Who are we?

The Health and Wellbeing Board is the forum where representatives of the Council, NHS and Third Sector hold discussions and make decisions on the health and wellbeing of the people of Brighton & Hove. Meetings are open to the public and everyone is welcome.

Where and when is the Board meeting?

This next meeting will be held in the Council Chamber, **Brighton Town Hall** on Tuesday 19 March 2019 starting at 4.00pm. It will last about two and a half hours.
There is limited public seating available for those who wish to observe the meeting. Board meetings are also available to view on the council's website.

What is being discussed?

There are six main items on the agenda:

- Reviewing the purpose and functioning of the Health and Wellbeing Board
- Better Care Fund – Extension to Section 75 Agreement
- Healthwatch Annual Report
- Healthwatch Brighton & Hove Let's Get You Home – a report on the experiences of older people being discharged from the Royal Sussex County Hospital, Brighton from July-September 2018
- Brighton & Hove Health and Wellbeing Strategy
- Pharmaceutical Needs Assessment consolidation of two pharmacies

Health & Wellbeing Board
19 March 2019
4.00pm
Council Chamber, Brighton Town Hall

Who is invited:

Voting Members: Cllrs Karen Barford (Chair), Clare Moonan, Dick Page, Nick Taylor and Andrew Wealls; Dr David Supple, Chris Clark, Wendy Carberry, Malcolm Dennett, and Dr Jim Graham (Brighton & Hove Clinical Commissioning Group)

Non-Voting Members: Geoff Raw, Chief Executive; Rob Persey, Statutory Director of Adult Social Care; Pinaki Ghoshal, Statutory Director of Children's Services; Alistair Hill, Director of Public Health; Graham Bartlett (Brighton & Hove Safeguarding Adults Board); Chris Robson (Local Safeguarding Children Board) Pennie Ford (NHS England); and David Liley (Brighton & Hove Healthwatch).

Contact: **Anoushka Clayton-Walshe**
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This Agenda and all accompanying reports are printed on recycled paper

Date of Publication - Monday, 11 March 2019

AGENDA

Formal matters of procedure

This short formal part of the meeting is a statutory requirement of the Board

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47 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

The Chair of the Board will formally ask if anyone is attending to represent another member, and if anyone has a personal and/or financial interest in anything being discussed at the meeting. The Board will then consider whether any of the discussions to be held need to be in private.

48 MINUTES **9 - 30**

To consider the minutes of the meeting held on the 29 January 2019 (copy attached).

49 CHAIR'S COMMUNICATIONS

The Chair of the Board will start the meeting with a short update on recent developments on health and wellbeing.

50 CALL OVER

(a) Items 53 – 58 will be read out at the meeting and Members invited to reserve the items for consideration.

(b) Those items not reserved will be taken as having been received and the reports' recommendations agreed.

51 FORMAL PUBLIC INVOLVEMENT

This is the part of the meeting when members of the public can formally ask questions of the Board or present a petition. These need to be notified to the Board in advance of the meeting Contact the Secretary to the Board at anoushka.clayton@brighton-hove.gov.uk.

52 FORMAL MEMBER INVOLVEMENT

53 REVIEWING THE PURPOSE AND FUNCTIONING OF THE HEALTH AND WELLBEING BOARD **31 - 36**

Report of the Executive Director of Health & Social Care and the Managing Director of South CCG

Contact: *Barbara Deacon* *Tel: 01273 296805*
Ward Affected: *All Wards*

54 BETTER CARE FUND - EXTENSION TO SECTION 75 AGREEMENT – TO FOLLOW

Report of the Head of Legal Services, the Director of Partnerships and Commissioning Integration BHCCG and the Head of Adult Social Care Commissioning

Contact: *Barbara Deacon* *Tel: 01273 296805*
Ward Affected: *All Wards*

55 HEALTHWATCH ANNUAL REPORT 2017/18 **37 - 72**

Report of the Executive Director for Adult and Social Care and the Chief Executive of Healthwatch Brighton & Hove

Contact: *Barbara Deacon* *Tel: 01273 296805*
Ward Affected: *All Wards*

56 HEALTHWATCH BRIGHTON & HOVE LET'S GET YOU HOME - A REPORT ON THE EXPERIENCES OF OLDER PEOPLE BEING DISCHARGED FROM THE ROYAL SUSSEX COUNTY HOSPITAL, BRIGHTON FROM JULY-SEPTEMBER 2018 – ACTION PLAN TO FOLLOW **73 - 136**

Appendix 2 of the report (copy attached)

Contact: *Barbara Deacon* *Tel: 01273 296805*
Ward Affected: *All Wards*

57 BRIGHTON & HOVE HEALTH AND WELLBEING STRATEGY **137 - 168**

Report of the Director of Public Health

Contact: *Alistair Hill* *Tel: 01273 296560*
Ward Affected: *All Wards*

58 PHARMACEUTICAL NEEDS ASSESSMENT CONSOLIDATION OF TWO PHARMACIES **169 - 182**

Report of the Director of Public Health

Contact: *Alistair Hill* *Tel: 01273 296560*
Ward Affected: *All Wards*

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For further details and general enquiries about this meeting contact Democratic Services, 01273 2913546 or email democratic.services@brighton-hove.gov.uk

Public Involvement
The Health & Wellbeing Board actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public.

If you wish to attend and have a mobility impairment or medical condition or medical condition that may require you to receive assisted escape in the event of a fire or other emergency, please contact the Democratic Services Team (Tel: 01273 291066) in advance of the meeting. Measures may then be put into place to enable your attendance and to ensure your safe evacuation from the building.

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An infrared system operates to enhance sound for anyone wearing using a receiver which are available for use during the meeting. If you require any further information or assistance, please contact the receptionist on arrival.

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- You should proceed calmly; do not run and do not use the lifts;
- Do not stop to collect personal belongings;
- Once you are outside, please do not wait immediately next to the building, but move some distance away and await further instructions; and

Health & Wellbeing

Do not re-enter the building until told that it is safe to do so.

1. **Procedural Business**

(a) Declaration of Substitutes: Where Members of the Board are unable to attend a meeting, a designated substitute for that Member 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.

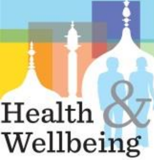
In each case, you need to declare
(i) the item on the agenda the interest relates to;
(ii) the nature of the interest; and
(iii) whether it is a disclosable pecuniary interest or some other interest.

If unsure, Members of the Board should seek advice from the Lawyer or Secretary preferably before the meeting.

(c) Exclusion of Press and Public: The Board will consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, that the press and public should be excluded from the meeting when any of the 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 public.

A list and description of the exempt categories is available from the Secretary to the Board.



BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING BOARD

4.00pm 29 JANUARY 2019

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Barford (Chair), Moonan (Deputy Chair), O'Quinn, Taylor (Opposition Spokesperson), Wealls and Page (Group Spokesperson); Brighton and Hove Clinical Comissioning Group (BHCCG): Dr David Supple (Deputy Chair), Lola Bojanko, Ashley Scarff and Malcolm Dennett

Also in attendance: Geoff Raw (Chief Executive), Rob Persey (Statutory Director- Adult & Social Care), Pinaki Ghoshal (Statutory Director of Children's Services), Alistair Hill (Director of Public Health), Graham Bartlett (Brighton & Hove Safeguarding Adults Board), David Liley (Brighton & Hove Healthwatch) and Liz Culbert (Head of Legal Services)

Apologies: Wendy Carberry (BHCCG) and Pennie Ford (NHS England)

PART ONE

34 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

34 (a) Welcome and introductions

34.1 Ashley Scarff had been appointed the new Director of Commissioning for BHCCG as a replacement to Chis Clark. He stated that his role with the BHCCG was to work with Local Authorities and partner agencies to commission integration as they looked to develop their ways of working.

34 (b) Apologies

34.2 Penny Ford and Wendy Carberry.

34 (c) Declaration of substitutes

34.3 Lola Banjoko, Deputy Managing Director BHCCG, was in attendance as a substitute for Wendy Carberry, Managing Director BHCCG.

35 MINUTES

35.1 **RESOLVED**: That the Minutes of the meeting held on 13 November 2018 be agreed and signed as a correct record.

36 CHAIR'S COMMUNICATIONS

36.1 The Chair stated:

"There is a long list of items and these will all make up part of the minutes.

The Health and Wellbeing Boards congratulates Adam Doyle as the CEO

Joint Health & Wellbeing Strategy update

As the Board is aware we will be having the city's Joint Health & Wellbeing Strategy presented at the March Board.

The Strategy is now out on the consultation portal for comments and views and there was an engagement event on 28th January. The consultation portal closes on 31st January - Thursday 31st March.

http://consult.brighton-hove.gov.uk/public/nhs/health/jhws/joint_health_and_wellbeing_strategy_1

The Policy Panel have been meeting to support this work and will have their final meeting to review the engagement responses and findings prior to the final report coming to the Board.

Kendal Court

As the Board is aware there was a review of Kendal Court. The Housing and New Homes committee received their report on 16th January 2019. I will ask that the link to this comprehensive report is attached here for information.

https://present.brighton-hove.gov.uk/Published/C00000884/M00008067/AI00070916/$20190108085740_018221_0063056_CommitteeReportTemplate210617newsavedformat.docxA.ps.pdf

Children and Young People's Mental Health – briefing for Health and Wellbeing Board

Purpose

For the Chair of the Health and Wellbeing Board to brief members on:

1. The Brighton and Hove Children and Young People's Local Transformation Plan refresh (vision, progress since last year and future plans); and

2. Brighton and Hove Trailblazer opportunity - *Transforming Children and Young People's Mental Health Provision: A Green Paper* (2017) 2019-2024

(1) Local Transformation Plan (LTP) 2018 refresh

Following the publication of Future in Mind (2015) which highlighted difficulties in access to mental health support to children and young people, all CCG's are required to produce an annual Children and Young People's Mental Health Local Transformation Plan (LTP) refresh.

The Brighton and Hove Health and Wellbeing Board approved the Brighton and Hove (LTP) in October 2015, the refresh in October 2016 and October 2017.

An Executive Summary can be found in *Appendix A.*

The CCG refreshed and republished their 2018 LTP in October 2018 and can be found here: http://www.brightonandhoveccg.nhs.uk/plans

There are several elements to the draft LTP refresh for 2017/18:

a) An update and progress on children and young people's mental health services vision and how the refreshed LTP will enable that to succeed;

b) The LTP plans for 2017/18 onwards in the context of the Five Year Forward View for Mental Health and developments within our Sustainability and Transformation Partnership (STP) and Commissioning Alliance; and

c) An update on 2017/18 (spend and activity).

Our progress and achievements so far and on-going challenges are:

"Our vision is to provide more responsive support for children and young people when they experience poor mental health or are in crisis. We will give them opportunities to build their own resilience and recognise their need earlier, encouraging them to support and confide in one another. They can access services when, where and how they choose, embracing digital and social media. Services will work closely together so that criteria and thresholds are less important than addressing holistic need in a timely way, generating good outcomes."

The changes have been developed around:

1. Infrastructure in place for successful change:

    a) AMBIT training (health and social care)
    b) Training for hospital staff in mental health awareness
    c) Training in Mental Health First Aid in schools
    d) Self-harm needs assessment
    e) The FindGetGive website

2. Building capacity at an early stage:

    a) Community Wellbeing Service
    b) Schools Wellbeing Service
    c) Developing a workforce strategy

d) Achieving the national children's mental health access target

3. Targeted support:

a) Specialist CAMHS redesign
b) Mental health support for Looked After Children in social care pods
c) Family Eating Disorder service

Benefits realisation

The impact of this investment and strategic improvement is able to be measured through various criteria:

a) More children accessing mental health services – 34% in 18/19 (17% 17/18);

b) Specialist CAMHS access – 92% first treatment within 8 weeks in 18/19 (compared to 100% first treatment within 18 weeks in 17/18); and

c) Schools Wellbeing – 309 treatments with 66% significantly improved after intervention (April-June 2018).

We recognise that we need to develop a more robust method of measuring the impact on quality, safety and outcomes of services as well as access and activity.

(2) Wave One Trailblazer (Green Paper) expression of interest – bid was submitted 17th Sept 2018

As well as investment following Future in Mind the government has committed to £215m additional funding to implement the recommendations in the *Transforming Children and Young People's Mental Health Provision: A Green Paper* (2017) 2019-2024. The emphasis is on increasing mental health support in schools through Mental Health Support Teams (MHSTs) as well as piloting 4 weeks to treatment for CAMHS. The key elements are:

- Increase resource to schools – more evidence based interventions and whole school approach, additional roles and training opportunities;
- Includes vulnerable CYP/ PRUs (inequalities) and independent schools;
- At least 2 MH Support Teams per CCG
    - (7.5 WTE per 8000 pupils/ 20 schools – 500 interventions (evidence based CYP IAPT)
    - Funding of £326K per MHST (no capital)
- Integrated whole system, referral process, collaborative working;
- Designated School Leads – one required in every school – strategic leads (training & support from DfE);
- Clear pathway to Specialist CAMHS and supervision;
- Tracked and evaluated via MHSDS;
- 4 week waiting time to treatment pilot (Specialist CAMHS); and
- Project resource funding available if required.

Brighton and Hove CCG has been advised that we are highly likely to be in Wave Two (summer 2019) so that we can align training with Sussex University becoming a provider of the appropriate courses from that time.

The CCG commissioner for children's mental health is happy to attend any future Health and Wellbeing Board meetings to provide more detail on anything that is outlined in this briefing.

Final version of the Brighton & Hove Food Partnership Food Strategy

The Board will remember we had a presentation of the Food Strategy in July 2018 with the DRAFT action plan. The action plan is now finalised and again the link will be added to the communications.

http://consult.brighton-hove.gov.uk/public/nhs/health/jhws/joint_health_and_wellbeing_strategy_1

Carers Rights day and our Great Carers Tea Party

Carers Rights Day aims to recognise the vital role that unpaid carers provide, and to raise awareness about local support available to them.

As part of the celebrations for Day on Friday 30 November, Adult Social Care team held a number of events to support the huge number of carers in our city. One of these events was the Carers Tea Party.

We want to make Brighton and Hove a 'Carer Friendly City' - one that supports carers to look after their family and friends, and recognises them as individuals with needs of their own.

CQC ratings for Brighton & Sussex University Hospitals

CQC have recently announced the ratings for the local hospitals. The full letter will be added to the minutes. Both the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath were also rated as 'Good' overall. In addition, NHS Improvement has confirmed the Trust is no longer in any form of special measures.

Update on Walk-In Centre

The CCG can confirm that we have no plans to change the current commissioning arrangements for the Brighton Station Walk-In Centre (Queens Road) for the contract year 2019-20 and are currently finalising the contractual details with Care UK. The exception to this is to comply with the national mandate for the term 'Walk-In Centre' to be removed from NHS terminology by December 2019. This will not involve removal of the service but will require using different terminology in the future.

We do know, based on conversations with the public and our providers, that same day urgent care services do not always appear to be integrated, and delivered, at the best place and time for patients. This includes the current Walk-In Centre provision. We are currently working with all providers, in primary, community, and secondary care, to agree how these services can best be provided, according to the best available evidence, in the city.

Following approval by the CCG Governing Body, the CCG will share it's draft plans with key health and care partners and the public to ensure they are appropriate and able to meet the needs of patients for the foreseeable future.

New Chief Executive Officer appointed for Sussex and East Surrey Clinical Commissioning Groups

The Alliance of CCGs that work across the whole of Sussex formally appointed Adam Doyle as the new Chief Executive Officer for the Clinical Commissioning Groups across Sussex and East Surrey.

Adam has been working across the eight organisations as Accountable Officer on an interim basis for the last three months and his leadership role has now been made substantive following a robust interview process. The job title has changed to a CEO as this better reflects the significant leadership responsibilities that the position holds. The appointment is fully supported by all the CCG Governing Bodies and has been endorsed by NHS England. The Chair and the Board gave their congratulation on his appointment.

Allied Healthcare

As the Board is aware at the last meeting in chairs communications we informed the Board about concerns with Allied Healthcare. These concerns were about the future viability of Allied Healthcare, CQC have been reassured with the financial plan put in place by CRG, (Health Care Resourcing Group, trading as CRG). On the back of this reassurance the officers were able to make the decision to confirm with the request by Allied Healthcare to novate it contract over to CRG.

Allied Healthcare confirmed that on 1st December 2018, the sale was successfully agreed of all Allied Healthcare's care and support service contracts in England, Scotland and Wales to CRG.

The Brighton branch of Allied Healthcare was able to sustain business continuity over the festive period. Officers felt adequately assured before the festive period to be able to lift the suspension on Allied Healthcare receiving referrals for new care packages. It is understood that referrals have subsequently been made and have been accepted by Allied Healthcare.

GP surgery at Old Steine and Palace Place

Since 2016 the council and its health partners have been working with the CCG to progress plans for a new GPs surgery at 62/63 Old Steine and 3 Palace Place for the relocation of Ardingly surgery.

The GP practice and the CCG obtained grant funding from NHS England as the practice was identified as the highest priority for the City and most in need of investment.

The CCG has now decided to withdraw from the project which is incredibly disappointing for everyone who has worked to progress this scheme and to the all the stakeholders involved, not least the people living in the area, but ultimately this is a decision which is the CCG's to make.

The council is committed to improving healthcare for its residents and continues to work with the CCG and health partners on other projects in the city to deliver a health hub at Preston Barracks and the disposal of Oxford Street Car Park to provide the combined St Peters and North Laine surgery.

That is the end of Chairs communications. However I did ask at the pre meeting of this Board if a short update could be provided for the Board on Winter demands particularly focused on our acute hospital and I am grateful that to officers who have supplied the following short slide which I have asked them to take us through as part of our communications"

PRESENTATION

36.2 The Chair stated that the Executive Director- Adult & Social Care and the Deputy Managing Director of Brighton and Hove CCG would give a presentation on the Update of Winter Demands.

36.3 In response to Councillor Page questioning whether the health service could cope with worse winter conditions with the existing measures, the Deputy Managing Director of Brighton and Hove CCG stated that they would and the impact of capacity in a crisis would rest on those who were scheduled for routine surgeries.

36.4 The Board agreed that in response to Councillor Page, the CCG would gather more ongoing information regarding the GP surgery at Old Steine and Palace Place to report back.

36.5 The Chair stated that it would be useful to have more information on how winter planning affects acute care on impacts, challenges and internal actions they were taking and the Board agreed that a more detailed report should go to the next Health Overview and Scrutiny Committee (HOSC).

36.6 Dr David Supple stated that the CCG was working on a same-day urgent care strategy with BSUH, the voluntary sector, mental health, primary care to explore ways to ensure patients are going to the right place quickly and to refrain from visiting A&E. He stated that a recent trend of teenagers attending A&E with viral illnesses had risen where the reasons where unknown as they could be looked after safely in a different facility.

36.7 In response to Councillor O'Quinn who stated that she believed the low uptake of flu vaccines this year was due to the vaccines arriving too late in the winter season, the Deputy Managing Director of Brighton and Hove CCG stated that the key reason was that the supply and the messaging the media gave sent conflicting information.

37 FORMAL PUBLIC INVOLVEMENT

37(b) Written questions

37.1 The Chair stated that five written public questions had been received.

37.2 The Chair stated that Ms Hudson and Mr Hadman were not in attendance to put forward their question and asked they be included in the minutes with their response.

(i) Written question submitted by Ms Hudson that was originally send to the Housing and New homes Committee before being referred to the Health and Wellbeing Board:

"Can the Committee explain the lack of preparatory work for implementation of the SWEP and why facilities have not yet been made available for those living on our streets?"

Written response:

"Following a public consultation about reducing the temperature trigger for opening the severe weather shelter, a competitive tender was issued. The tender, to run a new SWEP service opening on one night at a predicted temperature of 'feels like' 0 degrees was released in Summer 2018. Unfortunately the council did not receive any bids for the contract.

In September 2018 the council with the support of partner agencies developed plans for the delivery of the service without a lead provider. The council identified premises and developed a plan to deliver the service, at no point in this process would the council have been unable to deliver SWEP provision if the temperature posed a risk to life. The council continued to have SWEP available on the trigger of 2 nights at 0 degrees until the 26th November 2018.

From the 26th November 2018 the council began operating on the new 'feels like' temperature trigger. Initially SWEP provision was being offered from a number of venues across the city and this could have continued throughout the winter however the council subsequently found a suitable central venue. The council took possession of this property at Wagner Hall on the 1st December 2018 and it was ready for use one week later.

Due to the mild start to winter SWEP did not open for the first time until the 12th December however since this date we have opened on 21 nights (up to Friday 24th Jan) which is 9 more nights than we had opened at this point in the winter of 2017/18"

(ii) Written question submitted by Mr Hadman that was originally send to the Housing and New homes Committee before being referred to the Health and Wellbeing Board :

"Earlier this year, Brighton and Hove City Council said its night shelter for people forced to sleep rough would open from 2 November until the 20 March. We are now informed the opening date will be 30 November 2018 and that there will be nights when the premises at the Brighton Centre will not be available. Could the Chairperson explain why there is such inadequate organisation and planning?

Written response:

"During the summer of 2018 we invited organisations to apply to manage the night shelter from 2 November until 20 March, but unfortunately no applications were made because of the limited capacity of providers to run a temporary winter service.

We're disappointed not to be able to open the night shelter as early as we'd hoped but we worked closely with partners to build on the provision already in place and are

pleased that Brighton Housing Trust are running the shelter from 24 November 2018. The nights that the Syndicate Wing, Brighton Centre is not available due to existing booking, the shelter is moving to St Martins Church, so there is no break in provision."

37.3 The Chair invited James Wood to ask a question on behalf of Neil Jones:

"Following the decision by the Health and Well-being Board on 11th September 2018 to investigate the expansion of the Housing First project from 10 to 20 units, can the Housing and New Homes Committee confirm what steps they have taken to ensure the provision of 20 additional units for housing first and when the properties will be made available?"

37.4 The Chair thanked James Wood for his question and gave the following written response:

"Thank you for your question which was sent to Housing and New Homes and referred to the Board. Housing and New Homes do see to the overall allocations within the city. Obviously we are keen to ensure that there are suitable options for the expansion of Home First and officers are working together from housing and HASC to work through options of where these units can be sourced and we will provide an update to the March meeting."

37.5 The Chair invited John Kapp to ask a question:

"Please can the Board tell if they support the development of Community Care Centre above Wish Park surgery at 191 Portland Rd Hove, which would be a mental A&E, open 24/7/365 as a crisis centre to relieve pressure on primary care, and provide complementary therapy free at the point of use under the social prescribing agenda advocated under the NHS Long Term Plan announced last week."

37.6 The Chair thanked John Kapp for his question and gave the following written response:

"I am aware you have asked similar questions of both this Board and also CCG Governing Body in the past. Currently there are no plans to commission such services in Wish Park Surgery.

As you noted the NHS Long Term Plan was announced last week. The CCG will be undertaking a range of engagement activities shorty to help with planning and impact on future commissioning."

37.7 Dr David Supple stated that consultation was required prior to any commissioning and part of the process would be a discussion to address the best options for delivery of non-primary care.

37.8 John Kapp stated that the area designated for a health facility had now been vacant for four years in which time could have been serving west hove. He added that regarding the recent NHS initiative to recruit more non-medical staff to assist GPS in supporting patients with mental illness and suffer loneliness, the Health Secretary, Matt Hancock, welcomed plans for a new 'army of workers' and he hoped that the board will study his issues raised as these effected the whole city.

37.9 The Chair invited John Kapp to ask a question on behalf of Jacqui Madders:

"When are those in the positions of perceived power, in that they have tax payer and government funds, going to act upon the collective moral conscience in order to provide effective solutions for people suffering psychologically and emotionally in order to prevent suicides, self-harm and other reactive issues. The current contracts and those in charge as CEOs etc. are failing. So the solution is by giving vouchers so people may choose their treatment. Most effective therapists are around £60 per hour with long term economic benefits outweighing the short termism currently in place. What is the Board intending to do about this?"

37.10 The Chair thanked John Kapp for his question and gave the following written response:

"Thank you for your question

There are a range of services in place in the city to support people with mental health issues from early interventions to those with very complex and enduring needs. Commissioning of services is based on the evidence of needs and also those that are the most clinically effective. As and when services are recommissioned this will be done looking at the Joint Strategic Needs of the city and looking at the clinical effectiveness at that time."

37.11 John Kapp did not wish to ask a supplementary question but stated that more options for social prescription be considered.

37(c) Deputations

37.12 The Chair thanked Matthew Moors Coordinator of the Dementia Action Alliance (DAA) Brighton and Hove and invited The Executive Director- Adult & Social Care and Dr David Supple to speak on the council's position.

37.13 The Executive Director- Adult & Social Care thanked Matthew Moors for his deputation and stated that over the past 20 years of working in this area that there were increasingly good examples and awareness that was reflected in the numbers and the impact of the DAA. He added that the initiative was about delivering actions in the form of staff training sessions, carers support work and to support other significant organisations to promote the ongoing work.

37.14 Dr David Supple stated that he supported the direction of travel in the move to work with colleagues across the system and agreed that plans needed to be crystallised by clarifying timelines of actions. Many of the issues covered directly affected GP surgeries and it was important to recognise that dementia diagnosis had peaked, that it was not enough to solely diagnose the dementia and that aftercare was key.

37.15 Matthew Moore responded that DAA had been auditing and providing more resources for GP practices and that it was particularly difficult for patients to navigate some environments due to the peculiarities of dementia.

37.16 Councillor O'Quinn, the new lead member for mental health, stated that she wholly welcomed the initiative. She stated that certain services, such as the fire service, were leaders in staff training awareness of dementia and other conditions. She added that other services, such as the taxi industry, would benefit from this kind of training as the knowledge and attitudes towards disability affect everyday users.

37.17 Matthew Moore stated that the fire service had signed up to the DAA where every fire fighter had completed the session and were now all Dementia Friends. He added that in the past Stream Line taxis had undertook training however they would review transport as it was crucial for people to feel comfortable.

37.18 Councillor Page said that it was amazing to see examples of all the projects supporting the DAA. Dementia was a complex disease that would affect many of us and wanted the council to sign up to this cause. He asked if DAA was part of an age-friendly public health project and whether nursing and hospital staff feel that they were fully trained to support and recognise dementia.

37.19 Matthew Moore stated that the hospital had a dementia steering group and a dementia charter and the DAA was working with Brighton and Hove's aging well initiative.

37.20 Councillor Wealls asked for clarification on the Board was signing up to in the recommendations.

37.21 The Board agreed to support the DAA and Brighton and Hove City Council formally signed up to the DAA.

37.22 Dr David Supple stated that BHCCG would take the request to their Governing Body.

37.23 The Head of Legal Services stated that usually there would be financial and legal implications however as the council was already engaged in so additional implications were unnecessary.

37.24 The Executive Director- Adult & Social Care stated that it was easy for organisations to sign up to initiatives however to action plans proved more challenging and organisations needed to develop action plans to understand what their expected contribution was.

RESOLVED:

1. That the Health and Wellbeing Board note the Deputation and agreed to support DAA; and

2. Brighton and Hove City Council to formally sign up to the DAA; and

3. The CCG to take the request to formally sign up to their governing body.

38 FORMAL MEMBER INVOLVEMENT

38(b) Written questions from members

38.1 The following question was submitted by Councillor Sykes to the Policy Resources and Growth Committee on the 6th of December 2018 and referred to the Health and Wellbeing Board. Councillor page put the question to the Board:

"Given the extraordinary pressure on local authority finances including those of our council, and the particular stresses in Adult Social Care budgets, can Cllr Yates advise on the council Administration's response to apparent competition between BHCC and our local CCG for residential and nursing bed spaces in the city and the fact that this might be unnecessarily driving up prices, thereby impacting on budgets?"

38.2 The Chair thanked Councillor Page for asking his question on behalf of Councillor Sykes and gave the following written response:

"CCG colleagues face acute winter pressures, particularly in relation to nursing bed availability in the city. BHCC work in partnership with CCG colleagues to identify and secure provision during this difficult period. The high demand for placements in the city has driven up costs for CCG and BHCC. To support strategic planning and to gain greater control in the market, the HWB will today consider a proposal from Commissioners to explore the option of block contracting where it is deemed in the best interests of the Council. By entering into block contracts arrangements at an affordable capacity can be secured at more competitive rates, whilst maintaining good quality provision. Commissioners intend to undertake a small block contract pilot of 25 beds, based on a maximum of 5 beds with 5 different providers. This proposal has the full support of CCG"

38.3 Councillor Page asked if the Board could give a guarantee that BHCCG would end the practice gazumping in of spot purchasing in future.

38.4 Lola Banjoko, Deputy Managing Director of BHCCG, responded that spot purchases were not a 'business as usual' or a preferable outcome for the CCG but a crisis solution when patient safety was compromised and should take precedents. She added that a sustainable and affordable model that we would co-develop was required to address volatile situations that occasionally occur.

38.5 Councillor Page stated that this response suggested that the hospital was at bursting point and the perception has been that the CCG has been paying high prices to reduce the Delayed Transfers of Care (DToC) particular performance indicator so the rest of the system was struggling to find beds, to clarify this was not to tweak the DToC statistic but when the hospital was at full capacity.

38.6 The Executive Director- Adult & Social Care stated that the CCG was working closely with the council on bed purchasing policy and that a tripartite business model that had to take into account the Care Act responsibilities, to provide a sustainable market and a fair charge for self-funders, was required from providers.

