Brighton & Hove City Council

Health Overview & Scrutiny Committee

Title:	**Health Overview & Scrutiny Committee**
Date:	**20 March 2019**
Time:	**4.00pm**
Venue	**The Ronuk Hall, Portslade Town Hall - Portslade Town Hall**
Members:	**Councillors:** K Norman (Chair), Allen (Group Spokesperson), Bennett, Deane, Barnett, Greenbaum, Morris, Marsh and C Theobald **Co-opted Members:** Zac Capewell (Youth Council), Caroline Ridley (Community Sector Representative), Fran McCabe (Healthwatch), Colin Vincent (Older People's Council)
Contact:	**Giles Rossington** Senior Policy, Partnerships & Scrutiny Officer 01273 295514 giles.rossington@brighton-hove.gov.uk

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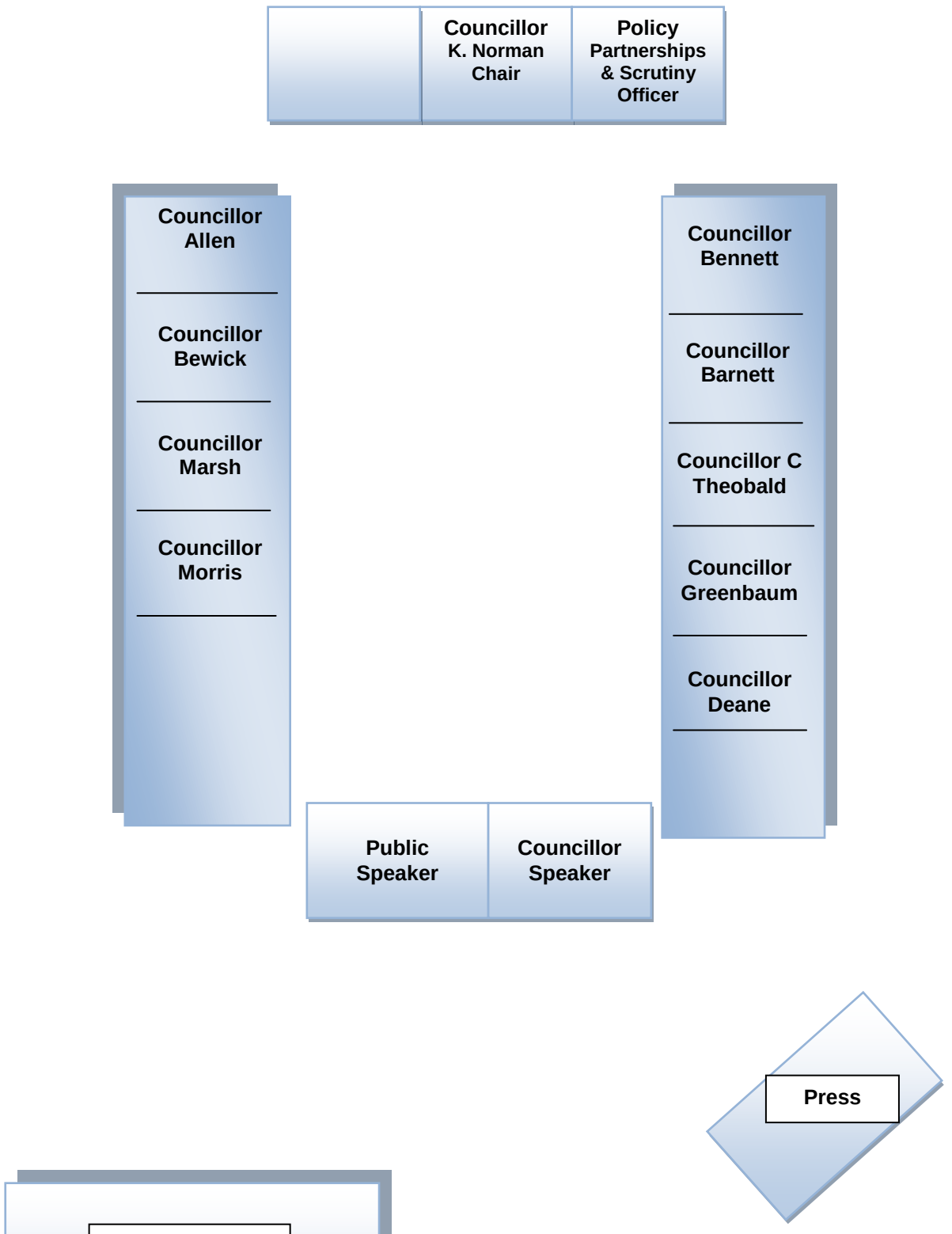
Democratic Services: Health Overview & Scrutiny Committee



AGENDA

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To consider the minutes of the last meeting held on the 23rd January 2019 (copy attached)

35 CHAIRS COMMUNICATIONS

36 PUBLIC INVOLVEMENT **19 - 20**

(a) A written question has been received from Ms Janet Sang (copy attached)

37 MEMBER INVOLVEMENT **21 - 22**

To consider a Notice of Motion referred from 30 January 2019 Council (copy attached)

38 BRIGHTON & SUSSEX UNIVERSITY HOSPITALS TRUST (BSUH): CARE QUALITY COMMISSION INSPECTION REPORT **23 - 42**

Report of the Executive Lead, Strategy, Governance & Law on the recent Care Quality Commission (CQC) inspection of Brighton & Sussex University Hospitals Trust (BSUH) (copy attached)

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

39 BRIGHTON & SUSSEX UNIVERSITY HOSPITALS TRUST (BSUH): WAITING TIMES **43 - 56**

Report of the Executive Lead, Strategy, Governance & Law, on Brighton & Sussex University Hospitals Trust (BSUH) waiting times and outpatient services

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

40 CANCER: UPDATE ON LOCAL PERFORMANCE **57 - 66**

Report of the Executive Lead for Strategy, Governance & Law on local cancer performance (copy attached)

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

41 HEALTHWATCH ANNUAL REPORT **67 - 102**

Report of the Executive Lead, Strategy, Governance & Law (copy attached)

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

42 HEALTHWATCH REPORT ON OLDER PATIENTS' EXPERIENCE OF HOSPITAL DISCHARGE **103 - 184**

Report of the Executive Lead, Strategy, Governance & Law (copy attached)

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

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OVERVIEW & SCRUTINY COMMITTEE

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Date of Publication - Tuesday, 12 March 2019

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 23 JANUARY 2019

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor K Norman (Chair)

Also in attendance: Councillor Allen (Group Spokesperson), Deane, Greenbaum, Morris, Marsh, Hill, Janio and Wealls

Other Members present: Fran McCabe (Healthwatch), Zac Capewell (Youth Council)

PART ONE

21 APOLOGIES AND DECLARATIONS OF INTEREST

21.1 Cllr Janio attended as substitute for Cllr Carol Theobald
Cllr Wealls attended as substitute for Cllr Barnett
Cllr Hill attended as substitute for Cllr Bewick.
Apologies were received from Colin Vincent (Older People's Council Representative) and from Caroline Ridley (Community Sector representative).

21.2 No member declared any interest in matters being considered.

21.3 It was resolved that the press & public should not be excluded from the meeting.

22 MINUTES

21.1 RESOLVED – that the minutes of the 17 October 2018 meeting were agreed as an accurate record.

23 CHAIRS COMMUNICATIONS

23.1 The Chair gave the following communications:

I've got four things to say today:

Firstly, the Care Quality Commission has recently published an inspection report on Brighton & Sussex University Hospitals Trust. I'm delighted to say that this is a really positive report: the Trust has been given an overall rating of good, with several services, including the care provided by staff rated as excellent. The CQC has also recommended that the Trust be taken out of quality and financial special measures.

This really is an extraordinary turnaround, and I'm sure the committee would like to congratulate everyone at BSUH for this achievement. It shouldn't be forgotten that this is a system success also – the CCG, other NHS providers and the council's social care teams have worked effectively together to support the hospital, and I'd like to congratulate them too.

This definitely isn't the end of the story – there are still lots of areas that BSUH needs to improve on, including outpatients, waiting times, and the performance of key services, including cancer. The HOSC will be monitoring work in these areas as well as keeping an eye on the progression of the 3Ts project which will eventually provide much needed additional capacity for hospital emergency services.

Secondly, we've also recently heard that Adam Doyle has had his role as Accountable Officer for CCGs across Sussex made permanent. There is a letter from the CCGs giving more details on this appointment at the back of today's HOSC papers. I'm sure the committee would like to congratulate Adam and wish him all the best in this challenging role.

Thirdly, following the last HOSC meeting I wrote to the Chair of BH CCG asking for more information about the Clinically Effective Commissioning programme. My letter and Dr Supple's response are included for information at the end of today's papers. We discussed the CCG response at the pre-meet for HOSC and it was agreed that it was possible for the CCG to pull together a bit more information about what the procedures in the first tranches of CEC are, what the impact of the changes is and so on. When we receive this additional information it will be circulated to members and included in the papers for the next HOSC meeting.

Finally, there's been some speculation in the local media about the future of the walk-in GP service currently being provided near Brighton Station. We've received some information from the CCG on this which has been circulated to members and will be included in the minute to this meeting. We can discuss this fully at the March HOSC, or people can ask questions now.

23.2 Cllr Morris noted that people using the walk-in centre frequently didn't fill-in the forms as they should, so use of the service may be under-reported.

23.3 Fran McCabe wondered what the future would be for sexual health services currently provided from the walk-in centre.

