homeless people who, for one reason or another are unable to reside in hostels. This project looks to provide a self contained property with high levels of support as an alternative. Recent developments in young people's services have seen a new service commissioned to provide accommodation for young men with high needs in the City. This project is currently at the tendering stage. Brighton Housing Trust were successful in obtaining Big Lottery Funds to look at service models in the City with a view to seeing what works and what does not work for this client group. The City Council is a key partner in this project.		
Progress at June 2015 – short commentary by service lead: As mentioned above we have successfully piloted a Housing First model which was evaluated by the University of York. Following the success of the project Brighton & Hove are one of the first local authorities to tender for a Housing First service. This tender includes support for young people with complex needs and will be released in the coming weeks.	**Status - (note status indicates progress by January 2015)** **Green**  Award Housing First contract End Sept 2015 Award Women only accommodation and support	

Scrutiny Report Recommendation No. 4 (February 2014)	Service Lead	ELT Lead
We are also tendering for a women only service to work with homeless women who have experienced trauma which will be based on successful models of practice from other areas of the UK A HCA bid has been submitted to develop a property in the outer wards of the city to provide a service for older people with substance misuse and physical health issues. We are currently remodelling a large in-house hostel service from a city centre location to smaller accommodation units in dispersed within the city. We are currently remodelling the hostel and supported accommodation services as part of the retender, this includes the remodelling of Band 3 accommodation and the introduction of medium support accommodation. High, Medium and Low support accommodation will be accessible from referral and their will be no bar on entering low support accommodation from point of referral.	service contract by November 2015 HCA bid determination date not known August 2015 commence remodelling End of 2015	

Scrutiny Report Recommendation No. 5 (February 2014)	Service Lead	ELT Lead
The council needs to produce a clear map of statutory and non-statutory homelessness services across the city and make it available via its website.	Sylvia Peckham	Geoff Raw
Council Response (December 2014)		

Scrutiny Report Recommendation No. 5 (February 2014)	Service Lead	ELT Lead
Recommendation accepted The Council is in the process of refreshing the Homelessness pages on the Council's Website. A mapping exercise is underway looking at all services that are available for those that are in danger of losing their homes or who have become homeless. The Housing Options service is in the final stage of producing "Options On-line" this service will carryout an assessment on a persons circumstances and offer an individual action plan to enable them to take appropriate action and obtain the support they require.		
Progress at June 2015 – short commentary by service lead: The council looks to constantly update the information that is contained on the council's web pages to enable members of the public to navigate housing pathways in Housing. All of the housing pages have been refreshed The council provides information to individuals based on their need. This comprises an action plan for members of the public would approach the housing service along with information that relates to there area of housing needs. The information that is provided in checked on a regular basis to check that the information that is given is as accurate as possible this involves checking web links and that services are still running The Options online package for on line advice and information is waiting for changes to major policies and the service transformation before it goes live. This is to ensure that it reflects new models of delivery.	**Status - (note status indicates progress by January 2015)** **Green**  Web pages refreshed Information pages updated at least twice a year. April 2016	

Scrutiny Report Recommendation No. 6 (February 2014)	Service Lead	ELT Lead
Homeless pathways should be revised to allow clients to move directly into band 3 support when it is clear that there is no realistic possibility of them progressing successfully through band 2 support	Brian Doughty	Denise D'Souza
Council Response (December 2014)		
Recommendation accepted This is being considered as part of the Integrated Support Pathway review along with other modifications to the model which will be intended to create greater flexibility and better outcomes for service users.		
Progress at June 2015 – short commentary by service lead: We are currently remodelling the hostel and supported accommodation services as part of the retender, this includes the remodelling of Band 3 accommodation and the introduction of medium support accommodation. High, Medium and Low support accommodation will be accessible from referral and their will be no bar on entering low support accommodation from point of referral	**Status - (note status indicates progress by January 2015)** **Green**  End of 2015	

Scrutiny Report Recommendation No. 7 (February 2014)	Service Lead	ELT Lead
New and refreshed BHCC housing strategies must explicitly address the housing needs of victims of domestic violence.	Sylvia Peckham	Geoff Raw

Scrutiny Report Recommendation No. 7 (February 2014)	Service Lead	ELT Lead
Council Response (December 2014)		
Recommendation Accepted The New Homeless Strategy 2014- 2019 was agreed by the Housing Committee in June 2014. This strategy was based on the review of homelessness in the city from 2007-2012. Domestic violence and non-violent breakdown of relationships still feature as one of the main causes of homelessness in the city. For this particular reason victims of domestic violence are considered to be a priority group within the new homelessness strategy		
Progress at June 2015 – short commentary by service lead: The city's new Housing Strategy 2015 was approved in March 2015. The Strategy incorporates and reinforces our commitments in the homeless strategy and also has a strategic action to: 65: ensure that housing support services support survivors of Violence Against Women and Girls (VAWG). The Council's Homelessness Strategy was agreed in June 2014 this strategy looks to the strategic direction and delivery of service that address the needs of victims and survivors of domestic violence. Specific actions include "Ensure that same sex domestic violence is treated in a sensitive manner and that discrimination does not occur" "Ensure that we are able to deal with people in crisis situations timely and with appropriate support"	**Status - (note status indicates progress by January 2015)** **Green**  Housing Strategy completed March 2015 Homelessness Strategy Completed June 2014 Housing Allocations Review Target date June 2016 Funding for GBT refuge spaces successful March 2015	

Scrutiny Report Recommendation No. 7 (February 2014)	Service Lead	ELT Lead
The Council was successful in a bid to provide GBT Male DV accommodation provision from the Home Office under the "Funding to strengthen accommodation based specialist domestic abuse service provision " This project in conjunction with RISE will provide 2/4 units of accommodation supporting up to 10/12 GBT male survivors of DV. This fills a gap in service provision in this area. The project is operational on the support side and with the accommodation expected to come on stream by the end of September 2015	Accommodation support of GBT DV project End of September 2015	

Scrutiny Report Recommendation No. 8 (February 2014)	Service Lead	ELT Lead
Training for housing staff dealing with homeless applications must explicitly include information on domestic violence		
Council Response (December 2014)		
Recommendation accepted Housing staff routinely have supervision sessions with their line managers and this includes Performance Development Plans(PDP) Part of the PDP process is to identify the training needs of staff. These needs feed into the Training Plans for each service area. Courses are provided as part of the Council's membership of the BEST &NHSS training programmes to ensure that staff are provided with the relevant skills to deal with cases of Domestic Violence.		
Progress at June 2015 – short commentary by service lead: We have a workforce development plan and in addition are developing the core competencies required for delivering Housing services and will be benchmarking staff against this to ensure they have received adequate training and have those competencies.	**Status - (note status indicates progress by January 2015)** **Completed** **Amber**  Core Competences for Housing Options July 2015	

Scrutiny Report Recommendation No. 8 (February 2014)	Service Lead	ELT Lead
The Service redesign for Housing will include specific training for all front line officers in the customer interface with the public in the service centre at Barts House and dealing with telephone enquires Community safety are recruiting a DV training and awareness officer who will take the lead on auditing multi-agency training need developing/coordinating training responses	Service Transformation Pilot in Housing Options to include induction including delivery of services to LGBT community October 2015 September 2015	

Scrutiny Report Recommendation No. 9 (February 2014)	Service Lead	ELT Lead
New and refreshed BHCC housing strategies must explicitly address the housing needs of LGBT people.	Sylvia Peckham	Geoff Raw
Council Response (December 2014)		
Recommendation accepted The City has one of the largest concentrations of LGBT communities in the country. Homelessness is a significant issue for the LGBT community and therefore this group is considered to be one of the cities Priority Groups within the new homelessness strategy.		
Progress at June 2015 – short commentary by service lead: The city's new Housing Strategy 2015 has 'Supporting our LGBT Communities' as a priority theme. Within this priority, we have strategic actions to: 85. Ensure that as services are reviewed we check that they are accessible and safe for all .	**Status - (note status indicates progress by January 2015)** **Completed/green?** **Amber** 	

Scrutiny Report Recommendation No. 9 (February 2014)	Service Lead	ELT Lead
86. Carry out more research in partnership with community groups to identify specific gaps and needs. 87. Joint work with Community Safety to resolve housing issues and harassment in a timely manner.	Trans Needs Assessment awaiting sign off by the council September 2015	
88. Investigate potential impacts of 'out of area' placements for LGBT people in relation to local services and support networks.	Out of area placement being developed to go to Housing Committee September 2015	
89. Work with sheltered housing providers to ensure that services are accessible for the LGBT communities.	Review of allocation policy and Review of Criteria used for sheltered Accommodation Target June 2016	
90. Support local LGBT agencies who are working with LGBT agencies in other areas where LGBT people are looking to move to Brighton to ensure this is done in a planned way. 91. Use the skills in LGBT community groups to deliver improvements to frontline housing services.		
92. Examine the provision of LGBT specific housing support services in the city.	Draft information guide put out of consultation July 2015	
93. Continue to implement Trans Scrutiny Panel Recommendations for Housing and consider the recommendations of the forthcoming Trans Needs Assessment. Action planning to achieve these strategic actions will be happening through 2015 and will involve LGBT stakeholder	Reported to the Trans Scrutiny Panel & Trans needs assessment awaiting sign off expected in September 2015	

Scrutiny Report Recommendation No. 9 (February 2014)	Service Lead	ELT Lead
groups	December 2015	

Scrutiny Report Recommendation No. 10 (February 2014)	Service Lead	ELT Lead
Training for housing staff dealing with homeless applications must explicitly include information on LGBT needs.	Sylvia Peckham	Geoff Raw
Council Response (December 2014)		
Recommendation Accepted The City has one of the largest concentrations of LGBT communities in the country. Homelessness is a significant issue for the LGBT community and therefore this group is considered to be one of the cities Priority Groups within the new homelessness strategy		
Progress at June 2015 – short commentary by service lead: We have a workforce development plan and in addition we are developing core competencies required for delivering Housing options and will be benchmarking staff against this to ensure they have received adequate training and have those competencies. • Work with trans groups to provide guidance on gender appropriate guidance for supported accommodation. • Produce guidance for private letting agents and landlords on protection for trans people. • Ensure that the assessment of homeless	**Status - (note status indicates progress by January 2015)** **Green**  Core Competences for Housing Options July 2015 Service Transformation in Housing Options to include induction including delivery of services to LGBT community September 2015	