38.7 The Board considered the member's letter submitted by Councillor Taylor.

38.8 Councillor Taylor stated that the motivation of the letter was not critical of individual councillors as there had been clear cross-party efforts to serve the city's residents, however there were concerns over the question of the strategy, accountability and broader governance to make sure value for money and the best outcomes for residents were delivered. This council had a good history, particularly on the issue of rough sleeping and homelessness, of working in a cross-party approach which was evident in policy panels and cross-party working groups.

38.9 The Chair thanked Councillor Taylor for his letter and gave the following written response:

"As you may be aware this issue has been raised and is going to the Constitutional Working Group (CWG) already. I will happily ask that this letter go to that meeting pack.

My understanding is that officers have already been drafting papers covering the issues that you have raised. These papers will go through the Constitutional Working Group and then if agreed to Policy, Resources and Growth.

The working group meet in early March and I hope to be able to provide an update to this Board at the next meeting."

RESOLVED: That the Health and Wellbeing Board note the Letter from Councillor Taylor and refer the Letter to the CWG.

A CALL OVER

38(A) The following items on the agenda were reserved for discussion:

Item 39 - Designing an Integrated Care Partnership and Reviewing the Purpose and Functioning of the Health and Wellbeing Board
Item 40 - Better Care Plan
Item 43 - Suicide Prevention Action Plan
Item 44 - Recommissioning Substance Misuse Services

39 DESIGNING AN INTEGRATED CARE PARTNERSHIP AND REVIEWING THE PURPOSE AND FUNCTIONING OF THE HEALTH AND WELLBEING BOARD

39.1 The Executive Director- Adult & Social Care introduced the report and stated that the Integrated Care Partnership (ICP) would be designed with existing organisations and stakeholders working together which was fundamentally about the future of patients, the operationally, funding prioritising and it was important that action started now. The current form of the Health and Wellbeing Board would be reviewed on its operation and aligned to continue with its statutory responsibilities but also maintaining appropriate governance and oversight for both the policy framework through the Health and Wellbeing Strategy and the ICP. He stated that governance could not be addressed until the ICP model was refined and would then return with a more detailed report for the Board in the summer.

39.2 Councillor Moonan praised the paper and stated that the theme of this report was the right direction to integration and was a recurring theme that had taken time to progress. She stated there was interest in the broader community, misinformation and concerns and asked how the ICP could take the public on that journey and help them understand the direction of travel, how we were moving forward and how they could influence the process.

39.3 The Executive Director- Adult & Social Care responded that there were a number of paths that were within the Health and Wellbeing Strategy which would include many opportunities to engage and consult with the community and to strengthen the joint commissioning approach. The NHS long term plan had been recently published and a key requirement was that locally a five year NHS plan would be in place for September 2019 which would link closely to the strategy and a comprehensive mechanism of engagement.

39.4 Councillor Taylor thanked officers and the CCG for the paper and stated that the Conservative Group had been staunch proponents of integration initiative and endorsed all of the recommendations of the report.

39.5 In response to Councillor Page asking for clarification on what the broader ICS regarding terminology and community engagement concerns, David Supple stated that engagement should raise reasonable concerns and bring reassurance to Brighton and Hove residents that they would be represented in the context of a larger foot print of the ICP, with the acronyms aside which could often be challenging, that would which would be true for every Health and Wellbeing Board in the country.

39.6 The Chair stated that the need for clarification was a crucial point and that when the recommendations pass that those explanations should be included in the paper.

39.7 David Liley, Brighton and Hove Healthwatch, stated that the engagement task in line with the long term NHS that they had already been in discussion locally and on Sustainability and Transformation Partnership (STP) on how they could integrate engagement. The pledge form Healthwatch Brighton and Hove was that engagement would be significant locally, the would be an independent element due to the element of Healthwatch and that it would be focussed on the patient experience and making it real for ordinary people.

39.8 Councillor Page stated that in 1.1.4 of the report, the Policy Panel reviews on the future purpose of the Board excluded health colleagues from the discussion and effectively functioned as a councillor working group. For policies with such strategic importance for the future arrangement of governance he asked that a report to go to the board so everyone could make a decision.

39.9 The Executive Director- Adult & Social Care responded that the Policy Panel did not have to be exclusively for councillors. The Panel established for the Health and Wellbeing Strategy preparation had representation from the CCG, external bodies to the Board, third sector organisations. The Panel would invite people to attend who could make a meaningful contribution. He added that they would look to constitute a Policy Panel with broader representation which could include the Sussex Community

Foundation Trust (SCFT), Sussex Partner Foundation Trust (SPFT) and the Brighton & Sussex University Hospital (BSUH).

RESOLVED: That the Health and Wellbeing Board agreed to the following:

(1) That the latest changes in the national policy landscape, including the NHS Long term Plan that supports the NHS Long Term Plan, and the awaited Green paper on Adult Social Care whilst addressing the local strategic case for change for integrated health and social care services be noted;

(2) That the progress that has been made so far with developing our joint services that positively impact upon the patient/service user experience be noted;

(3) That it be approved that senior officers across a range of key partners to negotiate and influence within their constitutional remit the design of an appropriate Integrated Health and Social Care Partnership for Brighton and Hove, meeting the national design requirements for an Integrated Care Partnership (ICP) within a broader Integrated Care System (ICS), and bring a proposal back to the HWB in summer 2019;

(4) That a Policy Panel be established with one representative from each Group to be nominated by the Group Leader to review future purpose and membership of the Health and Wellbeing Board with options to be brought back for consideration in summer 2019; and

Note: Terms of Reference and membership of the Policy Panel will be brought to the March Board for approval.

(5) That in this transition period to reaffirm the HWB's ongoing accountability for its statutory responsibilities and remit to include:

(a) The development and publication of the Joint Strategic Needs Assessment for our population.

(b) Agreement of a medium term Health and Social Care Strategy (joint draft health and wellbeing strategy currently being consulted upon).

(c) Working with the CCG to develop agreed health and social care budgets within the 4 -5 year financial planning horizons due in the Autumn to achieve appropriate alignment to deliver the Health and Social Care Strategy.

(d) An annual high level review of health and social care performance against relevant and meaningful KPIs including patient feedback and customer experience to inform future HWB strategic policy.

(e) An annual review of strategic service delivery and commissioning priorities, governance and strategic management and delivery arrangements at city-wide and regional levels in order to inform adjustment to national and regional priorities.

40 BETTER CARE PLAN

40.1 Ashley Scarff, Director of Commissioning BHCCG, introduced the report on the general update of performance and finance for the Brighton and Hove Better Care Fund (BCF) programme prepared by the Better Care Fund Steering Group for assurance and to note. He stated that the overall indicators showed good progress.

40.2 Councillor Page thanked Ashley Scarff for the report and welcomed the regular update on the BCF to the Board and that the programme could support wider health and social care services. He stated that in the case of a 100% funding cut by the CCG to a disability project and asked whether Better Care funding had been considered as an alternative source, given that it provided substantial grants to other social inclusion and support services

40.3 In response to Councillor Page, The Statutory Director- Adult & Social Care stated that he did not think it was appropriate to comment on individual organisations and all funding decisions had to be kept in their context and that this report was about the BCF performance on a strategic level.

40.4 Councillor Taylor welcomed the report and the progress made and stated that targets had to be constantly revised to ensure the best outcomes were delivered to residents and that he looked forward to future updates in due course. In terms of spending, he stated that there was a large variance in community equipment spending and asked for clarification as a written statement as to why this variance existed as there had been previous paper on preventing this imbalance.

40.5 The Chair stated that if this was something that the Board complied then this would be good information to have.

RESOLVED: That the Health and Wellbeing Board note the report.

41 JOINT STRATEGIC NEEDS ASSESSMENT 2018

RESOLVED:

(1) That the 2019 JSNA summary for publication, as set out in section 2 of the report and provided in Appendix 1 to the report be approved and that the summary be updated quarterly rather than annually.

42 MONEY MANAGEMENT PROCUREMENT

RESOLVED:

(1) That delegated authority be granted to the Statutory Director of Health & Adult Social Care (HASC) to undertake the procurement of a money management & handling service to the value of £600,000 per annum, and to award a contract for Money Management for Five (5) years; and

(2) That delegated authority be granted to the Executive Director of HASC to extend the contract at the end of the five year term for a further period of up to two years if it is deemed appropriate and subject to available budget.

43 SUICIDE PREVENTION ACTION PLAN

43.1 David Brindley, Public Health Programme Manager, introduced the paper to inform the Board on the new Suicide Prevention Strategy 2019-21 which had the objective of reducing the rate of suicide in the city. The strategy was tailored to local need through evidence, national guidance and multiagency partnership with other stakeholders in the city.

43.2 Councillor O'Quinn thanked Public Health Programme Manager for his useful and great work. She stated that a wide variety of people were affected by this issue, whether it was students suffering from stress or vulnerable older people, and that it was particularly concerning to see areas where vulnerable children were affected by parents that had tried to repeatedly commit suicide from her perspective sitting on the Adoption Panel and the Fostering Panel. She added that it was surprising to see suicide levels drop since the financial crash.

43.3 The Public Health Programme Manger stated that on there were representations from children's services and the Local Safeguarding Children's Board on the Action Panel Steering Group to base the foundations and to bring this work forward.

43.4 Councillor Moonan thanked the Public Health Programme Manager for the report and asked whether he could expand on homelessness as a risk factor, which linked to the work of the safeguarding board's work on homeless deaths, and for reassurance that these were being linked. She added that if they were not there was potential for this. Secondly she asked why female suicide, often mothers, was increasing in a contradiction to the national trend.

43.5 The Public Health Programme Manager responded that the Suicide Prevention Action Plan was linked in with homeless services and the CCG mental health lead who sits on the Homeless Board. There were no suicides recorded of people that were homeless at the time of suicide through the local suicide audit, however they were recognised as a vulnerable group and there was always room to explore this subject. Secondly he responder that increased female suicide was a recent national trend in the past couple of years and the cause was currently unknown, however the victims were predominantly male.

43.6 The Director of Public Health welcomed the strategy and stated that every suicide was a tragedy which effected many people in the long term. It should be highlighted that Brighton and Hove had the second highest suicide rate of all high level authorities in the country which was a poor position and meant this strategy had to be a priority for the Board and the city as a whole. He stated he would be chairing the suicide prevention boards in future and the implementation of the action plan should include key organisations of the city as absolute equal partners in the delivery and ownership of the strategy.

43.7 Councillor Wealls asked if there was any support or resource for the city's further education (FE) colleges, which accounted for 12,000 service users, or youth services as these had not been mentioned in the action. Secondly he questioned if the GPs and health professionals had the skills and resources in terms of appropriate signposting for patients as there were a broad range of interventions available. Thirdly he asked how older people were identified for intervention if they did not independently approach a GP. They were vulnerable to be forgotten then he asked whether state or voluntary services stepped in, particularly if there were no family members to organise integration services.

43.8 The Executive Director - Families Children & Learning responded that there was a mental health practitioner for all FE and sixth form colleges and they recognised this was a vulnerable demographic. Their key focus was self-harm, which was a broader programme for which suicide was an aspect, and part of their role was to raise awareness across the wider workforce in those institutions.

43.9 The Public Health Programme Manager responded that from the tender for an aging well service had been awarded to Impact Initiatives. They had a local partnership beneath which would help the service outcomes to reduce loneliness and social isolation which would have one phone number and a main point of contact for all those services. An expectation of this service would be to reach out and find isolated older people and there was ongoing work to tie this to the broader social care support to ensure people were aware of this service. Secondly he stated that there was a clinical lead who was a part of the suicide prevention work and that there was high levels of work towards strengthening health professional's skills of signposting and social prescribing. Thirdly for youth services, he stated that there were strong links to youth service colleagues and commissioners.

43.10 In response to Councillor Wealls stating that those answers should be incorporated in to the strategy, the Director of Public Health agreed and stated that the action plan should be updated and be more dynamic in future. He added that in terms of General Practice, that they had been working with colleagues from other areas such as the Sussex Partnership NHS Foundation Trust (SPNFT) to bid for national funding with a priority of recommissioning primary care in General Practice.

43.11 Dr David Supple stated that in terms of GPs, there was a tension in the system when multiple priorities existed, as in any system, and to an extent there was a trade-off between continuity of care and quick access to primary care. He stated that this was an issue that affected everyone and on some level and that there needed to be societal solutions.

43.12 Councillor Page thanked the Public Health Programme Manager for his report and stated that the discussion showed a complex challenge which had existed for many years and this action plan should be a priority for the City. He added there was a particular awareness push for the student population for which Brighton and Hove had a significant bulge population.

43.13 Graham Bartlett, Brighton & Hove Safeguarding Adults Board (SAB), stated that they had not seen issues of suicide detected in the realm of abuse and neglect or care and support and there were worries on whether they were asking the right questions. The

SAB had been anxious about their referral pathways for safeguarding adult reviews and those deaths may not have been flagged as potential themes in the same way as the Safeguarding Children's Board which triggered overview panels that provide a safety net to pick up issues. The SAB needed to identify those at risk in their sector whether this was implementing safeguarding adult reviews or multi agency audits.

RESOLVED: That the Health and Wellbeing Board approve the Suicide Prevention Strategy 2019-21.

44 RECOMMISSIONING SUBSTANCE MISUSE SERVICES

44.1 Stephen Nicholson, Lead Commissioner HIV Sexual Health & Substance Misuse, introduced the paper that described the problems of substance misuse in the City and the services that were in place to address drug and alcohol addiction.

44.2 Councillor Wealls stated that the success rates did not show results beyond six months and there needed to be a case that showed why a longer term benchmark was not used because the sustainability would indicate whether the services were worthwhile. He asked if there was a reason there were no longer term measures such as one, two or five year metrics presented in the paper.

44.3 Stephen Nicholson responded that he would look in to the success rate data that was mandated by Public Health England and report back to the Board.

44.4 The Director of Public Health responded that the metrics were national KPIs and monitoring systems which was comparable data that was quality assured across the country however they could explore options for longer term data although this would not then be comparable data to other areas.

44.5 The Executive Director- Adult & Social Care acknowledged this was a fair point and they would look how to get that into the specification for a report in choosing a future provider to form a part of the procurement on a local level with local data. He stated they we happy to explore this route however there would be issues surrounding the validity of quantitative data collected due to the position of patients 18 months ahead, for instance they may have moved out of the area.

44.6 The Director of Public Health stated he would first like to look at the feasibility, the advantages measured against the cost and the judgement on the reliability and validity of the longer term data collected.

44.7 Dr David Supple agreed with Councillor Wealls in the fact that the quality of the service had to be assessed because the service experience was not the same as service outcome.

44.8 Councillor Moonan Stated that quality and sustainability of outcomes were the goal; however that judgement needed to be put the provider, many patients were going back to environments that were not helpful for their recovery and there were other players and organisations involved in creating and maintaining the desired long term results.

44.9 Councillor Page asked whether there was knowledge and research on whether six month benchmark was a strong success indicator because this could be substantial longevity for addicts.

RESOLVED:

(1) That the procurement by tender for substance misuse services be approved;

(2) That delegated authority is granted to the Executive Director of Health & Adult Social Care (HASC) to undertake the procurement and award of a contract for substance misuse services with a term of five years and

(3) That delegated authority is granted to the Executive Director of HASC to extend the contract at the end of the five year term for a further period of up to two years if it is deemed appropriate and subject to available budget.

45 ANNUAL ADULT SOCIAL CARE CHARGES REPORT

RESOLVED:

(1) That it be agreed that the council continues with the current charging policies for non-residential care services and residential care homes which includes an individual financial assessment to determine affordability and complies with the requirements of Section 17 of the Care Act 2014. The charging policy is attached at Appendix 1.

(2) That all charges being uplifted by 2% (rounded up to the nearest pound or 10p if below £5) be agreed; and

(3) That the table of charges be approved with effect from 8th April 2019

46 CARE HOME BLOCK CONTRACT ARRANGEMENTS

RESOLVED:

(1) That delegated authority be granted to the Executive Director of Health & Adult Social Care to procure and award block contracts for up to 25 units, with a maximum of 5 suitably qualified providers of care home services able to meet the various residential care/nursing needs of residents, including those with special care needs.

(2) That block contracts would be for a maximum of two years, with a break clause after one year. These contracts are intentionally short, to allow officers to undertake a full review of future demand and contracting arrangements. A final decision regarding the contracted number of units will be reached once offers from providers have been assessed, to ensure that the Council is obtaining value for money.

The meeting concluded at 6.50pm

Signed Chair

Dated this day of

Item 53

Although a formal committee of Brighton & Hove City Council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults and Healthwatch.

Title:	Reviewing the purpose and functioning of the Health and Wellbeing Board
Date of Meeting:	19th March 2019
Report of:	Rob Persey, Executive Director of Health & Social Care and Wendy Carberry, Managing Director South CCG
Contact:	Barbara Deacon
Email:	barbara.deacon@brighton-hove.gov.uk
Wards Affected:	ALL
FOR GENERAL RELEASE	

Executive Summary

There have been several reports to Policy Resources and Growth highlighting the need for a review of the Health & Wellbeing Board which they have formally agreed to.

At the January Health & Wellbeing Board the Board agreed to :

- Establish a policy panel to review future purpose and membership of the Health and Wellbeing Board with options to be brought back for consideration in summer 2019

This report provides the draft scoping document for the Policy Panel, draft terms of reference for the Policy Panel with suggested membership for the Board and an outline timeline of meetings and content.

A key consideration is the timing of the Policy Panel. There are two options:

- start this work prior to councillor changes with the local election in May 2019. This would enable current councillors who have had experience of the Board to contribute with their views on the changes required
- start the work after the May elections with the new council.

Glossary of Terms

HWB – Health & Wellbeing Board

1. Decisions, recommendations and any options

1.1 That the Board agrees to the following:

1.1.1 Decide on when the Policy Panel will first meet;

1.1.2 Agree the draft Terms of Reference (Appendix 1)

2. Relevant information

2.1.1 The Health & Wellbeing Board was established following the Health & Social Care Act 2012. The Health & Wellbeing Board, like all HWBs across the country is a committee of the respective council and therefore has to comply with the council's constitution and with the statutory requirements of local authority committees.

2.1.2 The Health & Social Care Act 2012 provides the list of Board responsibilities and also the minimum membership of who should be on a HWB. Each Council has autonomy to develop its own specific Terms of Reference for its HWB that reflects local needs as long as the national 'must 'do's are included.

2.1.3 The Brighton & Hove HWB Terms of Reference has undergone minor changes, mainly relating to attendance at the Board and voting rights (for example, the statutory directors of the council no longer vote as part of the Board). However, the Board Terms of Reference and membership of the Board have not altered significantly in recent years. Given the significant ongoing and proposed changes in the Health & Social Care system nationally, regionally and locally, there is a clear and pressing need for review.

2.1.4 This review is timely as a key building block to support this work will be the Joint Health & Wellbeing Strategy which can be used as a driver to provide the framework for the Board, its future agenda and work plan. It will provide a 4 yearly structure with the policy drivers, local priorities and clear links to

finance and performance with an annual framework for formal review. This strategy is coming to the March 219 Board for approval.

2.1.5 The HWB has indicated that it seeks to:

- Be strategic, responsive and also focused through system leadership on improving services for local residents
- Have clear understanding of finance, performance and how these flow through the system
- Ensure that the Board reflects the policy decisions that have been made.

2.1.6 There is a need to review the remit and functions of our existing HWB given the national, regional and local changes that are in train. While the statutory functions of any Health & Wellbeing Board (and its legally required membership) are limited, there is the opportunity to include a broader role for the Board and to include wider partnership organisations. There is also the opportunity to review the current delegations to the Board against national good practice and legislative requirements to consider the most effective decision making arrangements for the Council.

2.1.7 The Board has also discussed potential future Board membership and this will be part of the Policy Panel review.

2.1.8 The proposed terms of reference for the HWB Review Policy Panel are attached at Appendix 1. Following the Policy Panel's deliberations, a report will be brought back to the Board no later than November 2019. These should include the future direction of the Board with suggested revised Terms of Reference, the support for the Board including a rolling plan of reporting.

2.1.9 Final decisions about changes to the Board and its Terms of reference will need to go through the following process:

- The Policy Panel to report their recommendations to the Health & Wellbeing Board as an option paper no later than November 2019.

- The agreed recommendations would then need to go through the appropriate Council Cross Party Constitutional Working Group followed by the Council Policy Resources and Growth Committee with Full Council making the final decision on any constitutional changes to what is a council committee.

2.1.10 The agreed recommendations would also go through Clinical Commissioning Group Governing Body.

2.1.11 A scoping document in will be part of the first Policy Panel discussions and will need to look at :

- Meeting frequency (if quarterly could suggest how this might work e.g. a planned cycle of activity);

- Plan for meetings, including invitees.

3. Important considerations and implications

3.1 Legal:

The Council's Scheme of Delegations to Committee delegates to Committees the power to establish time-limited Policy Panels to carry out short, sharply focused pieces of policy review and development work, as described in the paper.

Lawyer consulted: Elizabeth Culbert Date: 21/02/19

3.2 Finance:

There are no direct financial implications arising from this report. Any costs such as officer time required to implement the operational changes will be met within existing resources.

Finance Officer consulted: Sophie Warburton Date: 04/03/2019

3.3 Equalities

This review of the Health and Wellbeing Board is an opportunity to further embed equality, diversity and inclusion in the function and membership of the Board.

Supporting documents and information

Appendix 1 Terms of Reference for the Policy Panel

Appendix 1

DRAFT TERMS OF REFERENCE FOR HEALTH AND WELLBEING BOARD REVIEW POLICY PANEL

1. Name

Health and Wellbeing Board Review Policy Panel

2. Purpose

To support a review by the Health and Wellbeing Board (HWB) of the terms of reference and membership of the HWB.

The need for a review arises from significant changes in the Health and Social Care system nationally, regionally and locally. The outcome of the review will form recommendations to be presented by the HWB to Policy, Resources and Growth Committee and full Council.

3.Status

The Health and Wellbeing Board Review Policy Panel shall be an advisory board to the HWB that the Policy Panel will report to. The Policy Panel will not have subcommittee status and the political balance rules in section 15 of the Local Government and Housing Act 1989 will not apply. However, it is expected that the Board will be established on a cross party basis, together with representation from relevant partner organisations.

4. Areas of focus

To review the terms of reference for the HWB against legislative requirements, national good practice and changes in the Health and Social Care system to ensure that the HWB delivers effective decision making in relation to its core business.

To review the membership of the HWB against the same criteria.

5. Reporting

The Board will report to the HWB, with recommendations as necessary.

6. Membership

Membership of the Policy Panel shall consist of 5 elected Members, following nominations by their Group Leaders to reflect the political composition of the Council. In addition the Board shall include 3 members of the CCG. All non voting members of the current HWB will be invited to attend the Panel and one Member from each of the following partner organisations will also be invited to attend:-

Community Works;
Brighton & Sussex University Hospital;
Sussex Partnership Foundation Trust
Sussex Community Foundation Trust.

This does not preclude the Panel from inviting additional organisations or representatives to help inform the work of the Panel.

7. Meetings and ways of working

The timing and number of meetings will be dictated by the volume of business for the Policy Panel.

The Policy Panel will agree ways of working appropriate to the role and remit of the Group.

At the first meeting the Panel will agree the chairing of the Panel.

8. Consultation and engagement

The HWB are keen to ensure that wide engagement and feedback from stakeholders forms part of this review. Part of the initial scoping with the Panel will be consideration of how this can be undertaken in a meaningful and timely manner.

8. Review

These terms of reference may be reviewed and amended by the HWB from time to time.

Although a formal committee of Brighton & Hove City Council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults and Healthwatch.

Title:	Brighton & Hove Healthwatch Annual Report 2017/18
Date of Meeting:	19th March 2019
Report of:	Rob Persey, Executive Director Of Health and Social Care and David Liley, Chief Executive Healthwatch
Contact:	Barbara Deacon Tel: 01273 296805
Email:	Email: barbara.deacon@brighton-hove.gov.uk
Wards Affected:	All

FOR GENERAL RELEASE

Executive Summary

Healthwatch is the local independent consumer champion for health and care.

Healthwatch is a co-opted member of both the Brighton & Hove Health Overview & Scrutiny Committee (HOSC) and the Health & Wellbeing Board (HWB), and is this year presenting its annual report for 2017/18 to the Health & Wellbeing Board.

(Appendix 1).

Glossary of Terms

CCG – Clinical Commissioning Group

Community Works – Greater Brighton & Hove organisation that works across voluntary and community groups and networks that help people and organisations to use their time, expertise and energy effectively.

HOSC – Health Overview and Scrutiny Committee

CIC – Community Interest Company

HWB – Health & Wellbeing Board

NHS – National Health Service

1. Decisions, recommendations and any options

1.1 That the Board agrees to note the Healthwatch Annual Report

2. Relevant information

2.1 The 2012 Health & Social Care Act required each upper-tier local authority in England to commission a local Healthwatch organisation to undertake the statutory responsibility for being the independent consumer champion for health and social care.

2.2 Originally Community Works was the successful bidder for the local Healthwatch contract, to run from April 2013. In April 2015, Brighton and Hove City Council novated the Contract to the newly formed Healthwatch Brighton and Hove

2.3 In recognition of the changes within the local NHS and CCG structures, Brighton and Hove City Council agreed a waiver in March 2018 to extend this contract to March 2021.

Healthwatch B&H incorporated as an independent Community Interest Company (CIC) organisation with an asset lock on 14 October 2014. This meant that staff moved from Community Works to the new CIC and operated under the new company as of 01 April 2015. This is the current structure of Healthwatch.

2.4 The council as part of its statutory responsibility for performance management continues to monitor Healthwatch Brighton & Hove its performance monitoring framework

2.5 There is no statutory requirement for Healthwatch to present its annual report to the HWB, but there are obvious benefits in Healthwatch sharing its intelligence with the Board.

2.6 The report will also go to the June HOSC meeting also to note.

2.7 The development of the Annual Report is based on Healthwatch's

consistent approach to seeking to hear people's stories about their experiences of health and social care services, using these to develop an effective evidence base. They use their statutory powers to Enter and View any premises so that their authorised representatives can observe matters relating to health and social care services. They also gather information and insight through outreach and by sending trained volunteer representatives to a wide range of public meetings, specialist and strategic committees and decision making forums.

2.8 The report provides information on the range of consumer experience in the 2017/18 year and also highlights the future challenges for the 2018/19 year.

3. Important considerations and implications

Legal:

3.1 There are no legal implications arising from this report which is for the Board to note.

Lawyer consulted: Elizabeth Culbert Date: 18/02/2019

Finance:

3.2 There are no direct financial implications arising from this report.

Finance Officer consulted: Sophie Warburton Date: 22/02/19

Equalities:

3.3 Healthwatch Brighton & Hove updated their Equalities Impact Assessment when they became a CIC. Their reports and work include their demographic breakdowns and try to reflect the profile of the city and its residents.

As Healthwatch Brighton & Hove is an external organisation Brighton & Hove City Council have not been directly involved in assessing any impact on equalities.

Equalities Officer Consulted: Anna Spragg Date: 07/03/19

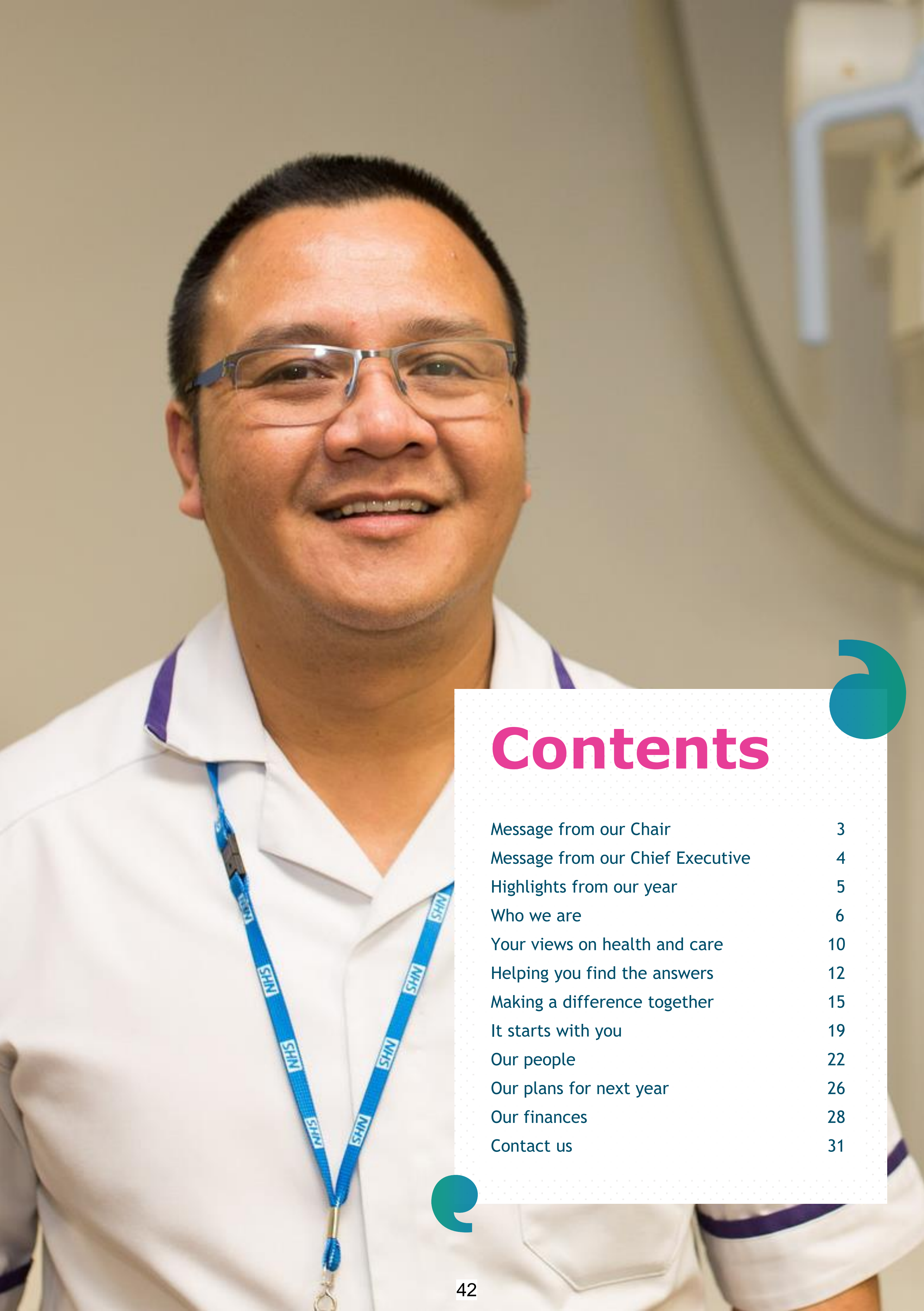
Supporting documents and information

Appendix 1: Healthwatch Brighton & Hove Annual Report 2017 /18

Apprendix 1

Healthwatch Brighton and Hove

Annual Report 2017/18



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Message from our Chair

A year of challenge and change

The context of Healthwatch work has been a continuation of pressures on health and social care in the city: closures of GP services; a hospital in special measures, and national health targets not met. NHS finances in the City stabilised, but the Royal Sussex County Hospital (RSCH) still carries significant debt as does the NHS across Sussex and East Surrey.