24 PUBLIC INVOLVEMENT

24.1 There was a Public Question from Ms Linda Miller. Ms Miller asked:

I would like to draw the HOSC's attention to the information provided by the BBC's NHS Tracker about the standard of NHS provision in Brighton and Hove
https://www.bbc.co.uk/news/health-41483322

Patients treated or admitted within four hours of arrival at A&E
October 2018 figures

TARGET
95.0%
YOUR TRUST (BSUH)
80.7%
ENGLAND
89.1%
Brighton & Sussex University Hospitals NHS Trust ranked 113 of 130 trusts

Patients starting cancer treatment within 62 days of urgent GP referral
September 2018 figures
TARGET
85.0%
YOUR TRUST (BSUH)
74.1%
ENGLAND
78.2%
Brighton & Sussex University Hospitals NHS Trust ranked 101 of 131 trusts

Patients having planned operations & care within 18 weeks of referral
September 2018 figures
TARGET
92.0%
YOUR TRUST (BSUH)
80.7%
ENGLAND
86.7%
Brighton & Sussex University Hospitals NHS Trust ranked 106 of 126 trusts

Patients starting mental health therapy within six weeks of referral
Apr - Jun 2018 figures
TARGET
75.0%
YOUR AREA
48.0%
ENGLAND
89.5%
NHS Brighton & Hove ranked 192 of 195 CCG areas

The NHS services provided to Brighton and Hove residents are falling far short of national targets and national averages. Do you agree that disbanding our local HOSC, in favour of a Sussex and Surrey-wide JHOSC, would weaken our ability to oversee and scrutinise, and hopefully improve, what is happening to our local NHS?

24.2 The Chair responded:

There are no proposals to disband the local HOSC in favour of a Sussex and East Surrey-wide Joint HOSC (JHOSC). Local authorities are required by law to appoint a JHOSC in order to scrutinise specific change plans involving the substantial development of a service or a substantial variation in the provision of a service which affect more than one local authority area, which NHS bodies or health service providers

are subject to a requirement to consult with local authorities on. Local authorities have no option other than to join a JHOSC when the conditions requiring one are met.

The requirement applies only where the law requires authorities to appoint a mandatory JHOSC. There is no such requirement to discharge jointly any other health scrutiny functions. Whilst there is a good deal of informal joint working between HOSCs in the region (for example, members from several HOSCs meeting jointly and informally with an NHS provider rather than holding separate meetings), the Council has no plans to combine any of its formal HOSC functions or responsibilities other than those which trigger the requirement to appoint a JHOSC with any other local authority. This explicitly includes the NHS performance issues detailed in your question.

24.3 Ms Miller asked a supplementary question:

"These figures are showing that the current level of funding is not adequate to meet the needs of our local population.

And yet we know that the CCG is having to make £14m of cuts this year, its share of the £50m being cut across the Sussex/Surrey region.

And the proposed Joint HOSC is required because the CCGs are planning Substantial Variations in Service.

What are the Cuts and Substantial Variations in Service that are being planned? When and where will they be published? The public needs to know."

24.4 The Chair agreed to provide a written response to this question. The following text was provided by Brighton & Hove CCG:

The amount of money the CCGs will be receiving from NHS England to pay for health services is going up for next year. However, the increase is not enough to bridge the gap with the ever-increasing rising demand and it is clear that further savings will have to be made during the year to ensure the CCGs do not carry on spending more money than is available.

This may require difficult decisions being made around services that are not deemed to be cost effective or less of a clinical priority when compared to other services that need investment.

The five CCGs of the Central Sussex and East Surrey Commissioning Alliance agreed a financial recovery plan last year with NHS England, which required £50m of savings to be made across the organisations from the total allocation of £1.4bn. This plan was published for the public to read in September and open conversations, information and engagement has taken place with the public, patients and stakeholders around what it means for them. Significant progress has been made to achieve the plan and the CCGs are expected to finish the financial year in a more stable financial footing than they have been in the past.

Due to rising demand, heath services across Sussex and East Surrey currently costs more money than is available. This means that for CCGs to be able to invest in existing

and new services, they have to look at where money can also be saved and then used more effectively.

The Clinically Effective Commissioning (CEC) programme is a Sussex-wide initiative which aims to improve the effectiveness of healthcare services by ensuring that commissioning decisions are consistent, reflect best practice, are in line with the latest clinical evidence and represent the most sensible use of limited resources.

At present there can be differences in the criteria used by local specialists to determine when patients should be referred for tests and treatment. This issue, often referred to as a “postcode lottery”, means some patients are not receiving treatment when they should, purely because of where they live, while others were receiving NHS-funded procedures that offer little or no clinical benefit - including alternative therapies such as aromatherapy, herbal remedies, reflexology and homeopathy.

The aim of the CEC programme is to bring a uniform systematic approach to policy review and implementation across all the CCGs to remove the unwarranted variation that exists and apply sound clinical decision making within mutually agreed policies. This ensures equity of access, improved clinical outcomes, better patient experience and efficient demand and capacity management across the system.

To enable this to happen, all Sussex CCGs have come together as part of the CEC Programme and agreed to take a single approach to identifying, developing and agreeing areas of focus. So far, the seven CCGs across Sussex have adopted a number of standardised polices, covering a range of tests and treatments including tonsillectomies, gallstones and trigger finger. Standardisation has meant minor changes to some CCG policies, or the introduction of policies where they did not exist before.

All of the updates to our clinical policies are evidence-based and built on NICE guidance and best practice to ensure we get the very best outcomes for our patients. The updates are consistent across all seven Sussex CCGs in Sussex and the treatments included are not new, most already had a defined procedure threshold.

The programme is now currently looking at policies where there are more significant differences between existing policies or the need for new policies. This will require and involve rigorous clinical scrutiny and engagement with patients, public, stakeholders and carers.

As well as being more clinically effective for patients, adopting a more standardised approach to clinical policies ensures that NHS funding is being spent more effectively. In some areas this will allow money to be saved which can be invested in other treatments and care that have more clinical benefit to our patients.

The potential savings that can be made from the CEC programme are part of the CCGs’ financial recovery plans. Every CCG in the country has a financial plan that outlines how they will meet their legal obligations around ensuring they are getting best value from taxpayers’ money.

The CCGs are in the early stages of assessing any further potential savings that need to be made and are looking at all areas thoroughly, with clinical insight and scrutiny. We do

not know at this stage if this will require any 'substantial variation' to services. Before any final decisions are made, we will be completing a thorough assessment to help understand how potential decisions may affect people, followed by a period of engagement with local patients, carers and the public. We want to be able to have regular and meaningful dialogue and engagement with the HOSC as these plans for savings develop and believe this can be best done with a Joint HOSC across Sussex. This will allow us to have more consistent conversations, allow discussion to be more thorough, and will allow engagement to be done once in a more timely way.

Additionally, there are other programmes of work that are taking place at regional level which would benefit from having oversight and scrutiny by a Joint HOSC. These may not particularly involve any 'substantial variation' to services but will aim to improve the care of our patients at scale. Currently, these programmes report to the HOSCs and HASC across Sussex and East Surrey at a local level when appropriate, which can cause inconsistency in the discussions around how they can benefit the populations across the region.

25 MEMBER INVOLVEMENT

25.1 There was none.

26 SUSSEX COMMUNITY NHS FOUNDATION TRUST: PLANS TO DEVELOP A COMMUNITY HEALTH HUB ON THE BRIGHTON GENERAL HOSPITAL SITE

26.1 This item was presented by Mike Jennings, SCFT Deputy Chief Executive.

26.2 Mr Jennings explained how the plans for the Brighton General Hospital (BGH) site had progressed, noting that the preferred option retains all patient-services on the site, other than some Brighton & Sussex University Hospital Trust (BSUH) services which are being temporarily provided at the BGH, but will either be moved back to the Royal Sussex County Hospital or provided in a city community setting. Oliver Phillips, BSUH Director of Strategy, confirmed that the two trusts were working closely together to ensure that this transfer is seamless.

26.3 In response to a question on bus access from Cllr Allen, Mr Jennings confirmed that the trust will talk to the bus company about access, specifically including the feasibility of having a bus enter the site to make patient access as simple as possible.

26.4 In answer to a query from Cllr Allen on the future of rough sleeping services, it was explained that there was no intention of moving user-facing services from their central Brighton location at Morley Street. However, some administrative staff would be moved.

26.5 Cllr Marsh noted that local residents had concerns about access for local people if GP services relocate to BGH. The area is very hilly, so that even residents who live only a short distance from the BGH may find accessing it difficult.

26.6 In response to a question from Cllr Greenbaum on staff consultation, members were told that over 80% are in favour of the trust's preferred option for development. Of the 20%

opposed, some prefer a different option or simply do not want to contemplate change. Specific concerns have been raised about traffic congestion, public transport provision and the hilly nature of the BGH site.

26.7 In answer to a question from Fran McCabe about health visitors, the committee was told that the BGH site is not used to provide a patient-facing health visitor service, so patients will not be adversely affected by the plans.

26.8 In response to a query by Cllr Hill as to the ambitions and the financial underpinning of plans, members were informed that the preferred option represents the simplest of the re-designs originally proposed. Any re-design must be wholly funded by disposing of some of the site for housing. SCFT need to secure a reasonable market value for this land to make their plans tenable, but do not need to secure maximum value for everything.

26.9 In answer to a question from the Chair about listed building status, the committee was told that A Block is listed, but that other aspects of the BGH site also have heritage value, including the flint wall curtilage.

26.10 Mr Jennings told members that there will be a mix of market, affordable and key worker housing on the BGH site. However, the precise details of this will have to be negotiated with developers. The Chair noted that he would like to see some extra care housing provision on the site also.

26.11 The Chair thanked Mr Jennings for his presentation and looked forward to future updates.

26.12 RESOLVED – that the report be noted.

27 SOUTH EAST COAST AMBULANCE NHS FOUNDATION TRUST (SECAMB): UPDATE ON QUALITY & PERFORMANCE

27.1 This item was presented by Steve Emerton, SECAmb Director of Strategy and Business Development; Andy Cashman – Regional Operations Manager: WEST; and Helen Wilshaw – Strategy and Partnerships Manager: WEST.