Scrutiny Report Recommendation No. 10 (February 2014)	Service Lead	ELT Lead
applications takes into account relevant issues for the LGBT community. • Ensure that information is available to members of the LGBT community who wish to relocate to the City so that it is available for them to do in a planned way. • Ensure that staff receive relevant training on homophobia, transphobia & biphobia. • Ensure that same-sex domestic violence is treated in a sensitive manner and that discrimination does not occur.	Trans Guide out for consultation July 2015 Successful bid to provide refuge provisions for GBT men March 2015	

Scrutiny Report Recommendation No. 11 (February 2014)	Service Lead	ELT Lead
Relevant new and refreshed homelessness strategies (e.g. the Joint Commissioning Strategy for Young people) should explicitly address need with regard to: • services for young people with high support needs; • ensuring that there is sufficient specialised housing to support young people; • the need to deliver 'holistic' support to young people (i.e. helping make young people work-ready at the same time as housing them)	Sylvia Peckham	Geoff Raw

Scrutiny Report Recommendation No. 11 (February 2014)	Service Lead	ELT Lead
Council Response (December 2014)		
Recommendation Accepted In the Autumn of 2013, the Joint Commissioning Strategy with Children's Services for young people was approved. One of the key outcomes from this strategy was the development of a 'positive transitions' pathway for young people. In April 2014 the new Young People's Accommodation and Support pathway was launched. This included action on designing the future shape of services to meet the needs of young people and to provide value for money. We are still working through some of the changes, which are may be linked to other areas of the council, but in order to meet the needs of high need young people we have successfully tendered Barnardo's to provide a supported lodgings service, and we are in the process of tendering a small accommodation based service for high need young males. With regards to ensuring there is sufficient specialist housing we are looking at the services with the intention of remodelling of re-commissioning services to ensure they meet the needs of young people and provide value for money, and provide as much accommodation with support as possible within the constrains of the resources available. The 'positive transitions pathway' model is a national good practice model which the Department of Communities and Local Government are promoting local authorities to use in developing their responses to young people with Housing and Support needs. This pathway emphasises 'positive transitions to adulthood', which requires an integrated approach from agencies in terms of young people achieving in education, economic independence, being healthy, having positive relationships and being involved in meaningful and enjoyable activities. The Young people's accommodation and Support pathway in Brighton and Hove have adopted this model with a requirement that agencies work to meet these needs in young people as well as their housing needs, and measure this by using appropriate tools such as the outcomes star.		
Progress at June 2015 – short commentary by service lead: Barnardo's to provide a supported lodgings service	**Status - (note status indicates progress by January 2015)** Barnardo's to provide a supported lodgings service, Contract awarded - July 2015	

Scrutiny Report Recommendation No. 11 (February 2014)	Service Lead	ELT Lead
The modelling of services for young people is ongoing and we are currently out to tender with the young peoples floating support service which is due to be awarded at the end of July. Young people have also been included in the Housing First tender about to be issued. Other tenders for young peoples services will follow in the coming months and are currently being developed.		

Scrutiny Report Recommendation No. 12 (February 2014)	Service Lead	ELT Lead
The Council should consider lobbying central Government (on the issue of people who are receiving employability training being required to attend the Job Centre to sign-on), reflecting the concerns of local voluntary sector providers that the rules dictating the ability of Jobcentre + to relax its signing-on requirements are still too inflexible.	Sylvia Peckham	Geoff Raw
Council Response (December 2014)		
Recommendation Accepted Following on from a regional event set up by DWP/Homeless Link in June, the Work and Learning working Group have set up a Task and Finish Group with the Sussex and Surrey DWP Social Justice Partnership Manager and Work Programme providers to improve outcomes for homeless ESA and JSA claimants • DWP Easement Rules for Homeless people • Upcoming changes to signing on procedures eg online		

<table>
<tr><th>Scrutiny Report Recommendation No. 12 (February 2014)</th><th>Service Lead</th><th>ELT Lead</th></tr>
<tr><td colspan="3">• DWP/Homeless Services Brighton & Hove/ Pilot August-Sept 2014/Proposed Phased rollout October 2014 onwards.
• Identifying “vulnerable” ESA/JSA claimants on the DWP local market system in order to give flexibility in the work related activity regime
• Flagged on system – trigger for JCP Work Coaches/Work Programme Providers to contact named support worker prior to any sanction decision for non-engagement in work related activity
• Work related activity undertaken with homeless providers included in claimant commitment (JSA) and Work Related Action Plan (ESA) as part of agreed work related activity requirements.
• Homeless/Social Justice Champions at both Job Centres
• Consent forms
a) Named support worker contacts for homeless clients to be contacted if any issues –
b) authorises the named worker to speak on client’s behalf
c) Outlines issues/barriers for the client</td></tr>
<tr><td colspan="2">Progress at June 2015 – short commentary by service lead:
The Vulnerability Pilot is a co production between the Council, DWP and Homeless link. The Pilot has now been rolled out to supported housing providers and homeless agencies across the city (increased from the 5 original agencies), as well as specialist housing support services in Temporary Accommodation and council housing. Early anecdotal evidence and feedback has been good, achieving positive outcomes for individuals including prevention of sanctions/benefit breakdown, quicker resolution of benefit issues, improved tailored support for benefit claimants.

The Pilot has been working with the National DWP Strategy Team as this project has been recognised as being a model of good practice to support</td><td>Status

Green
 

Collection of evidence to inform City Wide Roll out improved outcomes for JSA & ESA Claimants. March 2016

Evaluation of Project on improved outcomes for JSA and ESA claimants. March 2016</td></tr>
</table>

Scrutiny Report Recommendation No. 12 (February 2014)	Service Lead	ELT Lead
vulnerable claimants . The project is in the process of collecting evidence to inform further role across the city. The Project will also be the subjected to an evaluation on how this approach supports some of the most vulnerable households in the City.		

Scrutiny Report Recommendation No. 13 (February 2014)	Service Lead	ELT Lead
New or refreshed homelessness strategies should explicitly address the issue of working with private landlords to maximise the supply of private rented accommodation accessible to homeless people.	Sylvia Peckham	Geoff Raw
Council Response (December 2014)		
Progress at June 2015 – short commentary by service lead: The success of the private sector matching service that has continued to deliver enabling private landlords to let to households that would otherwise be homeless. This has continued to deliver despite the increasing cost of the private rented sector and increasing competition for accommodation. The council embarked on a comprehensive review	**Status - (note status indicates progress by January 2015)** **Green** .  **Ongoing**	

Scrutiny Report Recommendation No. 13 (February 2014)	Service Lead	ELT Lead
on how it commissions temporary accommodation from the private sector. The department has developed a commissioning "framework" all of which are now completed and delivering temporary accommodation to those in housing needs		

Scrutiny Report Recommendation No. 14 (February 2014)	Service Lead	ELT Lead
The council should explore what can be done to maintain people's tenancies should they be imprisoned for a short period of time. The aim should be to minimise the number of people with a local housing connection being made homeless as a result of imprisonment	Sylvia Peckham	Geoff Raw
Council Response (December 2014)		
Recommendation Accepted Recommendation accepted We have continued to work with offenders with a local housing connection who are in HMP Lewes and are on remand or sentenced to less than 12 months. This work is carried by our Housing Options Officer, Offender Pathway post under the Prevention of Offender Accommodation Loss project. The post holder works to both maintain people's tenancies where possible, through negotiation with landlords, housing benefit department and DWP. These tenancies may be in supported accommodation, private rented sector or social housing. Work is done to ensure that placements in supported accommodation are maintained for prisoners on remand / in custody. Support needs are common amongst this cohort, and are often best met in supported accommodation. Maintaining these placements allows not only for the bricks and mortar of accommodation to be maintained, but also that support to address need and reduce the potential for future re-offending remains in place. Of note in the recommendation is that it is questioned whether social housing tenants are able to resume their		

Scrutiny Report Recommendation No. 14 (February 2014)	Service Lead	ELT Lead
tenancies when released. Those on remand can claim housing benefit for up to 52 weeks, and those on short term sentences can claim for up to 13 weeks. This enables a certain amount of flexibility in negotiation with social landlords to ensure that tenancies are kept open where possible. Further of note is that social tenants can nominate a caretaker to their property while in custody, either on short or long term sentences. Throughout the 5 and half years of its existence the Offender Pathway post has worked with prisoners and social landlords to facilitate caretaker arrangements. This post also works towards finding accommodation for prisoners who were homeless on reception to HMP Lewes. Much of this side of the work is focused on referral to supported accommodation. However, we also assist ex-offenders to access private sector accommodation via a deposit guarantee.		
Progress at June 2015 – short commentary by service lead: Actioned and on-going. We have embedded the work of the POAL officer into the Housing options work and are successful at preventing homelessness where people are committed to prison for short sentences. The Department is in regular contact with both the National Offender Management Service for high risk offenders and the newly formed Kent, Sussex and Surrey offender trust. We will look to work with the new trust in developing models of delivery that prevent homelessness and await details of funding that may be available to support this aim	**Status - (note status indicates progress by**  **Amber** Await details of funding possibilities July 2015	

Scrutiny Report Recommendation No. 15 (February 2014)	Service Lead	ELT Lead
New and refreshed homelessness strategies must explicitly recognise that social care and housing increasingly need to work in an integrated manner, and should establish structures to enable this	Sylvia Peckham	Geoff Raw

Scrutiny Report Recommendation No. 15 (February 2014)	Service Lead	ELT Lead
Council Response (December 2014)		
Recommendation Accepted See recommendation 1 above.		
Progress at June 2015 – short commentary by service lead: - Refer to Action 1 above .	**Status - (note status indicates progress by**  **Amber**	

Scrutiny Report Recommendation No. 16 (February 2014)	Service Lead	ELT Lead
New and refreshed homelessness strategies should specifically address the support/advice needs of those who have been deemed ineligible for statutory housing support, recognising that this is a significant group of people, many of whom have genuine support needs		Geoff Raw
Council Response (December 2014)		
Recommendation Accepted The Homelessness Strategy acknowledges the wider impact of homelessness in the City and includes those to whom the Council does not have a statutory duty to accommodate. The council is obliged to provide advice on prevention of homelessness to all persons in its area free of charge, The council's Housing Options team includes Advice and Assessment officers who discharge this duty. In addition to this the council has a number of partners in the voluntary		