Despite this, there are positive changes such as; the building work at Royal Sussex County Hospital which will provide a new state of the art hospital; a £30m investment in the new Emergency Department and the mental health service; and both Sussex Partnership Foundation Trust and the Sussex Community Foundation Trust received 'good' ratings from the Care Quality Commission .

The challenge for Healthwatch has been to ensure the voices of Brighton and Hove citizens have been heard in this fast moving environment. We have worked with:

- Healthwatch Sussex colleagues to carry out a survey to improve the patient transport service
- Impetus to promote use of the free complaints advocacy service they deliver
- **PALS** to review how complaints are handled
- YMCA Downlink to launch Young Healthwatch and publish their first report looking at A&E and experiences of mental health services
- **MindOut** and other organisations to carry out a review of local health and disability benefits - and we are still using that work to argue for improvements.

We also carried out a major survey of nearly 1,500 patient's experiences of General Practice, as well as continuing with our regular audits of the RSCH.

We aim to make people's voices matter. We actively listened to people using local services and fed back their views to relevant departments as well as using our privileged access to decision makers in the NHS and City Council to secure improvements (Health & Wellbeing Board, Health Overview & Scrutiny Committee).

We fed our intelligence to city councillors, MPs and the Parliamentary Select Committees. And through Healthwatch England we provided evidence to a Parliamentary Select Committee on NHS sustainability and transformation.

Our work has only been possible with the assistance of dedicated Healthwatch Board members and many volunteers. Last year, Karin Janzon and John Davies resigned from the Board after three year stints. I wish to thank everyone who has contributed so much over the last year, and look forward to welcoming the new volunteers who will join us. I would also like to thank the CEO, David Liley, and our dedicated team of staff who have done influential work this year- as the rest of the report will show.

Message from our Chief Executive

Improving health and wellbeing must include the opinions and aspirations of people who use those services - that is the central message and purpose of Healthwatch.

Local people, patients and their families have helped us to improve NHS and care services in the City in 2017/18. Healthwatch have made over 200 recommendations to health and care decision makers and about half have already been implemented, and Healthwatch is pursuing answers about the rest.

Most of our work has been inspired by local people who have asked us about:

- GP services: raising concerns about access, closures and pressure of demand on family doctors
- Decent and humane social care: improving access to benefits for some the most vulnerable people in our City
- A safe and clean local hospital service and accessible A&E and
- Patient transport services that are reliable.

The positive message this year has been that services are improving, almost every Healthwatch review of services provides clear evidence that:

- The NHS and City Council are reaching out to local people and listening to their concerns
- Services previously in crisis and failing are showing signs of recovery
- As a community we are recognising and responding to 'the patient voice'.

There are challenges ahead with shrinking budgets and historic financial deficits but also evidence that the NHS and Social Care are:

- working in a more integrated way: City Council Social Care, and the NHS plans for joint commissioning
- listening to local people ('The Big Health and Care Conversation'
- building a meaningful partnership across the public sector Sustainability and Transformation Partnership.

Healthwatch has grown in the last year with:

- A secure contract and funding to until 2021
- More volunteers, with a more diverse profile better representing our community
- Influencing decision makers with evidence based service reviews
- A stable staff team and more partnership working with other local Healthwatch and Healthwatch England.

The challenges in the coming year will be:

- Helping the NHS and City Council to hear, and to be influenced by, patient and public voices when they are faced with difficult financial decisions
- Setting Healthwatch priorities, and a work programme, for the next three years in partnership with local people, voluntary sector partners and decision makers in the context of a continually changing environment
- Reaching out to people and communities who find it difficult to speak up for themselves.

Highlights from our year

Practice visits and engagement leading to service improvement

We undertook **61** visits to health and social care services to talk to people about their experiences and make observations about practice

61 visits to health and social care services

We visited **30** GP surgeries and reached **1483** patients to hear their views about primary care

21 Enter and View visits to Royal Sussex County Hospital

11 Patient-Led Assessments of the Care Environment (PLACE) in Brighton hospitals

531 recommendations to services were made as a result of these visits which led to **116** actions to improve practice. An estimated **360,000** patients benefitted from these changes

Communicating the voice of the patient through media

We issued **13** press releases raising the voice of the patient on critical issues

We produced **6** editions of our Healthwatch magazine; **940** paper copies and **500** digital copies of each edition were sent to subscribers, reaching an estimated audience of **5,000** people across Brighton and Hove

29

We did **29** interviews for local radio, newspapers and television

Our website had over **22,000** hits

1,642

555

We attracted **1,642** Twitter and **555** Facebook followers, and our Facebook posts reached over **35,000** people

Using volunteers to maximise value

Volunteers contributed an average of **26** hours for each visit made by Healthwatch to a health and social care services

Volunteers contributed work worth **£23,600** for the **61** site visits

23,600

Who we are

Healthwatch is the official consumer champion for Health and Social Care Services

We know that you want services that work for you, your friends and family. That's why we want you to share your experiences of using health and care services with us - both good and bad.

We use your voice to encourage those who run services to act on what matters to you.

We are uniquely placed as a national network, with a local Healthwatch in every local authority area in England.

Our Vision

We want better health and care services, with consumers expectations and preferences at the heart of how those services are provided, commissioned, designed, managed and funded.

We are working towards a society where all health and social care needs are heard, understood and met.

Achieving this vision will mean that:

- The people who use services shape their delivery
- People can influence the services they receive in a personal and individual way
- People hold services to account

Our priorities:

- To combat health inequalities
- To improve services by providing evidence of service user experiences
- To focus on those services and issues that most need improvement and where we can make the greatest impact
- To ensure decision makers honour their commitment to provide quality services.

Who we are

We achieve this by:

- listening hard to people, especially the most vulnerable, to understand their experiences and what matters most to them
- influencing those who have the power to change services so that they better meet people's needs, now and in the future
- informing and empowering people to get the most from their health and social care services and supporting other organisations to do the same
- working with the Healthwatch network to champion service improvement and empower local people.

Healthwatch Brighton and Hove - not for profit

We are a Community Interest Company (CIC) set up by and run by local people.

As a CIC we are non profit making and committed to reinvesting **100%** of our income, surplus and capital resources to promoting our aims and values and not for anyone's personal profit. Any funds we receive or earn are spent helping local people. We have a small paid staff of 4 people.

Healthwatch Brighton and Hove CIC has been established for almost three years. Our funding is provided by Brighton and Hove City Council but we are entirely independent from NHS or local council control.

Impetus provides our sister service the Independent Health Complaints Advocacy Service (IHCAS).

Run by local people for local people

We have 34 volunteers who visit services and ask people about their experiences and how they could be improved.

Healthwatch has a statutory power to enter any premises, observe and review services from the consumers perspective. This power can be applied anywhere public money is spent on health or care services.

Healthwatch volunteers attend decision making committees and discussion forums to represent patients and people who use social care services. We sit on the Health and Wellbeing Board (HWB) and the City Council Health Overview Scrutiny Committee (HOSC).

"Our job is to find out what matters to you and to help make sure your views shape the health and care support you need.

You can help make care better by telling us what you think.

The more people share their ideas, experiences and concerns about NHS and social care, the more services can understand what works, what doesn't and what people want from care in the future."

Imelda Redmond CBE
National Director
Healthwatch England

Meet the Board

Frances McCabe

Independent Chair

Frances has been Chair since 2013 and previously Chair of Age UK B&H, working for over 40 years in health and social care.

Bob Deschene

Director

Bob has 15 years of experience in senior NHS Management in a variety of roles across East & West Sussex.

Sophie Reilly

Director

Since 2003, Sophie has worked locally and nationally in both the voluntary and statutory sectors to improve health and social care services.

Neil McIntosh

Director

Neil volunteered in 2014 after a 30 year public sector career at a senior level in the Ministry of Justice, Dept of Health and NHS.

Catherine Swann

Director

With over 20 years experience in national NHS and academia, Catherine is a senior public health civil servant and a chartered psychologist.

Geoffrey Bowden

Director

Geoffrey started a successful healthcare business and is a former Councillor with significant experience of health & social care scrutiny.

Carol King

Board Advisor

Carol has many years of experience in the NHS and Children's Services at Brighton and Hove City Council.

Barbara Harris

Board Advisor

Since 2007 Barbara has been Head of Equality, Diversity and Human Rights for Brighton and Sussex University Hospitals NHS Trust.

Tony Benton

Board Advisor

Tony - our safeguarding expert - worked in social care and health for 30 years and though retired is still improving the quality of services and outcomes for users.

Meet the Team

David Liley

Chief Executive Officer
David has worked in Health and Social Care for almost 40 years. David also set up the NSPCC National Child Protection Helpline in the 1980s that later merged with Childline.

Roland Marden

Evidence & Insight Manager
Roland has over 20 years' research experience starting as an academic social scientist at the University of Sussex and since 2006 working in project evaluation in the charity sector.

Michelle Kay

Project Co-ordinator
Michelle has a background in project management and international development, with experience managing large scale projects in the UK and abroad, liaising with government grant-holders.

Alan Boyd

Project Co-ordinator

Alan works for Terence Higgins Trust, a prominent HIV charity based in Brighton, and has previously worked in mental health. He has a background in the civil service designing policy and running projects.

Will Anjos

Project Officer

Will is an experienced project manager. He set up the charity BrightonSoup to help small local community projects get funded. He also works for Volunteering Matters supporting activities for older people across the city.

Your views on health and care

Listening to people's views

We listen to your views in lots of different ways:

- **Young Healthwatch** is provided in Partnership with the YMCA Downlink Project. They held listening labs' seeking out the views of hundreds of young people about the health and care issues that matter to them. They also investigated the experience of young people using A&E services and their report is being used to implement changes to mental health services in Brighton and Hove

- Brighton Pulse is our online portal to gather your views on health and care, available 24hrs a day 7 days a week.

Making sure services work for you – working in partnership

- Working with local Healthwatch in East and West Sussex and East Surrey to support the NHS Sustainability and Transformation Partnership (STP)

- In partnership with Healthwatch East and West Sussex we have continued to gather your views and monitor the quality of Patient Transport Services. For the first time in two years we have recently been able to report a significant increase in patient satisfaction with these services (Patient Transport Service Report)

- Over the last year Healthwatch England has provided us with guidance, links to Healthwatch teams across the country, and a shared intelligence base. This year we also adopted their Customer Relationship Management (CRM) system helping us to record, manage and analyse the enquiries and personal stories that we received. In turn we provided evidence, reports and emerging issues to Healthwatch England to influence the national health and care agenda.

- Nationally and locally Healthwatch works closely with the health and care regulators – the Care Quality Commission (CQC). This year we have provided detailed evidence to CQC relating to The Royal Sussex County Hospital and participated in the CQC inspection of The Sussex Partnership Foundation Trust (SPFT) providers of local mental health services

- We have continued our close working links with the Independent Health Complaints Advocacy Service (IHCAS) provided by Impetus in Brighton and Hove

- The General Medical Council (GMC) were keen to get people involved in providing feedback on the standard of services provided by individual doctors. We arranged focus groups in Brighton and Hove to help the GMC improve the 'revalidation of Doctors'.

Helping you find the answers

Healthwatch GP Review

Healthwatch Brighton and Hove decided to undertake a review of GP practices in the city in response to mounting concerns that patients were experiencing difficulties accessing primary care.

Eight practices had closed between 2015 and 2017 leading to concerns about the accessibility of primary care for disadvantaged communities.

We had also received considerable feedback from patients about problems getting GP appointments and long waits for the consultation date.

Compounding these issues was an ongoing reduction in the number of GPs in the city leading to an average of **2,394** patients per FTE GP in 2017, considerably higher than the England average of **1,762**.

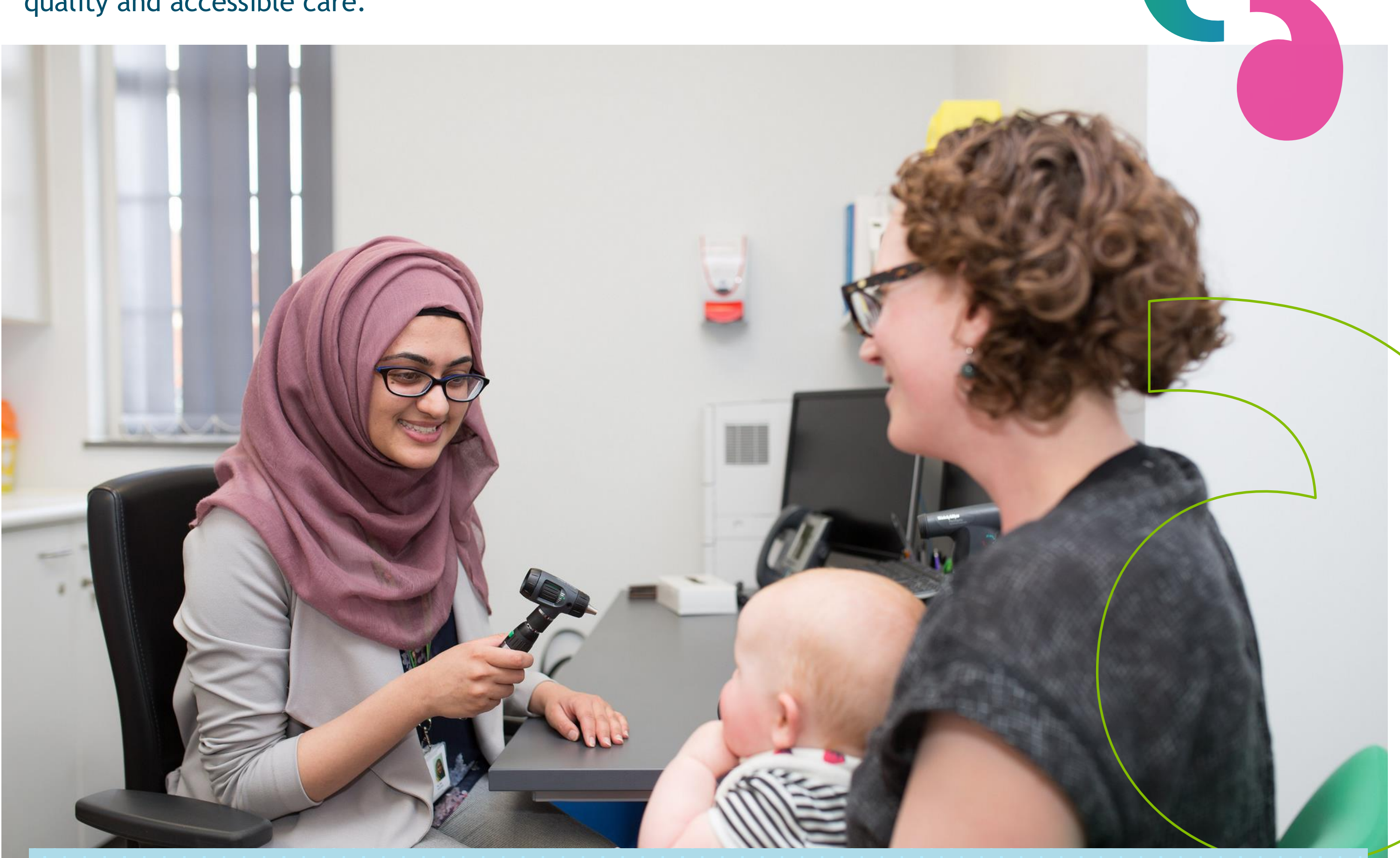
These concerns provided compelling reasons to investigate whether the system was coping with increased pressures and managing to provide high quality and accessible care.

Through the summer of 2017 Healthwatch undertook the largest ever patient-led review of GP surgeries in the city.

We gathered **1,483** questionnaire responses from patients, collecting patient feedback on **40** surgeries and undertaking visits to **30** of the **34** surgeries in operation at the end of 2017.

The review led to **31** individual practice reports that provided detailed information on performance compared to city averages and recommendations for improvement. We liaised closely with practice managers to encourage action on the recommendations made.

An overall report was produced that provided detailed information on city-wide performance against national averages and highlighted variation in quality between practices.



You can read the full GP Review at:
www.healthwatchbrightonandhove.co.uk/Reports/GP-Review-2018.pdf

Using evidence to encourage service improvement

The individual surgery reports made a total of **170** recommendations ranging from improving the timeliness of appointments, punctuality of consultations on the day, improved appointment booking systems and improved seating and signage in waiting areas. **52** of the recommendations were actioned by February 2018 which provided benefits for over **140,000** patients.

The main report made **13** strategic recommendations including improving the consistency of quality across practices, reducing patient caseloads for certain practices, and lower urgent appointment wait times. Healthwatch has met with Brighton and Hove CCG to discuss these issues and actions are being taken to increase practice capacity to meet demand in the city.

"Brighton and Hove CCG welcomed the findings from the Healthwatch GP report.

It highlighted some important opportunities for service improvement and I am confident this will provide an impetus to progress and improvement"

Dr David Supple
Clinical Chair,
Brighton & Hove CCG

Making a difference together

Environmental Audits

Over the last year our volunteers carried out independent monthly audits of 25 wards, departments or clinics within the Brighton and Sussex Hospital Trust (BSUH). BSUH provides key health services across the city and wider area, including responsibility for the main hospitals which serve hundreds of thousands of patients each year.

Our work builds on annual PLACE (Patient-led Assessment of the Care Environment) guidance, and this year we adopted the 'NHS 15-step challenge' to ensure our work was aligned with wider NHS standards. Our work resulted in 114 recommendations being made to the Trust for improving the physical environment of their services.

Three of the audits we undertook were 'follow-up' visits where our volunteers saw for themselves how the Trust had acted upon our earlier recommendations.

Our first report which summarised findings from our independent audits identified nine recurring areas where improvements are needed across the BSUH estate:

1. Improve the quality of patient information
2. Improve signage
3. Promote the consistent use of hand gels
4. Replace/update equipment or furniture
5. Undertake general maintenance sooner
6. Improve/identify better storage facilities
7. Improve ventilation, heating and lighting
8. Review cleaning standards
9. Improve security/safety

Healthwatch was also been pleased to report a large number of positive findings from our audits, including some areas of the BSUH estate which:

- were clean, tidy and well-organised
- had incorporated excellent natural and artificial lighting and ventilation
- included attractive décor, welcome signs and informative notice boards
- had adopted flexible systems of visiting times
- saw staff wearing colour coded uniforms to identify role and seniority.
- had built in low-level reception desks for wheelchair users.
- provided family and friend feedback boxes
- provided an excellent variety of quality seating

"Healthwatch's input is invaluable and promotes engagement with clinical colleagues, reinforcing that things are always considered and viewed from a patient's perspective.

There have been a range of projects that have had a significant impact on our environment, all of which Healthwatch has been instrumental in helping to deliver."

Caroline Davies
Nurse Director, BSUH

How your experiences are helping to influence change

In March 2017, our volunteers visited the two sexual health clinics based in the General Outpatients' building of the Royal Sussex County Hospital and subsequently raised a number of concerns with the Managing Director of the Trust. In September 2017 Healthwatch returned to re-audit both clinics and was pleased to see that a large number of improvements had been made.

Healthwatch applauds the Trust for taking rapid action to improve these clinical environments, which are judged to be safer and cleaner, and which provide more professional and welcoming spaces for patients.

March 2017 Audit Issues identified by Healthwatch	September 2017 Audit Improvements noted
In the summer, windows need to be opened to provide air and private consultations could be overheard.	Air conditioning has been installed and windows are only opened to air rooms, and not during consultations.
Examination rooms were cluttered, in need of decoration and furniture needing replacing.	Rooms have all been redecorated and feel cleaner, airier and less stuffy.
Water had penetrated from the roof staining the ceilings	Parts of the roof had been fixed and staff indicated that water leakage had stopped.
The flooring and skirting boards were stained and worn in places.	White block has been installed into a linking corridor, replacing dirty and worn ceramic tiles.
Some of the original windows were old and rotten.	All windows have been replaced with new UPVC.
The walls and woodwork in many areas were chipped, with holes in some walls from where old sanitisers had been removed.	Holes have been filled, and redecorated.
Furniture was in poor condition.	Reception held a large number of chairs all with wipeable covers and these were in good condition. A larger, specialised chair for those with a disability was also provided.
There is no accessible toilet for bariatric patients in wheelchairs or access to treatment rooms.	A new disabled toilet now exists.
The outside of the building was in poor repair and the parking bays were too small, making it difficult for a disabled person to get out of their vehicle.	The parking bays had been improved. Whilst the number of spaces had been reduced from 3 to 2, those now in use were much larger meaning that disabled patients would be able to manoeuvre in and out of them with greater ease.

Patient Advice and Liaison Service (PALS)

Healthwatch continued its collaboration with the PALS (Patient Advice and Liaison Service) team at BSUH by providing an independent assessment of the way in which they handled complaints.

This year we incorporated nationally recognised standards into our work notably the Patients Association: Good Practice standards for NHS Complaints Handling (2014); My Expectations for raising concerns and complaints (2013); the revised NHS Complaints policy (2017), and Parliamentary and Health Service Ombudsman's Principles of Good Handling (2009).

Our work has focussed on smaller numbers of more detailed cases, on topics such as cancer care, mental health services at A&E, and elderly discharge. We have also reviewed cases which have been investigated and reported by the Parliamentary Services Health Ombudsmen.

Our work identified a number of ways in which the Trust could improve the quality of its response letters which the Trust has adopted including:

- Identifying learning points from complaints so that patients can be reassured that the Trust has taken action to prevent similar issues from arising again
- Explaining all acronyms in full and avoiding jargon
- Adopting a robust system to ensure that all of the points raised in a complaint are identified and addressed.

"We welcome the continuing relationship between Healthwatch Brighton and Hove and the BSUH Patient Experience team."

Jane Carmody
Head of Patient Experience,
PALS and Complaints
BSUH

For further information on the Healthwatch reports mentioned please visit:
www.healthwatchbrightonandhove.co.uk/publications/healthwatch-reports

it starts with
YOU

#ItStartsWithYou

The more people share their ideas, experiences and concerns about NHS and social care, the more services can understand what works, what doesn't and what people want from care in the future.

As the NHS turns **70**, we're encouraging more people to tell us what they think and help make care better for them, their families and their communities. Thanks to people telling local Healthwatch what they think about health and care, services in Brighton and Hove have improved.

But to make the biggest difference, we need to hear from more people. No matter how big or small the issue, we want to hear about it. If it matters to one person, it's very likely that it matters to somebody else.

All of our projects and service reviews start with one person speaking up….”It starts with you….”. If you love the NHS be a 5 minute volunteer - take 5 minutes to contact Healthwatch and tell us how health and care can be improved at Brighton Pulse.

Health & Disability Benefits

Healthwatch undertook its first in-depth examination of the local benefits system. Our report “Personal Independence Payments and Employment Support Allowance: Examining the impact of PIP and ESA assessments on vulnerable people in Brighton and Hove” was published in February and received coverage in the local press, and on local TV in discussion with Caroline Lucas, MP.

We acted after being contacted by MindOut, a local mental health charity for the LGBTQ community, who provided us with several personal testimonies regarding PIP and ESA assessments. In response, Healthwatch spent the summer gathering further evidence from 29 local organisations and delivered a report to the local Council, MPs and providers highlighting the inadequacies of the current system.

The Chair of the Brighton and Hove Adult Safeguarding Board (SAB) has since raised the issues directly with those in charge of Adult Services.

“There is concern in Parliament over the way vulnerable people are treated by the benefits assessment system. Here in the streets of Brighton and Hove we see the reality of decent people trying to live a good life but challenged by chronic ill health treated in a shocking and insensitive way.”

David Liley
CEO Healthwatch Brighton & Hove

Our report identified:

- A lack of empathy shown by some assessors towards vulnerable claimants
- Assessors who sometimes displayed poor knowledge of common medical conditions, especially mental health conditions
- Advocates (who provide advice and support to claimants) being treated with disrespect by some assessors
- Reasonable requests being declined without explanation (e.g. for a home visit)
- Benefits assessment reports that contained factual inaccuracies and which bore little resemblance to assessment interviews
- An assessment approach which appeared to be more about ‘catching people out’ and declining claims rather than actively helping vulnerable people.

Claimant Experiences

“I've had at least three of these, and each time I end up feeling worthless afterwards because they do not acknowledge me as a person”

“Nothing was done or said to put me at ease, I was clearly distressed by the experience, this wasn’t acknowledged at all”

"Basically, I do not recall being asked anything directly about my mental health even though I have a bipolar diagnosis and a history of suicide attempts“

“I spoke about being suicidal, I was asked if I felt I was at risk, this wasn’t asked in a supportive way, more to ‘tick a box’ that they had asked the question”

Recommendations leading to service improvement

Healthwatch, working together with local partners, made a number of recommendations to providers ATOS (for PIP) and Maximus (for ESA):

1. Improve training for assessors to improve the applicant experience; better prepare assessors; and improve the quality of interviews, evidence and reports.
2. Ensure reasonable adjustments are provided; providing home visits for the most vulnerable and improving the physical environments of assessment centres.
3. We urge the providers to undertake a review of how reconsiderations of cases are undertaken as too many of these are later overturned at appeal.

With the support of the local SAB, who work to empower and protect some of the most vulnerable members of our community, Healthwatch plans to meet with the two organisations responsible for delivering these assessments to discuss what improvements can be made to ensure that these providers are answerable to the community they serve.

"Possability People fully supports this report by Healthwatch and believes it highlights some of the fundamental failings in the system"

Possability People
A local charity supporting people living with a disability or long term health condition.

Our people

Our Volunteers

We have a great team of volunteers helping us. Here, some of them explain in their own words, what they have gained through being involved in Healthwatch Brighton and Hove.

Sue Seymour

"I was attracted to Healthwatch by the wide variety of projects undertaken and the opportunity to capture the patient voice. Coming from a non-healthcare background, I was encouraged to attend in-house and local authority training to bring me up to speed. Different projects appeal to different people and I have gained a whole new language and a better understanding of how the NHS works.

We recently visited the emergency departments at the Royal Sussex County Hospital and the Royal Alexandra Children's Hospital. We were particularly interested in patient knowledge of services they could have accessed instead of going directly to the hospital. My involvement in capturing patient experience has contributed to two reports now published.

These reports give us a better understanding of the promotion needed for services like pharmacies, the NHS 111 service and the NHS Choices website. In addition to this, our engagement with patients provides an opportunity for them to tell their story. Patients are always grateful to us for providing the time to listen and represent their views."

"Without the dedication, enthusiasm and committed time given by our volunteers, Healthwatch could not make the positive impact it does."

Michelle Kay
Project Coordinator
Healthwatch

Mike Doodson

"I was looking for the opportunity to help make a positive difference to the healthcare experience of people in Brighton and Hove. At Healthwatch, I have taken part in regular reviews of the patient experience in the Royal Sussex County Hospital. Talking to patients is very enjoyable and gives some valuable insights into the high regard people hold the NHS in.

I also appreciate the way that as a Healthwatch volunteer, we are welcomed by hospital management and our views are respected. I am impressed by the extraordinary amount of trust patients and their relatives have in us when answering our questions. Several patients have shared with me highly personal aspects of their health stories and that make me feel humble.

I am also glad to have been able to help them voice their stories."

For further information on the reports mentioned by our volunteers above, please visit: www.healthwatchbrightonandhove.co.uk/publications/healthwatch-reports

Chris Jennings

"I was attracted to working with Healthwatch in order to help with analysing surveys and writing reports.

I felt this fitted in with experience I had gained at work. I have visited GP surgeries, asking patients to fill out questionnaires.