27.2 Mr Emerton told members that SECAmb is on a journey to improvement, and has seen significant advances in the past 12 months. There has been substantial new funding from CCGs following a Trust wide Demand and Capacity review, which has enabled the Trust to invest further in workforce and fleet throughout financial year 1819 to 2021. Performance in the Brighton & Hove City area is good, often meeting all targets set and has historically been so, although SECAmb has sometimes struggled in the wider Brighton and Hove CCG area to meet targets in the more rural parts of its patch.

27.3 Ms Wilshaw told the committee that SECAmb had worked hard with local commissioners and providers via the A&E Delivery Board and sub groups to reduce hospital handover delays and acute hospital conveyance where possible. Hospital handover performance is improving although some significant challenges remain and work is ongoing through a joint operational improvement group to enable continuous improvement. There has also been additional local focus on admission avoidance to

support more patients, where appropriate, in community facilities and at home. Specific focus areas of frailty, homelessness and falls have resulted in support initiatives and targeted resource, such as the 'longest one waiting' vehicle which aims to reduce very long patients waits for the lower acuity incidents at times of significant system pressure. Additional reporting has been developed, on frequent 999 caller nursing and care homes, to establish where further system support is required to reduce 999 calls and avoidable hospital admissions.

27.4 In response to a question from Cllr Marsh on category 3 calls, Mr Cashman explained that calls to 999 and referrals from GPs etc. are classified according to their urgency. Responses to category 3 calls will be slower than to categories 1 and 2, and where appropriate may involve sending a less highly-equipped vehicle.

27.5 In response to a question from Cllr Marsh about the new Make Ready Centre, Mr Cashman explained that this represents the implementation of long term aims. The centre will become operational by March 2020. There will be response posts across Brighton & Hove – not all ambulances will be despatched from the Centre at Falmer. HOSC members are invited to visit the current Brighton Ambulance Station at Elm Grove and then visit the new centre once complete.

27.6 In answer to a query from Cllr Deane about stroke response times, Mr Cashman told members that effective treatment for stroke was about identifying the most urgent cases and getting them to the most appropriate places for diagnosis and treatment. Ambulance response times are one part of this patient treatment journey.

27.7 In response to a question from Cllr Greenbaum about SECAmb involvement in the BHCC Outdoor Events consultation, the SECAmb representatives noted that they were unaware of the consultation. (Following the meeting SECAmb was sent a link to the on-line consultation. BHCC officers responsible for the consultation also explained that their plan has always been to engage fully with key partners, including SECAmb, in the second stage of this consultation. SECAmb have subsequently completed a submission as part of the consultation process.)

27.8 In answer to a question from Ms McCabe on managing falls risks, Mr Emerton told the committee that the Trust works hard to mitigate the risks of patients having to wait for a category 3 ambulance – e.g. by ensuring where possible that the patient is made comfortable and by keeping in touch with patients while they wait so as to be immediately aware of any deterioration. Helen Wilshaw added that it was important to ascertain whether someone was present and able to support the patient; this would be one factor in determining what type of ambulance response was appropriate. There is also further work to be done with care homes; in many instances there is no reason why care home residents need to be left where they fell until an ambulance arrives.

27.9 In response to a question from Cllr Janio on the proportion of unnecessary calls, Mr Cashman replied that this was difficult to estimate as callers may not always be in a good position to understand the seriousness of their condition. Placing more clinicians in call centres and building in more time to assess calls before a response is triggered should reduce the number of inappropriate call-outs. SECAmb also focuses on frequent callers to work out what their conditions are, whether they are receiving the support they

need and works directly with other health and social care colleagues to highlight additional needs.

27.10 In answer to a query from Cllr Greenbaum on the reliability of second-hand ambulances, Mr Emerton explained that the trust does plan for the need to make repairs when buying second-hand fleet. Most repairs are undertaken in-house, unless they are particularly specialist or can be done under warranty.

27.11 In response to a question from Cllr Morris on the categorisation of calls, Mr Cashman explained that this is based on national rules. Categorisation depends on the urgency of the call and also whether the problem is something that can be treated at the scene rather than requiring conveyance to hospital.

27.12 RESOLVED – that the report be noted.

28 NHS 111 PROCUREMENT: JANUARY 2019 UPDATE

28.1 This item was introduced by Colin Simmons, Coastal West Sussex CCG. Mr Simmons explained that the exercise to procure a new Sussex 111 service had been paused while commissioners investigated the potential for procuring a service jointly with Kent CCGs. This is indeed feasible and a redesigned 111 contract will be jointly procured with Kent CCGs.

28.2 Procurement decisions will be taken by a joint committee with delegated powers, rather than independently by each of the CCGs.

28.3 Procuring jointly with Kent presents an opportunity to make significant efficiencies. It is also the case that national requirements for 111 have been recently re-drawn and this required re-visiting the premise of the local contract.

28.4 The plans are now to award a contract in summer 2019, with mobilisation in the autumn.

28.5 In response to questions by Cllr Janio on the contract, Mr Simmons told members that the contract would be for five years with an option to extend for a further two years. There will be penalties if the provider fails to deliver the contracted level of service.

28.6 In answer to a question from Cllr Deane on technology issues, Mr Simmons told the committee that this was a significant aspect of the contract, particularly in terms of ensuring the interoperability of different NHS IT systems.

28.7 In response to a query from Cllr Marsh on transfer arrangements, Mr Simmons assured members that lessons had been learnt from recent procurements; a permanent team will manage the transition from the current provider.

28.8 RESOLVED – that the report be noted.

29 DIRECTOR OF PUBLIC HEALTH: ANNUAL REPORT

29.1 Alistair Hill, Director of Public Health, introduced this item, explaining that this year's DPH report focused on the links between health and the arts. The report uses the format of the 'four wells': starting well, living well, ageing well and dying well. The report's recommendations will be taken forward via the Cultural Framework.

29.2 The Chair congratulated Mr Hill and the Public Health team for the report.

29.3 In response to a question from Fran McCabe on how committed to this agenda the NHS is, Mr Hill replied that there is some CCG-funded arts related work locally, and the NHS Long Term Plan stresses the importance of social prescribing. Sussex Partnership NHS Foundation Trust is also extensively involved in art and culture. However, there is room to do more.

29.4 Cllr Deane noted that she agreed that arts and culture are integral to health and wellbeing, but was concerned that BHCC financial decisions may not support this. Mr Hill responded that the Annual Report seeks to argue the case for the value of investing in the arts.

29.5 RESOLVED – that the report be noted.

30 ESTABLISHING A JOINT HOSC (JHOSC)

30.1 This item was introduced by the scrutiny support officer.

30.2 Cllr Allen stated that he appreciated that BHCC would be required to join a mandated Joint HOSC (JHOSC), although he regretted this necessity. However, he saw no compelling argument to join a voluntary JHOSC, particularly since the May 2019 local elections could well lead to a very different HOSC membership. Victoria Simpson (council lawyer) confirmed that Cllr Allen was correct in saying that the Council would be required to join a mandated JHOSC, but that members have discretion regarding a voluntary JHOSC.

30.3 The Chair stated that he saw no reason not to join the JHOSC now and be fully involved in planning. Cllr Janio concurred, arguing that it was best to be fully involved at the start of the process.

30.4 Cllr Marsh stated that she had concerns about joining now, given the proximity of the local elections. She would therefore vote against. Cllr Morris also told members that he would vote against.

30.5 Cllr Greenbaum stated that she believed that there were good arguments to join now and also to refrain from joining. On balance, she would vote against joining at the present time.

30.6 Members voted on whether or not to accept the report recommendations, and agreed by six votes to two (with one abstention) to reject the recommendations.

30.7 RESOLVED – that the recommendations in the report be not accepted.

31 UPDATE FROM HOSC JOINT WORKING GROUPS

32 HOSC DRAFT WORK PLAN/SCRUTINY UPDATE

33 FOR INFORMATION - CORRESPONDENCE WITH BRIGHTON & HOVE CCG

The meeting concluded at 6:30pm

Signed Chair

Dated this day of

Public Question from Ms Janet Sang

"The CCG's Clinically Effective Commissioning Policies are prefaced with a statement about the responsibilities of the CCG in relation to Equality. What analysis has HOSC seen which considers the likely equality impact of the reduction of clinical procedures listed in the Policies, and what plans are there to monitor their impact?"

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 37 Brighton & Hove City Council

Subject:		**Hospital for Hove and Portslade: Extract from the proceedings of the Council Meeting held on the 31 January 2019**		
Date of Meeting:		**20 March 2019**		
Report of:		**Executive Lead Officer for Strategy, Governance & Law**		
Contact Officer:	Name:	**Mark Wall**	**Tel:**	**01273 291006**
	E-mail:	mark.wall@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

Action Required of the Health, Overview & Scrutiny Committee
To receive the notice of motion referred from the Council for consideration.

Recommendations: That the Health, Overview & Scrutiny Committee seek an update from the CCG on primary and urgent care services in Hove and Portslade.

BRIGHTON & HOVE CITY COUNCIL

COUNCIL

4.30pm 31 JANUARY 2019

COUNCIL CHAMBER - HOVE TOWN HALL

MINUTES

Present: Councillors Simson (Chair), Phillips (Deputy Chair), Allen, Atkinson, Barford, Bell, Bennett, Bewick, Brown, Cattell, Chapman, Cobb, Daniel, Deane, Druitt, Gibson, Greenbaum, Hamilton, Hill, Horan, Hyde, Janio, Knight, Lewry, Littman, Mac Cafferty, Marsh, Meadows, Mears, Miller, Mitchell, Moonan, Morris, Nemeth, A Norman, K Norman, O'Quinn, Page, Peltzer Dunn, Platts, Robins, Sykes, Taylor, C Theobald, G Theobald, Wares, Wealls, West and Yates.