Scrutiny Report Recommendation No. 16 (February 2014)	Service Lead	ELT Lead
sector who also give advice and assistance including Downslink YMCA and BHT		
Progress at June 2015 – short commentary by service lead: The council is looking towards a service redesign for the housing needs division within housing. This will look to develop the Housing Options Approach across all services. This piece of work will see officers getting closer to the front end of the service and will also look to stream line assessment and avoid hand offs between officers. This will also look to develop earlier intervention and prevention work with pilot projects with housing staff being placed with children's services to give earlier housing advice to both customers and children' service staff	**Status - (note status indicates progress by**  **Amber** April 2016 for full implementation Pilot September 2015	

Scrutiny Report Recommendation No. 17 (February 2014)	Service Lead	ELT Lead
The OSC should monitor the implementation of agreed panel recommendations on an annual basis until the committee is satisfied that all recommendations have been implemented		Geoff Raw
Council Response (December 2014)		
Recommendation Accepted Recommendation accepted As part of the part of the homelessness strategy the Housing Committee will receive an annual update report of the		

Scrutiny Report Recommendation No. 17 (February 2014)	Service Lead	ELT Lead
activities of the Council and its partners of the progress of meeting the aims and objectives in the area of homelessness. This will include an up date of the recommendations of the Homelessness Scrutiny Panel		
Progress at June 2015 – short commentary by service lead: This report looks at the work across a number of departments that look to mitigate some of the effects of homelessness in the city. This reporting will continue until the overview and scrutiny committee are satisfied that all of the recommendations are fully complied with. This action plan is only part of the overall work that is carried out throughout the year with some of our most vulnerable residents.	**Status - (note status indicates progress by** **Green**  2nd Annual Report July 2016	

OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 26 Brighton & Hove City Council

Subject:		**Bullying in Schools Scrutiny Panel Monitoring**		
Date of Meeting:		**9 September 2015**		
Report of:		**Executive Director for Children's Services**		
Contact Officer:	**Name:**	**Sam Beal**	**Tel:**	**293533**
	Email:	**sam.beal@brighton-hove.gov.uk**		
Ward(s) affected:		**All**		

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The report of the Scrutiny Panel on Bullying in Schools was published in June 2014. The seventeen recommendations made by the Scrutiny Panel were all agreed by Children and Young People's Committee on the 17th October 2014. The work on the recommendations has been supported by the Equality and Anti-Bullying Strategy Group (Educational Settings).

1.2 The progress made in implementing the recommendations in the report is detailed in Appendix 1.

2. RECOMMENDATIONS:

2.1 That Overview and Scrutiny Members consider and comment on the contents of this report and its appendix.

2.2 That Overview and Scrutiny Members decide whether there is a need for a further monitoring report following this one.

3 CONTEXT/ BACKGROUND INFORMATION

3.1 The Report of the Health & Wellbeing Overview & Scrutiny Panel, Scrutiny Panel on Bullying in Schools (June 2014) identified that there is a range of good practice in place in the Council and in individual schools related to bullying. The annual Safe and Well at School Survey data shows year on year reductions in the numbers of pupils and students reporting bullying. In addition, the Council has twice been awarded first place in Stonewall's Education Equality Index and been awarded second place twice. However, there is always room for improvement and the scrutiny panel report made some recommendations for further development of practice.

3.2 Significant progress has been made in acting on these recommendations, but there remain some further areas for development as shown in Appendix 1.

3.3 Anti-Bullying work in Brighton & Hove is monitored at a range of levels. For example there is an expectation that the Safe and Well School Survey shows a continual decline in bullying reported by pupils and students and this target is measured by Interplan. Reporting of bullying by type is regularly reported to the Racial Harassment Forum and other community and voluntary sector groups when requested. At school level every secondary school receives an annual visit from the Partnership Adviser: Health and Wellbeing to discuss their Safe and Well School Survey data and primary schools where there are higher levels than city average of bullying reported are also visited. Additionally, Ofsted Reports of schools routinely comment on anti-bullying practice. Data is also reported to the Equality and Anti-Bullying Strategy Group which provides support and challenge in response.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 None with regard to this monitoring report.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None with regard to this monitoring report.

6. CONCLUSION

6.1 This is a monitoring report and not one requiring a specific decision.

7. FINANCIAL & OTHER IMPLICATIONS:

7.1 None with regard to this monitoring report.

SUPPORTING DOCUMENTATION

Appendices:

1. Details of implementation in regard to each of the agreed panel recommendations.

Documents in Members' Rooms

1. None

Background Documents

1. Report of the Health & Wellbeing Overview & Scrutiny Panel, June 2014, Scrutiny Panel on Bullying in Schools

Scrutiny Report Recommendation: 1 that the Anti-Bullying and Equality Strategy Group (ABESG) should be supported and funded appropriately to allow it to undertake the key task of supporting anti-bullying initiatives across the city	**Service Lead** Sam Beal	**SLT Lead** Hilary Ferries
Progress at September 2015 The ABESG continues to meet and has been renamed the Equality and Anti-Bullying Strategy Group (Educational Settings) to be inclusive of its membership that includes Early Years and Further Education settings. The membership of this group includes a range of community and voluntary sector and statutory sector partners and provides support and challenge to the work in the following action plans: • Bullying Scrutiny • Improving Race Equality in Schools • Whole School approaches to disability equality In addition, the group has been active in developing the parents and carers bullying leaflet and guidance for educational settings on engaging with the parents and carers of Black and Minority Ethnic pupils and students.	**Status** **Green** 	

Scrutiny Report Recommendation: 2 that the ABESG develops a best practice forum to celebrate and spread anti-bullying best practice across city schools	**Service Lead** Sam Beal	**SLT Lead** Hilary Ferries
Progress at September 2015 Anti-bullying best practice is regularly shared in the following ways: • PSHE Networks and on Pier2Peer (the Virtual Learning Environment) • Head teacher meetings • Schools Bulletin The Equality and Anti-Bullying Strategy Group (Educational Settings) has steered the development of an online good practice toolkit which will be published in October 2015. Case studies from this resource were shared at a School and Business Leaders meeting on the 9th June. This meeting focused on sharing and developing anti-bullying and equality work.	**Status** **Green** 	

Scrutiny Report Recommendation: 3 that council officers continue to champion the Safe and Well School Survey (SAWSS) via the ABESG and other	**Service Lead** Sam Beal	**SLT Lead** Hilary

school partnerships including the Public Health Schools Programme		Ferries
Progress at September 2015 The SAWSS ran successfully again in 2014 with 5,596 pupils from 40 primary and junior schools, 8,320 students from 10 secondary schools and 87 students from 4 special schools participating. The survey will be reviewed for 2015 to include more emotional health and wellbeing questions. The primary school data shows a continued reduction in numbers reporting bullying totalling a 13% reduction since 2006 and for secondary schools the data plateaued, but there has still been a 14% reduction since 2005.	**Status** **Green** 	

Scrutiny Report Recommendation: 4a ABESG should produce a leaflet (or a template for individual schools to adapt) for parents and young people explaining school commitments to tackling bullying. This leaflet should: a. Detail parents' rights to complain b. Explain to whom parents can appeal if they are unhappy with the school's response to reports of bullying c. Make clear the role of school governors in dealing with parents who are unsatisfied with staff responses d. Provide contact details for independent advice e. Provide contact details for a parent-advocate and for the range of advocates available for particular groups (e.g. for the families of children with SEN)	**Service Lead** Sam Beal	**SLT Lead** Hilary Ferries
Progress at September 2015 A leaflet, covering these points has been produced for parents and carers and this is on the Council website. Educational settings are encouraged to link to this leaflet from their school websites: The Council sent to secondary schools one of these leaflets for every parent and carer for new Year 7 students in September 2015. This will be repeated for 2015 and in addition one leaflet for each child in any given year group will be sent to primary schools for schools to decide who to send them out to. Special schools will receive sufficient leaflets for all families in their settings.	**Status** **Green** 	

Scrutiny Report Recommendations: 4b ABESG should produce a leaflet (or a template for individual schools to adapt) for parents and young people explaining school commitments to tackling bullying. This leaflet should: a. Explain to young people what options they have if	**Service Lead** Sam Beal	**SLT Lead** Hilary Ferries

they feel they are being bullied		
Progress at September 2015 As part of core learning in PSHE education pupils and students in Brighton & Hove schools are supported to develop the skills to ask for help; including if they are bullied. As part of marking anti-bullying week pupils and students are reminded at school level who they can tell. The Equality and Anti-Bullying Strategy Group will be producing a leaflet for pupils and students in consultation with the Youth Council and other youth groups. This will be in place prior to anti-bullying week 2016.	**Status** **Amber** 	

Scrutiny Report Recommendation: 5 we need a more systematic approach to identifying and learning from families who have opted out of the local state education system because they feel it has let them down – for example via an 'exit interview' of all those who permanently take their children out of local schools. This should build on the work already undertaken to track school moves within the LEA.	**Service Lead** Gavin Thomas (EOTAS) Henry Kannike (Admiss-lons)	**SLT Lead** Ellen Mulvihill (EOTAS) Michael Nix (Admiss-ions)
Progress at September 2015 When the Educated Other than at School Service (EOTAS) is informed that a pupil has been removed from school to home educate the service contacts the family in order to arrange an initial visit to talk through the home education and to find reasons why that child has been removed. If the parent is prepared to talk about it or to meet then we always record the reason for home education on a spreadsheet, including bullying issues. That data is available, although not all parents choose to disclose it to us. The Association of Home Educating Professionals is looking for those reasons to be consolidated across the country to allow for shared data. The Admissions Team have amended IMPULSE (their data system) so they are able to recording bullying as a reason for moving school or leaving school. When the new Head of Admissions comes into post the Partnership Adviser: health and wellbeing will meet with them to explore any team training needs related to talking with parents and carers who are reporting that their child is being bullied.	**Status** **Amber** 	

Scrutiny Report Recommendation: 6 ABESG should identify best practice in terms of BME anti-	**Service Lead**	**SLT Lead**

bullying work and encourage the best performing schools to share their learning with their peers across the city.	Sam Beal	Hilary Ferries
Progress at September 2015 The Equality and Anti-Bullying Strategy Group (Educational Settings) monitors the Improving Whole School approaches to race equality action plan which was developed in response to recommendations made in the *The Changing Ethnic Demographic in Brighton & Hove – How prepared are Brighton & Hove Schools?* Report by Global HPO, February 2014. This has set out a work plan to close achievement gaps, increase numbers of BME staff and governors in schools and to develop anti-bullying and equality practice. A key element of this work is equality and anti-bullying learning walks in secondary schools supported by Community Champions from BMECP and these include focus groups of BME pupils and students and asking them about their experiences in school. This is informing the development of practice in schools. Four of these learning walks have taken place with more planned. Practice from these learning walks will be shared over the next academic year. The Ethnic Minority Achievement Service delivered a well-attended Closing the Gap Conference in March 2015 which provided schools with skills and strategies for improving the wellbeing and achievement of black and minority ethnic pupils and those with English as an additional language. At the School & College Leaders Business Meeting on the 9th June there was sharing of good practice case studies related to: • Engaging with parents and carers of BME children • Traveller Education • Supporting pupils and students during Ramadan The Black and Minority Ethnic Young People's Project is also supporting the development of resources in schools. A lot has been achieved, but this area of work is being continued under the three year work plan mentioned above.	**Status** **Green**	