My main role to date has been helping with the data analysis and report writing for the GP Review published earlier this year.

I find the work with Healthwatch is intellectually challenging, enabling me to use the skills gained in my working career. I have also learnt new things, met new people and feel part of a very worthwhile organisation."

> ***"I find the work with Healthwatch is intellectually challenging, enabling me to use the skills gained in my working career."***
>
> *Volunteer*
> *Chris Jennings*

Vanessa Greenaway

"I was looking for a volunteering role that fitted in with my other care commitments as well as using my skill set.

Healthwatch is very flexible, so that if my personal responsibilities need priority, I can opt out of a project. Equally, I can volunteer several hours a week, if I have the available time.

Healthwatch has given me the opportunity to see how the charitable sector works alongside public services. I have met new and interesting people from different walks of life and have enjoyed working together to contribute to improving the health provision in Brighton and Hove. I found my involvement with the Patient Transport Service review particularly rewarding. We interviewed patients in the dialysis ward and they shared with us their traumatic experiences.

After a number of difficult days spent in renal dialysis, they were often being left for hours waiting for a lift home. In particular, one patient had been taken home in an ambulance called from Nottingham, as the local service was unable to provide the transport.

It is very rewarding to be able to contribute to providing patient experience that will help improve the way a service is provided."

For further information on the reports mentioned by our volunteers above, please visit:
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Authorised Representatives

Healthwatch has 34 Authorised Representatives: Board members, staff and volunteers, who conduct Enter & View visits and those who attended decision-making forums and spoke up for patients and care service users.

We thank them all for their dedication and invaluable support.

Alan Boyd
Barbara Harris
Barbara Marshall
Barbara Myers
Bob Deschene
Carol King
Caroline Whiteman
Catherine Swann
Catherine Will
Charlotte John
Chris Jennings
David Liley
Denise Bartup
Frances McCabe
Geoffrey Bowden
Hilary Martin
Imogen Campbell
James Mann

Louise Spry
Karin Janzon
Lynne Shields
Maureen Smalldridge
Michelle Kay
Michelle Lamb
Mike Doodson
Neil McIntosh
Nick Goslett
Robin Guilleret
Roger Squier
Roland Marden
Sam Hubbert
Sophie Reilly
Sue Seymour
Sylvia New
Tony Benton
Vanessa Greenaway

Our plans for next year

What next?

Our plans for 2018/19 will continue to reflect the views od patients, and staff in the NHS and care services.

We will incorporate evidence from the Joint Strategic Needs Assessment (JSNA), Annual Reports from the local Director of Public Health, and the Healthwatch England research team.

In setting our priorities we'll take note of the priorities of the City Council for social care services and the voluntary sector, and the NHS for health services.

Our top priorities for next year

1. Social care services
2. Support for older frail people when they come home from hospital
3. Counselling and emotional support in schools (Young Healthwatch)
4. A&E - adults and children
5. Dentists and dental services

Our finances

Income & Expenditure

Healthwatch is funded and Commissioned by Brighton and Hove City Council. The funding process is managed carefully to protect our independence and ensure we can speak without fear or favour. We are careful therefore not to be party political but to be evidence based. Independent however does not mean neutral and we are always on the side of service users, promoting their voices.

This has been a year of financial stability and our contract and funding is secure for the next three years. We will be absorbing a reduction in income over the next two years in line with the efficiency savings expected in the public sector.

We should acknowledge that Brighton and Hove Council support to local Healthwatch is excellent in comparison with the national and regional picture.

However in common with many people in Brighton and Hove our staff deserve more reward than we could ever hope to pay them. NHS funding for the City stands at £425m, Social Care costs the City Council £84.8m. The Healthwatch budget is less than £200,000.

We hope you will agree that we provide value for money.

Income	£
Funding received from local authority to deliver local Healthwatch statutory activities	199,000
Additional income	1,430
Total income	200,430
Expenditure	**£**
Operational costs	27,545
Staffing costs	126,574
Office costs	31,937
Total expenditure	186,056
Balance brought forward	14,374

> ***"We can and do make a difference. This keeps me volunteering for Healthwatch."***
>
> **Sue Seymour**
> Healthwatch Volunteer

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Our annual report will be publicly available on our website by 30th June 2018. We will also be sharing it with Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

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Although a formal committee of Brighton & Hove City Council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults and Healthwatch.

Title:	Healthwatch Brighton & Hove Let's Get You Home – a report on the experiences of older people being discharged from the Royal Sussex County Hospital, Brighton from July – September 2018	
Date of Meeting:	19th March 2019	
Report of:	Rob Persey, Executive Director Health & Social Care, Wendy Carberry, Managing Director South, Central Sussex and East Surrey Commissioning Alliance, & David Liley, Chief Executive Healthwatch Brighton & Hove	
Contact:	Barbara Deacon	Tel: 01273 296805
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Wards Affected:	All	

FOR GENERAL RELEASE

Executive Summary

Healthwatch is the local independent consumer champion for health and care and is a co-opted member of both the Brighton & Hove Health Overview & Scrutiny Committee (HOSC) and the Health & Wellbeing Board (HWB).

Each year Healthwatch undertakes a number of reviews which vary in focus and size. This report, 'Let's Get You Home', asked local older people about their experience of getting advice and support when being discharged from hospital to home.

Healthwatch interviewed 80 people in hospital and followed up on 49 people two months later at home. 41% of those who took part were over 80yrs old.

This review (see appendix 1) raises concerns about the quality and consistency of

care planning and a lack of coordination and personalisation of care and includes a number of recommendations. These recommendations have been turned into an action plan (appendix 2) agreed by the bodies concerned.

1. Decisions, recommendations and any options

1.1 That the Board agrees to the following:

1.1.1 to note the report

1.1.2 refer the report to the Health Overview and Scrutiny Committee to monitor how the recommendations are implemented and the outcomes/impact on residents

2. Relevant information

2.1 In the summer of 2018, Healthwatch asked local older people about their experience of getting advice and support when being discharged from hospital to home. Healthwatch interviewed 80 people in hospital and followed up on 49 people two months later at home. 41% of those who took part were over 80 years old.

2.2 The review raises concerns about the quality and consistency of care planning and a lack of coordination and personalisation of care.

- **Personalised care – "make it real…"**
  59% people felt they were not involved or only partly in decisions about their care. Over half of these patients 53% felt they had not been asked for their opinion

- **Integrated health and social care – "make it real…"**
  39% of all patients felt the advice they had received while in hospital was not good enough to prepare them for being at home. 44% of all patients felt they were either not ready or only partly ready to return home.

- **Being in control of your own health and social care – "make it real…"**
  At the time Healthwatch spoke to hospital patients, only 3% had received written advice on discharge planning, 11 people had received a hospital discharge letter, and only two people had received a written care plan.

2.3 The NHS 'Let's get you home' hospital discharge cornerstone initiative of 2017 does not seem to have been rolled out consistently within the Brighton & Hove area to gain traction in implementation. The review has highlighted that there are a number of areas that need improvement. These have led to several recommendations within the report (appendix 1, 7-10).

2.4 In December 2018 Healthwatch Brighton and Hove provided an Interim Report to the local NHS and City Council. These have been translated into actions and can be seen in appendix 2. It is important to note that a number of additional actions including how people are supported in the Discharge Lounge and how to maximise patient comfort during transfers is also underway.

3. Important considerations and implications

3.1 Legal:

There are no legal implications arising from this report which is for noting.

Lawyer consulted: Elizabeth Culbert Date: 20/02/19

3.2 Finance:

There is the potential for financial efficiencies to be obtained by improving the client pathway from hospital through better co-ordination across multiple agencies. Detailed modelling would need to be carried out to ascertain the likely financial impacts from the implementation of the recommendations.

Finance Officer consulted: Sophie Warburton Date: 20/02/2019

3.3 Equalities

The equalities considerations are included within this report.

Supporting documents and information

Appendix1: Let's Get You Home – the Experiences of Older People being discharged from the Royal Sussex County Hospital Brighton from July 2018 – September 2018

Appendix 2: Summary of recommendations and agreed actions to date (to be completed by partners – to follow

“Let’s Get You Home”

The experiences of older people being discharged from the Royal Sussex County Hospital, Brighton from July to September 2018

Published February 2019

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1. "Make it Real" – Executive Summary by David Liley, Healthwatch Chief Executive

The NHS and Brighton City Council are making plans to better integrate health and social care in the City. The way the NHS is managed in Sussex and East Surrey is changing with much closer alignment of Commissioning - purchasing health and care services, over that region. The whole health and care system is dealing with higher demands and funding pressures, many quality and performance targets are not being met and GP's in the City have much higher numbers of patients to treat than in other parts of the country.

In this context Healthwatch asked local older people about their experience of getting advice and support when being discharged from hospital to home. Healthwatch interviewed 80 people in hospital and followed up on 49 people two months later at home. 41% of those who took part were over 80yrs old.

This review raises serious concerns about the quality and consistency of care planning and a lack of coordination and personalisation of care.

Personalised care – "make it real…"

- ✓ 59% people felt they were not involved or only partly in decisions about their care. Over half of these patients 53%[1] felt they had not been asked for their opinion

Integrated health and social care – "make it real…"

- ✓ 39% of all patients[2] felt the advice they had received while in hospital was not good enough to prepare them for being at home. 44% of all patients[3] felt they were either not ready or only partly ready to return home.

Being in control of your own health and social care – "make it real…"

- ✓ At the time we spoke to hospital patients, only 3%[4] had received written advice on discharge planning, 11 people[5] had received a hospital discharge letter, and only two people[6] had received a written care plan.

The NHS 'Let's get you home' hospital discharge cornerstone initiative of 2017 seems to have failed to gain traction in implementation. Healthwatch Brighton and Hove have heard much from local system leaders about integration, personalisation, and people taking more responsibility for their own health. These are all fine words and great intentions but how can we "make it real". The issues

[1] 18 patients, Table 9
[2] 21 patients, Table 51
[3] 26 patients, Table 52
[4] Two patients, Table 14
[5] 17%, Table 14
[6] 3%, Table 14

and failures might be in policy, practice or funding but wherever they are the system is not delivering what it promises for older people.

In December 2018 Healthwatch Brighton and Hove provided an Interim Report to the local NHS and City Council. We welcome the response from the Brighton and Hove Clinical Commissioning Group CCG (printed in section 4 of this full report). They have pledged to act to improve the information and advice given to people on discharge from hospital and on other Healthwatch Brighton and Hove recommendations.

2. Summary of Findings

What we did

Healthwatch ran a project to seek the views of older people (65 years and older) about their experience of hospital discharge. The project collected patient experience from 80 people at the Royal Sussex County Hospital, Brighton, between July and September 2018. Healthwatch volunteers interviewed people in hospital and again post-discharge in their home or other residence.

Our findings

Experience in hospital

High quality of care in hospital: Healthwatch found that 86%[7] of patients spoken to, felt that overall staff had treated them well while in hospital. When asked in hospital, the majority of patients spoken to (71%[8]) were happy with the arrangements being made for leaving hospital.

Inconsistent Information provided to patients:
Almost half the people we visited in hospital (44%[9]) had not been spoken to about what would happen to them after leaving hospital. Two thirds of people (66%[10]) had not received any *written* information at the time we spoke to them.

Lack of personalised care:
The majority of all people felt they were not involved or only partly in decisions (59%[11]) about their care. Over half of these patients (53%[12]) felt they had not been asked for their opinion.

Lengthy stays in hospital:
58% of the people we interviewed in hospital had been admitted for more than six days. 16% of these people had been admitted for over 20 days.

Experience at home

General satisfaction with discharge arrangements at home:
70%[13] of all patients reported that overall, they were satisfied or very satisfied with the discharge arrangements made for them at home.

Inconsistency in service provision at home:
Five patients[14] reported that they did not know who to contact should a problem arise. Four patients did not receive services at home, that they had been told to expect, while in hospital.

[7] 79 patients, Table 2
[8] 35 patients, Table 19
[9] 34 patients, Table 3
[10] 43 patients, Table 14
[11] 41 patients, Table 8
[12] 18 patients, Table 9
[13] 40 patients, Table 54: A combination of patients asked at home and online
[14] 24%, tables 43 and 44

Lack of preparation for returning home:
Once home, 39% of all patients[15] felt the advice they had received while in hospital was not good enough to prepare them for being at home. 44% of all patients[16] felt they were either not ready or only partly ready to return home.

The importance of involving a patient's support network in the discharge process:
Half of patients (52%) spoken to at home mentioned the importance of the support of family and/or friends in their discharge experience.

[15] 21 patients, Table 51
[16] 26 patients, Table 52

3. Recommendations

Healthwatch has identified recommendations in four areas:

- Communication
- Personalised care
- Delayed transfers of care (DoTC)
- Independent living.

Patients and staff highlighted the need for a consistent and standardised approach in discharge planning. People asked to be more involved and to have their opinions considered in the decisions made around their discharge. The majority of people are likely to return to their own homes. It is important that those living alone and unsupported are distinguished from patients who have a strong supportive network of friends and/or family. The following recommendations might help to reduce delayed transfers of care.

Communication

1: Improved patient communication from hospital to home: discharge planning to start within 24 hours after admission; written and verbal communication with every patient, consistent use of one document covering hospital to home patient advice.

Discharge planning should start within 24 hours after admission[17].
Informing patients early on about plans for discharge and giving patients an idea of how long they are likely to be in hospital, could help people and their families make their own plans, and be more involved in planning care with hospital and community care staff. Improving information could include sharing potential discharge dates as early as possible with patients and providing detailed information at the point of discharge.[18]

Written discharge information should be provided to all patients, rather than relying on verbal advice only. Amongst this group of people, some are suffering from memory loss and written information would help ensure that it can be shared most effectively with family members, support networks and professionals who visit the patient.

Communication should be consistent for all patients. Prior to our review, Healthwatch were made aware of two patient leaflets, "Let's get you home" and 'Planning your discharge'. We were advised that the hospital is in the process of combining both into one booklet that meets all discharge information needs. Healthwatch recommends that patients are fully involved in the development of this booklet.

Every patient to receive one document covering all patient advice. The majority of the patients interviewed had not had sight of either of the available leaflets.

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[17] In line with the "Let's get you home" campaign priorities, Sussex & East Surrey Sustainability & Transformation Partnership
[18] See Alan's story in Section 4.

This is disappointing as one of the key recommendations Healthwatch made in 2015 was that the 'discharge booklet' was given out 'as a matter of course for all patients being discharged from the [Royal Sussex County] hospital'.[19]

2: Improved communication between hospital and community-based staff. Information to be consistent, complete and timely; One person should be appointed as having responsibility for the overall discharge planning.
Hospital and community-based staff should share consistent, complete and timely information. To encourage a joined-up approach, one person should be appointed as the main person to ensure safe and sustainable discharge for the patient. With the person, family friends and other support agencies made aware of who this person is.

3. Hospital staff should maintain a written or electronic record of all discussions taken place with patient and family member/carer about the patient's discharge. This information should be held in one form and patients and family members/carers should be given a copy of this form; the *Discharge plan extension form* should be redesigned to allow this information to be recorded.
As recommended above, each patient should receive one written/electronic document containing patient advice. In addition, the written record of all communication between patient, family/carer and hospital staff should be given to patients and shared with community staff.

Personalised Care
4: Patients and family members, carers or those in their support network should be involved in the decisions about the patient's care both during their stay and also regarding what will happen to them on leaving hospital. They should be made fully aware of any choices and given the opportunity to say for themselves what kind of care they might need at home. Where possible, practical and safe to do so these views should be factored into pre- and post-care arrangements; and where not achievable, explanations should always be provided.
Patients and family members should be more involved in decisions around what will happen to them after hospital. Both patients and family members can provide a context for patient need that can inform the type of provision made. While choice cannot be guaranteed, if the patient is aware of the situation, they are less likely to be anxious about the future. People should have an opportunity for their personal preferences to influence the planning and delivery of care in the hospital and at home in line with personalised care.[20]

5: Hospital and community care services should differentiate between patients living with, or regularly supported by family and/or friends, and those living alone and unsupported.
Hospital, Community and Social Care staff should take active steps to identify each person's support network and ensure that family members, carers and friends are

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[19] This followed our review of discharge in the Royal Sussex. Please read our report for further information.
[20] See NHS website for more detail on the importance of personalised care.

involved in decisions. All of these groups can provide essential context to the patient's home environment. Staff should actively consider which networks to directly engage with where the patient does not have any immediate family or a named carer.

People who are living alone and unsupported could be provided with additional visits from support services, and they could receive phone-calls to check that post-discharge arrangements are working well or whether the patient requires anything different. Their GP should be made aware of the persons circumstance so that they can offer additional support where needed. As well as professional support, patients should be advised about local community activities and support groups via the Ageing Well service.

Some people will have a partner or primary carer who is also vulnerable, frail and in poor health. Care plans for hospital discharge and care at home should take that into consideration.

The British Red Cross assisted discharge service[21] brought in for the Winter period 2018 could be extended to around the year. This would assist with the transition from hospital to home. The service could also help with provision of additional phone calls and visits for those living alone and unsupported and those being cared by someone who is also older.

Reduction of delayed transfers of care

6: The hospital should identify and implement workable actions that reduce the number of stranded patients, particularly for this age group (65 years old plus).
Involving people (and their support network) at an early stage in their discharge plan would help identify the patient's needs both in hospital and post discharge. This may also reduce the length of time that patients wait for care packages to be arranged. Nursing staff mobilizing people, or providing physiotherapy in hospital, may help patients to be physically able sooner and this may enable patients to leave hospital earlier.[22]

7: The hospital should maintain services such as blood tests, x-rays and access to medical prescriptions during the weekend at the same level of service as during the week.
Maintaining services at the weekend that reflect those offered during the week, could support the hospital in reducing the number of delayed transfers of care.

[21] The British Red Cross assisted discharge service aims to ease the pressure on hospital services over the busy winter months, and offer extra support to people who might struggle to cope with the transition back to home life.
[22] For example in the case of Alan's story

Independent living

8: All patients who are discharged home, should receive an assessment for independent living and where needed, provided with the appropriate support structure (adaptation) to enable independent living.

Where possible, every patient should be enabled to live independently, with the provision of the right support structure, adaptations, and appropriate advice.

9: All patients should be provided with written advice about living independently post-discharge. This should include advice about how to maintain good hydration and nutrition and how to access local support groups and activities e.g. the Brighton and Hove Ageing Well service.

More advice could be given about living independently, considering the majority of patients were expected to return home. The patient discharge document should include advice about how to maintain better nutrition and hydration.[23] Patients should also receive advice about accessing local support groups and activities via the Brighton and Hove Ageing Well service.

10: Better follow-up arrangements: Every patient to be provided with advice on who is likely to contact them and who they should contact should a problem arise. Each patient to be provided with a suitable support structure at home. Service provision discussed in the hospital should be followed through to service provided at home.

On leaving hospital, all patients should be given information on who is likely to contact them and who to contact should a problem arise at home. Some patients, particularly those who live alone and are unwell, may be fearful of letting people into their homes. This should be included in the patient discharge document.

While in the majority of cases, patients felt ready to go home, there were those who didn't. With these patients, reassurance could be provided by better information and ensuring the appropriate support structure is at home.[24]

Unfortunately, there is a recognition that some patients will never feel ready to go home despite reassurance. Amongst this group of patients will be some that are unable to live independently. It is recognized that sometimes a patient's inability to live independently may not be possible to predict prior to the patient returning home.

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[23] Baden have demonstrated the potential for malnutrition in this age group. The Food Partnership have highlighted the importance of ensuring good nutrition and hydration amongst older people. Age UK are amongst a number of organisations who provide social networking opportunities for older people. They have also highlighted the prevalence of lonliness amongst this age group and have carried out research into ways to prevent isolation through participation.

[24] See John's daughter's story in Section 4.

4. Clinical Commissioning Response to the Interim Report[25]

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3rd January 2019

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Dear David

Re: Healthwatch Brighton's Interim Report on Let's Get You Home

On behalf of Adam Doyle, CEO of the eight Sussex and East Surrey CCGs, I would like to thank Healthwatch for the Interim Report on "Let's Get You Home" which will inform our ongoing improvement journey.

In recognition of the importance of ensuring that patients don't stay in hospital longer than they should the System held a chief officers Delayed Transfers of Care (DToC) summit in August 2018 and agreed to strengthen a number of areas such as the Let's Get You Home (LGYH) policy.

As I am sure you know we have seen significant improvement in DToC from Brighton and Sussex University Hospitals NHS Trust, since that summit, which has seen a reduction from 6% to 3.2% between August and December 2018
The areas from the emerging recommendations (extracted below) we will be taking forward are;

Improved communication

Discharge planning to start within 24 hours after admission; written and verbal communication with every patient, consistent use of one document covering all patient advice.

---

[25] Healthwatch produced an Interim report for key stakeholders distributed at the end of November 2018 with some headline findings and recommendations.

The BSUH LGYH document is being improved and adapted based on one used at Western Hospitals NHS Trust, where they have successfully combined their LGYH and Planning your Discharge booklet, which is a very good document. This will support improved communication and discharge planning with patients and their families.

Patient involvement

All patients (and/or family members) to be involved in decisions and being made aware of any choices. There will be on-going education with ward teams, by the end of quarter one 2019 present at Medical and Nursing Inductions, and the increased discharge team will be able to spend more time on the wards and be able to participate and encourage ward staff to have these early conversations with patients and their families.

Better preparation for independent living post discharge

All patients to receive advice on nutrition and hydration and accessing community groups. BSUH dietetics will provide some information to go into the Discharge Information Leaflets by the end of quarter one 2019.

Better follow-up arrangements:

Every patient to be provided with advice on who to contact should a problem arise and to be provided with a suitable support structure at home. This will also be included in the new Discharge Info leaflet.

'Alan's Story' – BSUH are aware that the Discharge Lounge is not an ideal environment for patients/families or staff. The redevelopment of the discharge lounge will be reviewed by the end of quarter one 2019.

With regards to the manner used by staff members, BSUH will share the report when the final version is released, and discuss patient/customer care with all staff as this is not acceptable that members of the public take away this perception from BSUH.

BSUH have requested more information about Alan's Story, e.g. a date so they can investigate as ordinarily if we have a patient who is unsettled in the discharge lounge they would usually deploy a health care assistant to be with the patient, also it is unusual for the Discharge Lounge to have patients who are very confused as it is deemed not always in the patient's best interest to move multiple times before discharge, because it does unsettle them.

I would like to thank you again for the interim report and we look forward to seeing the final document. In the meantime we will ensure that your recommendations are put in place as part of our work to continually improve care for patients.

Yours sincerely

Wendy Carberry
Managing Director South
Central Sussex and East Surrey Commissioning Alliance

Cc Adam Doyle

5. Introduction

Background

The problem of lengthy stays in hospital is an issue that has been widely recognised by a number of commissioners, providers and researchers. The Department of Health has identified that delayed transfer of care (DToC) is problematic for both patients and hospitals.[26] Muscle-waste has been widely recognised as a result of lengthy stays in hospital;[27] For hospitals, the effect is shortage of beds and their lack of availability to admit Accident & Emergency patients who are requiring admission.

Healthcare providers have made a concerted effort to respond to these concerns. Locally, the Sussex & East Surrey Transformation Partnership created an initiative around "Let's get you home" to prioritise speedy and safe discharge of hospital patients.[28] The NHS Clinical Commissioning Group Brighton and Hove (CCG) have prioritised the reduction of DToCs as a key issue for the local area.[29] In addition, the CCG have identified "frail older people" as a particular group of people they are concern about in their "Caring Together" programme.[30]

Objectives

Healthwatch aimed to gather patient experience of hospital discharge with these issues in mind. In discussion with key stakeholders, the following concerns were raised, namely:

- Increased delayed transfers of care;
- Poor quality of life post-discharge, particularly for older people (65 years of age plus);
- Older people were not receiving the care they required post-discharge, and this included concerns about their diet and well-being.

Project Scope

In developing the project, we chose to speak to older people (65+ years) including those who were considered frail, about their experience of discharge. We considered that this group included a higher number of vulnerable people who were more likely to be adversely affected by delayed discharge. We planned to

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[26] The Kings Fund highlights the issues in 'Delayed transfers of care: a quick guide' including a link to the NHS' *National Audit of intermediate care*. Also worth looking at is The Telegraph's article on a Department of Health pledge to free up beds.
[27] See this article by the British Geriatic Society.
[28] See the "Let's get you home" campaign for further details.
[29] The Brighton and Hove CCG Quality Report in April 2018 stated that DToC's were above target at 9.3%. The CCG Governing Body Meeting (Public) in May 2018 and the Local Accident and Emergency Delivery Board in November 2018 both highlighted the reduction in DoTCs as a target for the current year.
[30] 'Caring Together' programme and more details on 'Caring Together objectives'.

speak to patients prior to discharge (in hospital) and after leaving hospital, wherever they were located.

Our aim was to identify what worked well in the existing discharge process, and what improvements could be made that might decrease the likelihood of the issues mentioned above.

Context

This was a challenging project to manage due to a number of considerations. We interviewed patients in eleven areas of the hospital (ten wards and the discharge lounge)[31] and this needed cooperation from a number of ward managers and other staff. Due to the cohort of patients, we had to consider potential memory loss, fragility, long-term physical and mental conditions and therefore sensitivities in speaking to these patients. We needed to gain consent from the patients to visit them after discharge, and this process took time to work out.

As with all Healthwatch projects, anonymity was important to maintain and we had an added challenge of linking anonymous hospital interviews with anonymous home visits. In addition, we conducted three online surveys, one for patients/carers, and two others aimed at staff who are involved in patient discharge, hospital and community-based staff respectively.

Clinical Commissioning Group Response

Prior to this report we produced an interim report at the end of November 2018 which was circulated to key stakeholders. The Clinical Commissioning Group responded positively to the interim report and their response to our recommendations in that report is attached as Section 4.

[31] Volunteers interviewed patients in the following wards: Catherine James; Egremont; Bristol, Chichester, Jowers, Valance, Overton, Donald Hall, Solomon, Bailey. We also visited the Discharge Lounge. Wards were chosen, as the ones most likely to have a high number of patients aged 65 years and over.

6. Methodology

The project took place between July and September 2018. Healthwatch volunteers interviewed 80 patients (and their family members) in person in the Royal Sussex County Hospital. The majority of patients (76.5%)[32] were from Brighton and Hove and 41% were over 80yrs[33]. Volunteers asked patients whether they had received discharge information and in what format, written or verbal. Patients were asked what type of information they had received (advice, information on support they would receive after hospital etc). We also asked patients what type of support they were expecting and where they expected to go after hospital.[34] With the patient's consent, we also asked the hospital staff some questions on the patient's condition, how long they had been in hospital, where they were likely to go after discharge and what discharge information had been given to the patient.[35]

Gaining consent from the majority of patients, our volunteers successfully visited 49 patients in their homes or other community residence ("home").[36] Patients were visited one – two months after discharge as we felt this would give time for the patient to reflect on their "home" experience. We had also been advised by key stakeholders that patients already received a high volume of professional visitors in the first few weeks after discharge. During these visits, patients were asked if the arrangements they had expected while in hospital, were provided for when they returned "home". They were asked if the arrangements had gone well and they had received the support they needed or if there were any problems with the arrangements made. Patients were also asked if they had been readmitted to hospital since the time our volunteer had visited them in hospital. They were asked what factors had made their discharge arrangements successful or not.[37]

In addition, Healthwatch promoted an online survey to capture the experiences of patients who had been discharged from the Royal Sussex in 2018. This survey asked similar questions to those asked in person, and was available to patients and their family members to respond to. We received 21 responses from the online survey.

The data tables at the end of the report show all questions that were asked of patients and family members/carers and the responses we received.

[32] From 81 patients interviewed in hospital, 62 were from Brighton and Hove. Other patients were from Lewes, Newhaven, Peacehaven, Hassocks, Haywards Heath, and two patients were from outside Sussex. We did not ask this question of those patients who completed the online survey.
[33] See Demographic questions for breakdown of all patient ages including those who responded to the online survey.
[34] See Tables 1 – 19.
[35] See Tables 20 – 32.
[36] See Table A (Supplementary analysis) for where patients went after hospital.
[37] See Tables 33-58.

In addition to patient experience, we promoted two staff surveys, one aimed at the hospital staff and the other, aimed at staff working with patients in the community. Both surveys asked staff whether they felt the discharge process was successful, and what factors made it work or not. We also asked staff for best practice suggestions for a good discharge process. We received seven responses to the community staff survey and two to the hospital staff survey. While this was not enough to provide valid data for full analysis, we have captured staff experience in our section on Systems and Processes.

Our findings are based on all the observations and conversations with patients, carers and staff, supported by the statistical data captured during interviews with patients. The supplementary analysis section under data tables, contains additional analysis including where we compared two questions to identify if there was any relationship between them. We have also included case studies and comments (within the report) directly gathered from patients and some staff, who wanted to tell us their story.

7. Key Findings

Healthwatch identified a number of key findings from the surveys and interviews conducted. We have grouped these into experience in hospital and experience at home and also included a section drawn from the staff surveys we conducted.

The majority of patients spoke highly of hospital staff and the quality of service. However, either lack of or inconsistent communication was the main reason for negative feedback from patients, family members and staff.

Patients felt they wanted more involvement in discussions around discharge plans and by being more involved, they would feel better prepared for going home. The patient experience at home, was dictated by patients having received appropriate advice so they knew what to expect and receiving appropriate service provision. Often the patient experience was positively influenced by a good support network of friends and family.