PART ONE

68 THE FOLLOWING NOTICES OF MOTION HAVE BEEN SUBMITTED BY MEMBERS FOR CONSIDERATION:

(4) Hospital for Hove and Portslade

68.1 The Mayor noted that an amendment had been submitted by the Green Group to the notice of motion and put it to the vote which was carried by 27 votes to 19.

68.2 The Mayor then put the following motion as amended to the vote:

"This council requests that the Health, Overview & Scrutiny Committee seek an update from the CCG on primary and urgent care services in Hove and Portslade."

68.3 The Mayor confirmed that the motion had been agreed unanimously.

NOTE: A closure motion had been passed prior to the item being reached and therefore the amendment and motion were put straight to the vote by the Mayor without debate.

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 38 Brighton & Hove City Council

Subject:		**Brighton & Sussex University Hospitals Trust (BSUH): Care Quality Commission Inspection Report**
Date of Meeting:		**20 March 2019**
Report of:		**Executive Lead for Strategy, Governance & Law (Monitoring Officer)**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 01273 295514**
	Email:	**giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**(All Wards);**

FOR GENERAL RELEASE

Glossary

BSUH: Brighton & Sussex University Hospitals Trust
CQC: Care Quality Commission – statutory regulator which inspects NHS and social care services
RSCH: Royal Sussex County Hospital, Brighton
PRH: Princess Royal Hospital, Hayward's Heath
NHSi/NHS Improvement – statutory regulator of NHS Trusts
RTT: Referral To Treatment - the national NHS target for patients to undergo elective procedures within 18 Weeks of being referred to a consultant

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The Care Quality Commission (CQC) is the statutory inspector of health and social care services. The CQC is responsible for a rolling programme of inspections of NHS providers.

1.2 Brighton & Sussex University Hospitals Trust (BSUH) provides general hospital services for the populations of Brighton & Hove and Mid Sussex, and more specialist services on a sub-regional and a regional basis. BSUH operates from two major sites: the Royal Sussex County Hospital (RSCH) in Brighton, and the Princess Royal Hospital (PRH) in Hayward's Heath.

2. RECOMMENDATIONS:

2.1 That the Committee notes the contents of this report.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The CQC Inspection Process

3.1.1 The CQC undertakes a rolling programme of inspection of NHS provider trusts. Every NHS trust is inspected at least every three years, although underperforming trusts may be inspected more frequently. When it inspects an NHS trust, the CQC examines key service-areas against five quality domains: ***caring***, ***well-led***, ***safe***, ***effective***, and ***responsive***. The CQC scores performance under each domain as either: ***outstanding***, ***good***, ***requires improvement*** or ***inadequate***. Where an organisation operates across more than one major site, each site is typically inspected and scored separately. The CQC also gives each trust an overall organisational score. (For Trusts already rated as ***good*** the CQC typically undertakes lower-key inspections focusing on the ***well-led*** domain.)

3.1.2 CQC inspection reports highlight areas where trusts either *must* make improvements (e.g. where there are clear legal breaches occurring) or *should* make improvements. Following an inspection every Trust is required to develop and publish a Quality Improvement Plan (QIP). NHS Improvement (NHSi), the NHS trust regulator, monitors the implementation of QIPs.

3.2 Special Measures

3.2.1 Should the CQC judge that a trust is inadequate across a significant number of domains, it may recommend to NHSi that the trust be placed in Special Measures. Trusts in Special Measures are able to access additional support for improvement.

3.3 BSUH

3.3.1 BSUH is a large NHS trust which provides acute (i.e. general hospital) services for the populations of Brighton & Hove and Mid Sussex. BSUH operates two major hospital sites: at the Royal Sussex County Hospital, Brighton (RSCH) and the Princess Royal Hospital, Hayward's Heath (PRH). BSUH also runs the Royal Alex Children's Hospital (RACH), the Sussex Eye Hospital, and the Queen Victoria Hospital, Lewes. Significant numbers of people from other areas also choose to use the RSCH or the PRH as their local hospital (particularly people living on the western edge of East Sussex and the eastern edge of West Sussex).

3.3.2 BSUH increasingly provides specialist services from the RSCH for the whole of Sussex, and some very specialised services (e.g. trauma) on a regional footprint.

3.3.3 BSUH employs just over 8000 people and has an annual turnover of C£600M. Standard hospital services are commissioned for their populations by Clinical Commissioning Groups (CCGs), and specialised services are commissioned by NHS England (NHSE). BSUH receives significant funding from NHSE for its specialist provision; and from Brighton & Hove CCG, Horsham & Mid Sussex CCG, West Sussex Coastal CCG, and High Weald Lewes Havens CCG for general hospital care.

3.4 BSUH CQC Inspections

3.4.1 BSUH underwent a full CQC inspection in April 2016, the results of which were published in August 2016. The Trust was rated as ***Inadequate*** and was placed in

Special Measures by NHSi. Management of the Trust was subsequently taken on by Western Sussex Hospitals (the NHS trust responsible for Worthing and Chichester hospitals).

3.4.2 Another full inspection of the Trust was undertaken in September and October 2018, with the CQC inspection report published in January 2019. The report found that there had been significant improvement across most areas of the Trust's operations, and BSUH was given an overall score of ***good***, with the care it provides ranked as ***outstanding***. Both RSCH and PRH are rated as ***good***. This represents a remarkable turn-around from 2016, and the CQC has recommended that the Trust be taken out of Special Measures.

3.4.3 Although it found services much improved and noted a number of areas of outstanding practice, the 2019 CQC reports also highlights areas of remaining challenge. In particular, BSUH is rated as ***requires improvement*** under the ***responsiveness*** domain. Part of the problem here is down to capacity at RSCH, which is being addressed by the 3Ts development and by parallel plans to build a new acute floor. In the short term 18 new beds were opened in February 2019 at RSCH, but capacity pressures are likely to continue, particularly in emergency care.

3.4.4 BSUH also performs relatively poorly against the national 18 week RTT target and against the 62 day cancer RTT target. In addition, the CQC criticised elements of outpatient provision, including the suitability of some outpatient environments for people with disabilities or dementia as measured in user-led assessments.

3.4.5 The January 2019 CQC inspection reports are available here: LINK and the CQC's brief summary of its findings is included for reference as **Appendix 1** to this report.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Not relevant to this report for information.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None undertaken.

6. CONCLUSION

6.1 Members are asked to note the much improved performance of BSUH reflected in the recent CQC inspection report.

6.2 Whilst showing a remarkable improvement across many services areas, BSUH still faces considerable challenges, particularly in terms of its consistent failure to meet national waiting times targets.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this report for information.

Legal Implications:

7.2 There are no legal implications to this report.

Lawyer Consulted: Elizabeth Culbert; Date: 01/02/19

Equalities Implications:

7.3 The CQC reports explore equalities issues in detail.

Sustainability Implications:

7.4 None identified

Any Other Significant Implications:

7.5 None identified

SUPPORTING DOCUMENTATION

Appendices:

1. CQC report summary

Documents in Members' Rooms
None

Background Documents
None

Appendix 1

Provider: Brighton and Sussex University Hospitals NHS Trust Good

On 08 January 2019, we published a report on how well Brighton and Sussex University Hospitals NHS Trust uses its resources. The ratings from this report are:

- Use of resources: Requires Improvement
- Combined rating: Good

Read more about use of resources ratings

Reports

Inspection carried out on 25 September 26 September

During a routine inspection

Our rating of the trust improved. We rated it as good because:

- The trust had made huge improvements since the new executive team had introduced improved systems of working. The trust had a new strategy, vision and values which underpinned a culture which was patient centred. The 'Patient First Improvement System' had empowered front line staff by equipping them with the lean tools, methods and a structured process which had helped to build and promote a culture of continuous improvement across the whole trust.
- A new divisional structure had been created around the pre-existing directorate structure. This had strengthened the existing leadership and management arrangements of the clinical services.
- Quality was a 'golden thread' running through the trust Patient First Strategy. In all the interviews undertaken on inspection this was evident in the use of data both quantitative and qualitative and how this was triangulated and reported through the Quality Steering Group to the Quality Assurance Committee and the trust board.
- All staff we spoke with on inspection were clear about the trust's approach and priority to deliver high quality sustainable care to patients. Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. To support the roll-out of Patient First across the trust, a communications plan was developed and implemented. The plan was tailored to different audiences to best reach staff in different parts of the organisation. Staff spoke about feeling that the Patient First Strategy had given them the ability to all speak the same language.

- The board received holistic information on service quality and sustainability. There was a programme of board visits to services and staff we spoke with told us that that leaders were approachable.
- Staff felt equality and diversity were promoted in their day to day work. We spoke with the newly formed Black and minority ethnicity working group. The trust had held an event in May where over 200 members of staff had come together to discuss equality and Black and minority ethnicity issues and start the forming of a new strategy. The output of this meeting was three workstreams; communication, recruitment, and education. The group we spoke with told us that they had seen a dramatic change in the past 6-9 months. They described this as powerful, positive and feeling included in the strategy and change. Staff told us that although they had not always felt supported in the past since the new executive team had arrived they now felt confident that they could raise any concerns about staff behaviours towards them with their line managers, and they felt assured that their concerns would be listened to and acted on appropriately.
- Staff felt respected, supported and valued. The executive teams and divisional leaders told us how they felt that improving the experience and engagement of their staff was fundamental to delivering a culture of high sustainable care and trust strategic objectives.
- The trust's Patient First Improvement System empowered staff to make improvements and to be listened to and respected. In areas where 'Patient First' had been introduced the level of engagement and motivation had significantly improved as staff felt empowered to make improvements in their work. This was evident both on CQC engagement events at the trust and on inspection.
- A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to act as needed. The trust had governance and management arrangements had been strengthened significantly since the management agreement with Western Sussex Hospitals Foundation Trust and NHS Improvement. These arrangements enabled all clinical and management staff to function in an effective and efficient manner through both line management arrangements and governance arrangements.
- The board had invited the Good Governance Institute (GGI) carry out a review of the trust's quality governance structures, which resulted in 31 separate recommendations being made. The trust acted to address these issues and the Good Governance institute carried out a further review reporting on progress against these actions. A focus of this work has been to strengthen quality governance arrangements at divisional level.
- The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures. The trust reported regularly through its governance arrangements on progress against delivery of its strategy to the board, Trust Executive Committee and to other relevant committees. However, the structure needed more time to become fully embedded.
- The trust executive team had worked hard to roll out Patient First Strategy across the trust. They had done this in a structured way by considering which areas of the trust would benefit the most from the methodology and training. There was no doubt that areas who had imbedded Patient first had made the largest impact on improvement. Although we were impressed at the speed and spread of improvement the trust needed more time to embed this methodology across the whole trust.