Scrutiny Report Recommendations: 7 & 8	**Service Lead**	**SLT Lead**
that the ABESG includes student involvement in the development of school anti-bullying strategies as one of the elements of its best practice work. that ABESG invites the city Youth Council to become a co-	Sam Beal	Hilary Ferries

opted member of the partnership (ideally with two Youth Council members co-opted)		
Progress at September 2015 The Youth Council has been offered two places on the Equality and Anti-Bullying Strategy Group with one place regularly taken. The contributions from this young person are highly valued. A young person from Patcham High School evaluated anti-bullying practice in Brighton & Hove as part of Takeover Day in November 2014 and her recommendations have been acted on. Case studies from educational settings who involve pupils and students in anti-bullying work are featured in the good practice toolkit (see recommendation 2) and practice in this area was shared at the School & College Leaders Business Meeting on the 9th June. This meeting also included input from a pupil with impairments and two trans students talking about good inclusive practice in their schools. Young people from the Black and Minority Ethnic Young People's Project are developing resources for use in schools as part of PSHE education and Black History Month. Allsorts (LGBTU) young people support peer education work in Brighton & Hove primary and secondary schools. A Disability Equality DVD 'Nothing about us, without us' is being developed locally and this will feature children, young people and adults as positive role models for us in lessons, assemblies and staff training/	**Status** **Green** 	

Scrutiny Report Recommendation: 9 the views and experiences of parents are key to developing effective bullying strategies, and schools should actively involve parents in this work.	**Service Lead** Sam Beal / Tasha Barefield	**SLT Lead** Hilary Ferries / Steve Barton
Progress at September 2015 The Parents Forum has been active in supporting the development of resources for parents and carers and a resource to support schools to better engage with parents and carers of BME children and young people. Groups such as AMAZE and MOSAIC are represented on the Equality and Anti-Bullying Strategy Group and they provide feedback on the views of their members.	**Status** **Green** 	

A new exemplar Anti-Bullying Policy has been developed for use in educational settings and the guidance for this recommends that parents and carers are involved in policy review and development. As a Lead local authority for special educational needs and disability (SEND) bullying we have organised a bullying training session delivered by the Anti-Bullying Alliance for the parents and carers of pupils and students with SEND.	

Scrutiny Report Recommendation: 10 ABESG best practice in terms of anti-bullying should include how to communicate with parents whose children are involved in bullying incidents	**Service Lead** Sam Beal / Tasha Barefield	**SLT Lead** Hilary Ferries / Steve Barton
Progress at September 2015 In consultation with the Parents Forum a top tips sheet for schools on how to communicate with parents and carers about bullying in schools has been developed and disseminated to all schools.	**Status** **Green** 	

Scrutiny Report Recommendation: 11 ABESG best practice guidance should explicitly encourage schools to offer young people a range of ways in which they can report bullying	**Service Lead** Sam Beal	**SLT Lead** Hilary Ferries
Progress at September 2015 The *Brighton & Hove Schools bullying and prejudice-based incident recording and reporting guidance* provides advice to educational settings on developing a range of reporting methods. Encouraging the reporting of bullying will be the focus of this year's anti-bullying week 'Make a noise about bullying'. The leaflet for pupils and students being developed in response to recommendation 4b will also feature information on reporting. Over the past year we have also been working with the Community Safety Case Work Team so that parents, carers and students can report incidents of bullying or prejudice happening inside or outside of school to them. Referrals to this service are increasing.	**Status** **Green** 	

Scrutiny Report Recommendation: 12 that the ABESG anti-bullying best practice work explicitly includes how best to provide support for school staff	**Service Lead** Sam Beal	**SLT Lead** Hilary Ferries
Progress at September 2015 Consultancy, advice and resources are available from the Partnership Adviser: Health and Wellbeing and on Pier2Peer to support school staff to review and develop whole school approaches to anti-bullying. Resources available include: • *Brighton & Hove Schools bullying and prejudice-based incident recording and reporting guidance* • Exemplar Anti-Bullying Policy • Materials for anti-bullying week • Materials to support teaching and learning about equality and anti-bullying in PSHE education A training audit of school staff related to supporting and understanding the needs of black and minority ethnic children and young people is currently under-way and will report in October 2015. This will inform the further development of a training offer which already includes: • Council training on identifying, challenging and recording bullying and prejudiced based incidents • Training from community and voluntary sector partners such as Allsorts, Safety Net and BMEYPP • SEND anti-bullying training - Anti-Bullying Alliance • Homophobic, Biphobic and Transphobic Bullying Training for Primary Schools	**Status** **Green**	

Scrutiny Report Recommendation: 13 the ABESG should ensure that planning effective primary to secondary transition forms part of its best practice work	**Service Lead**	**SLT Lead**
Progress at September 2015 The Council sent to secondary schools a parents' anti-bullying leaflet for every parent and carer for new Year 7 students in September 2014. This ensured that all parents and carers know how best to support their child if that child experiences any bullying at transition or beyond. The newly developed Vulnerable Pupil Register will support primary to secondary transition for those who may be vulnerable to bullying or being bullies.	**Status** **Green**	

Scrutiny Report Recommendation: 14	**Service Lead**	**SLT Lead**

that the ABESG includes cyber-bullying in its best practice anti-bullying work. This should explicitly include work on: engaging directly with young people a. training for parents b. encouraging young people to think about on-line safety and who they share personal information with c. working with young people to improve their understanding that being kind and courteous in on-line interaction is as important as in face-to-face interaction d. recognising how quickly the on-line landscape is changing – and the need for teachers and trainers to constantly update their knowledge e. what can be done to utilise local digital media resources to make the Brighton & Hove approach to cyber-bullying as innovative as it can be.	Sam Beal Paul Platts	Hilary Ferries
Progress at September 2015 Ofsted Reports across the City report favourably on the awareness of children and young people in keeping safe online. The Youth Council has advised us is to treat cyber-bullying as one type of bullying behaviour rather than something different and unique. Therefore, the focus is on including e-safety as part of all aspects of work. This work is very much ongoing, but the following work has been delivered locally over the last year: • The anti-bullying toolkit will include a dealing with cyber-bullying case study • Paul Platts - Computing \ICT Teaching & Learning Consultant has offered and delivered school-based sessions for parents and carers related to e-safety • The parent and carer bullying leaflet (recommendation 4a) provides advice on cyberbullying • Staff training on sexual exploitation contains an on-line training element • Chelsea's Choice – Theatre in Education Production on sexual exploitation delivered to all Year 8 students in Brighton & Hove secondary schools contained clear online safety messages • Materials developed for secondary PSHE included learning about online safety in regards to sexual exploitation • Safeguarding training for school staff contains an online training element • A Social Media Think Tank co-ordinated by the Public Health Schools Programme and involving young people and a range of professionals is going	**Status** **Green** 	

to result in a city wide approach to e-safety and a work plan • The 'local offer' will also signpost information for pupils and students with special educational needs and disabilities about e-safety • There will be a city wide approach to Internet Safety Day in February 2016.	

Scrutiny Report Recommendation: 15 that CAMHS and EPS develop better systems for recording bullying. This should specifically include a system where service-users' experiences of bullying are actively solicited where it is therapeutically appropriate to do so	**Service Lead** Paul Myzsor (EPS) Paul Goodwin (CCAMHS)	**SLT Lead** Regan Delf
Progress at September 2015 Educational Psychology Service has responded to this recommendation and as a result: • EP "request for involvement form" has a section asking the school to record if bullying is an issue for the child or young person. • EPs, in their assessment work, will systematically clarify if there are bullying issues for the child or young person, even if school or parents do not consider this to be an issue. • Bullying is now recorded on the Impulse database and can be searched as a query alongside other variables such as SEND category, gender, ethnicity, school and year group. Community CAMHS now collect via closing data collection data information about whether child is being bullied or is bullying others. This will provide quantitative information about number of young people reporting being bullied or who are reported as being bullies. Community CAMHS Team members now routine ask if appropriate during Initial Assessment or subsequent intervention about bullying and whether this is contributing towards presenting issue.	**Status** **Green** 	

Scrutiny Report Recommendation: 16 that the implementation of agreed panel recommendations should be monitored by OSC via an annual report co-ordinated and produced by Children's Services	**Service Lead** Sam Beal	**SLT Lead** Hilary Ferries

Progress at September 2015	Status
This is the report on progress.	**Green** 

Scrutiny Report Recommendation: 17 that officers from the council's Children's Services directorate share the panel report with all city schools	Service Lead Sam Beal	SLT Lead Hilary Ferries
Progress at September 2015 The Report was shared with city schools via the Schools Bulletin in June 2014 and prior to anti-bullying week in November 2014. It was also emailed to PSHE co-ordinators and school governors.	**Status** **Green** 	

Goodwood Court Medical Centre

Quality Report

52 Cromwell Road
Hove
Brighton and Hove
BN3 3ER
Tel: 01273 201977
Website: www.goodwoodcourt.org

Date of inspection visit: 4, 8 and 9 June 2015
Date of publication: 27/08/2015

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inadequate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an un-announced comprehensive inspection at Goodwood Court Medical Centre on 4, 8 and 9 June 2015. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing safe, effective, caring, responsive services and being well led. It was also inadequate for providing services for older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

We found the provider to be in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The regulations breached were:

Regulation 12: Safe care and treatment

Regulation 13: Safeguarding service users from abuse and improper treatment

Regulation 15: Premises and equipment

Regulation 16: Receiving and acting on complaints

Regulation 17: Good governance

Regulation 18: Staffing

Regulation 19: Fit and proper persons employed

Our key findings across all the areas we inspected were as follows:

- Patients were at serious risk of harm because the practice had not provided sufficient suitably qualified staff to meet their needs.
- Patients were at serious risk of harm because systems and processes were not in place to keep them safe. For example, appropriate recruitment checks on staff had not been undertaken prior to their employment and actions identified to address concerns with infection control practice had not been taken.
- Staff were not clear about reporting incidents, near misses and concerns and there was no evidence of learning and communication with staff.
- Medicine management practices were unsafe and placed patients at serious risk of harm. This included requests for prescriptions. These had not been processed in a timely manner to ensure patients had access to their medicines.