Experience in hospital

1: Quality of care and overall arrangements.

86%[38] of patients spoken to, felt that overall staff had treated them well while in hospital. Good care and attention can ensure a positive experience for the patient even where the context is difficult (see Charlie's story). Alternatively, patient's can experience a poor discharge where they are not treated appropriately, as with Alan's story.

[I] couldn't praise the staff highly enough for the care received.
Patient

When asked in hospital, the majority of patients spoken to (71%[39]) were happy with the arrangements being made for leaving hospital. However, improvements could be made in a number of areas.

[The staff] have been fantastic.
Patient

[I was treated] like a human...not like a patient.
Patient

2: Advice and information

Sussex & East Surrey Sustainability & Transformation Partnership (the NHS and local council partnership for this area)[40] created an initiative called the "Let's get you home" campaign.[41] This initiative sets out to *"ensure that patients spend no longer than they need to in hospital. It supports people to return home safely or, if this is not possible, to move to a care home or supported housing once their treatment in hospital is complete"*. The initiative includes *"Staff having earlier conversations with patients about how they will leave hospital – usually within 24 hours of being admitted – and being given clear information about their choices."*

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[38] 79 patients, Table 2
[39] 35 patients, Table 19
[40] See SES Health and Care for further information about Sussex & East Surrey Sustainability & Transformation Partnership
[41] See the "Let's Get You Home" campaign for further details.

> *She is happy that her Mum can go home and be adequately cared for.*
> *Patient's daughter*

Some of the patients we interviewed received good advice and information and felt reassured with the discharge plans put in place.

However, almost half of the patients we visited in hospital (44%[42]) had not been spoken to about what would happen to them after leaving hospital. This was confirmed by the staff we spoke to who reported that 48%[43] had not received any information. Also, 32%[44] of hospital patients had no information on how long they would be staying in hospital. Read Peter's story for a personal experience of this.

> *It is always me asking about discharge. The staff tell me that they have no idea when I will be discharged…it is patient driven.*
> *Patient*

27%[45] of patients who completed our online survey responded that they had not received any discharge information by the time they left hospital.

Two thirds of patients (66%[46]) had not received any *written* information at the time we spoke to them. This included seven patients who had already been discharged (responding to our public survey)[47]. There was a lack of consistency with the information received. While 11 patients[48] received a discharge letter, only 3%[49] were handed a copy of the "Let's get you home" leaflet and only one patient[50] had received 'planning your discharge booklet'. Two had received a copy of their care plan.[51]

When we asked staff the same question, their records showed that more patients had received written information than the patients remembered themselves (26 hospital patients had received something written as opposed to 16 recalled by patients themselves)[52]. However, staff explained that 37% of those who had been given information (13 patients), received it verbally only.[53]

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[42] 34 patients, Table 3
[43] 32 patients, Table 28
[44] 19 patients, Table 6
[45] 4 patients, Table 3
[46] 43 patients, Table 14
[47] Of the hospital patients we spoke to, all had been in hospital at least one day and 94% had been in two days or more. All patients met the criteria stated in the "Let's get you home" campaign. See Table 21 for days in hospital.
[48] 17%, Table 14
[49] Two patients, Table 14
[50] 2%, Table 14
[51] 3%, Table 14
[52] Table 29
[53] Table 29

Our findings show that there is a general lack of standardisation in the way information is provided to the patient. This finding was also reflected in our Healthwatch Complaints Review meeting held in November 2018.[54]

Recommendation: Healthwatch recommends that discharge planning (and communication with patients) should begin earlier in line with the "Let's get you home" campaign pledge.[55] Communication should be consistent for all patients. This should be provided in written as well as verbal form and consist of one document covering all patient advice.

3: Preparation for home living

The majority of patients (85%[56]) expected to return home after hospital. Of those patients we visited, 80% (39 patients) did return home, with a further four patients (8%) who went to live with family.[57] However, there were variances in the completeness and quality of advice given that would enable a patient to live independently at home. Of the 39 patients who responded to this question in hospital:

- Nine patients (23%) had been provided with advice on home help (with shopping, cleaning etc);
- Two patients (5%) had been advised about Telecare;[58]
- Another two (5%) had received advice about District nurses;
- One patient had received advice on diet and liquid intake;
- No one had received advice on social groups and local activities.[59]

With concerns about the potential for malnutrition in this age group[60], it is important that discharge information includes advice about good nutrition and hydration. Also, that it includes suggestions on how to access local groups that can support the patient with these needs post discharge.[61]

With those who responded to this question in the public survey, only a small proportion had received any advice.[62]

Recommendation: All patients should be provided with written advice about living independently post-discharge. This should include advice about how to maintain good hydration and nutrition as well how to access support groups and activities via the Ageing Well service.

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[54] The Healthwatch Complaints Peer Review meeting was held on 27th November 2018. Four complaints presented at the meeting demonstrated that the discharge procedure was dependent on the capability of the individual staff and recommended that more standardisation was required.
[55] "Let's get you home" campaign priorities, Sussex & East Surrey Sustainability & Transformation Partnership
[56] 62 patients, Table 4
[57] See Table A in Supplementary Analysis.
[58] A Telecare Alarm service provides elderly people who live alone with 24-hour access to somebody to call for help if they suffer a fall, feel unwell or need some reassurance.
[59] All Table 7
[60] See the Bapen website for more information on this.
[61] For example, The Food Partnership.
[62] Two patients, 29%, Table 7

4: Personalised care

"Personalised care means people have choice and control over the way their care is planned and delivered" as stated by the NHS England website.[63]

The majority of all patients felt they were not involved or only partly in decisions (59%[64]) about their care. Over half of these patients (53%[65]) felt they had not been asked for their opinion.

> *[I felt staff were] treating the illness and not the patient.*
> Patient

Half of all patients (50%[66]) were either not helped to understand their options or only partly helped. Of these patients, only just over a third (37%[67]) were given the option to clarify anything they had not understood. Being given the chance to raise questions, and being helped to understand that information is critical to the patient discharge experience as is shown in the positive story from Charlie.

> *I am Italian and they helped me to understand [the information].*
> Patient

Patients and family members can provide a context for patient need that can inform the type of provision made. While choice cannot be guaranteed, if the patient is aware of the situation, they are less likely to be anxious about the future. People should have an opportunity for their personal preferences to influence the planning and delivery of care in the hospital and at home in line with personalised care.[68] It is important to recognise that despite a need for physical support, many amongst this patient cohort are independent and are very capable of stating what care they require once leaving hospital.

> *I have been through this before several times and didn't need much advice.*
> Patient

Recommendation: Patients and family members, carers or those in their support network should be involved in the decisions about the patient's care both during their stay and also around what will happen to them on leaving hospital.

They should be made fully aware of any choices and given the opportunity to say for themselves what kind of care they might need at home. Where possible, practical and safe to do so, these views should be factored into pre- and post-care arrangements; and where not achievable, explanations should always be provided.

[63] See NHS Website for further details.
[64] 41 patients, Table 8
[65] 18 patients, Table 9
[66] 29 patients, Table 10
[67] 11, table 11
[68] See NHS website for more detail on the importance of personalised care.

5: Delayed Discharge - "Stranded Patients"

NHS England defines "stranded patients" as those patients who have been in hospital for more than six days. They also discuss long stay patients as those who have been in hospital for more than 20 days and this is commonly known as "super stranded".[69]

58% of the patients we interviewed in hospital are considered "stranded" by this definition and 16% of these patients were "super stranded" at the time of interview.[70] By adding on the likely time they had remaining before discharge, the stranded numbers increased to 88% in total (with 39% of these super stranded).[71] These high numbers suggest extended hospital stays are an ongoing issue. The hospital should take action to reduce these numbers and achieve the commitment made in the "Let's Get you Home" campaign.

It is well-documented that "bedrest in hospital over 10 days leads to 10 years of muscle ageing for people over 80."[72] From all patients surveyed, 41% (34)[73] were in this age group. Particularly poignant is one patient's story, where his wife felt his long stay in hospital had been detrimental to his progress, both physically and mentally (see Clarissa's story).

Recommendation: The hospital should identify and implement workable actions that reduce the number of stranded patients, particularly for this age group (65 years old plus).

They have lost test results which has meant it has been repeated and delayed potential discharge.
Patient

24% (14)[74] of all patients felt their discharge was later than expected. In the majority of cases this was less than five days.[75] Reasons were various and included waiting for care packages to be put in place.[76] Some patients referred to delayed discharge due to *"lost tests"* (one patient) and waiting for medication (one patient). Another patient commented that they were not given enough time to make arrangements. After a period of no information, there was a *"sudden announcement that [I was] going home that day."* The result was a delay of one day to ensure the patient could make appropriate arrangements.

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[69] See the NHS June 2018 paper 'Guide to reducing long hospital stays' for more details.
[70] See Tables B and 21 in supplementary analysis. 42% (29 patients) were stranded and 16% (11 patients) were super-stranded.
[71] See Table B in supplementary analysis.
[72] See "Guide to reducing long hospital stays", page 44.
[73] See Demographic questions.
[74] See Table 16
[75] 85% (11 patients), Table 17
[76] Table 18

I was told on the Wednesday that I was ready to go home …nothing happened over the weekend so it dragged on until the Monday. I was told not a lot happens over the weekend - why not?

Patient

Several patients we spoke to commented on delays due to lack of service provision at the weekend. One patient commented: "[It] all happened at the weekend and they don't do blood tests at the weekend" so they had to wait until Monday. In two cases, patients felt they were sent home too quickly.

Recommendation: Hospital staff should keep patients informed as early as possible about potential discharge dates.

The hospital should maintain services such as blood tests, x-rays and access to medical prescriptions during the weekend at the same level of service as during the week.

Experience at Home

6: Overall experience at Home

70%[77] of all patients reported that overall, they were satisfied or very satisfied with the discharge arrangements made for them at home.
The main reasons patients gave as to why they felt the home experience had been effective[78] were around:

- Available and understandable information (54%[79]);
- Access to and understanding about medication (58%[80]);
- Suitable arrangements being in place (34%[81]);
- Ability to access support (38%[82]);
- Ability to self-manage (26%)[83].

The majority of patients (71%[84]) reported effective or very effective arrangements. However, where it went wrong, this was related to a number of things.

- Lack of information or understanding of information (10%[85]);
- Inability to access support (6%[86]);
- Incomplete adaptations or absent arrangements at home (14%[87]);
- Lack of ability to self-manage.[88]

[77] 40 patients, Table 54: A combination of patients asked at home and online
[78] Table 36
[79] 27 patients, Table 36
[80] 29 patients, Table 36
[81] 17 patients, Table 36
[82] 19 patients, Table 36
[83] 13 patients, Table 36
[84] 42 patients, Table 37
[85] Five patients, Table 36
[86] Three patients, Table 36
[87] Seven patients, Table 36
[88] Four patients, 8%, Table 36

7: Service provision at home

The majority of patients (76%[89]) felt support at home had been good or very good. For some patients like John (see John's daughter's story) the service provision went above and beyond expectations.

However, five patients[90] reported that they did not know who to contact should a problem arise. Other patients did not receive the care they had expected. In Simon's Daughter's Story, Simon did not receive the follow-up care he needed or the adaptations he required. From those who were interviewed at home, two patients (33%)[91] didn't receive physiotherapy and another two patients (67%)[92] didn't receive speech therapy. All four patients had expected to receive these services when they were asked about this in hospital. One stroke patient had been receiving speech therapy for six months following an earlier hospital admission. After readmission, there *"seems to be a wait before the next sessions begin."* Another stroke patient was due to receive speech therapy but this took two months before the appointment was arranged and then cancelled before it took place. For a third patient, the lack of physiotherapy provision at home is illustrated by Clarissa's experience with Ernest.

> *I cancelled [the speech therapist] after they cancelled me.*
> *Patient*

> *I just want a physio to help him walk again.*
> *Patient*

For other patients, it was not the lack of provision that was the issue so much as not knowing who to expect or when. The care provision for one patient was not *"joined up"*. She was happy that she was being looked after, but she received *"a lot of unexpected visitors and [is] not always sure who [is] coming and why."*

Recommendations:
As part of the discharge information provided all patients should be provided with advice on who they should contact should a problem arise at home.

All patients who are discharged home should receive an assessment for independent living and where needed, provided with the appropriate support structure (adaptation) to enable independent living.

Service provision discussed in the hospital should be followed through to service provided at home.

Service provision should be "joined up" between community services and the patient kept informed in advance of visitors.

[89] 42 patients, Table 45
[90] 24%, tables 43 and 44
[91] See Comparative Table A
[92] See Comparative Table A

8: Advice and information

Once at home 39% of all patients[93] felt the advice they had received was not good. This included two patients who had not been informed about the option of the patient transport service.[94] 44% of all patients[95] felt they were either not ready or only partly ready to return home. Reasons given for not feeling ready were various:

- Lack of information or understanding about information provided (13%[96]);
- Unable to access support (9%[97]);
- Inability to self-manage (11%[98]).

> *The letter was the same one as [my] doctor was getting and [I] didn't understand the meaning of all the words.*
>
> Patient

One patient who responded to our online survey reported they were 'discharged from hospital in a rush' without any support or information, that their 'head was spinning'.

Of those patients we interviewed at home 26 patients rated the advice and information either good or very good and all 26 (100%)[99] were either satisfied or very satisfied with the discharge arrangements. Similarly, 10 patients we interviewed at home felt the advice and information was poor and seven of these patients (70%)[100] were also unsatisfied with the discharge arrangements. We might expect advice received and satisfaction with arrangements to be linked. However, this strong connection indicates just how important good advice and information is to ensuring discharge arrangements work effectively.

Recommendations:
Communication should be consistent for all patients. This should be provided in written as well as verbal form and consist of one document covering all patient advice.

9: Family and Friend Support

Half of patients (52%) spoken to at home mentioned the importance of the support of family and/or friends in their discharge experience. 10 of these patients (21%) mentioned they were living with a family member (or partner).[101] This context was often reflected in the answers given to how well the discharge process had gone. It is therefore worth recognising that those supported by family and friends

[93] 21 patients, Table 51
[94] One patient arranged for a friend to pick them up. However, the other patient did not have this option and was taken to the discharge lounge from 9am and waited until 5pm when a friend was available to collect them.
[95] 26 patients, Table 52
[96] Six patients, Table 53
[97] Four patients, Table 53
[98] Five patients, Table 53
[99] See Table D in supplementary Analysis.
[100] See Table D in supplementary Analysis.
[101] Patients were not asked explicitly whether they had family or friends support. Therefore, the numbers given here (25 and 10 respectively) are the numbers of patients who mentioned family or friends support within the narrative answers to our home questions (total 49 patients).

may not have the same requirements for professional support as those who do not have a support structure.

Several patients mentioned that family members were involved in hospital discussions speaking *"to the consultant"* about the patient's *"care at home."* In some cases, it was due to the proactivity of the family that discharge information was received at all:

"[My] family had to help a lot to get this information…[as they found it] difficult […] to get the information [they] needed to help [the patient]."
It was also sometimes due to the family member that the patient was helped to make decisions: *"My daughter is involved as well…she helps me to make decisions'.*

My daughter has been fantastic and has popped in everyday to see if I need anything. She helps me to stay positive and think about the future. I love it when my noisy grandchildren pop in.
Patient

At home, some patients were helped with *"acquiring medication and food."* In some cases, a relative *"makes most of the arrangements"* so there was little requirement for professional arrangements to be made. Several patients commented that family members researched the care home options as *"we had to find out information for ourselves." "There was no help from the staff with this."*

Recommendation: Hospital staff should differentiate between patients living with, or regularly supported by family and/or friends, and those living alone and unsupported.

Patients who are living alone and unsupported are likely to need additional support post-discharge and this context should be factored into the discharge plan. For example, these patients should be provided with additional visits from support services, and they should receive phone-calls to check that post-discharge arrangements are working well or whether the patient requires anything different. Their GP should be made aware of the patient's circumstances so that they can offer additional support where needed. As well as professional support, patients should be advised about local community activities and support groups via the Ageing Well service.

I am a member of the local church and have really good friends who will help me.
Patient

In one case, it was due to friends intervening that ensured the patient received support at home. Described by a friend as someone "who was *used to being independent"*, the patient may not have provided a true picture of their ability to live alone. Friends stepped in, spoke to the Doctor and a short-term care package was provided to get the patient back on their feet again. It should be recognised that family and friends can shed light on the contextual needs of the patient, as in "Simon's Daughter's Story".

Recommendation: Family should be given the opportunity to assist staff in understanding the patient's situation. In the case of no family being available, appropriate friends who are akin to a family connection should be involved in these discussions.

For those without any support, patients experienced "*loneliness*" and even where the discharge process had gone well, a patient may "*just not want to return home.*"

[I am] most worried about going to an empty house as [my] dog died a few days before admission.
Patient

Recommendation: Home arrangements should include regular visits for those living alone and particularly where the patient has mobility issues. Patients should be advised about local community activities and support groups via the Ageing Well service.

Other patients experienced a change of situation. *"On leaving hospital, [they] were given enough information for [them] to manage."* Once home their main carer *"became ill too"* and the requirement for support changed.

Recommendation: Consideration should also be given to those patients, where the main carer is older themselves and may also have health problems.

10: Systems and Process: Staff views

We did not gain a high enough number of responses to provide valid data for a full analysis.[102] Of those who did respond, one social worker referred to lack of resources, both in *"staffing"* and in *"step down beds [for patients who] are medically fit to be discharged [but require] rehabilitation"* before returning home. Lack of resources in the community was also seen as a challenge to good discharge picked up in the Healthwatch Complaints Review meeting in November this year.[103] The majority of comments, however, were around communication and information.

Poor communication internally and between hospital staff and community-based staff were the main reasons given by hospital staff for the discharge process not working.[104]

[102] We received seven responses from community based staff two from hospital staff.
[103] Healthwatch noted that staff shortages paid a large part in the complaints reviewed and were linked to poor hospital discharge. It was suggested in the meeting that there was a role for voluntary organisations to help more formally in discharge.
[104] Both respondents to the hospital staff survey chose these options as the primary reasons for the discharge process not working.

Some referrals have all the relevant information, others have very poor information.
Hospice professional

Similarly, respondents to the community staff survey felt that information from the hospital was **inconsistent and sometimes incomplete.** One hospice professional commented that some referrals made by *"general staff" (rather than the "Hospital palliative care team"*), do not contain all the information. With the specific context missing (e.g. if the patient has *"diarrhoea, confusion"*), the patient could be wrongly placed in the Hospice when *"the patient would have been better off in a care home."* A nursing home professional commented that important information such as *"incidents [including those relevant to safeguarding] that have happened in hospital are [sometimes missing]."* This can affect the ability of the nursing home to put appropriate post-discharge care in place.

Missing information such as next of kin and incomplete medication can create *"a lot of extra work."*(Hospice professional) Reasons behind decisions are sometimes not given: *"why a catheter has been inserted"*(nursing home professional) or why medications have been stopped (GP). The need for better communication between hospital and care home (and care home assessors) was also recommended to staff in the Healthwatch Complaints Review meeting. In particular, providing the care home with a discharge summary containing clear advice about the discharge needs of the patient.[105]

We have had occasions when we have not been informed and an ambulance has turned up - on one occasion I was unable to accept the resident and they had to return to hospital.
Hospice professional

Information from the hospital could be **provided earlier.** *"We get the [discharge] summaries too late […] 2-3 days after discharge [rather than] prior to discharge."*(GP); *"Often we will not know that the patient has been discharged until some days/weeks after discharge."*(Clinical nurse specialist). This can lead to the onward care provision not being ready to accept the patient: The Hospital doesn't *"communicate a time"* with the nursing home and the patient is discharged *"past [the] hours [we can] accept a discharge [patient]."*(Nursing home professional)

[105] The review picked up good as well as poor practice. Staff were reminded of the importance of proper communication between Care homes (and assessors).

Better **joined up communication** between patient, family, hospital staff and community-based staff is important. The process can go wrong, when the *"patient/family are unclear about why the patient is coming to [the] in-patient unit."* It is important that *"patient and/or family have made an informed decision."* (Hospice professional). Equally, involving Social workers can have an impact in the care provided post-discharge. Providing insight to the patient's context, one social worker cited two occasions where their intervention with the hospital meant the patient was discharged to appropriate care in the community.

Patients and relatives can have unrealistic expectations of what care we can provide in the community.
Hospice professional

Recommendation: Communication between hospital staff and community-based staff should be consistent, complete and produced in a timely fashion.

One hospital staff member should be appointed as the main person to ensure safe and sustainable discharge for the patient. This will also encourage a joined-up approach between the hospital and all community services involved in the patients care, pre- and post-discharge.

In addition to the survey, one of our volunteers spoke in person to hospital staff about the discharge process and this highlighted some interesting findings.

There are a number of patient forms that are completed by hospital staff. These include:

- *The Admission, Assessment, Transfer and Referral Document* completed on patient arrival, which contains existing care arrangements.
- The *Discharge Planner*, described by our volunteer as *"an impressive and comprehensive document."* Used from day one of the patient arrival, this should record every discussion with the patient and family/carer, about the patient's discharge plans.
- The *Discharge Summary Form*, a clinical document for the patient's GP and pharmacist to describe the patient's medication needs.

However, there appears to be a number of weaknesses with these documents, primarily:

1. There is no *one* document containing all patient information.
2. The *Discharge Planner* is not given to patients. Our volunteer spoke to one hospital staff member who realised this *"could be a significant weakness especially for dementia patients or elderly patients [...] with poor memories."*

3. If space on the *Discharge Planner* runs out, the *Discharge plan extension form* is used. However, there is no space on this form to record whether the plan was discussed (or with who).
4. The *Discharge Summary Form* given to patients, contains clinical language which *“sometimes [contains] indecipherable abbreviations”* according to one GP.[106]
5. Also as the GP receives the *Discharge summary form* electronically while the patient is sometimes transferred to the discharge lounge without medication, it is possible the patient may go home without medication and therefore there could be an assumption by the GP that the patient is taking medication where in fact they are not.
6. Our volunteer spoke to a number of hospital staff and it seemed as if no *“written discharge plan is given to anybody, whether patient or carer.”*

There appears to be good intention in producing forms that contain useful information to hospital staff, community staff as well as patients and their family members/carers. However, the information is inconsistent, sometimes indecipherable and incomplete and not produced in a timely fashion.

Recommendation: Hospital staff should maintain a written record of all discussions taken place with patient and family member/carer about the patient’s discharge. This information should be held in one form and patients and family members/carers should be given a copy of this form; the extension form should be redesigned to allow this information to be recorded.

[106] This was in response to our community staff survey.

8. Conclusion

Hospital and community-based staff are often under pressure from lack of resources and high numbers of patients. The majority of patients we interviewed spoke highly of staff and the quality of care they received. However, Healthwatch identified a number of areas that could be improved and we believe that many of these are relatively easy to implement. They should also greatly increase patient's preparation for their discharge and care arrangements afterwards.

Both patients and staff spoke about the need for a consistent and standardised approach in discharge planning. Patients asked to be more involved and to have their opinions considered in the decisions made around their discharge. As the majority of patients are likely to return home, it is important that discharge plans prioritise supporting patients to live independently. These concerns are in line with the "Let's Get You Home" campaign and the local CCG's prioritising of reducing delayed transfers of care.

Within this cohort of patients there are many that are vulnerable, living alone and need a high degree of professional support. The discharge plan should take this into consideration. These patients can be offered additional visits from support services, and/or phone-calls to check that post-discharge arrangements are working well or whether the patient requires anything different. Their GP should be made aware of the patient's circumstances so that they can offer additional support where needed. As well as professional support, patients should be advised about local community activities and support groups via the Ageing Well service. By offering additional support and advice, this could lead to a reduction in patients returning to hospital with conditions related to malnutrition and hydration, or caused by loneliness and self-neglect.

However, there are patients within this group who are independent and who already have a strong family or friendship network and this differentiation should be taken into consideration when putting together their discharge plan. Their support network (friends, family or carers) should be involved in the decisions around the patient's discharge plan, as they can help provide a context that could ensure that appropriate plans are made.

By differentiating patients in this way and providing the personalised care as defined by the NHS, the hospital would improve patient experience of being discharged. The hospital may also be able to reduce delayed transfers of care and prevent repeat admissions.

9. Thanks

We are indebted to a number of people who enabled this project to succeed. Our thanks go to the hospital staff and management, particularly Caroline Davies and Sara Allen, who enabled us to access patients across 11 wards.[107]

To ensure we gathered data both before and after discharge, patients were asked to consent to our volunteers visiting them in their place of residence. As this was often their own home, we are indebted to the kindness of these patients and their families for enabling us to visit them. We are also grateful for the openness and honesty in offering feedback on their experiences.

Two people have provided invaluable advice throughout the project, and we would like to thank Marlize Phillips, Royal Sussex County Hospital, Rapid Discharge Team and Sharlene Small, Crossroads Care.[108]

We would also like to thank Graham Hawkes (previously CEO for Healthwatch Hillingdon) and Dr Lizzie Ward (Principal Research Fellow, University of Brighton). Both of whom provided advice and learning from related projects.

Lastly and certainly not least, thanks go to our dedicated team of volunteers: Mike Doodson, Jacqueline Goodchild, Nick Goslett, Chris Jennings, Frances McCabe, Sylvia New, Sue Seymour, Lynne Shields, Roger Squier, Alli Willmore. From providing insight to the draft patient questions, carrying out pilot interviews, to interviewing over 80 patients in hospital and ensuring follow-up of 49 of these patients. In addition, Chris Jennings provided additional help with preparing data for analysis that was invaluable.

[107] We visited patients in ten wards and the discharge lounge.
[108] See Crossroads website for further detail.

10. Patients' Stories

"Charlie's story": A positive discharge experience

This patient received good advice and was involved in the decisions made concerning his discharge. This contributed to a good experience despite the difficult context of his condition.

Charlie is in his late 60's. He had a routine bowel screening test which turned out positive and was given a colonoscopy within two weeks. He was told immediately that he had bowel cancer and was followed up with a one and a half hour conversation with a specialist nurse on what would happen next. He was given lots of time for questions and to raise concerns. He was told to bring someone with him and his daughter was also able to support him through the process.

He was operated upon within two weeks. Having received the initial interview, he felt confident about what was happening. He stayed in hospital, which was what he expected. His discharge went well. He had already received plenty of leaflets from the first visit so he only felt he needed a GP letter.

Within two weeks, as he had been told, he was given the results of the surgery. He has visited his GP and is to see the surgeon next week. He feels the whole experience was exemplary and is very optimistic about the future.

“Alan’s Story”: How lessons can be learned from a poor patient experience

This patient experienced poor quality of care and lack of information at the point of discharge. He also felt that lack of physiotherapy in hospital did not prepare him for going home.

Alan was admitted to A&E and diagnosed with a pelvic fracture, sustained after an accidental fall. After waiting over an hour and a half for an ambulance, and being told he could wait another two hours, he was lifted and brought to hospital in a taxi.

He received “very good treatment” in A&E and in the Acute Assessment Unit (admitted for one day). However, he felt his treatment in Jowers Ward was very poor.

He wanted to be out of hospital as soon as possible, but was concerned that he would not be able to care for his wife who has Alzheimer’s until he was physically fit. However, he was provided with no physiotherapy while in hospital and felt this meant his stay in hospital was longer than necessary. The reason given to Alan for not providing physiotherapy was that “I had been moved from one ward to another and missed it.”

On the day of discharge, a physiotherapist/occupational therapist visited Alan with a zimmer frame and invited him to walk to the toilet and back. This was the first time he had been out of bed or walked for a week.

At 10am, Alan was advised that he could leave hospital. However, he was left in the ward “blocking a bed” for several hours. Later that same day, he was wheeled to “an exceptionally small, scruffy, poorly furnished room at the front of the Barry Building.”

Having sat around for some time with no information, Alan’s son asked the receptionist how long it would be before they would be going, only to be told in an “offhand manner”, ‘Oh, it could be three hours. They are very busy’. The reception staff made it clear that they did not want to be bothered with questions. Alan was finally discharged at 6pm that day.

In addition to his own lack of care, Alan was distressed by the treatment of a lady, also in the waiting room. She was still in her hospital gown, clearly with dementia, and who kept getting out of her seat. She had no one with her to assist with this, despite being “very wobbly clutching her blanket.”

The lack of hygiene in the waiting area, the absence of care to both himself and the lady he was waiting with and poor communication contributed to a very poor discharge experience for Alan.

His daughter added ‘The reception created unnecessary tension. A smile and friendly manner, a bit of information and some reassurance all would have changed the experience into a positive one.’

“Peter’s Story”: How lessons can be learned from a poor patient experience

This patient experienced poor communication both prior to and following discharge on two hospital admissions.

First admission to the Royal Sussex
Peter was admitted to hospital and discharged one week later. He had to wait an hour in the discharge lounge to get his medicines as these weren’t ready. He described this as a miserable place to be in. His family collected and took him home.

He was not given any information prior to his discharge. However, he was aware that he was being discharged and was ready to go home. He did not receive any calls or visits from anyone once at home. He would have preferred better information prior to discharge and he would have liked a follow-up call.

Readmission to the Royal Sussex
About a week after his first discharge he felt unwell, sick and tired. He therefore attended A&E a couple of days after this.

After spending over 24 hours in A&E, he was readmitted onto a ward.

After eight days, he was discharged from this ward direct to the Sussex Cancer Centre. However, he was given no prior information that this was happening. Overall, he felt the discharge was very poor.