Download full report

Inspection report published 8 January 2019 PDF | 1.09 MB (opens in a new tab)Inspection report published 8 January 2019 PDF | 4.86 MB (opens in a new tab)

CQC inspections of services

Inspection carried out on 5th-8th April 2016

During a routine inspection

The Royal Sussex County Hospital (RSCH) in Brighton forms part of Brighton and Sussex University Hospitals Trust. RSCH is a centre for emergency and tertiary care. The Brighton campus includes the Royal Alexandra Children's Hospital (The Alex) and the Sussex Eye Hospital.

The hospital provides services to the local populations in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex. and more specialised and tertiary services for patients across Sussex and the south east of England.

The Trust has two sites, Royal Sussex County in Brighton and the Princess Royal Hospital in Haywards Heath, consisting of 1,165 Beds; 962 General and acute, 74 Maternity, and 43 Critical care. It employs 7,195.92 (WTE) Staff; 1,050.59 of these are Medical (WTE), 2,302.52 Nursing (WTE), 3,842.81 other.

It has revenue of £529,598km; with a full cost of £574,417k and a Surplus (deficit) of £44,819k

Between 2015-2016 the Trust had 118,233 inpatient admissions; 640,474 Outpatient attendances, and 156,414 A&E attendances.

This hospital was inspected due our concerns about the Trusts ability to provide safe, effective, responsive and well led care. We inspected this hospital on 4-8 April 2016 and returned for an announced inspection on 16 April 2016.

Our key findings were as follows:

Safe

- Incident reporting was understood by staff but there was a variation in the departments on completion rates and a lack of learning and analysis.
- The trust had reported seven never events (5 of which were at RSCH) between Jan' 15 to Jan' 16, all seven were attributed to surgery and four of which were related to wrong site surgery incidents.
- Not all areas of the hospital met cleaning standards and the fabric of the buildings in some areas was poor, and posed a risk to patients, particularly with regard to fire safety.
- We had particular concerns that the risk of fire was not being managed appropriately. We found that the Barry and Jubilee buildings were a particular fire safety risks as

they were not constructed to modern safety standards and had been altered and redesigned many times during their long history. They were overpopulated, overcrowded and cluttered with narrow corridors and inaccessible fire exits. We found flammable oxygen cylinders were stored in the fire exit corridors. We found that fire doors with damaged intumescent strips which would not provide half an hour fire barrier in the event of horizontal evacuation.

- Patients in the cohort area of the emergency department were not assessed appropriately; there was a lack of clinical oversight of these patients and a lack of ownership by the Trust board to resolve the issues.
- There were no systems in place for the management of overcrowding in the 'cohort' area. Staff were not able to provide satisfactory details of "full capacity" protocols or triggers used to highlight demand exceeding resources to unacceptable levels of patients in the area.
- The recovery area at RSCH in the operating theatres was being used for emergency medical patients due to having to reduce the pressure on an overcrowded ED and to help meet the emergency departments targets such as 12 hour waits. Some patients were transferred from the HDU to allow admission to that area and some patients were remaining in recovery when there was no post-operative bed available. Some patients were kept in the recovery area for anything between four hours and up to three days
- Staffing levels across the hospital were on the whole not enough to provide safe care for example the mixed ICU and cardiac ICU frequently breached the minimum staff to patient ratios set by the Intensive Care Society and the Royal College of Nursing.
- In some areas the trust had systematically failed to respond to staff concerns about this and mitigating strategies had failed.
- Medicines management in the hospital was generally good, with the exception of Critical Care and out patients, significantly below the standard expected.
- We mostly saw that records were well managed and kept appropriately, However in OPD we observed records lying in unlocked areas that the public could access.
- The trust had a safeguarding vulnerable adults and children policy, and guidelines were readily available to staff on the intranet and staff were able to access this quickly. However, safeguarding training for all staff groups was lower than the Trusts target.

- Staff compliance in mandatory training, statutory training and appraisals fell below the trust target of 95% for statutory training and 100% for mandatory training, for both nurses and doctors across every department in the hospital.
- The trust had a Duty of Candour (DOC) policy, DOC template letters and patient information leaflets regarding DOC, and we saw evidence of these. The trust kept appropriate records of incidents that had triggered a DOC response, which included a DOC compliance monitoring database and we saw evidence of these. Most staff we spoke with understood their responsibilities around DOC.

Effective

- Staff generally followed established patient pathways and national guidance for care and treatment. Although we saw some examples of where patient pathway delivery could be improved.
- National clinical audits were completed. Mortality and morbidity trends were monitored monthly through SHIMI (Summary Hospital-level Mortality Indicator)

scores. Reviews of mortality and morbidity took place at local, speciality and directorate level although a consistent framework of these meetings across all specialities was not in place. The trust's ratio for HSMR was better than the national average of 80%.

- Staff knew how to access and used trust protocols and guidance on pain management, which was in line with national guidelines.

- Patient's nutritional needs were generally met although patients in the cohort area at RSCH, ED at PRH and recovery RSCH did not always have easy access to food and water. In critical care there was no dedicated dietician.

- Appraisal arrangements were in place, but compliance was low across the hospital. Trust wide 68% of staff had received an annual appraisal against the trust target of 75%. Accountability for these lapses was unclear.

- Some services were not yet offering a full seven-day service. For example in medical care constraints with capacity and staffing had yet to be addressed. Consultants and support services such as therapies operated an on-call system over the weekend and out of hours. This limited the responsiveness and effectiveness of the service the hospital was able to offer.

- There were innovative and pioneering approaches to care with evidence-based techniques and technologies used to support the delivery of high quality care and improve patient outcomes in children and young peoples services

Caring

- Staff were caring and compassionate to patients' needs, and patients and relatives told us they received a good care and they felt well looked after by staff.
- Children and young people at the end of their lives received care from staff who consistently went out of their way to ensure that both patients and families were emotionally supported and their needs met.
- Privacy, dignity and confidentiality was compromised in a number of areas at RSCH, particularly in the cohort area, out patients department and on the medical wards in the Barry building.
- The percentage who would recommend the trust (Family and Friends Test) was lower than the England average for the whole time period until the most recent data for Dec '15, where is it currently above the England average.
- Patients reported they were involved in decisions about their treatment and care. This was reflected in the care records we reviewed.
- We saw no comfort rounds taking place whilst we were in the ED department. This meant patients who were waiting to be treated may not have been offered a drink or had their pressure areas checked.

Responsive

- The admitted referral to treatment time (RTT) was consistently below the national standard of 90% for most specialties. The trust had failed to meet cancer waiting and treatment times.

- The length of stay for non-elective surgery was worse than the national average for trauma and orthopaedics, colo-rectal surgery and urology
- The percentage of patients whose operations were cancelled and not treated within 28 days was consistently higher than the England average.
- According to data provided by the trust, between January 2015 and December 2015 3,926 people waited between 4 to 12 hours (and 71 people over 12 hours) from the time of "decision to admit" to hospital admission. Since the inspection an additional 12 patients have been reported as waiting over 12 hours.
- Interpreters were available for those patients whose first language was not English. This was arranged either face to face or through a telephone interpreter. Staff told us that under no circumstances would a family member be able to act as an in interpreter where a clinical decision needed to be made or consent needed to be given.
- We saw examples of wards including the dementia care ward that operated the butterfly scheme. The butterfly scheme is a UK wide hospital scheme for people who live with dementia. We also saw that they had a dignity champion. This is someone who works to put dignity and respect at the heart of care services.

Well Led

- Staff in general reported a culture of bullying and harassment and a lack of equal opportunity. Staff survey results for the last two years supported this. Staff from BME and protected characteristics groups reported that bullying, harassment and discrimination was rife in the organisation with inequality of opportunity. Data from the workforce race equality standard supported this. Staff reported that inconsistent application of human resource policies and advice contributed to inequality and division within the workforce and led to a lack of performance and behaviour management within the organisation. These cultural issues had been longstanding within the trust without effective board action.
- There was a clear disconnect between the Trust board and staff working in clinical areas, with very little insight by the board into the key safety and risk issues of the trust, and little appetite to resolve them.
- The trust had a complex vision and strategy which staff did not feel engaged with. There was a lack of cohesive strategy for the services either within their separate directorates or within the trust as a whole. Whilst there were governance systems in place they were complex and operating in silos. There was little cross directorate working, few standard practices and ineffective leadership in bringing the many directorates together.

- The culture at RSCH was one where poor performance in some areas was tolerated and 50% of staff said in the staff survey they had not reported the last time they were bullied or harassed.
- There was a problem with stability of leadership within the trust. There were several long term vacancies of key staff. During the inspection we noted a number of senior management staff had taken leave for the period of the inspection.
- BME staff felt there was a culture of fear and of doing the wrong thing. They told us this was divisive and did not lead to a healthy work place where everyone was treated equally.

- Ward mangers and senior staff reported that they received little support from the trust's HR department in managing difficult consultants or with staff disciplinary and

capability issues. They told us that HR advised staff to put in a grievance as a first step in resolving any issue. However the Trust workforce evidence that HR Department supported 36 disciplinary matters and 16 dismissals and that the grievance rate had reduced significantly during 2015/16.