Summary of findings

- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Urgent appointments were usually available on the day they were requested. However patients said that they had to wait a long time for non-urgent appointments and that it was very difficult to get through to the practice when phoning to make an appointment. Patients often experienced long delays when waiting to be seen by the GP.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.
- There were multiple breaches of regulations relating to safe; a safe track record; learning and improvement from safety incidents; reliable safety systems and processes; medicines management; cleanliness and infection control; staffing and recruitment; monitoring safety and responding to risk, and arrangements to deal with emergencies and major incidents.
- There were multiple breaches of regulations relating to effective; management, monitoring and improving outcomes for people; effective staffing; working with colleagues and other services; consent to care and treatment; and health promotion and prevention.
- There were multiple breaches of regulations relating to responsive; responding to and meeting people's needs; access to the service; listening and learning from concerns and complaints.
- There were multiple breaches of regulations relating to well-led; vision and strategy; governance arrangements; leadership openness and transparency; and seeking and acting on feedback from patients, public and staff.

If the provider had continued to be registered with the Care Quality Commission, this location would have been placed into special measures. The areas where the provider must have made improvements are:

- Ensure staffing levels are sufficient to meet the needs and size of the patient group.
- Ensure safe medicine management systems are in place to protect patients.
- Take action to address identified concerns with infection prevention and control practice.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure all staff is supported by means of supervision and appraisal.
- Ensure audits of practice are undertaken, including completed clinical audit cycles.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure systems are in place to respond to the concerns and complaints raised by patients and other stakeholders
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.

On the basis of the concerns identified at this inspection we took enforcement action. The CQC applied for and were granted an urgent order to cancel the registration of the provider. This was subject to appeal by the provider in the First Tier Tribunal. An initial appeal was made but subsequently withdrawn. The order stands and the provider's registration has been cancelled.

As part of this action CQC liaised with NHS England to ensure measures were put in place to provide support, care and treatment for the patients affected by this closure. Patients previously registered with Goodwood Court Medical Centre were transferred to another local practice.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services. Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. The infection control practices did not keep staff and patients safe. There was insufficient information about safety because there was a significant lack of information available in the practice. The practice did not have sufficient staffing to meet the needs of the practice and patient list. Medicines management practices were unsafe and placed patients at serious risk of harm. There were multiple breaches of regulations relating to; a safe track record; learning and improvement from safety incidents; reliable safety systems and processes; medicines management; cleanliness and infection control; staffing and recruitment; monitoring safety and responding to risk; and arrangements to deal with emergencies and major incidents.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services. Patient outcomes were hard to identify as little or no reference was made to audits and there was no evidence that the practice was comparing its performance to others; either locally or nationally. There was minimal engagement with other providers of health and social care. There was limited recognition of the benefit of an appraisal process for staff. There were multiple breaches of regulations relating to effective; management, monitoring and improving outcomes for people; effective staffing; working with colleagues and other services; consent to care and treatment; and health promotion and prevention.

Are services caring?

Inadequate

The practice is rated as inadequate for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

We found that the significant shortfalls in staffing, lack of planning and monitoring the practice had caused significant impact on the level of service provided to patients. Long waiting times for appointments and delays when attending the practice to see a GP had caused patients to feel frustrated and unhappy with the practice.

Summary of findings

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services. Patients reported considerable difficulty in accessing a named GP and identified poor continuity of care. Appointment systems were not working well so patients did not receive timely care when they needed it. Limited information about how to complain was available for patients and did not explain the process properly. There was uncertainty in the practice as to who was the designated person responsible for handling complaints and these were not being responded to. A significant backlog of complaints had not been addressed by the practice. There were multiple breaches of regulations relating to responsive; responding to and meeting people's needs; access to the services; and listening and learning from concerns and complaints.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. It did not have a clear vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. There was no clear leadership structure and staff did not feel supported by management. The practice had no policies and procedures to govern activity. The practice did not hold regular governance meetings. The practice had not proactively sought feedback from staff or patients since 2012 and did not have a patient participation group (PPG). Staff told us they had not received regular performance reviews and did not have clear objectives. There were multiple breaches of regulations relating to well-led; vision and strategy; governance arrangements; leadership openness and transparency; and seeking and acting on feedback from patients, public and staff.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Inadequate

The provider was rated as inadequate for providing safe, effective, caring, responsive and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as inadequate for older people. There were multiple breaches of regulations relating to; a safe track record; learning and improvement from safety incidents; reliable safety systems and processes; medicines management; cleanliness and infection control; staffing and recruitment; monitoring safety and responding to risk; and arrangements to deal with emergencies and major incidents. There were multiple breaches of regulations relating to effective; management, monitoring and improving outcomes for people; effective staffing; working with colleagues and other services; consent to care and treatment; and health promotion and prevention. There were multiple breaches of regulations relating to responsive; responding to and meeting people's needs; access to the services; listening and learning from concerns and complaints. There were multiple breaches of regulations relating to well-led; vision and strategy; governance arrangements; leadership openness and transparency; and seeking and acting on feedback from patients, public and staff.

People with long term conditions

Inadequate

The provider was rated as inadequate for providing safe, effective, caring, responsive and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as inadequate for patients with long term conditions. There were multiple breaches of regulations relating to; a safe track record; learning and improvement from safety incidents; reliable safety systems and processes; medicines management; cleanliness and infection control; staffing and recruitment; monitoring safety and responding to risk; and arrangements to deal with emergencies and major incidents. There were multiple breaches of regulations relating to effective; management, monitoring and improving outcomes for people; effective staffing; working with colleagues and other services; consent to care and treatment; and health promotion and prevention. There were multiple breaches of regulations relating to responsive; responding to and meeting people's need; access to the service; listening and learning from concerns and complaints. There

Summary of findings

were multiple breaches of regulations relating to well-led; vision and strategy; governance arrangements; leadership openness and transparency; and seeking and acting on feedback from patients, public and staff.

Families, children and young people

Inadequate

The provider was rated as inadequate for providing safe, effective, caring, responsive and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as inadequate for Families, children and young people. There were multiple breaches of regulations relating to; a safe track record; learning and improvement from safety incidents; reliable safety systems and processes; medicines management; cleanliness and infection control; staffing and recruitment; monitoring safety and responding to risk; and arrangements to deal with emergencies and major incidents. There were multiple breaches of regulations relating to effective; management, monitoring and improving outcomes for people; effective staffing; working with colleagues and other services; consent to care and treatment; and health promotion and prevention. There were multiple breaches of regulations relating to responsive; responding to and meeting people's needs; access to the service; listening and learning from concerns and complaints. There were multiple breaches of regulations relating to well-led; vision and strategy; governance arrangements; leadership openness and transparency; and seeking and acting on feedback from patients, public and staff.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for providing safe, effective, caring, responsive and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as inadequate for working age patients (including those recently retired and students). There were multiple breaches of regulations relating to; a safe track record; learning and improvement from safety incidents; reliable safety systems and processes; medicines management; cleanliness and infection control; staffing and recruitment; monitoring safety and responding to risk; and arrangements to deal with emergencies and major incidents. There were multiple breaches of regulations relating to effective; management, monitoring and improving outcomes for people; effective staffing, working with colleagues and other services; consent to care and treatment; and health promotion and prevention. There were multiple breaches of regulations relating to responsive; responding to and meeting people's needs; access to the service; listening and learning from

concerns and complaints. There were multiple breaches of regulations relating to well-led; vision and strategy; governance arrangements; leadership openness and transparency; and seeking and acting on feedback from patients, public and staff.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for providing safe, effective, caring, responsive and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as inadequate for patients whose circumstances may make them vulnerable. There were multiple breaches of regulations relating to; a safe track record; learning and improvement from safety incidents; reliable safety systems and processes; medicines management; cleanliness and infection control, staffing and recruitment; monitoring safety and responding to risk; and arrangements to deal with emergencies and major incidents. There were multiple breaches of regulations relating to effective; management, monitoring and improving outcomes for people; effective staffing, working with colleagues and other services; consent to care and treatment; and health promotion and prevention. There were multiple breaches of regulations relating to responsive; responding to and meeting people's needs; access to the service; listening and learning from concerns and complaints. There were multiple breaches of regulations relating to well-led; vision and strategy; governance arrangements; leadership openness and transparency; and seeking and acting on feedback from patients, public and staff.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for providing safe, effective, caring, responsive and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as inadequate for patients experiencing poor mental health (including patients with dementia). There were multiple breaches of regulations relating to; a safe track record; learning and improvement from safety incidents; reliable safety systems and processes; medicines management; cleanliness and infection control; staffing and recruitment; monitoring safety and responding to risk; and arrangements to deal with emergencies and major incidents. There were multiple breaches of regulations relating to effective; management, monitoring and improving outcomes for people; effective staffing; working with colleagues and other services; consent to care and treatment; and health promotion and prevention. There were multiple breaches of regulations relating to responsive; responding to and meeting people's needs; access to the service; listening and

Summary of findings

learning from concerns and complaints. There were multiple breaches of regulations relating to well-led; vision and strategy; governance arrangements; leadership openness and transparency; and seeking and acting on feedback from patients, public and staff.	

Summary of findings

What people who use the service say

We spoke with six patients during the inspection and feedback was very mixed. Patients told us that they felt listened to and involved in their care when seeing either a GP or nurse. All felt that they were treated with respect and their dignity was maintained during consultations and treatment.

Patients reported long delays in obtaining a routine appointment and waiting times in the surgery were often long. Patients also told us of the confusion and disorganisation which occurred when appointments were delayed or had to be cancelled due to a lack of GPs.

We reviewed recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. We noted that 90% of patients had responded that the nurse was good at treating them with care and concern, whilst 80% of patients reported that the GP was good at treating them with care and concern. Data from the national patient survey showed that 61% of patients rated their overall experience of the practice as good compared to a CCG and national average of 85%. We also noted that just 49% of patients indicated they would recommend the practice to someone new in the area compared to a CCG and national average of 78%. This reflected the level of concerns in terms of obtaining appointments and being able to contact the practice by telephone.