Discharge from the Sussex Cancer Centre
His experience at the Sussex Cancer Centre was brilliant- no complaints at all.

The discharge process was also very good. He remained in his ward until it was time to go. His medicines were handed to him in person whilst still on the ward. He was also given information about what these were and how to take them, together with contact information. However, the numbers provided to him didn’t work when he tried them later and he was directed from one person to another and ultimately to 111.

After his discharge he only received one call and this was to check if he was feeling well enough to attend for his scheduled appointment. He didn’t hear from or see anyone else.

"Clarissa's story about caring for Ernest": How lessons can be learned from a poor patient experience

This couple experienced communication issues from the hospital, potentially an overlong stay in hospital for Ernest, and did not receive the service provision required at home.

Ernest has dementia and Clarissa, his wife, is his full-time carer.

Clarissa explained how they had care support from Apex four times a day (NHS funded) which gave Clarissa time to do things around the house. They are also paying for regular support from Crossroads for someone to play games with Ernest to 'keep his mind active'. Clarissa also explained that they pay for weekend support from another care company.

Ernest had recently had a stroke and an ambulance was called. The paramedics suggested that he be taken to hospital, not due to the stroke which was resolved, but due to the knee pain he was still experiencing from an operation on his leg he had had earlier this year.

This hospital visit resulted in a nine hour wait in A&E, due to 'no bed being available for Ernest'. Clarissa couldn't understand why they had to wait so long for a scan and x-ray, which in the end just confirmed what she already knew – that the pain was due to Ernest's previous operation.

More frustrating for Clarissa, was the hospital's decision to admit Ernest. His stay was five weeks in total and Clarissa wants to know why he needed to be in so long. She feels strongly that this 'put us back six months' in terms of Ernest's ability to walk and in his confidence in general. Prior to his hospital admission, Ernest's walking was limited but now he requires constant help to move around their bungalow and he no longer enjoys sitting in the conservatory. He also lost a stone of weight while in hospital.

Having been in hospital for this length of time, meant Clarissa had to reinstate the care support that Ernest had received, prior to his admission. Clarissa repeated several times that she had requested a physiotherapist in hospital but has not received this support for Ernest. They were visited by the equipment and adaptation service, Adult Social Care, where the only requirement Clarissa had was for a ramp from the front door down to the drive. They have not received any follow-up on this. They also discussed mental health support to help with Ernest's confidence but again, there has been no follow-up.

“John’s daughter’s story”: A positive discharge story

This patient received excellent service provision by community staff. He also experience smooth discharges from two hospital admissions.

John has poor short memory and therefore our volunteer spoke to his daughter.

John was discharged from the hospital in early October. He was discharged to a care home (as the family were on holiday at the time and unsure when he would be discharged) but subsequently moved in to stay with his daughter. The daughter explained that their experience had been excellent. John had been visited at his daughter’s home by occupational therapists, physiotherapists and care link. They had been supplied with all the adaptions equipment John needed. The lady from Carelink was fantastic and helped push along their application to have John moved into sheltered accommodation. The occupational therapists were described as going “above and beyond” their expectations. The only negative was the social worker who was apparently unhelpful.

John was admitted back into hospital three weeks after his first discharge. The occupational therapists had noticed that he wasn’t well and his GP advised that he returned to hospital as soon as possible. John had suspected pneumonia and possible norovirus. John stayed in for a week. His second discharge was again very good and the family have no complaints or concerns about the process – quite the opposite in fact. John was offered, but refused a care package at the point of second discharge. The occupational therapists followed this up around a week later to check that he hadn’t changed his mind.

The only thing the daughter couldn’t advise was what - if any – information John had been given prior to his discharge. But their post discharge experience had been excellent.

“Simon’s Daughter’s Story”: How lessons can be learned from a poor patient experience

This patient received poor communication in hospital regarding his discharge plans, including lack of information about why plans changed. His family were not kept informed either. Post discharge he did not receive the service provision he required.

There was confusion over where my Dad would go once he left hospital. We were told he would go to a rehab place in Hastings (but why so far away) and that he had to wait for a place to become available. So he waited - but was then sent to Haywards Heath hospital. [We were given] no explanation for change of plan. Then the plan changed again to no rehabilitation [provision] but to going [straight] home. He was pleased about going home, but I felt there should be continuing physio. [The hospital staff told us] that wouldn't happen for two weeks.

The Discharge Plan was given to Dad but not discussed with us.

We knew Dad had to have daily injections on his discharge which would be administered by a district nurse. I received a phone call from a district nurse on the day he was discharged, but she had the wrong address - for another patient with the same name as my Dad. She said not to worry, she would sort it out. But I didn't get another phone call to confirm.

It was very worrying because I didn't know if another nurse was coming or not. I had to phone the hospital who gave me the number of the agency, who then confirmed.

[My Dad] had [been given] most of the medication, but not enough paracetamol. [He was] also not [given] enough of the blood thinning injections which are required by the district nurse, so they had to be ordered from his GP. Luckily, he has a neighbour who was able to go and pick them up.

Dad has the mobility aids that he needs. But there is a step from the kitchen into [the] utility room where the fridge is. He hadn't practised [walking between these rooms] before he left hospital. So he had to buy a new fridge for the kitchen.

A physio is now coming once a week. But he is unable to have a shower or wash his hair on his own.

I think more care should have been put in place.

11. Data Tables

Supplementary Analysis:

Table A: Where did patients go after hospital?	No of patients	%
Own home	39	80%
Family home	4	8%
Nursing home/Rest home	4	8%
Home with warden support (on or offsite)	2	4%
Total patients visited at home	49	100%

Note: One patient had rehabilitation first before returning home. Another patient was discharged to a friend's house for a short while, before returning home. Both of these patients were interviewed at home. A third patient received respite before returning to the family home where we interviewed them.

The following tables (B, C and D) are where we have compared two questions to identify any relationship between them.

Table B: How long were patients in hospital for?	*N = No of patients*		
Q28: How long has patient been in hospital (staff question)?	N	%	
0-6 days	29	42%	mean time in hospital
7-20 days	29	42%	**10.7** days
21 days&+	11	16%	
	69	100%	
Table 21 (below) shows Q28 in more detail			
Q34: How much longer is patient likely to stay in hospital (staff question)?	N	%	
0-6 days	24	41%	mean time likely to be in hospital from now to discharge
7-20 days	26	44%	**13.8** days
21 days&+	9	15%	
	59	86%	
Q28+Q34 Combined in hospital already plus likely time to discharge*	N	%	
0-6 days	7	12%	combined: mean time estimate from admission to discharge
7-20 days	29	49%	**24.6** days
21 days&+	23	39%	
	59	100%	
**Only where both questions were answered*			

Table 21 below shows Q28 in Table B in more detail:

21. How long has the patient been in hospital? (Q28 hospital, not asked in online or home surveys)			
Days	Hospital Interviews	*Total Respondents*	Stranded or Super-stranded?
1	6%	4	Not stranded:
2	6%	4	Total Patients: 29
3	6%	4	42%
4	4%	3	
5	14%	10	
6	6%	4	
7	10%	7	Stranded: Admission above six days
8	3%	2	
9	6%	4	Total Patients: 29
10	6%	4	42%
11	1%	1	
12	3%	2	
14	9%	6	
18	3%	2	
20	1%	1	
21	4%	3	Super-stranded: Admission above 20 days
22	1%	1	
24	1%	1	
25	1%	1	Total Patients: 11
26	1%	1	16%
33	1%	1	
35	1%	1	
40	1%	1	
47	1%	1	
Total Answered	100%	69	

Table C: Did patients receive the support they expected?		Q11 Home Survey: What kind of support have you received?			
		No of patients		*%*	
Q14 Hospital Survey: What kind of support do you expect to receive?	Total	Yes	No	Yes	No
Care Agency	16	13	3	81%	19%
Occupational therapist (adaptation service)	5	3	2	60%	40%
Occupational therapist - Other	2	0	2	0%	100%
District nurse	4	2	2	50%	50%
Physiotherapist	6	4	2	67%	33%
Age UK	0	0	0	-	-
Possability People	0	0	0	-	-
Social Worker	2	0	2	0%	100%
Speech Therapist	3	1	2	33%	67%

Note: The numbers shown are only of those patients that were interviewed at home and comparing their answers, with the answers they gave in hospital.

Table D: Was the patient satisfaction with the discharge arrangements *at home* better as a result of receiving good advice and information *in hospital* ?*	**Very Satisfied and Satisfied with the discharge arrangements**	**Unsatisfied and very unsatisfied with the discharge arrangements**
Very Good and Good advice and information (26 patients)	100%	0%
Poor and Very poor advice and information (10 patients)	0%	70%

**A comparison of Q21 Overall, how would you rate how good the advice and information was that you received vs. Q27a considering your overall experience, how satisfied were you with the discharge arrangements made for you? Where both questions were answered*

Survey Questions Asked:

Questions about the hospital experience:
Directed to the patient and and/or carer/family member

1. What is the reason you/the patient came to hospital? (Q8 hospital, Q5 online, not asked in home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Respiratory	23%		7%	18		1	19
Fall	18%		20%	14		3	17
Chest Infection	3%		7%	2		1	3
Other infection	5%		0%	4		0	4
Urinary Tract Infection	1%		13%	1		2	3
Other	50%		53%	39		8	47
Total Answered	100%		100%	78		15	93

2. While being in hospital, do you (did you) feel overall that staff (have) treated you/the patient well? (Q10 hospital, Q6 online, not asked at home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes, fully	90%		67%	69		10	79
Yes, partly	9%		27%	7		4	11
No	1%		7%	1		1	2
Total Answered	100%		100%	77		15	92

3. Since being admitted to hospital, has anyone spoken to you/the patient about what might happen when you/they leave hospital /When you were in hospital, did anyone speak to you about what would happen when you left hospital? (Q11 Hospital, Q7 online, not asked at home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes	56%		73%	43		11	54
No	44%		27%	34		4	38
Total Answered	100%		100%	77		15	92

4. Where do you expect (the patient) to be going after hospital?/Where were you told you would go after hospital? (Q13 hospital, Q8 online, not asked at home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Own home	83%		93%	48		14	62
Other residence	9%		7%	5		1	6
Nursing home	3%		0%	2		0	2
Home with warden on site	2%		0%	1		0	1
Care home	2%		0%	1		0	1
Family home	2%		0%	1		0	1
Total Answered	100%		100%	58		15	73

5. What kind of support do you expect (the patient) to receive? /What kind of support were you told you would receive? Select all that apply. (Q14 hospital, Q9 online, not asked at home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Social Worker	10%		8%	5		1	6
District Nurse	12%		0%	6		0	6
Care Agency	56%		15%	29		2	31
Occupational therapist (adaptation service)	12%		0%	6		0	6
Occupational therapist - Other	4%		0%	2		0	2
Physiotherapist	15%		23%	8		3	11
Mental Health Nurse	0%		0%	0		0	0
Red Cross	0%		8%	0		1	1
Alzheimers Society	0%		0%	0		0	0
Age UK	0%		8%	0		1	1
Possability People	0%		0%	0		0	0
Other	54%		54%	28		7	35
No of people who answered question				52		13	99

6. When do you expect (the patient) to be leaving? (Q15 hospital, not asked in the online survey or at home)							
				Total Respondents			
Days	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
0	19%			11			11
1	20%			12			12
2	15%			9			9
3	5%			3			3
4	3%			2			2
6	2%			1			1
7	2%			1			1
100	2%			1			1
Don't know	32%			19			19
Total Answered	100%			59			59

7. What advice and information did you/have you (the patient) received? Select all that apply. (Q17 hospital, Q10 online, not asked at home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Advice about independent living (including adapting home)	13%		0%	5		0	5
Advice about independent living (Care link)	10%		0%	4		0	4
Advice about social services	10%		0%	4		0	4
Information on district nurses	5%		0%	2		0	2
Other support services e.g. home help, help with shopping etc.	23%		0%	9		0	9
Advice about medication	36%		0%	14		0	14
Advice on diet and liquid intake	3%		0%	1		0	1
Info on social groups and local activities	0%		0%	0		0	0
Telecare (elderly person alarm)	5%		0%	2		0	2
Other	21%		29%	8		2	10
None	15%		71%	6		5	11
No of people who answered question				39		7	46

8. Do you/did you feel involved in the decisions being made regarding plans for your/the patient's care when you/the patient leave hospital? (Q18 hospital, Q11 online, not asked at home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes definitely	43%		36%	24		5	29
Yes partly	32%		21%	18		3	21
No	25%		43%	14		6	20
Total Answered	100%		100%	56		14	70

9. If Yes (to 8. above) How? Select all that apply. (Q19 hospital, Q12 online, not asked at home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Given options for accommodation	14%		0%	4		0	4
Given options for different care/support	34%		0%	10		0	10
The care/support you had before hospital has been discussed and considered in planning your discharge	41%		60%	12		3	15
You (the patient) has been asked for your opinion	48%		40%	14		2	16
No of people who answered question				29		5	34

10. Were you/the patient helped to understand the options? (Q20 hospital, Q13 online, not asked at home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes fully	53%		36%	25		4	29
Yes partly	26%		9%	12		1	13
No	21%		55%	10		6	16
Total Answered	100%		100%	47		11	58

11. If Yes (to 10. above) How? Select all that apply. (Q21 hospital, Q14 online, not asked at home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Explanation of types of accommodation	12%		0%	3		0	3
Explanation of types of care/support	65%		0%	17		0	17
Explanation of any changes to your care from before you entered hospital to when you leave	15%		25%	4		1	5
Given the option to clarify anything not understood	27%		100%	7		4	11
Other	12%		0%	3		0	3
No of people who answered question				26		4	30

12. Were you/the patient given the opportunity to talk about any concerns you/they had? (Q22 hospital, Q15 online, not asked at home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes	71%		46%	36		6	42
No	20%		38%	10		5	15
Don't know	10%		15%	5		2	7
Total Answered	100%		100%	51		13	64

13. Are/were you confident that the arrangements being made will/would be suitable for you/the patient to live away from hospital? (Q23 hospital, Q16 online, not asked at home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes fully	67%		38%	34		5	39
Yes partly	22%		15%	11		2	13
No	12%		46%	6		6	12
Total Answered	100%		100%	51		13	64

14. Were you/the patient provided with any written information on your/their care plan? (Q24 hospital, Q17 online, not asked at home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes - Discharge letter with information on medication, care contact details etc.	12%		38%	6		5	11
Yes - Discharge letter without any additional information	0%		0%	0		0	0
Yes - 'Let's get you home' leaflet	4%		0%	2		0	2
Yes - 'Planning your discharge' booklet.	2%		0%	1		0	1
Yes - I have seen my care plan and I am assigned to a social worker	4%		0%	2		0	2
Yes - Other	10%		8%	5		1	6
No	69%		54%	36		7	43
Total Answered	100%		100%	52		13	65

15. Did you/Do you/the patient feel prepared to go home? (Q25 hospital, Q18 online, not asked at home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes fully	57%		50%	31		7	38
Yes partly	26%		21%	14		3	17
No	17%		29%	9		4	13
Total Answered	100%		100%	54		14	68

16. Was your/the patient's discharge later than you/the patient were originally told? (not asked in hospital, Q19 online, Q22 in home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes		26%	15%		12	2	14
No		74%	85%		34	11	45
Total Answered		100%	100%		46	13	59

17. By approximately how many days? (not asked in hospital, Q19a online, Q22a in home)							
				Total Respondents			
Days	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
1		27%	50%		3	1	4
2		36%	0%		4	0	4
3		27%	0%		3	0	3
5		0%	50%		0	1	1
35		9%	0%		1	0	1
Total Answered		100%	100%		11	2	13

18. What were the reasons for the delay? Select all that apply. (not asked in hospital, Q20 online, Q23 in home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Medication/prescriptions not ready		9%	50%		1	1	2
Care home place not available		0%	0%		0	0	0
Care home couldn’t' accept me on the discharge day		0%	0%		0	0	0
Occupational therapist had not assessed my home for adaptation		0%	0%		0	0	0
My home had been assessed but adaptations had not been made		0%	0%		0	0	0
Patient transport service not available		0%	0%		0	0	0
Care package being put in place		55%	0%		6	0	6
Other		45%	50%		5	1	6
No of people who answered question					11	2	13

19. Overall, how satisfied are/were you with the arrangements being made for leaving hospital? (Q26 hospital, not asked online or at home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Very Satisfied	43%			21			21
Satisfied	29%			14			14
Neither Satisfied nor Unsatisfied	20%			10			10
Unsatisfied	4%			2			2
Very Unsatisfied	4%			2			2
Total Answered	100%			49			49

Questions about the hospital experience: Directed to the staff

20. Is this patient considered "frail" by the hospital? (Q27 hospital, not asked in online or home surveys)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes	60%			42			42
No	40%			28			28
Total Answered	100%			70			70

Table 21 is under supplementary analysis

22. Is this a readmission patient ie discharged and readmitted for related conditions since 1st January 2018 (Q29 hospital, not asked in online or home surveys)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes	26%			18			18
No	74%			52			52
Total Answered	100%			70			70

23. If Yes (to 19. above) How many days ago was the patient in last? (Q30 hospital, not asked in online or home surveys)							
				Total Respondents			
Days	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
1	18%			2			2
7	27%			3			3
10	9%			1			1
21	9%			1			1
28	18%			2			2
60	9%			1			1
62	9%			1			1
Total Answered	100%			11			11

24. If Yes (to 19. above) Where was the patient living before he/she was admitted this time to hospital? (Q31 hospital, not asked in online or home surveys)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Own home	83%			15			15
Nursing home	6%			1			1
Other	11%			2			2
Total Answered	100%			18			18

25. Where is the patient likely to be discharged to once they leave hospital? (Q32 hospital, not asked in online or home surveys)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Own home	80%			55			55
Family home	1%			1			1
Nursing home	6%			4			4
Care home	1%			1			1
Newhaven Rehabilitation	1%			1			1
Cravenvale Rehabilitation	0%			0			0
Knoll House Rehabilitation	0%			0			0
Other temporary home	1%			1			1
Home with warden on site	0%			0			0
Other	9%			6			6
Total Answered	100%			69			69

26. If Q32 rehabilitation - Where is patient likely to go after this? (Q33 hospital, not asked in online or home surveys)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Own home	100%			1			1
Total Answered	100%			1			1

27. How long is patient likely to be in hospital for? (Q34 hospital, not asked in online or home surveys)							
				Total Respondents			
Days	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
0	8%			5			5
1	8%			5			5
2	7%			4			4
3	5%			3			3
4	3%			2			2
5	10%			6			6
7	16%			10			10
8	3%			2			2
9	2%			1			1
10	3%			2			2
11	2%			1			1
12	3%			2			2
14	3%			2			2
16	7%			4			4
17	2%			1			1
18	3%			2			2
22	2%			1			1
23	2%			1			1
25	3%			2			2
27	2%			1			1
36	2%			1			1
100	5%			3			3
Total Answered	100%			61			61

28.Has the patient received information on discharge? (Q35 hospital, not asked in online or home surveys)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes	52%			35			35
No	48%			32			32
Total Answered	100%			67			67

29. If Yes (to 25. above) What kind of information as he/she received? Select all that apply. (Q36 hospital, not asked in online or home surveys)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Discharge letter with info on medication, care contact details etc.	20%			7			7
Discharge letter without any additional information	0%			0			0
'Let's get you home' leaflet	6%			2			2
Planning your discharge' booklet	0%			0			0
Care plan explaining arrangements for after hospital	40%			14			14
Verbal information only	37%			13			13
Other	9%			3			3
No of people who answered question				35			35

30.What condition is the patient in hospital for? (Q37 hospital, not asked in online or home surveys)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Respiratory	27%			19			19
Fall	10%			7			7
Other infection	3%			2			2
UTI	4%			3			3
Other	56%			39			39
Total Answered	100%			70			70

31. Did the patient have a care plan before they entered hospital? (Q38 hospital, not asked in online or home surveys)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes	38%			25			25
No	62%			41			41
Total Answered	100%			66			66

32. What kind of support did they receive? Select all that apply. (Q39 hospital, not asked in online or home surveys)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Social worker	4%			1			1
District nurse	22%			5			5
Care agency	78%			18			18
Occupational therapist (adaptation service)	4%			1			1
Occupational therapist - Other	0%			0			0
Physiotherapist	9%			2			2
Mental health nurse	4%			1			1
Red Cross	0%			0			0
Alzheimers Society	0%			0			0
Age UK	0%			0			0
Possability People	0%			0			0
Other	9%			2			2
No of people who answered question				23			23

Questions about the home experience:
Directed to the patient and and/or carer/family member

33. Since I visited you in hospital, have you been readmitted?/Have you been readmitted to hospital this year? (not asked in hospital, Q23 online, Q2 in home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes		17%	7%		8	1	9
No		83%	93%		39	14	53
Total Answered		100%	100%		47	15	62

34. Why were you readmitted? (not asked in hospital, Q25 online, Q4 in home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Respiratory		38%	0%		3	0	3
Urinary Tract infection		0%	0%		0	0	0
Chest infection		0%	0%		0	0	0
Other infection		0%	0%		0	0	0
Fall		13%	0%		1	0	1
Other		50%	100%		4	1	5
Total Answered		100%	100%		8	1	9

35. Where did you go after hospital? (not asked in hospital or at home, Q27 online)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Own home			93%			13	13
Family home			0%			0	0
Nursing home			0%			0	0
Care home			0%			0	0
Newhaven rehabilitation			0%			0	0
Cravenvale rehabilitation			0%			0	0
Knoll House rehabilitation			0%			0	0
Other temporary home			0%			0	0
Home with warden on site			0%			0	0
Other residence			7%			1	1
Total Answered			100%			14	14

36. What issues made the arrangements effective/ineffective? (not asked in hospital, Q28 online, Q7 home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Reasons given for effective arrangements							
Information was provided		37%			17	0	17
Understanding about information provided		22%			10	0	10
Suitable arrangements		37%			17	0	17
Accessing support		39%	25%		18	1	19
Ability to self-manage		28%			13	0	13
Clarity around instructions about medications		13%			6	0	6
Medication provided		35%			16	0	16
Ability to get the medication needed		7%			3	0	3
Explanation of why medication has been presented/changed		9%			4	0	4
Contact with Care link		4%			2	0	2
Appropriate/completed Adaptations		15%			7	0	7
Other-positive		17%			8	0	8
Reasons given for ineffective arrangements							
Lack of information provided		7%			3	0	3
Lack of understanding about information provided		4%			2	0	2
absent arrangements		7%	75%		3	3	6
Unable to access support		7%			3	0	3
Inability to self-manage		9%			4	0	4
Unable to get the medication needed		2%			1	0	1
Incomplete adaptations		2%			1	0	1
Other-negative		13%			6	0	6
Mixed or neutral experience of arrangements							
Other-neutral		7%			3	0	3
Other-mixed		9%			4	0	4
Total Answered			100%		46	4	50

37. Please rate how well arrangements for where you lived went? (not asked in hospital, Q29 online, Q6a home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Very effective		21%	50%		10	6	16
Effective		53%	8%		25	1	26
OK		13%	17%		6	2	8
Ineffective		11%	17%		5	2	7
Very ineffective		2%	8%		1	1	2
Total Answered		100%	100%		47	12	59

38. Did anyone from the healthcare service make contact to find out how you/the patient were getting along following discharge? (not asked in hospital or online, Q8 home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes		76%			34		34
No		24%			11		11
Total Answered		100%			45		45

39. If yes to 38. Who contacted you? Select all that apply. (not asked in hospital or online, Q9 home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
District Nurse		30%			10		10
Social worker		9%			3		3
Occupational therapist (supplying mobility and equipment/safety aids)		36%			12		12
Other Occupational therapist		12%			4		4
Care link		9%			3		3
Finance Team		0%			0		0
Care agency		52%			17		17
Other		55%			18		18
Carers/Family members only: Carer's assessment		3%			1		1
Carers/Family members only: Carer's hub		0%			0		0
Carers/Family members only: other Carer's support		3%			1		1
No of people who answered question					33	0	37

40. If no to 38. Would a follow-up call within 30 days after discharge, have helped you/the patient? (not asked in hospital or online, Q10 home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes a lot		18%			2		2
Yes somewhat		9%			1		1
No		45%			5		5
Don't know		27%			3		3
Total Answered		100%			11		11

41. What kind of support have you received after leaving hospital? Select all that apply. (not asked in hospital, Q30 online, Q11 home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Social worker		11%	9%		5	1	6
District Nurse		36%	0%		16	0	16
Care agency		50%	9%		22	1	23
Occupational therapist (adaptation service)		25%	0%		11	0	11
Occupational therapist (other)		14%	0%		6	0	6
Physiotherapist		25%	18%		11	2	13
Mental health nurse		0%	0%		0	0	0
Red cross		0%	0%		0	0	0
Alzheimers society		0%	0%		0	0	0
Age UK		2%	9%		1	1	2
Possability people		2%	0%		1	0	1
Other		43%	64%		19	7	26
No of people who answered question					44	11	55

42. Were there any serious problems with the arrangements made? (not asked in hospital, Q31tomatch online, Q12 home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes		22%	33%		10	2	12
No		78%	67%		36	4	40
Total Answered		100%	100%		46	6	52

43. If Q42 is yes, what were the problems with the arrangements made? Select all that apply (not asked in hospital or online, Q13 home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Understanding about information provided		20%			2		2
Appropriate arrangements		40%			4		4
Accessing support		40%			4		4
Ability to self-manage		30%			3		3
Clarity around instructions about medications		0%			0		0
Suitable medication provided		10%			1		1
Getting the medication needed		20%			2		2
Contact with Care link		0%			0		0
Suitable/completed adaptations to home		0%			0		0
Not knowing who to contact		20%			2		2
Other		80%			8		8
No of people who answered question					10		10

44. Did you know who to contact should a problem arise? (not asked in hospital or at home, Q32 online)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes			73%			8	8
No			27%			3	3
Total Answered			100%			11	11

45. Overall, how would you rate how well the arrangements for support are? (not asked in hospital, Q33 online, Q14 home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Very Good		27%	40%		12	4	16
Good		56%	10%		25	1	26
OK		2%	10%		1	1	2
Poor		4%	40%		2	4	6
Very Poor		11%	0%		5	0	5
Total Answered		100%	100%		45	10	55

46. Were you/the patient involved in the decisions about leaving hospital? (not asked in hospital or online, Q15 home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes fully		44%			20		20
Yes partly		27%			12		12
No		29%			13		13
Total Answered		100%			45		45

47. How? Select all that apply (not asked in hospital or online, Q16 home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Given options for accommodation		4%			1		1
Given options for different care/support		25%			7		7
The care/support you had before hospital was discussed and considered in planning discharge;		64%			18		18
Patient was asked for their opinion		54%			15		15
No of people who answered question					28		28

48. Were you/the patient provided with any written information on your/their care plan? (not asked in hospital or online, Q17 home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes - Discharge letter with information on medication, care contact details etc.		53%			24		24
Yes - Discharge letter without any additional information.		16%			7		7
Yes - "Let's get you home" leaflet, "Planning your discharge" booklet.		2%			1		1
Yes - (I am assigned to a social worker) and have seen my care plan.		11%			5		5
Yes – Other		11%			5		5
No		22%			10		10
No of people who answered question					45		45

49. Would you/the patient have felt more prepared if you/the patient had received something written? (not asked in hospital or online, Q18 home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes		50%			5		5
No		30%			3		3
Don't know		20%			2		2
Total Answered		100%			10		10

50. Were you able to access enough food and drink, and any support you/they needed to be able to eat well? (not asked in hospital, Q35 online, Q20 home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes		98%	63%		45	5	50
No		2%	38%		1	3	4
Total Answered		100%	100%		46	8	54

51. Overall, how would you/the patient rate how good the advice and information was that you received? (not asked in hospital, Q36 online, Q21 home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Very Good		19%	36%		8	4	12
Good		42%	27%		18	3	21
OK		14%	9%		6	1	7
Poor		21%	27%		9	3	12
Very Poor		5%	0%		2	0	2
Total Answered		100%	100%		43	11	54

52. On reflection, do you feel you were/the patient was fully prepared for going home? (not asked in hospital, Q18 online, Q25 home)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes fully		58%	50%		26	7	33
Yes partly		31%	21%		14	3	17
No		11%	29%		5	4	9
Total Answered		100%	100%		45	14	59

53. In what way did you feel prepared/not prepared? Select all that apply (not asked in hospital or online, Q26 home)

				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Ways given for feeling prepared							
Information provided		11%			5		5
Understanding about information provided		7%			3		3
Appropriate arrangements		47%			21		21
Accessing support		31%			14		14
Ability to self-manage		16%			7		7
Clarity around instructions about medications		16%			7		7
Suitable medication provided		29%			13		13
Getting the medication needed		18%			8		8
Contact with Care link		4%			2		2
Suitable/completed adaptations (to home)		9%			4		4
Other-positive		7%			3		3
Ways given for not feeling prepared							
Lack of information provided		7%			3		3
Lack of understanding about information provided		7%			3		3
Inappropriate/absent arrangements		4%			2		2
Unable to access support		9%			4		4
Inability to self-manage		11%			5		5
I didn't feel ready to leave hospital		4%			2		2
Other-negative		16%			7		7
Neutral comments							
Other-neutral		9%			4		4
No of people who answered question					45		45

54. Considering your overall experience, how satisfied were you/the patient with the discharge arrangements made for you/them? (not asked in hospital, Q37 online, Q27 home)

				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Very satisfied		27%	38%		12	5	17
Satisfied		48%	15%		21	2	23
Neither unsatisfied nor satisfied		9%	15%		4	2	6
Unsatisfied		11%	15%		5	2	7
Very unsatisfied		5%	15%		2	2	4
Total Answered		100%	100%		44	13	57

55. If you/the patient were readmitted, do you feel the arrangements made this time around were better than the first time? (not asked in hospital or online, Q29 home)

				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Better		0%			0		0
Same		50%			4		4
Worse		50%			4		4
Total Answered		100%			8		8

56. Patient only: I have been feeling optimistic about the future. (not asked in hospital or online, Q30 home)

				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
None of the time		10%			4		4
Rarely		15%			6		6
Some of the time		30%			12		12
Often		40%			16		16
All of the time		5%			2		2
Total Answered		100%			40		40

57. Patient only: I have been dealing with problems well. (not asked in hospital or online, Q31 home)

				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
None of the time		3%			1		1
Rarely		10%			4		4
Some of the time		33%			13		13
Often		38%			15		15
All of the time		18%			7		7
Total Answered		100%			40		40

58. Patient only: I have been feeling good about myself. (not asked in hospital or online, Q32 home)

				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
None of the time		3%			1		1
Rarely		10%			4		4
Some of the time		38%			15		15
Often		38%			15		15
All of the time		10%			4		4
Total Answered		100%			39		39

Demographic questions

The following questions were not asked of the home survey patients as they had already been asked these questions in hospital

Age Group	Hospital Interviews	Home Interviews	Online Survey	*Total Respondents* Hospital Interviews	Home Interviews	Online Survey	Total respondents
65-70	18%		25%	13		3	16
71-80	39%		42%	28		5	33
81-90	30%		25%	21		3	24
91+	13%		8%	9		1	10
Total Answered	100%		100%	71		12	83

Gender	Hospital Interviews	Home Interviews	Online Survey	*Total Respondents* Hospital Interviews	Home Interviews	Online Survey	Total respondents
Female	64%		67%	49		10	59
Male	36%		33%	27		5	32
Total Answered	100%		100%	76		15	91

Sexuality	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Heterosexual	100%		93%	57		13	70
Gay	0%		7%	0		1	1
Lesbian	0%		0%	0		0	0
Bisexual	0%		0%	0		0	0
Total Answered	100%		100%	57		14	71

				Total Respondents			
Ethnic Origin	Interviews			Interviews			
Only the ethnic origins that were responded to, are recorded here	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
White British	96%		93%	70		14	84
White Irish	1%		0%	1		0	1
White - Other	1%		7%	1		1	2
Mixed White & Asian	1%		0%	1		0	1
Total Answered	100%		100%	73		15	88

Disability	Hospital Interviews	Home Interviews	Online Survey	*Total Respondents* Hospital Interviews	Home Interviews	Online Survey	Total respondents
Yes	50%		43%	31		6	37
No	50%		57%	31		8	39
Total Answered	100%		100%	62		14	76

If yes to disability, **Type of Impairment.** Select all that apply. (Q46 Hospital, Q43 Online)							
				Total Respondents			
	Hospital Interviews	Home Interviews	Online Survey	Hospital Interviews	Home Interviews	Online Survey	Total respondents
Physical Impairment	67%		83%	20		5	25
Sensory Impairment	3%		33%	1		2	3
Learning Disability	0%		0%	0		0	0
Long Standing Illness	23%		17%	7		1	8
Mental Health condition	7%		17%	2		1	3
Other	17%		33%	5		2	7
No of people who answered question				30		6	36

Item 57

Although a formal committee of Brighton & Hove City Council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults and Healthwatch.