- The relocation of neurosurgery intensive care from Hurstwood Park to Brighton in June 2015 had been managed without appropriate planning and risk assessment and also lacked evidence of robust staff consultation. This had led to a culture in which nurses did not feel valued and there was significant and sustained evidence of non-functioning governance frameworks.
- The executive team failed on multiple occasions to provide resources or support to clinical staff in critical care to improve safety and working conditions and there was no acknowledgement from this team that they understood the problems staff identified.

We saw several areas of outstanding practice including:

- The play centre in The Alex children's hospital had an under the sea themed room with treasure chests full of toys and a bubble tank. There was also an interactive floor where fish swam around your feet and changed direction according to your footsteps.
- The children's ED was innovative and well led, ensuring that children were seen promptly and given effective care. Careful attention had been paid to the needs of children attending with significant efforts taken to reassure them and provide the best possible age appropriate care.
- The virtual fracture clinic had won an NHS award for innovation. It enabled patients with straightforward breaks in their bones to receive advice from a specialist physiotherapist by telephone.It reduced the number of hospital attendances and patients could start their treatment at home.
- We found that an outstanding service was being delivered by dedicated staff on the Stroke Unit (Donald Hall and Solomon wards). The service was being delivered in a very challenging ward environment in the Barry building. Staff spoke with passion and enthusiasm about the service they delivered and were focused on improving the care for stroke patients. The results of audits confirmed that stroke care at the hospital had improved over the past year.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly the trust must:

- Ensure that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of patients using the service at all times.
- Ensure that all staff have attended mandatory training and that all staff have an annual appraisal.
- Ensure that newly appointed overseas staff have the support and training to ensure their basic competencies before they care for and treat patients.
- Undertake an urgent review of staff skill mix in the mixed/neuro ICU unit and this must include an analysis of competencies against patient acuity.
- Establish clear working guidelines and protocols, fully risk assessed, that identify why it is appropriate and safe for general ICU nurses to care for neurosurgery ICU patients. This should include input from neurosurgery specialists.

- Take steps to ensure the 18 week Referral to Treatment Time is addressed so patients are treated in a timely manner and their outcomes are improved. The trust must also monitor the turnaround time for biopsies for suspected cancer of all tumour sites.
- Ensure that medicines are always supplied, stored and disposed of securely and appropriately. This includes ensuring that medicine cabinets and trollies are kept locked and only used for the purpose of storing medicines and intravenous fluids. Additionally the trust must ensure patient group directives are reviewed regularly and up to date.
- Implement urgent plans to stop patients, other than by exception being cared for in the cohort area in ED.
- Adhere to the 4 hour standard for decision to admit patients from ED, i.e. patients should not wait longer than 4 hours for a bed.
- Ensure that there are clear procedures, followed in practice, monitored and reviewed to ensure that all areas where patients receive care and treatment are safe, well-maintained and suitable for the activity being carried out. In particular the risks of caring for patients in the Barry and Jubilee buildings should be closely monitored to ensure patient, staff and visitor safety.
- Ensure that patient's dignity, respect and confidentiality are maintained at all times in all areas and wards.
- Stop the transfer of patients into the recovery area from ED /HDU to ensure patients are managed in a safe and effective manner and ensure senior leaders take the responsibility for supporting junior staff in making decisions about admissions, and address the bullying tactics of some senior staff.

- Review the results of the most recent infection control audit undertaken in outpatients and produce action plans to monitor the improvements required.
- Ensure its governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services across all directorates.
- Urgently facilitate and establish a line of communication between the clinical leadership team and the trust executive board.
- Undertake a review of the HR functions in the organisations, including but not exclusively recruitment processes and grievance management.
- Develop and implement a people strategy that leads to cultural change. This must address the current persistence of bullying and harassment, inequality of opportunity afforded all staff, but notably those who have protected characteristics, and the acceptance of poor behaviour whilst also providing the board clear oversight of delivery.
- Review fire plans and risk assessments ensuring that patients, staff and visitors to the hospital can be evacuated safely in the event of a fire. This plan should include the robust management of safety equipment and access such as fire doors, patient evacuation equipment and provide clear escape routes for people with limited mobility.

In addition the trust should:

- Review the consent policy and process to ensure confirmation of consent is sought and clearly documented.

- Review the provision of the pain service in order to provide a seven day service including the provision of the management of chronic pain services.

- Consider improving the environment for children in the Outpatients department as it is not consistently child-friendly.
- Ensure security of hospital prescription forms is in line with NHS Protect guidance.
- Ensure that there are systems in place to ensure learning from incidents, safeguarding and complaints across the directorates.
- Ensure all staff are included in communications relating to the outcomes of incident investigations.
- Implement a sepsis audit programme.
- Provide mandatory training for portering staff for the transfer of the deceased to the mortuary as per national guidelines.
- Ensure there is a robust cleaning schedule and procedure with regular audits for the mortuary as per national specifications for cleanliness and environmental standards.
- Review aspects of end of life care including, having a non-executive director for the service, a defined regular audit programme, providing a seven day service from the palliative care team as per national guidelines and recording evidence of discussion of patient's spiritual needs.
- The trust should ensure all DNACPR, ceilings of care and Mental Capacity assessments are completed and documented appropriately as per guidelines.
- The trust should implement a formal feedback process to capture bereaved relatives views of delivery of care.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Download full report

Inspection report published 17 August 2016 PDF | 484.46 KB (opens in a new tab)
Inspection carried out on 21-23, 27 & 30 May 2014

During a routine inspection

Brighton and Sussex University Hospitals Trust is an acute teaching hospital located in Sussex. There are eight sites registered with the Care Quality Commission (CQC). These are the Royal Sussex County Hospital in Brighton, the Princess Royal Hospital in Haywards Heath, Bexhill Hospital, Hove Polyclinic and the Park Centre for breast care services, Lewes Victoria hospital, Brighton General hospital and Worthing hospital Dixon ward. The Brighton campus includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital, and the Haywards Heath campus includes the Hurstwood Park Neurosciences Centre. The trust also provides some community services from the Brighton site and these were included in this inspection. We visited all sites except the Park Centre as part of this inspection.

We carried out a comprehensive inspection for a number of reasons. Brighton and Sussex University Hospitals Trust was an aspirant foundation trust, it was also an example of a 'medium risk' trust, according to our Intelligent Monitoring model. We also wanted to follow up on the issues that had been raised by staff as part of the listening event held in December 2013. The inspection took place on 21-23, 27 and 30 May 2014.

The trust is dealing with very significant and long standing cultural issues that are reflected in the staff survey results. The current leadership of the trust are tackling issues that have remained unresolved for a number of years. The increased pace of change and improvement dates from the chief executive's arrival in July 2013. The team noted major strides in the six months since the listening event in December 2013.

Overall, Brighton and Sussex University Hospitals Trust requires improvement. We rated it as good for providing services that are effective and caring. It requires improvement in providing services that are consistently safe, in being responsive to patients' needs and in being well-led.

Our key findings were as follows:

- Every service at each location was found to be caring. We observed staff communicating with, and supporting, people in a very caring and compassionate way. Patients and their families spoke highly of the care they had received. The overwhelming majority of the feedback given to the team from all sources was positive.
- People were receiving care, treatment and support that achieved good outcomes.
- The trust had a significant change programme underway. The Foundations for Success programme, which started in August 2013, had involved work on vision and values, clinical structure, clinical strategy and accountability and management systems. There was also a long-term development plan that included a major building project and the reconfiguration of services, including the movement of services between sites.
- The board, executive team and senior management demonstrated a shared understanding of the challenges and risks facing the trust and had plans in place to deal with them.
- Staff spoke very positively about the chief executive, who they said was highly visible, engaged, focused and committed to improvement. Staff across the trust and at every level referred to communication having been "transformed" since his arrival. Nursing staff also spoke positively about the chief nurse and the impact that she was having.
- With very few exceptions, staff across the trust described their pride in the services they were delivering and the support they received from colleagues and managers. Staff were excited about the recent announcement of the £420m redevelopment of the Royal Sussex Hospital site, which was described as a "huge boost".
- Mortality rates were within expected ranges and there were no indicators flagged as being a risk or an elevated risk. There has been one mortality outlier alert in adult cardiac surgery that was raised in July 2013, which had been dealt with. There had not been any outlier alerts in maternity.
- The areas of the trust that we visited appeared clean and cleaning was taking place throughout our inspection. The age of some of the buildings made them more difficult to keep clean. The trust's infection rates for Clostridium difficile were within an acceptable range, taking into account the size of the trust and the national level of infections. The trust reported five cases of MRSA infections in the last 12 months, with the infections occurring in April and October 2013. This is slightly higher than would be expected. The trust had an effective infection control team and we observed good hygiene practices by staff.