Goodwood Court Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, CQC inspectors and specialist advisors: a specialist nurse advisor, a practice manager advisor and a pharmacist inspector.

Background to Goodwood Court Medical Centre

Goodwood Court Medical Centre provides primary medical services to approximately 10,000 registered patients. The practice delivers services to a higher number of patients who are aged 15 to 45 years, when compared with the local clinical commissioning group (CCG) and England average. Care is provided to a small number of patients living in local residential and nursing homes. The practice delivers services to patients living within a population of average deprivation levels.

Care and treatment is delivered by one GP partner. This is due to the long term absence of another GP partner. A salaried GP also works in the practice however they had commenced maternity leave. The practice employs a team which comprises a nurse practitioner, two practice nurses and two healthcare assistants. GPs and nurses are supported by the practice manager and a team of reception and administration staff.

The practice has opted out of providing Out of Hours services to its own patients and uses the services of a local Out of Hours service.

Services are provided from

52 Cromwell Road

Hove

Brighton and Hove

BN3 3ER

The practice has a branch surgery located at The Eaton Centre, 3 Eaton Gardens, Hove, BN3 3TL. However this was closed at the time of our inspection due to flooding.

During this inspection we found that the regulated activity Family Planning was being carried out. The provider is not registered to provide the activity under Health and Social Care Act (Registration) Regulations 2009. This was brought to the provider's attention at the inspection.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We brought the date of this inspection forward and carried it out unannounced as we had received significant concerns about the practice.

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the NHS Brighton and Hove Clinical Commissioning Group

Detailed findings

(CCG). We carried out an unannounced visit on 4 June 2015. Subsequent visits took place on 8 and 9 June 2015. During our visits we spoke with a range of staff, including the lead GP partner, the practice manager, practice nurses and administration staff.

We observed staff and patient interaction and spoke with six patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We also reviewed the personal care or treatment records of patients.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Inadequate

Are services safe?

Our findings

Safe track record

The practice could not demonstrate that it prioritised safety or that it used a range of information to identify risks and improve patient safety. For example, we found that incidents recorded in the accident/incident book, staff disciplinary concerns, as well as 135 complaints received from patients had not been responded to and used to inform the practice on areas of risk.

We were unable to find any records of significant event meetings or discussions in relation to events that had taken place in the practice. We identified at least three significant events that had taken place. These included an incident of aggression, an issue of breach of confidentiality and the closure of the branch facility. An incident recorded in the accident book that raised concerns about patient and staff safety had not been reviewed or discussed in any forum to ensure the practice learnt from this and put measures in place for the future.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents. However they were not confident that concerns raised would be acted upon.

Learning and improvement from safety incidents

The practice did not have a robust system in place for reporting, recording and monitoring significant events, incidents and accidents. We asked to see the records of significant events that had occurred during the last two years. This could not be provided and the GP we spoke to was unable to tell us how many incidents had taken place if any, over this period. During the inspection we noted that an incident had taken place with a patient and there was another incident regarding patient records. Whilst some information had been recorded in patient's notes and the accident / incident book, no other actions had been taken. The practice did not have practice meetings and was unable to demonstrate that time was dedicated to review actions from past significant events and complaints. There was no evidence that the practice had learned from these events.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details of local authority safeguarding teams were easily accessible.

The lead GP partner was the lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who the lead was and who to speak to within the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

We were told that staff were required to chaperone patients. There was no chaperone policy, and no information on this service for patients. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Reception staff would act as a chaperone if nursing staff were not available. Receptionists had not undertaken training to help them understand their responsibilities when acting as chaperones. Not all staff undertaking chaperone duties had been subject to a risk assessment or to a criminal records check via the Disclosure and Barring Service (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). This placed patients at risk of harm.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was no

policy for ensuring that medicines were kept at the required temperatures. (This policy should describe the action to take in the event of a potential failure). Records showed that the practice relied on an electronic data logging device to monitor fridge temperatures. These results were not checked regularly and the practice could not be sure that the fridges were maintaining safe operating temperatures. The lack of appropriate checks meant that medicines may not be safe to administer to patients placing them at risk of harm.

Processes were not in place to check medicines were within their expiry date and suitable for use. Some the medicines we checked were not within their expiry dates. The practice staff could offer no explanation for this.

On the 8 June 2015, the first day of our inspection, we found medicines in a consultation room adjacent to the patient waiting area. Whilst the room had a system for securing access via keypad entry, the room was unlocked on our arrival. The room contained a number of medicines for named patients, including a used vial of medicine for injection. Staff told us that they did not know how the medicines had come to be in this room. The lead GP partner told us he was unaware of the medicines and could not offer any explanation for this. This meant staff at the practice had not tracked how and when medicines had been used.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms for use in printers were not handled in accordance with national guidance as these were not tracked through the practice and not kept securely at all times. For example, the unlocked consultation room had printable prescription forms on a desk in the room. The lack of appropriate systems for monitoring and securing these prescriptions meant that there was a risk of unauthorised access and improper use of these documents.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that were in date. The health care assistants administered vaccines and other medicines. Patient Specific Directions (PSDs) required when healthcare assistants carry out these functions were not in place. When we spoke with a healthcare assistant they did not know if these directions were in place. The nurse practitioner produced a copy of these directions, however they had not been signed by the prescriber or health- care assistant. There was no evidence that nurses and the health- care assistant had received appropriate training and had been assessed as competent to administer the medicines referred to, either under a PGD or in accordance with a PSD from the prescriber. A member of the nursing staff was qualified as an independent prescriber. They told us that they did not receive regular supervision at the practice. The nurse had taken steps to access external peer group support in order to keep updated in the specific clinical areas of expertise for which they prescribed.

Concerns had been raised by patients and staff about the processing of repeat prescription requests. A number of staff from administrative and clinical areas of the practice told us of a backlog with this process. We were told that prescription requests had mounted up, dating back to 20 May 2015 and staff concerns regarding this had not been responded to. We saw evidence of emails from staff requesting that this was attended to as they had run out of space to house them in the reception office. During our inspection we overheard calls from patients asking when their prescriptions would be ready. The practice manager confirmed this was a problem. The practice manager told us that when they arrived in the practice on the day of our inspection the requests dated prior to 1 June 2015 had gone. Neither the practice manager nor the lead GP partner could explain what had happened to the outstanding requests.

We spoke with the lead GP partner who told us that there was a delay of three days in processing prescription requests. The lead GP partner confirmed that all other requests had been processed and they knew nothing about a large backlog of requests.

On 8 June 2015, the second day of our inspection, we saw that the prescription requests dating back to the 1 June 2015 remained on the table in the reception administration area and had not been attended to.

On 9 June 2015 we observed that the table in the reception administration area held 11 piles of documents dated from 1 June 2015 to 9 Jun 2015 and an “urgent” pile. These were mainly repeat prescription requests. A number of phone calls were taken from patients during the day which resulted in repeat requests being transferred from the “date

received" pile to the "urgent" pile. The delays in ensuring patients received their prescriptions meant that they were unable to obtain medicines required to treat their medical conditions This placed patients at serious risk.

The practice kept some medicines to be administered to individual patients when attending the practice. When we checked a cupboard containing these medicines we identified that:

- Four stock drugs were past their expiry dates.
- Two individually dispensed items were past their expiry dates
- One ampoule had been mis-stored in a box of the same drug but of a different dose.
- One product had not been kept refrigerated as required by the manufacturer.

Cleanliness and infection control

We observed the premises to be clean and tidy in most areas. We saw there were cleaning schedules in place and cleaning records were kept. One consulting room was in a very untidy and unclean state. The shelving and surfaces were dusty, one sharps box was full and dated back to 2013.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Staff received training about infection control specific to their role. We saw evidence that the lead had carried out a recent audit. This was the only audit carried out at the practice. The audit recorded a score of 100%, meaning no improvements were needed. At this inspection we saw that a consultation room was dirty and presented a risk to patients and staff. This indicates that the infection control audit had been ineffective and therefore patients were at risk. The consultation rooms had washable privacy curtains. The date for replacement was April 2015. We asked what action the practice took with regard to these and we were told that they were disposed of rather than cleaned. The practice did not have replacements available and there were no records to show how this was to be actioned.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). There were no records to confirm the practice was carrying out regular checks to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested. The records we saw confirmed that the last testing took place in November 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice did not have a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at were not consistent and not all contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, we looked at seven staff records and found that five of these records did not contain the information required by regulations. The records for two new nursing staff recruited by the nurse practitioner included proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

The practice had little information to support locum GPs working in the practice. We asked to see the records for three locum GPs who had worked at the practice in recent weeks. These records could not be provided. The records for administration staff were also incomplete or were not in

place. For example, we asked to see the personnel records of a staff member who carried out administrative and reception tasks in the practice. The practice manager told us they did not hold any records for that person. We were told by the practice manager that the lead GP partner had taken over this role, however when asked, the lead GP partner said that this was the role of the practice manager.

We asked about the arrangements for planning and monitoring the number of staff and the mix of staff needed to meet patients' needs. There were no arrangements in place to predict and arrange cover for staff shortages.

Staff told us there were not enough staff to maintain the smooth running of the practice and there were concerns that there were not enough staff on duty to keep patients safe. Neither the practice manager nor registered manager could show us records to demonstrate that actual staffing levels and the skill mix met planned staffing requirements.

On the first day of our inspection we found that only one GP was available to cover the practice that day. On our arrival there were no GPs present at 8.30am. Reception staff told us that nobody was available and the registered manager was due in just before 9.00am. The practice had patients waiting to be seen. The nurse practitioner had been called in to assist and was working in a triage role covering the list of patients that had been booked to see a locum GP who was unable to attend the practice. When we examined the plans for the rest of that week and the following week, we found similar levels of cover for the practice. The lead GP acknowledged the staffing shortage and told us that a plan would be put in place to improve GP cover for patients.

On 8 June 2015, the second day of our inspection, we found the levels of GP cover to be of significant and immediate concern and placed patients at risk of harm. We found that with the exception of two patients, all patients had either been seen by the nurse practitioner or another individual who was not a GP or nurse. We were told by staff that this person was identified to them as a physician's assistant. We asked to see the individual's recruitment checks and the lead GP provided a CV. No other information could be seen as the practice had not carried out robust checks on this individual. There was no evidence that he was qualified to practise as a GP or a physician's assistant. The records we saw confirmed that this individual had seen nine patients. We looked at the consultation records for these patients and found that this individual had seen and offered advice to patients in areas that there was no evidence he was qualified to assess. As a result of this concern being reported to NHS England they contacted these patients to arrange appropriate consultations with a GP.