Title:	Brighton & Hove Health and Wellbeing Strategy 2019-2030
Date of Meeting:	19 March 2019
Report of:	Director of Public Health, Health and Adult Social Care
Contact:	Alistair Hill, Director of Public Health Tel: 01273 296560
Email:	alistair.hill@brighton-hove.gov.uk
Wards Affected:	All

FOR GENERAL RELEASE

Executive Summary

Health and Wellbeing Boards have a duty to prepare a Joint Health and Wellbeing Strategy for meeting needs identified in the Joint Strategic Needs Assessment (JSNA).

This refreshed strategy, for the period 2019 to 2030, describes a vision that everyone in Brighton & Hove will have the best opportunity to love a healthy, happy and fulfilling life.

It sets out the core principles that will guide delivery by the Board and its partners and identifies key areas for action in taking the strategy forward. These are both at City level and more specifically to support the outcomes of starting well; living well, ageing well and dying well.

Implementing the strategy will require the health and care system to develop a greater focus on population health and prevention. It will also require working across city partners and strategies to influence the wider determinants of health.

Glossary of Terms

JNSA – Joint Strategic Needs Assessment

CCG – Clinical Commissioning Group

GPs – General Practitioners

NHS Long Term Plan – the new plan for the NHS to improve the quality of patient care and health outcomes. It sets out how the £20.5 billion budget settlement for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next 5 years.

1. Decisions, recommendations and any options

1.1 That the Board approves the 2019-2030 Brighton & Hove Health and Wellbeing Strategy.

2. Relevant information

2.1 Health and Wellbeing Boards have a duty to prepare a Joint Health and Wellbeing Strategy for meeting needs identified in the Joint Strategic Needs Assessment (JSNA).

2.2 This is the third strategy published by the Brighton & Hove Health and Wellbeing Board and is a refreshed version that builds on the strategy approved by the Board in December 2015.

2.3 Following approval at the March 2018 Health and Wellbeing Board, a Policy Panel was established to guide the development of the strategy. The Panel met on four occasions (July, September, November 2018 and January 2019). The membership of the Panel included Board members (including the local members, GPs, the CCG, BHCC Health & Adult Social Care and BHCC Families Children & Learning) and partners including representatives of the community & voluntary sector, Chamber of Commerce and the Economic Partnership.

2.4 The work of the Policy Panel informed the format, content (including principles and key areas for action) and the engagement described below.

2.5 Engagement with local people and organisations has informed the content of the strategy. This included the results of the Big Health and Care Conversation (involving more than 2,000 people), which were reported to the

Board in 2018, and a strategy engagement event in January 2019. Details of the latter are provided in Appendix 2.

2.6 This is a high level strategy that sets out the vision of the Board for improving health and wellbeing and reducing health inequalities in Brighton & Hove. The vision for the Board and its partners is that:

Everyone in Brighton & Hove will have the best opportunity to love a healthy, happy and fulfilling life.

2.7 The strategy describes eight principles that will guide the leadership of the Board and its partners in delivering the strategy:

- Partnership and collaboration
- Health is everyone's business
- Health and work
- Prevention and empowerment
- Reducing health inequalities
- The right care, in the right place, at the right time
- Engagement and involvement
- Keeping people safe.

2.8 The strategy sets an ambition that by 2030:

- People will live more years in good health (reversing the current falling trend in healthy life expectancy) and
- The gap in healthy life expectancy between people living in the most and least disadvantaged areas of the city will be reduced.

2.9 To achieve this will require action involving individuals, communities and city wide. Four key outcomes for local people are identified: starting well, living well, ageing well and dying well.

2.10 At the city level, Brighton & Hove will be a place which helps people to be healthy. Key areas of action identified within the strategy include inclusive economic growth; planning healthy places (including green and open spaces); prioritising active travel; improving air quality; supporting safe and warm housing; tackling homelessness; adopting a whole city approach to food and wellbeing; and making the best use of city assets such as libraries, community spaces and arts and culture to improve health and wellbeing.

2.11 In addition, partners across the city will work with communities and residents to tackle the risks presented by substance misuse and excessive alcohol use.

2.12 Key areas of action have been identified for each life stage including:

2.13 Starting well: a focus on early years; promotion of healthy lifestyles and resilience; improving emotional health and wellbeing and improving mental

health services; and providing high quality and joined up services around the family.

2.14 Living Well: information and advice to support people to eat well, move more, drink less and stop smoking; improving mental health & wellbeing and sexual health; and a focus on workplace health and supporting people, including people with disabilities, into work.

2.15 Ageing well: creating an age friendly and dementia friendly city (including the physical environment); reducing social isolation, loneliness and falls; and connecting people with their communities to help them live independently for longer.

2.16 Dying well: developing a city wide approach to improve health and wellbeing at the end of life; and supporting more people to die at home or in a place that they choose.

2.17 The health and care system will need to focus on achieving population health outcomes to support the delivery of the strategy. The NHS Long Term Plan was published as this local strategy was being developed and the direction of travel indicated in the plan is reflected in our strategy, including the NHS increasing its contribution to preventing ill health and reducing inequalities and local health services coming together into geographical networks covering a population of 30,000 to 50,000 people.

2.18 Following the Board's approval of the strategy, the key areas of action will be taken forward. Some will be incorporated into work already underway to deliver existing plans and some will require the establishment of new plans.

2.19 A set of key indicators to identify progress will be brought to the Board for approval later in 2019.

2.20 Key next steps for the health and care system include developing a local plan to deliver the NHS Long Term Plan by Autumn 2019, and a joint medium term financial strategy for the CCG and City Council by 2020. The financial strategy will support health and care services to implement the prevention and population health focus identified in this strategy.

3. Important considerations and implications

Legal:

3.1 The Health and Wellbeing Board is required to publish a joint Health and Wellbeing Strategy pursuant to the Health and Social Care Act 2012 Section 193. In preparing the Strategy the Local Authority and the CCG must have regard to Guidance and involve local people and the local Healthwatch organisation.

Lawyer consulted: Elizabeth Culbert Date: 18/02/19

Finance:

3.2 The Health and Wellbeing Strategy informs priorities, budget development and the Medium Term Financial strategy of the Council, Health and other partners. This will require a joined up process for future budget setting in relation to all local public services. This will ensure that the Council and CCG have an open, transparent and integrated approach to agreeing the budget. This will require both organisations to align their budget procedures whilst adhering to individual financial governance and regulations.

The financial risks for both organisations will need to be detailed within medium term financial planning and reported on a regular basis.

Finance Officer consulted: Sophie Warburton Date: 20/02/19

Equalities:

3.3 The strategy includes a strong focus on reducing heath inequalities. The strategy and its delivery is underpinned by the data within our Joint Strategic Needs Assessment which takes the life course approach identifying specific actions for children and young people; adults of working age and older people; and key areas for action that reflect specific equalities issues including inclusive growth and supporting disabled people and people with long term conditions into work. An Equalities Impact Assessment is not required for the strategy itself but should be completed for specific projects, programmes and commissioning and investment decisions taking forward the strategy.

Sustainability:

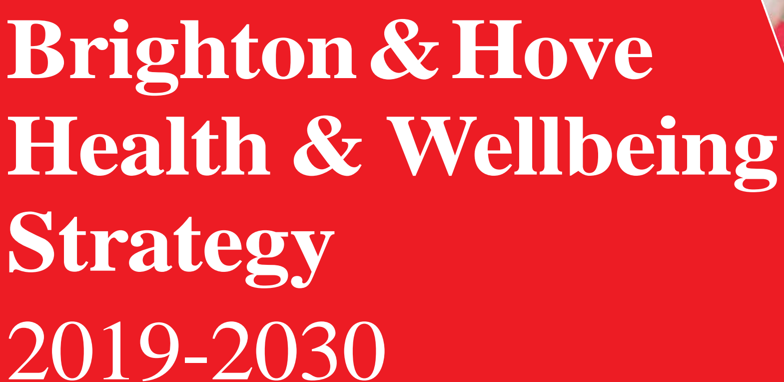
3.4 Sustainability is at the heart of the health and wellbeing and this is reflected in the inclusion of active travel, improved air quality and use of green and open spaces in the key areas of action.

Supporting documents and information

Appendix 1: Draft Health and Wellbeing Strategy 2019-2030

Appendix 2: Summary of the feedback received from strategy engagement

Appendix 1



NHS
Brighton and Hove
Clinical Commissioning Group

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Delivering the strategy

This strategy sets out our vision for improving the health and wellbeing of local people and reducing health inequalities:

Everyone in Brighton & Hove will have the best opportunity to live a healthy, happy and fulfilling life

What is the purpose of the strategy?

This strategy sets out our vision for the health and wellbeing of people and communities in Brighton & Hove, together with the core principles which will guide local action to deliver the vision. It presents a shared view of where we are and of the challenges and opportunities that we face.

We want to make health and wellbeing everyone's business. Therefore local organisations and communities should use the strategy to develop actions that will contribute to improving health and wellbeing.

Who developed the strategy?

This is a refreshed strategy that builds on the Health & Wellbeing Strategy which was approved by the Health & Wellbeing Board in December 2015.

The strategy was developed by a Policy Panel that reported to the Brighton & Hove Health & Wellbeing Board. The panel included members nominated from the Board plus representatives of Community Works (representing the Community & Voluntary Sector), Brighton & Hove Chamber of Commerce and the Brighton & Hove Economic Partnership.

How were local people involved?

The views of local people and organisations have been instrumental in the development of this strategy. These were gathered through the following means:

- More than 2,000 people took part in the Brighton & Hove Big Health and Care Conversation in 2017, which aimed to find out more about what local people need to keep them healthy.

- Engagement on the draft strategy was conducted from December 2018 to January 2019, culminating in an engagement event attended by more than 100 people.

Our principles

Eight principles will guide the delivery of our strategy:

Partnership and collaboration	Individuals, communities and organisations across the city will work collaboratively to deliver our shared vision.
Health is everyone's business	Services and plans will reflect the contributions that factors such as education and learning, housing, employment, environment, leisure & culture, and transport make to improving health and wellbeing.
Health and work	Fulfilling work, including volunteering, contributes to good health and wellbeing – and local employers, communities and the economy will benefit from healthy workplaces and a healthy workforce.
Prevention and empowerment	Communities will be supported to develop networks and local solutions that lessen social isolation and improve wellbeing, and reduce the need for more specialist services. People will be encouraged and empowered to take responsibility for their health and wellbeing where they can. Early action will help people to live well for longer and to remain independent.
Reducing health inequalities	The physical and mental health of those with the poorest outcomes will improve the fastest. Services will be accessible to those who need them, including people with learning and physical disabilities, those who are socially isolated and those living in different parts of the city.
The right care, in the right place, at the right time	Health and care services will provide high quality care, feel more joined up and will be delivered in the most appropriate place. Often, this will mean that more services are delivered in or close to people's homes.
Engagement and involvement	Local people of all ages will be active partners in the design, development and delivery of health and care services and supported to manage their health.
Keeping people safe	We want everyone to be safe from avoidable harm, taking particular care of our most vulnerable residents.

Our challenges

A growing population

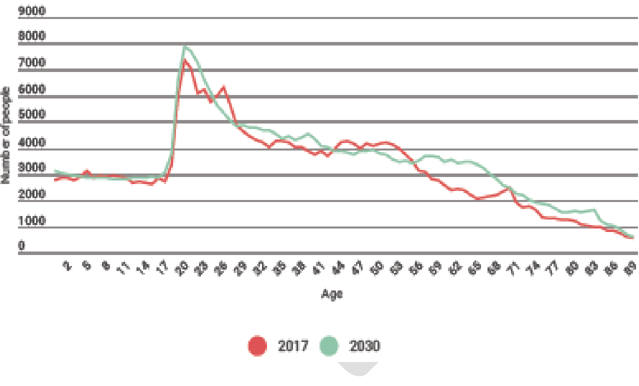
There are currently around 288,000 people living in the city and our population profile is younger than England.

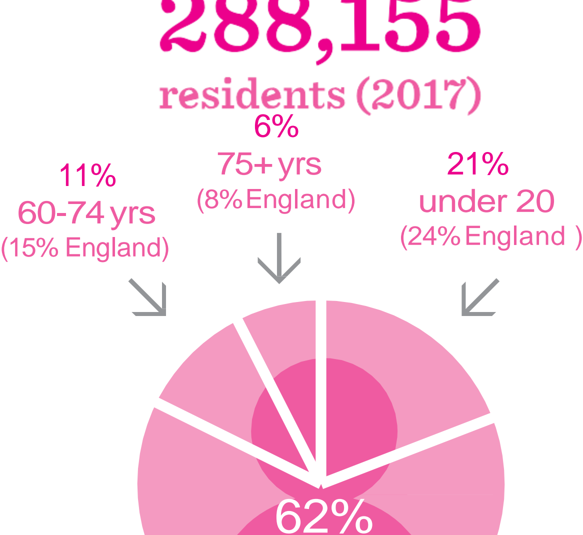
Our population is predicted to increase at a faster rate than the South East and England by 2030 (by 23,300 people or 8%).

By 2030, Brighton & Hove's population is predicted to get older: there will be 29% more people aged 75 or older (5,200 people) compared with 2017, including 400 more people aged 90 or over.

The number of children in Brighton & Hove will increase slightly. It is predicted there will be 800 more children (6%) aged 0-4, with more than half of the increase (500 people) happening by 2020. The number of 5-14 years old is expected to remain around the same (100 fewer children). There are, however, projected to be 4,800 more young people (a 10% increase) aged 15-24 years by 2030.

Brighton & Hove population profile 2017 and 2030





Health and wellbeing needs

Life expectancy in Brighton & Hove was 83.4 years for women and 79.5 for males in 2014-16. It has increased over recent decades, however data suggests that this trend may have stalled in the last five years (nationally, life expectancy began to plateau in 2010).

Healthy life expectancy (a measure of how many years of life are lived in good health) has fallen in the city. This means that on average a larger proportion of life is now spent in poor health, increasingly with multiple long-term health conditions. In Brighton & Hove women can expect to live 25% of their life in poor health (23% in England), whilst males in Brighton & Hove can expect 22% of their life to be lived in poor health (20% in England).

In addition, there are significant health inequalities across our population. For example, there is a gap in life expectancy of 10 years in men and six years in women between the most and least disadvantaged areas in the city. The gap in healthy life expectancy is greater still, highlighting that people living in our more disadvantaged communities spend more years living in poor health.

Local data highlight relatively good health and wellbeing in younger children, however we have high rates of smoking, substance misuse and mental health needs in young people. In adults, some of our health outcomes, for example relating to mental health, are worse than average. For older people, we have worse than average rates of falls.

Research suggests that the majority of people would prefer to die at home and few wish to die in hospital. More than 9 out of 10 bereaved relatives believed that when their loved ones had died at home or in a hospice it was the right place for them (compared with 3 out of 4 in the case of hospitals).

Health and care services

Healthcare is often organised around individual health conditions and does not always meet the needs of those who have multiple long-term conditions.

Some people are being treated in hospital when they could receive better care provided by services in their home or their neighbourhood.

Challenges for delivering local services include the capacity and resilience of GP practice services and recruitment to the health and care workforce.

In January 2019, the NHS Long Term Plan was published, which describes how:

- the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal setting
- the contribution the NHS makes to preventing ill health and reducing health inequalities will be strengthened
- NHS organisations and local authorities will work more closely together as part of Integrated Care Partnerships to deliver health and care services
- Local health services will come together into geographical networks covering populations of 30,000 to 50,000 to provide better coordinated care closer to patients' homes.

- a local 5 year delivery plan for the NHS Long Term Plan will be published in Autumn 2019
- the role and membership of the Health & Wellbeing Board will be reviewed by Autumn 2019
- the NHS Clinical Commissioning Group and City Council will develop a joint medium term financial strategy by 2020.

Our high level outcomes: starting, living, ageing and dying well

We want everyone in Brighton & Hove to have the best opportunity to live a healthy, happy and fulfilling life.

Our approach will focus on achieving good health and wellbeing outcomes for the city and for the key life stages of local residents: starting well, living well, ageing well and dying well.

Our ambition for Brighton & Hove in 2030 is that:

People will live more years in good health (reversing the current falling trend in healthy life expectancy).

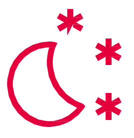
The gap in healthy life expectancy between people living in the most and least disadvantaged areas of the city will be reduced.

Our city

Our health and wellbeing is influenced by social, economic and environmental factors:

102nd most deprived local authority (of 326) (2015)

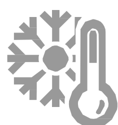
64 rough sleepers (Street count 2018)



5.8% of adult mortality is attributable to particulate air pollution (2017)

Those on the lowest 25% of earnings need **12 times their earnings** to afford the lowest 25% of house prices (2017)

11% 14,600 people estimated to be in fuel poverty (2016)



56 per 100,000 people killed or seriously injured on the roads in the city (2015 to 2017)

4.8% 7,700 people in the city are unemployed (2017) Employment rates are lower for those with: **long-term conditions**; a learning disability; and **in contact with secondary mental health services** (2017/18)

4% of 16-64 year olds are out of work due to long-term sickness (Oct 2017 – Sept 2018)

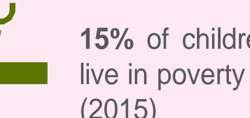
37 per 100,000 people admitted to hospital due to violent crime (inc sexual assault) (2015/16 - 17/18)

Starting well

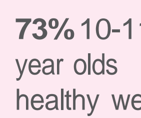
We do well in many areas: fewer mothers smoke, more breastfeed and more children are a healthy weight:

88% breastfeeding by 48 hours (2016/17)

6% smoking at delivery (2017/18)



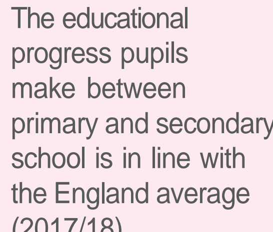
15% of children live in poverty (2015)



73% 10-11 year olds healthy weight (2017/18), but 14,000 children are overweight/obese

73% achieving a good level of development at end of reception (2017/18)

The educational progress pupils make between primary and secondary school is in line with the England average (2017/18)



77 per 10,000 children and young people under 18 years in care (Sept 2018)

Conceptions to under 18s fell from 48 per 1,000 15-17 yr old females (1998) to **18 per 1,000** (2016)

However, we have worse rates of smoking, drinking and drugs use, sexually transmitted infections (STIs) and poorer emotional wellbeing:

544 per 100,000 10-24 year olds admitted to hospital for self-harm (2016/17)

Most childhood vaccination rates, including MMR, are **below the 95% required for population protection**

The highest % of 15 year olds who smoke, have tried cannabis and the 3rd highest % drinking weekly in England (2015)

Young people aged 15-24 experience high rates of STIs, and are more likely to be reinfected within 12 months (2017)

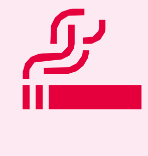
Living well

78% of adults are physically active (2016/17)

14% of adults cycle to work at least once a week (2017)

697 per 100,000 people had an alcohol specific hospital admission (2017/18)

18% of adults are current smokers (2017)



22% of adults aged 20+ have 2+ long-term physical or mental health conditions, **8%** have mental **and** physical conditions, with a strong link with deprivation (2017)

10% of adults are on GP practice depression registers (2017/18)

The highest rates of new STI diagnosis and HIV prevalence outside of London (2017)

Whilst life expectancy has been increasing, healthy life expectancy has fallen. People are therefore living longer in ill health. This, alongside the rising retirement age, means increasing numbers of people of working age are living in ill-health:

	Male	**Female**
Life expectancy (2015-17)	**79.1 years**	**83.0 years**
Healthy life expectancy (2015-17)	**62.2 years**	**65.3 years**

Ageing well

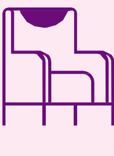
A relatively high proportion of older people live alone and a higher proportion of older people are income deprived:

58% of those surveyed receiving adult social care had good quality of life (2017/18)

Similar carer quality of life to England (2016/17)

The risk of loneliness for those 65+ in the city is in the top 20% in England (2011)

41% of people aged 65+ live alone (2011)



20.5% of older people are income deprived (2015)

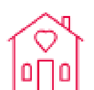
164 in every 1,000 65+ year olds have age-related macular degeneration (preventable sight loss) (2016/17)

4.4% of 65+ year olds have a record of dementia (2017)

Flu immunisation uptake at **67.5%** in 65+ year olds (2017/18) is below the goal of 75%

2,465 per 100,000 people aged 65+ were admitted as an emergency to hospital due to a fall (2017/18)

749 per 100,000 people aged 65+ admitted to permanent residential / nursing care homes (2017/18)



Dying well

The majority of people would like to die at home. In **half of all deaths**, people die in their usual residence (2016). This is a higher proportion than England and has increased from 40% in 2006

Key

- Significantly better than England
- Not significantly different to England
- Significantly worse than England
- Significance cannot be calculated
- Significantly higher than England
- Significantly lower than England

Based upon statistical significance

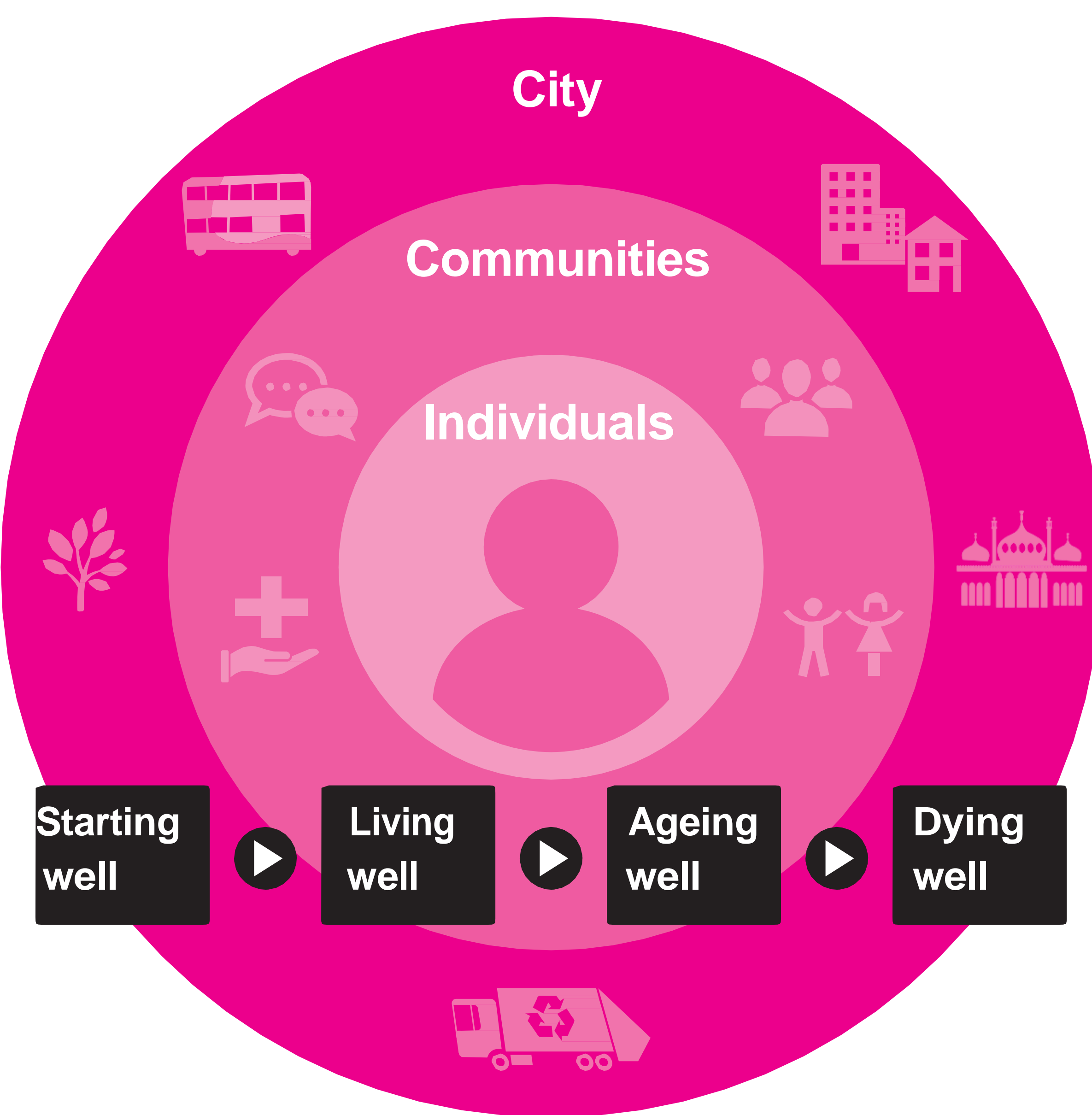
Key areas for action

Our approach to improving health and wellbeing

Social, economic and environmental factors have a major impact on our health and wellbeing.

Therefore, to achieve our vision we need Brighton & Hove to be a city where health and wellbeing is everyone's business

Partners across the city, including local communities, the Council, NHS, the community and voluntary sector, universities, schools, police, the fire & rescue service and businesses, all have a part to play in ensuring everyone in Brighton & Hove has the best opportunity to live a healthy, happy and fulfilling life.



Our city

Brighton & Hove will be a place which helps people to be healthy.

- The benefits of economic growth will be reinvested to support greater levels of inclusion. The gap between and within our communities will be narrowed.
- Planning of major developments and transport schemes will promote health and wellbeing.
- More people will travel actively, and walking and cycling will be prioritised, benefitting physical and mental health.
- Air quality will be improved.
- Residents will be supported to be safe, warm and well in their homes.
- The underlying causes of homelessness will be tackled.
- A whole city approach to food and wellbeing will be adopted, prioritising those with the poorest diets or least access to healthy food.
- Green & open spaces and sports & leisure facilities will be used effectively to improve wellbeing.
- Libraries and community spaces will be used to improve wellbeing.
- Arts and culture will benefit our health and wellbeing, including within local health and care services.
- Partners across the city will work with local residents to challenge the normalisation of substance misuse and excessive alcohol consumption and raise awareness of the detrimental impact they have on individuals and communities, so to reduce the associated harm, including physical and mental health problems and the exploitation of young or vulnerable people.
- People with caring responsibilities will be supported.