- The older buildings and some aspects of the layout of the Brighton campus presented a significant challenge in delivering care. For example, patients could not be moved between buildings during bad weather. Some issues could not be resolved until the planned building programme is complete, but, in the meantime, work had been carried out to make improvements, where possible. An example of the latter was the new dementia service, the Emerald Unit in the Barry Building.
- There were issues with the flow of patients into, through and out of hospital. This was having an impact on care and patient experience in the emergency department (ED), in the medical assessment units, in surgery, in critical care, on the wards and also on the planning and support that people received when they were ready to leave. Some patients were being cared for in wards that were not with their required speciality. The trust needed to achieve 100 discharges a day and, at the time of the inspection, it was achieving between 65 and 70.
- The pressures on the emergency department were significant and connected to the flow issues described above. The department does not have enough physical space to deal with the number of patients that attend. The department is consistently failing to meet the target to admit, transfer or discharge 95% of patients within four hours. Immediately after the inspection the trust reviewed progress with these work streams to address flow and escalated their actions, in particular the management of the co-hort area in the ED. The trust has been working further with the key stakeholders and has shared these actions and their plans to ensure the effective management of these concerns with us. We are pleased to note the trusts response and will be monitoring and reviewing the impact of these actions.
- The implementation of a centralised booking system (known as the 'Hub') for outpatient and follow-up appointments had not gone smoothly and had caused problems for patients and staff alike. The problems included late notice of appointments, cancelled appointments and clinics, delays in dealing with urgent referrals and clinics running without patients being booked for them. The trust had a comprehensive action plan in place and improvements were in progress.
- The trust was dealing with a number of significant cultural issues. These included improving engagement with staff, improving and promoting race equality and dealing with some long-standing related issues, addressing the issues that had influenced the staff survey results and improving the take-up of appraisals and access to training.
- Staffing was an issue. The trust increased its staffing levels from April and filling vacancies had been a challenge. Changes to nursing bank rates had had an impact and some shifts have been hard to fill. The trust still paid the highest NHS bank rates in Sussex, although some staff we met were unaware of that. The trust had invested in improved nursing ratios and supernumerary band 7 nurses from 1 May 2014. Not all posts were filled and the impact of this investment was not yet evident across all services.
- Staffing levels, particularly in medicine and surgery, and the high use of bank or agency staff placed pressure on staff and put patients at risk of their care needs not being appropriately met. These pressures meant that staff were not always able to attend training, as required.
- The current arrangements for cleaning services at the trust did not seem to be meeting the needs of all departments in a consistent way.
- Concerns about the quality of food were a recurring theme in patient feedback during the inspection and in patient survey results. Patient records showed that nutritional risk assessments were being carried out using the Malnutrition Universal Screening Tool (MUST) and, additionally, staff were completing food and nutrition charts for

patients who were at risk of weight loss. Fluid charts were also being completed appropriately.

- Hove Polyclinic was providing outpatient services and was running 63 specialist clinics each week, together with a pain management service. The Polyclinic had a clean and bright environment and patients spoke highly of the care they received. The issues with the implementation of the Hub appointment system had impacted on patients, who were frustrated with the delays and cancellations they had experienced. Two patients whose urgent referrals were not actioned, subsequently required emergency admission to hospital. Additional clinics were being run to clear the backlogs.
- The Children's Community Nursing Team (CCNT) was providing a good service that was appreciated by children and their families. The team communicated well with other professionals and agencies involved with supporting children and their families.
- The Renal Dialysis Unit at Bexhill Hospital was well managed and had good links with the renal service in Brighton. The service was clean and well maintained, staff had a good rapport with patients and patients spoke highly of the care they received. At the previous inspection, the service was found to be in breach of four regulations relating to safeguarding, cleanliness and infection control, staffing and supporting workers. Bexhill Hospital had taken effective action and these areas were found to be compliant.

We saw several areas of outstanding practice including:

- The team felt that the trust was exceptionally open and engaged with the inspection. Information requested was readily supplied without the need for executive-level authorisation, as had been the case in some other trusts. Staff had been encouraged to speak to inspectors and many came forward to speak to us outside of meetings, focus groups and time on the wards.
- The awareness of staff of the work on values and behaviours was almost universal. With one exception, all the staff we talked to about this had been involved directly in this work, knew a colleague who had been, or were aware of the opportunities that they had had to engage with and influence this work.
- Care for patients with dementia was very good in both Royal Sussex County Hospital and Princess Royal Hospital, where staff had been innovative and creative in order to provide a safe and stimulating environment for people. Awareness of dementia has been raised across the trust through the 'Dementia is my business' campaign and a new care pathway had been launched. The trust presented its work around dementia at the National Dementia Congress in November 2013.
- The critical care teams at the Royal Sussex County Hospital and the Princess Royal Hospital were strong, committed and compassionate. The feedback from patients was overwhelmingly positive.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Evaluate the effectiveness of the current patient flow and escalation policy and take action to improve the flow of patients within the ED and across the trust. Improvements are needed with discharge planning and arrangements to ensure people

are able to leave hospital when they are ready. The trust must continue to engage with partners and stakeholders to achieve sustainable improvement.

- Ensure that there are enough suitably qualified, skilled and experienced staff to meet the needs of all patients.
- Ensure that the values, principles and overall culture in the organisation supports staff to work in an environment where the risk of harassment and bullying is assessed and minimised and where the staff feel supported when it comes to raising their concerns without any fear of recrimination.
- Ensure that relationships and behaviours between staff groups, irrespective of race and ethnicity, is addressed to promote safety, prevent potential harm to patients and promote a positive working environment.
- Ensure that the environment is suitable for patient investigations, treatment and care and that hazards related to the storage of equipment, which may impact on staff, are minimised.
- Ensure that all equipment used directly for patient treatment or care is suitably checked and serviced to ensure that it is safe and fit for use.
- Ensure that the planning and delivery of care on the obstetrics and gynaecology (O&G) units meets patients' individual needs.
- Ensure that there are effective systems in place so that patients needing urgent referrals for assessment or treatment are dealt with promptly.
- Continue the work to ensure that the Hub is providing an effective service to patients and staff.
- Ensure that staff are supported to receive mandatory training in line with trust policy.
- Ensure that staff receive an annual appraisal.
- Review the current cohort protocol to ensure there are clear lines of clinical accountability and responsibility for patients that all trust staff and ambulance trust staff are aware of.
- Ensure that the privacy of dignity of patients is maintained within the ED, including the current cohort area.
- Ensure that staff reporting incidents receive feedback on the action taken and that the learning from incidents is communicated to staff.
- Review the provision and skills mix of staff to ensure they are suitably trained to meet the needs of children who use the service.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Download full report

Inspection report published 8 July 2014 PDF | 343.89 KB (opens in a new tab)

Use of resources

These reports look at how NHS hospital trusts use resources, and give recommendations for improvement where needed. They are based on assessments carried out by NHS Improvement, alongside scheduled inspections led by CQC. We're currently piloting how we work together to confirm the findings of these assessments and present the reports and ratings alongside our other inspection information. The Use of Resources reports include a 'shadow' (indicative) rating for the trust's use of resources.

- Brighton and Sussex University Hospitals NHS Trust: Use of Resources published 08 January 2019 PDF | 698.59 KB (opens in a new tab)

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 39 Brighton & Hove City Council

Subject:		**Brighton & Sussex University Hospitals Trust (BSUH): Waiting Times and Outpatient Services**
Date of Meeting:		**20 March 2019**
Report of:		**Executive Lead for Strategy, Governance & Law (Monitoring Officer)**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 01273 295514**
	Email:	**giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**(All Wards);**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 This report was requested by HOSC members who were eager to learn of Brighton & Sussex University Hospitals Trust (BSUH) plans to improve outpatient services and reduce waiting times (particularly for elective procedures).

1.2 There will be a presentation by BSUH at the meeting and slides from this presentation will be circulated to members in advance of the meeting.

2. RECOMMENDATIONS:

2.1 That the Committee notes the information in this report.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The January 2019 Care Quality Commission (CQC) inspection report on BSUH shows that the Trust has made significant improvements in recent months, with the Trust rated as 'good' overall and many service areas as 'good' or 'outstanding'. However, the CQC has rated BSUH as 'requires improvement' in terms of responsiveness (this domain includes waiting times). The CQC report also makes measured criticism of aspects of BSUH outpatient procedures. An excerpt from the CQC inspection report, which includes the summary findings on ***responsiveness*** and on ***Outpatients*** is included as **Appendix 1** to this report. More details of the CQC's findings can be found HERE

3.2 The CQC's focus on issues with waiting times and with aspects of outpatient services (particularly in terms of making and cancelling appointments) has been echoed by comments from service users reported to Healthwatch Brighton & Hove and to members of the HOSC.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 None to this report for information.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 Healthwatch Brighton & Hove has been consulted about this report.

6. CONCLUSION

6.1 Members are asked to note CQC concerns about aspects of waiting times and outpatient services at BSUH and to note the Trust's improvement planning in reference to these issues.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this report for information

Legal Implications:

7.2 There are no legal implications to this report

Lawyer Consulted: Elizabeth Culbert Date: 01/03/2019

Equalities Implications:

7.3 The CQC inspection report (January 2019) identifies specific access problems in Outpatients for people with disabilities and for people with dementia.

Sustainability Implications:

7.4 None identified.

Any Other Significant Implications:

7.5 None identified.

SUPPORTING DOCUMENTATION

Appendices:

1. Extracts from CQC inspection report

Documents in Members' Rooms
None

Background Documents
None

Appendix 1

Excerpts from CQC Report January 2019

Summary of Findings Re: Responsiveness

Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

• The trust was open and transparent about the issues they had and would continue to have with capacity until the new 3Ts building project was completed. This would give the trust additional capacity. The trust had effective strategies in place to address capacity, performance and flow challenges. However, they were dependant on building work completion to create more capacity within the emergency department and the creation of additional bed capacity within the hospital.

• Funding had been made available to secure the building of a new acute floor, which was expected to provide additional capacity to cope with the increased volume of patients who attend the emergency department. Building work was due to commence within the next couple of months.

• This meant that in the emergency department the service took account of patients' individual needs but was not always successful in meeting them. During busy times it was not always possible to manage individual needs if patients were cared for in 'the cohort area'. This was the same as our last inspection. Issues around the departments inability to meet surges during demand remained a concern. The service had undertaken a number of changes since our last inspection to improve efficiency and the performance against national standards. However, performance against national targets still required improvement.

• From June 2017 to June 2018 the trust's referral to treatment performance was consistently worse than the England average.

• Cardiology and gastroenterology medical specialties at the trust were below the England average for admitted RTT pathways (percentage within 18 weeks).

• Patients were staying longer than their required recovery time in theatre due to a lack of bed availability in critical care and some ward areas.

• Waiting times for referral to treatment within 18-weeks were below the England average in three out of the eight surgical specialities provided at the trust. Out of the remaining five, three were similar to the England average, and two were better. This

was an improvement on the previous inspection when all specialties were below the England average.