A nurse practitioner was present at the time CQC inspected the practice and they were found to be appropriately skilled and experienced to carry out their role. Further investigation identified a pattern of the lead GP partner and one locum working each day. On the first two days of our inspection we found that only the lead GP partner was present. The inspectors found that this was insufficient for the list demand. On 9 June 2015 when our pharmacy inspector visited the practice we found only one locum GP was available to meet the needs of the patient list.

Monitoring safety and responding to risk

The practice did not have systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice had a health and safety policy. Some health and safety information was displayed for staff to see and there was an identified health and safety representative. The practice could not demonstrate that this person had been trained or had the necessary skills to carry out this role.

Risks associated with service and staffing changes (both planned and unplanned) were not documented or addressed. We saw that the practice was significantly short of both clinical and administrative staff. Whilst we were told by the lead GP partner that they were trying to address the staffing shortage, no evidence of a formal assessment and rationale for the safe provision of services for patients had been produced.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked the pads for the automated external defibrillator and they were within their expiry date.

Inadequate

Are services safe?

Emergency medicines were available in the practice and all staff knew of the locations. We saw records for these emergency medicines and whilst the practice had identified three medicines had expired, replacement stock had not been obtained.

The practice had a branch and this had been closed for some time due to flooding. A business continuity plan was not in place to deal with emergencies that may impact on the daily operation of the practice.

The practice had carried out risk assessments in January and April 2015 that included actions required to maintain safety in the kitchen, boiler room and reception. There was no fire risk assessment and the practice had not ensured risks were adequately addressed. For example, the areas identified, such as the kitchen also contained a significant number of electrical items namely the server and computer systems. The risk assessment did not adequately address how this area was to be monitored and safety maintained.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of clinical meetings for nurses and health care assistants which showed that current guidance and clinical best practice was then discussed and implications for the practice's performance and patients were identified. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Interviews with the GP showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

During this inspection it was not possible to access information on how the practice monitored patient needs and reviewed information to improve outcomes for patients. When asked, the practice could not show us any clinical audits that had been undertaken in the last two years. (A clinical audit is a way to find out if healthcare is being provided in line with standards and lets care providers and patients know where their service is doing well, and where there could be improvements). The practice could not demonstrate that they were reviewed their practice against the national and local standards to ensure safe outcomes for patients.

The team was not making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with were unaware of any expectations in terms of clinical audit.

The practice had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw the minutes of three of these meetings and noted that the lead GP had not attended two of the last three meetings that had taken place. These meetings had been attended by the nurse practitioner.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff records and saw that, for the records we reviewed, staff were up to date with attending mandatory training courses such as annual basic life support. We noted that due to the severe shortage of GPs the practice could not demonstrate a good skill mix was in place. For those locum GPs engaged by the practice, little information was available to demonstrate that they fulfilled the needs of the practice due to poor recruitment information.

The lead GP was up to date with their yearly continuing professional development requirements and had been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

Annual appraisals were not in place to identify learning needs for staff. Our interviews with staff confirmed that the practice was not proactive in providing training and support for staff. We noted that the advanced nurse practitioner, employed on a locum basis, had put training and development on the agenda for nurses and health care assistants and had set up meetings to review their practice.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and we found evidence that, in most cases, they were trained appropriately to fulfil these duties. For example, one staff member told us that they carried out procedures in relation to family planning services, however we found no evidence that they had been trained in procedures they described to us. Nurses had received training in administration of vaccines, cytology and wound care. Those with extended roles, for example, seeing patients with long term conditions such as diabetes, were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified, action had been taken to manage this in some cases. For example we noted that there had been significant delays in dealing with performance and disciplinary matters which meant that

two staff members had been unable to work for an extended period. The lead GP advised that they were seeking the support of another practice to address this situation due to their significant staff shortage.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice did not have a policy available outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications, however they were able to describe their roles. We reviewed patient records and found that discharge summaries and letters from outpatients were seen and actioned on the day or within two days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles, however they felt the system did not work well. Staff reported concerns to the inspection team about a large build-up of reports, paperwork and prescription requests that had gone unattended to for some weeks. They told us that these documents were in the practice on the evening prior to our inspection on 4 June 2015 but had disappeared by the next morning. When correspondence, reports and prescriptions had not been responded to patients may not receive appropriate and timely care and treatment placing them at serious risk.

The practice held multidisciplinary team meetings every six to eight weeks to discuss patients with complex needs. For example, those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. We noted that for the records of the last three meetings held since December 2014, a GP was in attendance on only one occasion. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from the hospital, to be saved in the system for future reference. We did not see evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

The practice did not have a policy for documenting patients' consent. We did note that the patients view was recorded within the notes of consultations.

Health promotion and prevention

The practice's performance for the cervical screening programme was 69.14% for 2013/14 which was below the national average of 81.29%. There is a risk that patients who were at risk would not be identified. We were unable to establish what steps the practice was taking to follow up patients who had not attended for their screening appointment.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Performance for 2013/14 was average for the majority of immunisations where comparative data was available. For example Flu vaccination rates for the over 65s were 68.57%, and at risk groups 42.8%. These were similar to national averages.

Inadequate

Are services effective?

(for example, treatment is effective)

The data for childhood immunisation rates for the vaccinations given to children under the age of two years was unavailable to CQC at the time of the inspection. The practice was unable to provide this information during the inspection. The practice did provide evidence that records were maintained in respect of these procedures after the first day of the inspection. Only one record was made available to the inspectors which did not demonstrate a complete and accurate record was maintained.

Inadequate

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with six patients during our inspection. Whilst feedback on the practice was mixed, some patients told us they felt the practice offered a caring service and staff were helpful and took the time to listen to them. They said staff treated them with dignity and respect. Interactions we observed on the day of our inspection also confirmed that patients were treated with dignity and respect. Some patients felt let down by the practice, having had appointments cancelled when they turn up to the surgery as a GP was unavailable to see them.

We reviewed recent GP national survey data available for the practice on patient satisfaction. The survey was based on 113 responses. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. We noted that 90% of patients had responded that the nurse was good at treating them with care and concern, whilst 80% of patients reported that the GP was good at treating them with care and concern. Data from the national patient survey showed that 61% of patients rated their overall experience of the practice as good compared to a CCG and national average of 85%. We also noted that just 49% of patients indicated they would recommend the practice to someone new in the area compared to a CCG and national average of 78%. This reflected the level of concerns in terms of obtaining appointments and being able to contact the practice by telephone.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatment in order that confidential information was kept private. The main reception area and waiting room were combined but a screen had been placed around the reception desk window in order to improve the level of privacy for patients speaking with a receptionist. Some telephone calls were taken away from the reception desk so staff could not be overheard. Staff were able to give us practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view, speaking in lowered tones and asking patients if they wished to discuss private matters away from the reception desk.

We found that the significant shortfalls in staffing, lack of planning and monitoring the practice had caused significant impact on the level of service provided to patients. Long waiting times for appointments and delays when attending the practice to see a GP had caused patients to feel frustrated and unhappy with the practice.

Care planning and involvement in decisions about care and treatment

We reviewed GP national survey data available for the practice. The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. We noted that 83% of patients had responded that the nurse was good at involving them in decisions about their care. The survey found that 77% of patients said the last GP they saw was good at involving them in decisions about their care. Both of these results were comparable to the local clinical commissioning group and national average.

Patients we spoke with on the first day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

On the 8 June 2015, the second day of our inspection we saw that a number of patients were seen by an individual who was not a GP or a nurse practitioner. Patients were not told that the person they would see was not a GP and did not have the opportunity to seek an alternative consultation with a qualified GP. This meant patients were not given appropriate information to make decisions on their treatment and care.

Staff told us that translation services were available for patients who did not have English as a first language. We noted that the practice website included a facility to translate the contents into 90 different languages.

Inadequate

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The results of the most recent national GP survey showed that 80% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 90% of patients said the nurses were good at treating them with care and concern. We noted that 83% of respondents said the last GP they saw was good at listening to them and 91% of respondents said the last nurse they saw was good at listening to them. Comments we received from patients on the day of our inspection were also positive and aligned with these views.

New carers were encouraged to register with the practice. We saw written information was available for carers to ensure they understood the various avenues of support available to them. Notices in the patient waiting room signposted patients to a number of support groups and organisations. The practice website provided further information to carers, including ways to access respite care and financial benefits.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had last conducted a patient survey in March 2012. At that time the survey report indicated that the practice had established a virtual patient participation group of 132 members. (A virtual patient participation group does not meet, but provides support to the practice by providing electronic and written feedback when requested). The practice website included information about the virtual patient participation group and invited patients to join the group.

Results of the 2012 survey and a corresponding action plan were available on the practice website. The action plan highlighted a number of proposed actions such as improving the communication of blood test results to patients and the development of improved services for patients with long term conditions and those experiencing poor mental health. However, progress towards completing the proposed actions had not been reviewed or recorded. We were told that the practice had no current VPG or PPG in operation and there were no systems in place to consult with the wider patient group.

Tackling inequity and promoting equality

Staff told us that translation services were available for patients who did not have English as a first language. We noted that the practice website included a facility to translate the contents into 90 different languages.

The practice was situated in premises within a complex of residential flats. Patient services were provided from the ground floor level. The practice made use of another unit within the complex to store records and carry out administrative functions. The practice was accessed via a sloping pathway which made it suitable for wheelchair users. Access was via a single door which opened automatically. We noted the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to the treatment and consultation rooms. Toilet facilities were accessible for all patients and contained grab rails for those with limited mobility and an emergency pull cord. Baby changing facilities were available for mothers with young babies

Access to the service

We were told the practice was open from 8am until 8pm on Mondays, Tuesdays and Wednesdays and from 8am to 6.30pm on Thursdays and Fridays. Patients could call to make appointments from 8am. There were also online facilities for patients to book appointments. Appointments could be booked up to two weeks in advance. However on the 4 June 2015 we observed that access to appointments of advance booking was extremely limited and not appointments were available until 15 June 2015. The advanced nurse practitioner provided appointments for patients with minor ailments. At the time of our inspection the advanced nurse practitioner was providing a triage service in response to the shortage of GP sessions.