Starting well

The health and wellbeing of children and young people in Brighton & Hove will be improved.

- A focus on early years will maintain our good breastfeeding rates and improve the uptake of childhood immunisation.
- Healthy lifestyles and resilience will be promoted, including in school and other education settings, to reduce the risk of experiencing health problems in later life.
- Risks to good emotional health and wellbeing will be addressed, including parental substance misuse and domestic abuse, and mental health services will be easier to access.
- High quality and joined-up services will consider the whole family and, where appropriate, services will intervene early to provide support to prevent problems escalating.

Living well

The health and wellbeing of working age adults Brighton & Hove will be improved.

- Information, advice and support will be provided to help people to eat well, move more, drink less and stop smoking to reduce their risk of developing long term health conditions. Local people and communities will make the most of these opportunities to improve their health and wellbeing.
- Mental health and wellbeing will be improved and easier access to responsive mental health services will be provided.
- Sexual health will be improved, including reducing new HIV infections.
- People will receive support to improve their wellbeing in workplaces, and people with disabilities and long term conditions, and the long term unemployed, will be supported into work.

Ageing well

Brighton & Hove will be a place where people can age well.

- The contribution that people of all ages make to Brighton & Hove will be nurtured and celebrated and we will be both an age friendly city and a dementia friendly city.
- The needs of our ageing population will be considered in the design of the physical environment and in planning new housing developments.
- People will be supported to reduce loneliness and social isolation and to reduce their risk of falls and fractures.
- More people will be helped to live independently in the community by services that connect them with their communities.

Dying well

The experiences of those at the end of their life, whatever their age, will be improved.

- A city wide approach will be developed to improve health and wellbeing at the end of life and to help communities to develop their own approaches to death, dying, loss and caring.
- More people will die at home or in the place that they choose.
- Support for families, carers and the bereaved will be enhanced.

Delivering the strategy

How will the strategy be delivered and monitored?

Some of the required action will be incorporated into work already underway while some will require the development of new plans.

The Health & Wellbeing Board will be responsible for monitoring the delivery and impact of the strategy and will agree a set of key indicators by Autumn 2019.

Other strategies that support health and wellbeing

This strategy provides a bridge between the plans produced by local health and care services and other plans that impact on health and wellbeing in Brighton & Hove. The content of this strategy will be reflected in the development and delivery of these plans.

6553 Brighton & Hove City Council Communications Team

Appendix 2

Brighton & Hove Joint Health & Wellbeing Strategy

2019-2030

Summary of the feedback received from strategy engagement Dec 2018-Jan 2019

NHS
Brighton and Hove
Clinical Commissioning Group

Health and Wellbeing Strategy engagement event 31/1/19

Engagement

During late 2018 and January 2019 engagement took place with stakeholders and residents on the draft new Joint Health and Wellbeing Strategy for Brighton & Hove

This included attendance at a drop in engagement event at Hove Town Hall and an online survey

- Over 100 people attended the event
- 23 people responded to the online survey and 2 people submitted detailed responses

The online survey asked all questions below, at the event attendees discussed the questions in bold on each table (starting well, living well, ageing well & dying well):

- Is there anything we could do or add to strengthen our strategy?
- Do you agree with this overarching ambition?
- Please add any comments you have about the overall ambition of the strategy
- **Would it help to include ambitions for each life stage? Please give details**
- **How do you think services, communities and people in Brighton & Hove can work together to create a healthier city?**

Survey responses

All respondents to the survey agreed with the overarching ambition of the strategy:

By 2030 people will live more years in good health and the gap in healthy life expectancy between people living in the most and least deprived areas of the city will be reduced

Most respondents said there should be specific ambitions for each life stage

Some commented that the strategy could be strengthened by including more actions

Analysis of engagement event and survey

Starting well– how services, communities and people in Brighton & Hove can work together to create a healthier city

Support in the early years: Health visitors including specialist health visitors for communities to build trust; More supportive services and less judgement; more continuity of maternity care; links with benefit and debt advice and increase uptake of healthy start vouchers

Emotional and mental wellbeing: Talk to young people about protecting their mental health / resilience at school; Continue to support activities such as yoga and mindfulness and meditation in schools and push for these to be part of the school day; support for young people who don't meet threshold for mental health services

Use of community spaces: Financially accessible to all; Schools and libraries to be community hubs; Child and family friendly green and outdoor spaces

Think family: Whole family approach; Family peer support; encourage families to engage with each other, build community trust and support

Widely available physical activity, including increasing walking and cycling, and promotion of healthy eating: Ensure physical activity is prioritised throughout school from primary to secondary; Links with local sporting organisations for activities and to deliver health messages; Better health eating approaches in schools; more out of school family focused activities; increase cycling and walking –prioritise walkingand citywide cycle network

Living well– how services, communities and people in Brighton & Hove can work together to create a healthier city

Housing and homelessness: Quality and availability of housing; Social housing to live and age well; Community led housing

Transport: Public transport cost high and higher for those in more deprived areas; For those with chronic health conditions, disabilities or impairments community transport to reduce social isolation and manage health

Social isolation: Intergeneration projects; Good neighbour schemes; More outreach into communities; Buddying programmes for older people

Green and open spaces: Everyone should have access; Green spaces other than parks should be enhanced; Pedestrian only areas of the city centre which is has very heavy traffic; More activities in parks and open spaces

Physical activity, walking and cycling and food: Increase social prescribing of physical activity; Free/reduced membership for those on low incomes and other disadvantaged groups; Prioritise/promote walking and cycling as means to improve physical and mental health and the environment of the city

Mental health: Easier access to mental health and wellbeing support; Reduce waiting times for mental health support

Support for self-management: More support for those with long-term conditions to help manage their conditions; Expert patient programmes; People living with many health conditions should be supported holistically

Ageing well– how services, communities and people in Brighton & Hove can work together to create a healthier city

All the themes under living well were within ageing well also. With the addition of:

Support at or close to home: In home support for healthy living and physical activity; More awareness of services such as libraries home delivery service; community hubs for all ages; use of assets such as sheltered housing to run activities for local communities

More information on activities and support available across the city: Easy accessible information; Improve digital skills of older people; More information on prevention

Supported housing and care homes to consider differing needs of ageing population: LGBT older people; Those with HIV;BAME older people

Change the discussion to the positive assets older people bring to the city: Volunteering; Grandparents providing childcare; Mentoring.

Dying well– how services, communities and people in Brighton & Hove can work together to create a healthier city

Talk about dying well as a city: We need to openly discuss dying; Make information available online and for example through libraries; We know less on this area and need to consult more

Early planning: Promote and support planning with families; Indivualised planning; support for will writing and for living wills; counselling support

Support for dying in a place of your choice: Make dying at home the norm and provide specialist care and equipment at home to allow this to happen; more information on hospices – option to made available to anyone who chooses; consider how sheltered housing can support people

When someone dies in hospital, consider the environment: More music and arts; calming spaces; consider simple things like lighting, plants and refreshments

Training for clinicians: Listen to and involve patients and families ; coordination between professionals and services; support in care homes so not automatically taken to hospital

Support for carers, family and the bereaved: Training and support for family members; Provide more information on available support; More support for carers (e.g. shopping, respite care)

Culturally sensitive support: Ensure cultural background and needs are taken into account

Cross cutting themes

- Focus on prevention and staying healthy, rather than on illness
- Make the city a healthy city for all - a place where everyone can access and enjoy green and open spaces, live in good housing and cycle and walk
- Provide information and support to enable people to make healthier choices
- Reduce health inequalities and poverty
- Join up the commissioning and provision of services between health, the council and the community and voluntary sector
- Ensure that communities and individuals are involved in commissioning from the outset and throughout the process
- Consider the needs of specific groups and provide culturally sensitive services

Suggested ambitions

Starting well

- Ensure that everybody achieves the recommended weekly activity levels to improve physical and mental health
- Breastfeeding - the gap between the most and least deprived families = great prevention
- All children in Brighton & Hove have the opportunity to participate in cricket! / and football!
- Cutting air pollution
- Narrowing the gap in relation to food inequalities e.g. difference in obesity rates between most and least deprived areas.
- Walking (at least part-way) to school
- All able to be housed and educated well - and something about how this will be achieved

Living well

- To equalise rather then reduce the gap in healthy life expectancy in Brighton & Hove
- to have the highest life expectancy amongst homeless population in the UK

Ageing well

- Would want to see no gap between different areas of the city - how will you link impact/contribution to progress along the way
- That everybody achieves the recommended weekly activity levels through sport and physical activity
- No people on the streets

Dying well

- Would want to see gap closed rather than reduced
- Progress on dying in normal place of residence is good - feel it should be able to reach 80% Is this possible by 2030. What changes are planned?

Item 58

Although a formal committee of Brighton & Hove City Council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults and Healthwatch.

Title:	Pharmaceutical Needs Assessment
Date of Meeting:	19th March 2019
Report of:	Alistair Hill, Director of Public Health on behalf of Brighton & Hove Pharmaceutical Needs Assessment Steering Group
Contact:	Nicola Rosenberg Tel: 01273 296558
Email:	Nicola.Rosenberg@brighton-hove.gov.uk
Wards Affected:	All

FOR GENERAL RELEASE

Executive Summary

The Health and Wellbeing Board (HWB) has a statutory responsibility to publish a revised Pharmaceutical Needs Assessment (PNA) every three years. The PNA maps current pharmaceutical services, identifying gaps and exploring possible future needs. It's used by NHS England to decide upon applications to open new pharmacies and informs the commissioning of pharmaceutical services.

The most recent PNA was approved by the HWB in March 2018 and published in April 2018. This followed an extensive range of surveys with the public and professionals about the provision of local pharmacy services; as well as a statutory two month public consultation.

An application has now been received by NHS England from Pharma Supply Ltd to consolidate two pharmacies (Blake's Pharmacy, 91, Blatchington Road, Hove, BN3 3YG with Trinity Pharmacy, 3 Goldstone Villas, Hove, BN3 3AT).

Under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the Regulations), the HWB is required to make a written representation to

NHS England indicating whether, if the application were granted, the proposed closure of the pharmacy and its removal from the pharmaceutical list would or would not create a gap in pharmaceutical services. NHS England must refuse an application if it would create a gap in pharmaceutical services and the HWB must publish a supplementary statement if the closure does not create gap in pharmaceutical services. This is to prevent future unsuccessful applications to replace the closing pharmacy – as there is no gap to be filled.

The purpose of this paper is to request for the HWB to make a representation to NHS England that the proposed consolidation of the two pharmacies would not create a gap in pharmaceutical services, subject to having received certain assurances as detailed in the report.

Glossary of Terms

HWB – Health and Wellbeing Board

PNA – Pharmaceutical Needs Assessment

NHS England – National Health Service England

1. Decisions, recommendations and any options

1.1 That the Board agrees that the following representation should be made to NHS England:

a) That the proposed consolidation of two pharmacies (Pharma Supply Ltd trading as Blake’s Pharmacy, 91 Blatchington Road, Hove, BN3 3YG with Trinity Pharmacy, 3 Goldstone Villas, Hove, BN3 3AT) does not create a gap in pharmaceutical services subject to receiving confirmation from Pharma Supply Ltd that the number of pharmacists available to provide services in the consolidated pharmacy, in comparison to the previous number across both sites, will be sufficient to prepare and provide prescriptions without causing untoward delays.

b) The Board further notes that there is a reduction in hours due to lunchtime closure and asks whether this can be rectified by Trinity Pharmacy and whether the pharmacy can have a loop fitted for people with hearing impairments.

1.2 If the response to the above issues is that the consolidation of the pharmacies will not reduce service provision, then the Board would not consider that a gap in services is being created as defined in the Regulations.

2. Relevant information

2.1 Paragraph 19(5), Schedule 2 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (as amended) requires the Health and Wellbeing Board to make representations on consolidation applications to NHS England. Those representations must (in addition to any other matter about which the Health and Wellbeing Board wishes to make representations) indicate whether, if the application were granted, in the opinion of the Health and Wellbeing Board the proposed removal of premises from the pharmaceutical list would or would not create a gap in pharmaceutical services that could be met by a routine application (a) to meet a current or future need for pharmaceutical services, or (b) to secure improvements, or better access, to pharmaceutical services. The Health and Wellbeing Board's representations should be sent 45 days following receipt of the letter. The letter from NHS England was received by the Health and Wellbeing Board Tuesday February 12th 2019, with a response due from the HWB within 45 days i.e. by March 29th 2019.

2.2 At the HWB meeting in March 2018, the Board approved the process for supplementary statements delegating authority to the Director of Public Health working with the PNA Steering Group to identify and implement any future amendments to the PNA and to bring back a full revised PNA to the HWB in April 2021. As this consolidation of a pharmacy results in a closure this is being reported to the HWB. A supplementary statement has been published to record the previous consolidation which took place August 2018.

2.3 The consolidation of pharmacies is a growing national trend. Primary Care Commissioning advises that nationally there were 12 applications for consolidations of pharmacies in 2017/18 and 23 in 2018/19 (as at 25.02.19). The South East region has had the second highest number of applications over this period (8) after the North Midlands (9).

2.4 The merger and consolidation of Blake's and Trinity pharmacies will reduce the number of pharmacies in the city from 55 to 54 (including one distance selling online pharmacy). This translates to 18 pharmacies per 100,000 residents,[1] (excluding the distance selling pharmacy) compared to a range of 18 to 26 per 100,000 for our comparable local authority neighbours (where 2018 PNA data has been published). The median provision of pharmacies in 2018 in Kent, Surrey and Sussex was 19 per 100,000 and 22 for England. The PNA Steering Group has previously concluded this number of pharmacies and pharmacists is sufficient to meet pharmaceutical needs of residents in Brighton and Hove. This is due to the proximity of pharmacies in the city and the increasing numbers of pharmacist roles and the numbers of non-medical prescribers which supports increased access to pharmaceutical advice and support overall in the city. The recently published JSNA on Adults with Multiple Long Term Conditions (2019) identified the following pharmaceutical roles in the community: Clinical medication reviews and

[1] This is based on Office of National Statistics mid-year estimates 2016.

prescribing advice carried out by CCG Medicines Optimisation Pharmacists and Pharmacy Technicians and Consultant cardiac pharmacist; Medicines optimisation in Care Homes and Cluster Pharmacists who identify patients at high risk of frailty.

2.5 In terms of any loss of service provision resulting from this merger, the PNA Steering Group does not think a gap is being created because the remaining pharmacy has four other pharmacies within 1 km distance of the closed pharmacy, which is only 500 meters from the remaining pharmacy. In addition the provision of enhanced services will be increased at the remaining pharmacy with the continuation of a needle exchange and intention to provide an emergency contraception service. The remaining pharmacy is also a Healthy Living Pharmacy and provides smoking cessation. The other four pharmacies within walking distance of the remaining pharmacy also provide smoking cessation and emergency hormonal contraception services.

2.5 In terms of any loss of geographical access to pharmacy services, the PNA Steering Group does not think a gap is being created by this change. The two pharmacies proposing to consolidate are approximately 500m apart along Blatchington Road and Goldstone Villas. There are also four other pharmacies within walking distance from Trinity pharmacy. Trinity Pharmacy is also on the same site as Trinity GP Practice which had a registered list size of 23,103 in December 2018.

2.6. In terms of loss of access due to changes in opening hours, there will be a loss of 5 hours per week because Trinity pharmacy is not open at lunchtimes. Although this should be mitigated by its proximity to Boots in George Street which is open at lunch time, the Board would like Trinity pharmacy to commence opening during lunchtime hours.

2.7. The most recent Supplementary Statement published by BHCC http://www.bhconnected.org.uk/content/needs-assessments (February 2019) to reflect changes in opening hours in the city since June 2018, shows an overall reduction of 31½ per week in pharmacy opening hours, mainly as a result of the previous pharmacy consolidation as five pharmacies have increased their hours.

2.8. The PNA steering group will continue to monitor the impact on the capacity of all pharmacies in the city regarding workload.

3. Important considerations and implications

Legal:

3.1 As referred to in the report, the Regulations set out the legislative basis and requirements of the Health and Wellbeing Board to review applications for consolidation of two or more pharmacies. The proposals set out in this paper are consistent with the requirements of the Health and Wellbeing Board as set out in the Regulations. The HWB does not have the power to make a decision on the matter, but it can make representations to NHS England.

Lawyer consulted: Elizabeth Culbert Date: 01/03/19

Finance:

3.2 There are no financial implications as a direct result of this application.

Finance Officer consulted: David Ellis Date 01/03/19

Equalities:

3.3 Equality Act 2010 requirements were incorporated within the full PNA document. During the PNA process we took into consideration protected characteristics and vulnerable groups at each stage of the process and details relating to how services affect different groups are detailed in the main report.

3.3.1 An Equalities Impact Assessment has been completed as part of the Supplementary Statement process and is included as Appendix 1. The equalities issues identified include that there will be an improvement in disability access, with the provision of an accessible toilet at Trinity Pharmacy. The provision of emergency contraception will also improve provision for women and young people. If the waits for dispensing is increased this may have a detrimental impact on older people.

Equalities Officer consulted: Anna Spragg Date: 05/03/19

Supporting documents and information

Appendix 1: Pharmacy consolidation Equality Impact Assessment Blake's into Trinity pharmacy

Appendix 1

Brighton and Hove City Council

Policy and Equalities Impact Assessment Process for Reviewing NHS England Pharmacy Consolidation Applications

According to Consolidation Amendment Regulations 26A (2016), when two pharmacies based at two different sites in the same Health & Wellbeing Board (HWBB) area make an application to NHS England (NHSE) to consolidate their services onto one site, NHSE invites the HWBB to make representations within 45 days, as to whether or not a consolidation would result in a gap in local pharmacy provision.

The **HWBB must publish a supplementary statement** if the closure **does not create a gap** in pharmaceutical services.

NHSE must refuse an application if it would create a gap in pharmaceutical services.

When consolidation applications are received for representations by the HWBB the following short Equality Impact Assessment (EIA) template should be completed. The EIA process provides the details by which consolidations will be assessed in order to ascertain whether there will be a gap in pharmaceutical services.

The Health and Adult Social Care Directorate public health team will be responsible for completing the assessment and the Pharmaceutical Needs Assessment Steering Group[1] will approve the final version and make a recommendation to DMT for sign off on behalf of the Health and Wellbeing Board, regarding the representation that the Health and Wellbeing Board should make to NHSE.

The EIA can be included as part of the formal representation by the HWBB to NHSE, who may also undertake their own EIA.

[1] The PNA Steering Group is chaired by a Consultant in Public Health and its membership includes representatives from the Clinical Commissioning Group (CCG), NHS England, Local Pharmaceutical Committee, Healthwatch and BHCC public health team.

Short Equality Impact and Outcome Assessment (EIA) Template - 2019

EIAs make services better for everyone and support value for money by getting services right first time.

EIAs enable us to consider all the information about a service, policy or strategy from an equalities perspective and then action plan to get the best outcomes for staff and service-users[1].They analyse how all our work as a council might impact differently on different groups[2]. They help us make good decisions and evidence how we have reached these decisions.

See end notes for full guidance. Either hover the mouse over the reference number which is the end note link (eg: ID No.[6]) or use the hyperlinks ('Ctrl' key and left click).

For further support or advice please contact the Communities, Equality and Third Sector Team on ext 2301.

1. Equality Impact and Outcomes Assessment (EIA) Template

Title of EIA[3]	**Pharmacy consolidation of Blake's Pharmacy, at 91, Blatchington Road, Hove BN3 3YG, onto the site of Trinity Pharmacy at 3, Goldstone Villas, Hove, BN3 3AT**	**ID No.[4]**	
Team/Department[5]	Public Health, Health & Adult Social Care Directorate		
Focus of EIA[6]	• To identify whether any gaps in pharmacy service provision will arise relating to people who share a legally protected characteristic (see endnote 2) from the consolidation of two pharmacies or any opportunities to increase or improve provision • To review whether there is a detrimental impact on local residents as a whole, or any particular group – in terms of access, provision of advanced and enhanced pharmacy services and health & wellbeing needs. • To provide assessment to inform the HWBB representation to NHSE, the pharmacy commissioner, as to whether any gap will arise. No gaps have been identified in the provision of services to protected characteristic groups following the consolidation of these pharmacies. Provision for wheelchair using patients will be improved by this consolidation; Blake's pharmacy does not have a wheelchair accessible toilet, whereas Trinity pharmacy does.		

	There will be a minor detrimental impact on local residents caused by this consolidation because Trinity pharmacy is proposing a total of 44 opening hours a week, compared to Blake's current total opening hours of 49 a week. The reduction is due to lunch time closures between 1-2pm at Trinity pharmacy 5 days a week. This should be offset though by its close location to Boots pharmacy on George Street which is open at lunch times. The provision of advanced services should be improved for Blake's pharmacy patients because Trinity pharmacy provides a needle exchange service, which is not currently provided by Blake's pharmacy. Patients at both pharmacies will also benefit from the intended provision of an Emergency Contraception services, which was not available at either pharmacy prior to consolidation. Trinity pharmacy also provides a smoking cessation service and is Healthy Living Pharmacy.

Assessment of overall impacts and any further recommendations[7]
For clarity all disproportionate impacts on specific groups with protected characteristics and other groups are highlighted in the single section below. Overall impacts and notes: • E.g. distance between pharmacies after consolidation • E.g. access for people with physical disabilities • E.g. provision of specialist services like chlamydia screening, condom distribution or emergency contraception and likely impact on women and young people in particular • E.g. likely impact of changes in opening hours on specific groups, such as older people and full time employees There is no negative overall impact in terms of increased distance for patients to travel following consolidation. The two pharmacies are located about approximately 500 meters from each other. Access for people with physical disabilities should be improved as Trinity pharmacy has an accessible toilet. Trinity pharmacy is co-located with a GP Practice (Trinity Surgery, which had 23,103 registered patients at December 2018) and the GP Practice has an onsite

car park, which will assist patients with disabilities.

The intended provision of emergency contraception at Trinity pharmacy following consolidation will have a positive impact for women and young people in particular.

The reduction of opening hours, with lunchtime closure at Trinity pharmacy, will have a negative impact on full time employees in particular, although Boots pharmacy nearby is open at lunch times.

The consolidation of the pharmacies is likely to lead to increased numbers of people using Trinity pharmacy, which may increase the waiting time for medicines to be dispensed. This may have a negative impact on older patients in particular.

Potential issues	**Mitigating actions**
• Longer waits for dispensing of medicines • Access (physical access to the premises and ability to move within the premises) no/reduced/improved access at combined/new site for people with -sensory impairment - mobility impairment - who are wheelchair users - with learning disabilities - people with mental health problems • Access – is the distance of travel from the old to new consolidated pharmacy worse or an improvement for patients and carers • Worsening / improvement in access to public transport at new/combined site • Loss of/increase in specialist services in new/combined pharmacy – note likely impacts on specific groups Potential issues identified by this Equality Impact Assessment include: • Longer waits for dispensing of medicine • As presently, there will be no induction loop provision at Trinity pharmacy after consolidation • The distance between the old and new pharmacy is not an issue, as they are very close to each other.	• More staff required in new/combined pharmacy • Physical adaptations to be made to the building (specify and note what funding is available for these) • Note distance between old and new pharmacy • Note distances from public transport and any options available • Note services to be added/removed/reduced and where else these are available and what benefits will arrive. • Will there be increased staffing from the old site to mitigate against longer waits? • Are there any plans to include induction loop provision? • The distance between old and new pharmacy is approximately 400-500 meters. There are also 4 pharmacies within approximately 1km of the closing Blake's site. The range of locally commissioned services provided at these

• The access to public transport at the new site is the same as at the old. • Specialist services will be improved at the combined pharmacy with the provision of emergency contraception, and will have a positive impact for women.	other pharmacies include smoking cessation, and emergency hormonal contraception – which are also provided by Trinity pharmacy. • The new site is next to a bus stop and within walking distance of Hove Station • Specialist services will be improved at the combined pharmacy with the provision of emergency contraception, and will have a positive impact for women. A needle exchange will also be provided, which was not previously available to Blake's pharmacy patients. Trinity pharmacy is also a Healthy Living Pharmacy, whereas Blake's pharmacy is not. Both pharmacies provide a smoking cessation service.
Actions planned[8]	
Recommended representations by HWBB to NHSE It is recommended that the HWBB make representations to the NHSE to say that no gap in pharmacy provision will arise as a result of this consolidation. It may though want to clarify whether there will be any increase in staffing at the Trinity site to mitigate increased waiting time and also ascertain whether there are any plans to open at lunchtimes or introduce an induction loop system.	

EIA sign-off: (for the EIA to be final an email must be sent from the relevant people agreeing it or this section must be signed)

Lead Public Health Consultant: Nicola Rosenberg Date: 06.02.19

Communities, Equality Team and Third Sector officer: Anna Spragg Date: 06.02.19

Guidance end-notes

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[1] The following principles, drawn from case law, explain what we must do to fulfil our duties under the Equality Act:

- **Knowledge:** everyone working for the council must be aware of our equality duties and apply them appropriately in their work.
- **Timeliness:** the duty applies at the time of considering policy options and/or before a final decision is taken – not afterwards.
- **Real Consideration:** the duty must be an integral and rigorous part of your decision-making and influence the process.
- **Sufficient Information:** you must assess what information you have and what is needed to give proper consideration.
- **No delegation:** the council is responsible for ensuring that any contracted services which provide services on our behalf can comply with the duty, are required in contracts to comply with it, and do comply in practice. It is a duty that cannot be delegated.
- **Review:** the equality duty is a continuing duty. It applies when a policy is developed/agreed, and when it is implemented/reviewed.
- **Proper Record Keeping:** to show that we have fulfilled our duties we must keep records of the process and the impacts identified.

NB: Filling out this EIA in itself does not meet the requirements of the equality duty. All the requirements above must be fulfilled or the EIA (and any decision based on it) may be open to challenge. Properly used, an EIA can be a tool to help us comply with our equality duty and as a record that to demonstrate that we have done so.

[2] **Our duties in the Equality Act 2010**

As a council, we have a legal duty (under the Equality Act 2010) to show that we have identified and considered the impact and potential impact of our activities on all people with 'protected characteristics' (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation, and marriage and civil partnership.)

This applies to policies, services (including commissioned services), and our employees. The level of detail of this consideration will depend on what you are assessing, who it might affect, those groups' vulnerability, and how serious any potential impacts might be. We use this EIA template to complete this process and evidence our consideration.

The following are the duties in the Act. You must give 'due regard' (pay conscious attention) to the need to:

- **avoid, reduce or minimise negative impact** (if you identify unlawful discrimination, including victimisation and harassment, you must stop the action and take advice immediately).
- **promote equality of opportunity**. This means the need to:
  - Remove or minimise disadvantages suffered by equality groups
  - Take steps to meet the needs of equality groups
  - Encourage equality groups to participate in public life or any other activity where participation is disproportionately low
  - Consider if there is a need to treat disabled people differently, including more favourable treatment where necessary
- **foster good relations between people who share a protected characteristic and those who do not**. This means:
  - Tackle prejudice
  - Promote understanding

[3] **Title of EIA:** This should clearly explain what service / policy / strategy / change you are assessing

[4] **ID no:** The unique reference for this EIA. If in doubt contact Clair ext: 1343

[5] **Team/Department:** Main team responsible for the policy, practice, service or function being assessed

[6] **Focus of EIA:** A member of the public should have a good understanding of the policy or service and any proposals after reading this section. Please use plain English and write any acronyms in full first time - eg: 'Equality Impact Assessment (EIA)'

This section should explain what you are assessing:

- What are the main aims or purpose of the policy, practice, service or function?
- Who implements, carries out or delivers the policy, practice, service or function? Please state where this is more than one person/team/body and where other organisations deliver under procurement or partnership arrangements.
- How does it fit with other services?
- Who is affected by the policy, practice, service or function, or by how it is delivered? Who are the external and internal service-users, groups, or communities?
- What outcomes do you want to achieve, why and for whom? Eg: what do you want to provide, what changes or improvements, and what should the benefits be?
- What do existing or previous inspections of the policy, practice, service or function tell you?
- What is the reason for the proposal or change (financial, service, legal etc)? The Act requires us to make these clear.

[7] **Assessment of overall impacts and any further recommendations**

- Make a frank and realistic assessment of the overall extent to which the negative impacts can be reduced or avoided by the mitigating measures. Explain what positive impacts will result from the actions and how you can make the most of these.
- Countervailing considerations: These may include the reasons behind the formulation of the policy, the benefits it is expected to deliver, budget reductions, the need to avert a graver crisis by introducing a policy now and not later, and so on. The weight of these factors in favour of implementing the policy must then be measured against the weight of any evidence as to the potential negative equality impacts of the policy,
- Are there any further recommendations? Is further engagement needed? Is more research or monitoring needed? Does there need to be a change in the proposal itself?

[8] **Action Planning:** The Equality Duty is an ongoing duty: policies must be kept under review, continuing to give 'due regard' to the duty. If an assessment of a broad proposal leads to more specific proposals, then further equality assessment and consultation are needed.