Some patients reported difficulty in accessing the practice by phone. Results of a recent GP patient survey showed that just 47% of respondents found it easy to get through to the practice by phone, compared with a local clinical commissioning group average of 77%. The survey indicated that just 45% of patients described their experience of making an appointment as good. We reviewed feedback provided by patients on the NHS Choices website. The practice had received 59 ratings with an overall rating of 1.5 stars. Feedback on the NHS Choices website reflected the difficulties patients had experienced in obtaining a routine appointment and accessing the practice by phone. Some patients described how their appointment had been cancelled at short notice.

Staff told us that there were insufficient GPs within the practice to support the number of routine and urgent appointments required. On the day of our inspection all pre-bookable appointments for the next two weeks had been taken. Patients we spoke with on the day of our inspection told us they experienced difficulty in obtaining a timely appointment.

Information was available to patients about appointments on the practice website. This included how to arrange home visits, how to book appointments and the number to call outside of practice hours. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Patients were advised to call the out of hours' service.

Concerns were raised about the practices ability to provide home visits to patients. Staff told us that they were concerned that home visit requests had not been responded to. We looked at patient records and spoke with the lead GP partner. We were told by the GP partner that

the visits identified had been undertaken but not written up on the patient record. The records had not been completed a week after the home visits took place. Patients were at risk of inappropriate care as incomplete records meant that other practitioners would be unaware of the patients latest consultation, healthcare need and treatment prescribed. Patents and their representatives were contacted and confirmed that the GP had attended.

Listening and learning from concerns and complaints

We reviewed a written notice in the practice waiting area which described the process should a patient wish to make a complaint. However, we were unable to see evidence of a practice policy to support staff in the management of complaints. There was limited information on how to make a complaint on the practice website. A Friends and Family test suggestion box was available within the patient waiting area.

Written information available to patients in the waiting area and on the practice website indicated that the practice manager handled all complaints in the practice. However, the practice manager told us they no longer handled complaints received. They told us the lead GP partner now handled all complaints.

We reviewed the practice complaints log and the written letters of complaint for those received since 2012. We noted that 135 complaints had been received. The practice manager told us that these did not include complaints received since March 2015. We were unable to confirm the number and nature of complaints received since March 2015.The practice complaints log indicated that a written acknowledgement had been sent in relation to only five of the complaints received since 2012. We saw no evidence that any of the complaints had been discussed, investigated or reviewed. There was no record of learning from complaints. The practice did not hold meetings to discuss complaints. The practice manager told us that none of the complainants had been sent a written response.

The lead GP partner was unaware of the number of complaints received by the practice and could not give an explanation as to why none of these had been responded to. They told us that they had taken two of these complaints dating back to September 2014 to discuss with the practice manager. However, they had not taken any action on these as the practice manager had been away and they wanted to discuss the complaints before deciding what action to take.

Are services well-led?

Inadequate

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The practice had no clear vision to deliver high quality care and promote good outcomes for patients. There was no business or strategic plan.

We spoke with six members of staff and they all expressed concerns about the future of the practice and the lack of any clear structure and communication.

Governance arrangements

The practice did not have policies and procedures in place to govern. The nurse practitioner had developed policies to address day to day clinical issues to ensure nursing and health- care assistants carried out their roles in accordance with national guidelines. The practice manager had introduced a health and safety policy to address this aspect of the practice.

There was some leadership in place with named members of staff in lead roles however this was ineffective. For example, there was a lead nurse for infection control and the GP partner was the lead for safeguarding. The feedback from staff was very mixed. Most told us they did not feel valued or well supported. They all knew who to go to in the practice with any concerns, however the information we received showed that they were not confident that these concerns would be addressed.

The GP and practice manager did not have systems in place to monitor the quality of the service.

The practice did not have a programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Additionally, processes were not in place to review patient satisfaction and action had not been taken, when appropriate, in response to feedback from patients or staff.

The practice did not hold regular staff meetings where governance issues were discussed.

There was lack of clarity between the practice manager and lead GP on who was responsible for human resource policies and procedures. We were given conflicting information on who had responsibility for managing and overseeing recruitment processes in the practice. Records we saw did not demonstrate that the practice had safe systems for recruiting staff and this had not been identified by the practice, despite a previous inspection by CQC in 2013 that highlighted failures in this area.

Leadership, openness and transparency

Staff did not feel involved in discussions about how to run the practice and how to develop the practice. The staff we spoke with were unsure of how the practice was to develop. They felt their concerns were not being addressed by the lead GP partner. Our observations found that staff managed their own roles without any form of co-ordination from the GP partner.

Team meetings were not held with any regularity. Staff told us that there was a supportive culture within the practice team, however they had not had the opportunity to raise any issues at team meetings. We also noted that some protected learning sets took place. We asked to see the records of these and one set of minutes was provided for a meeting that took place on 14 May 2015.

Seeking and acting on feedback from patients, public and staff

The practice could not demonstrate that they encouraged and valued feedback from patients. It did not have a patient participation group (PPG) to gather patient feedback, surveys were not undertaken and complaints received had not been responded to.

We also saw that the practice had not reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was not actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice did not engage with the staff team to gather their views as there were no forums to gather this information. For example an annual staff survey, meetings, appraisals and discussions.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. The practice nurse was taking steps to improve support and mentoring for nurses and healthcare assistants. We looked at nine staff files and saw that appraisals did not take place and staff did not have a personal development plan.

Are services well-led?

Inadequate

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

The practice had not completed reviews of significant events and other incidents

Brighton & Hove City Council

Overview & Scrutiny Committee
Work Plan
Edition 02

This is the Overview & Scrutiny Committee Work Plan for the year 2015/16
It will be updated and circulated on a monthly basis to officers and will be used to set agenda items for the forthcoming meetings.

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For further detailed information regarding specific issues to be considered by the Committee please contact the named contact officer for the item concerned.

Ref	Report Details	Lead Director	Consultation	Lead Officer
9 SEPTEMBER 2015				
48807	**CCG Proposals for Hanover Crescent** *All Committee Decisions* Report from Brighton and Hove Clinical Commissioning Group about proposals for Hanover Crescent, an inpatient rehabilitation service that has been temporarily closed. *Wards affected: All Wards*	Report of:		Report Author:
48803	**Sussex Partnership Foundation Trust CQC Inspection Summary and Brighton and Hove Action Plan & 2020 Vision** *All Committee Decisions* *Wards affected: All Wards*	Report of: Executive Director for Finance & Resources		Report Author: Kath Vlcek Tel: 01273 290450
48387	**Homelessness Scrutiny Panel Monitoring Report** *All Committee Decisions* This is the first monitoring report for the homelessness scrutiny panel report *Wards affected: All Wards*	Report of: Executive Director for Environment, Development & Housing, Dr Tom Scanlon		Report Author: James Crane Tel: 293316
48380	**Bullying in Schools Scrutiny Panel Monitoring** *All Committee Decisions* First monitoring update to scrutiny committee *Wards affected: All Wards*	Report of: Executive Director for Children's Services		Report Author: Sam Beal

Ref	Report Details	Lead Director	Consultation	Lead Officer
25 NOVEMBER 2015				
49154	**Update on Unscheduled Care/ Emergency Dept at BSUH** *All Committee Decisions* Follow up from the July meeting *Wards affected: All Wards*	Report of: Executive Director for Finance & Resources		Report Author: Kath Vlcek Tel: 01273 290450
49156	**Update on 3Ts Hospital Development** *All Committee Decisions* *Wards affected: All Wards*	Report of: Executive Director for Finance & Resources		Report Author: Kath Vlcek Tel: 01273 290450
48449	**Flood Risk Management Plans** *All Committee Decisions* *Wards affected: All Wards*	Report of: Executive Director for Environment, Development & Housing, Dr Tom Scanlon		Report Author: Robin Humphries Tel: 29-1313
48425	**Traveller Strategy Scrutiny Panel Monitoring Report** *All Committee Decisions* Third monitoring report *Wards affected: All Wards*	Report of: Executive Director for Environment, Development & Housing		Report Author: Andy Staniford Tel: 29-3159

Ref	Report Details	Lead Director	Consultation	Lead Officer
48423	**Seafront Infrastructure Scrutiny Panel Monitoring Report** *All Committee Decisions* First monitoring report *Wards affected: All Wards*	Report of: Executive Director for Environment, Development & Housing		Report Author: Nick Hibberd Tel: 01273 293756, Geoff Raw Tel: 29-7329
48421	**Adults with Autism Scrutiny Panel Monitoring** *All Committee Decisions* Third monitoring report *Wards affected: All Wards*	Report of: Executive Director for Adult Services		Report Author: Anne Hagan Tel: 01273 296370
48429	**Short Term Holiday Lets Panel Monitoring** *All Committee Decisions* First monitoring report *Wards affected: All Wards*	Report of: Director of Public Health		Report Author: Tim Nichols Tel: 29-2163
3 FEBRUARY 2016				
49160	**Update on Mental Health Service Provision in Brighton and Hove** *All Committee Decisions* *Wards affected: All Wards*	Report of: Executive Director for Finance & Resources		Report Author: Kath Vlcek Tel: 01273 290450

Ref	Report Details	Lead Director	Consultation	Lead Officer
48418	**Trans Equalities Scrutiny Panel Monitoring** *All Committee Decisions* Third monitoring report *Wards affected: All Wards*	Report of: Executive Director for Finance & Resources		Report Author: Emma McDermott Tel: 01273 29-6805
48431	**Public Toilets Scrutiny Panel Monitoring Report** *All Committee Decisions* Second monitoring report *Wards affected: All Wards*	Report of: Executive Director for Environment, Development & Housing		Report Author: Jan Jonker Tel: 29-4722
48427	**Children with Autism Scrutiny Panel Monitoring** *All Committee Decisions* First monitoring report *Wards affected: All Wards*	Report of: Executive Director for Children's Services		Report Author: Regan Delf Tel: 01273 293504
49158	**Musculoskeletal Contract update** *All Committee Decisions* *Wards affected: All Wards*	Report of: Executive Director for Finance & Resources		Report Author: Kath Vlcek Tel: 01273 290450
23 MARCH 2016				
48435	**Social Value Scrutiny Panel Monitoring** *All Committee Decisions* First monitoring report *Wards affected: All Wards*	Report of: Executive Director for Finance & Resources		Report Author: Cliff Youngman Tel: 01273 291408, Andy Witham Tel: 01273 291498

Ref	Report Details	Lead Director	Consultation	Lead Officer
48433	**Private Sector Housing Scrutiny Panel Monitoring** *All Committee Decisions* First monitoring report *Wards affected: All Wards*	Report of: Executive Director for Environment, Development & Housing		Report Author: Martin Reid Tel: 01273 93321