• Patients could not always access the service when they needed it. Overall waiting times from referral to treatment were worse than the national average. Summary of findings 8 Brighton and Sussex University Hospitals NHS Trust Inspection report 08/01/2019

• Patients referred on a cancer pathway were not always treated within 62 days of referral from their GP. The trust was performing worse than the England average in this area.

• The patient led assessment of the care environment audits for dementia and disability scored significantly worse than the national average across four outpatients areas that were assessed. The trust wide dementia strategy did not have any outpatient related actions.

However:

• Since our last inspection, we saw a range of implemented initiatives designed to improve referral to treatment times and the impact this had on patients.

• Staff provided coordinated care and treatment with other services and other providers.

• Staff made reasonable adjustments and removed barriers when people found it hard to use or access services.

• Managers planned and provided services in a way that met the needs of the local people. They were flexible and had made changes to improve services and support patients more effectively. The hospital had a significant redevelopment programme underway, directions to the surgical wards and departments were clear and easy to follow. Information about the building work and services was clearly available to visitors at the main entrances of the hospital.

• Initiatives had been taken to review all patients on the waiting list for specific bowel surgery which meant no patient was waiting 52 weeks. This was an improvement since the last inspection when there was a backlog of patients waiting for surgery. Theatre utilisation rates were monitored to make sure the theatre was used efficiently.

• Staff took account of patient's individual needs and had access to specialist nurses and other staff to support patient specific needs. Support was available for patients with dementia, learning disabilities and mental health problems with lead practitioners and link persons at department level. • The trust had improved the provision of information for patients and visitors that did not speak English as a first language.

• Where people's needs, and choices were not being met we saw this was identified and used to inform how services were improved. An example of this was the development of a transgender and non-binary protocol. This included building the teams presence at relevant local events and working alongside local transgender support groups to encourage and support those who wished to have a family.

• Patients referred on a two week wait pathway for suspected cancer could expect to see a specialist within two weeks of referral from their GP and the trust was performing better than the England average in this area.

• Once a decision to treat had been made for a patient with a cancer diagnosis, they could expect to be treated within the operational standard of 31 days, and the trust was performing better than the England average in this area.

Outpatients

Key facts and figures:

- The outpatient department at the Princess Royal Hospital is part of the Brighton and Sussex University Hospitals Trust.
- Between May 2017 and April 2018 there were 192,492 appointments at the Princess Royal Hospital, which equated to 20% of the overall appointments across the trust during the same period.
- Outpatient services at the Princess Royal Hospital are located throughout the site, with the main outpatient clinics and physiotherapy and occupational therapy located on the ground floor, and the neurology outpatients building which was behind the main hospital building.
- As part of our announced inspection we visited the main outpatients' department; neurology outpatients; physiotherapy; the fracture clinic; phlebotomy (taking blood for testing) and the outpatients pharmacy.
- The hospital provides outpatient services covering a range of specialities including but not limited to: medicine, cardiology, neurology, rheumatology, diabetes, respiratory and dental. The service provided both consultant and nurse led outpatient clinics across a range of specialities.
- Outpatient clinics were held between 08:30am and 5:30pm with some additional ad-hoc clinics on a Saturday dependent on speciality.
- During our inspection we spoke with ten patients and their relatives. We spoke with 21 members of staff including nurses, health care assistants, therapists, phlebotomists and managers. We reviewed eight patient records. We reviewed performance information about the department and the trust.
- The service was previously inspected in 2017. That inspection also included diagnostic imaging services. Diagnostic imaging services are now inspected

separately and have a separate report and therefore we cannot directly compare ratings.

- During this inspection, we only looked at services provided within outpatients. The last inspection rated the service as requires improvement overall. On this inspection we maintained this rating, however the rating for safe improved from requires improvement to good.

Summary of this service:

Our rating of this service stayed the same, although we saw that improvement had been made. We rated it as requires improvement because:

• The service did not always share feedback from patient safety incidents. We did not see evidence of incidents being discussed in team meeting minutes. There were daily staff huddles but these did not have incidents as a set part of the agenda.

• Patients could not always access the service when they needed it. Overall waiting times from referral to treatment and for those patients referred on a 62-day cancer pathway were worse than the national average.

• The service did not always take account of people's individual needs. The patient led assessment of the care environment audits for dementia and disability scored significantly worse than the national average across four outpatients areas that were assessed. The trust wide dementia strategy did not have any outpatient related actions.

• The service did not collect, analyse and action data to improve waiting times. Waiting times for individual clinics were not recorded or collected by the services. Outpatients 66 Brighton and Sussex University Hospitals NHS Trust Inspection report 08/01/2019

• The service treated concerns and complaints seriously, investigated them and learned lessons from the results. However, trust wide not all complaints were responded to within the timeframe set in the trust guidelines.

• The service leads could describe a vision for what it wanted to achieve with clear priorities for delivering good quality and sustainable care. However, this was in a draft format that we were not able to view, and was not developed with involvement from key staff. Staff we spoke to in outpatients had no knowledge of, or involvement in developing these goals.

• There was a plan to implement systems and processes to ensure the governance of the department, but these were not embedded. There was no evidence that governance issues such as incidents were discussed at local level or fed into the overarching divisional or trust governance meetings.

• The service had managers with the right skills and abilities to run a service providing high quality, sustainable care, however there were key vacancies at the time of our inspection which left some staff without formal line management or face to face supervision. Visibility of the service senior leadership team was poor.

However:

• The service provided mandatory training to all staff and made sure everyone completed it. We saw a significant improvement in training compliance since our previous inspection, with training compliance better than the trust target.

• The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. All areas we visited appeared visibly clean and cleaning audits were consistently at a high standard.

• The service responded appropriately when things went wrong. Staff apologised and gave patients honest information and suitable support.

• Staff cared for patients with compassion. Feedback from patients via the Friends and Family Test and from patients we spoke with at our inspection was positive regarding the care they received from staff.

• Staff involved patients and those close to them in decisions about their care and treatment. Patients confirmed that they felt involved in decision-making and medical and nursing staff shared enough information to support this.

• Patients referred on two-week wait and 31-day cancer pathways could access the service when they needed it. The trust was performing better than the national average in these areas.

• A change in the structure of the service enabled better oversight of staff and management of key performance indicators. Since our previous inspection where outpatient services were within the head and neck directorate, a divisional restructuring had taken place across the trust. Since April 2018 general outpatients and central administration services had operated within the central clinical services division.

• The service demonstrated a commitment to improvement and innovation. There had been a significant improvement in the friends and family response rates and the successful roll out of the e-referral system.

Is the service safe? Up one rating: Good —— Our rating of safe improved. We rated it as good because:

• Staff recognised incidents and serious incidents and reported them in line with the trust policy. When things went wrong, staff apologised and gave patients honest information and suitable support. Root cause analysis reports were completed to

identify areas for improvement. Outpatients 67 Brighton and Sussex University Hospitals NHS Trust Inspection report 08/01/2019

• The main outpatient areas and the neurology (treatment of the nerves and nervous system) outpatient area had suitable premises to provide the service.

• The service had enough staff with the right skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

• The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. Cleanliness of the environment audits consistently met or were better than the trust compliance target and patients we spoke with told us the hospital felt clean. This had improved from the previous inspection.

• Patient records were stored securely and ensured patient confidentiality was maintained. This had improved since our last inspection where patient notes were sometimes left unattended. At this inspection we saw that all notes were in locked cupboards or trolleys that were secured to walls.

• Outpatient staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and we saw that all members of the outpatient team within the Central Clinical Services division had received this training which had improved since the previous inspection.

• The service provided mandatory training and key skills to all staff and made sure everyone completed it. This had improved since our last inspection and the rate of training compliance across outpatient staff was better than the trust target.

• The service had systems which promoted patient safety and we saw staff following these. Daily huddles were held where safety issues such as staffing, premises and patient care were discussed. Where patients had minor procedures such as dental extractions, World Health Organisation surgical safety checklists were completed to ensure risks to were minimised.

However:

• Learning from incidents was still not embedded within the service. At our last inspection we found that learning from incidents was not discussed at team meetings. This had not improved at this inspection.

Is the service effective? Not sufficient evidence to rate —— We do not rate outpatients service for effective. Our findings are as follows:

• The service provided care and treatment based on national guidance. There were policies and procedures in place that staff knew how to access. All policies and procedures were kept electronically and all staff had access to these.

• The service made sure staff were competent for their roles. Staff that were new to the department had an appropriate induction and trust wide the compliance for outpatient staff completing an appraisal in the last 12 months was better than the trust target.

• Staff of different kinds worked together to benefit the patient. Multidisciplinary meetings were held in various specialities including cancer, to ensure a holistic view of the patient's needs were taken into account.

• Staff gave patients enough food and drink, where appropriate, to meet their needs whilst in the outpatient department.

• The service ensured that consent was taken from patients in line with the trust policy. We reviewed patient records and saw that consent forms were signed and dated by both the consultant and patient and risks of the procedures were documented as part of this process.

• Staff understood their roles and responsibilities regarding the Mental Capacity Act 2005 and received training on this as part of their safeguarding level two training.

However:

• Although there was a trust wide programme for providing training to staff regarding the Mental Health Act 1983, no staff in outpatients had received Mental Health Act training. However, staff told us that they knew how to escalate issues

Is the service caring? Same rating: Good —— Our rating of caring stayed the same. We rated it as good because:

• Staff cared for patients with compassion. We observed staff interacting with patients in a kind and caring manner. Feedback from patients we spoke with on inspection told us that the care was "excellent" and that staff were "pleasant and helpful".

• The Friends and Family Test results for patients had a consistently high recommend rate and the response rate had improved over the last six months. Between February and June 2018, the rate was similar to or better than the national average recommended score.

• Staff involved patients and those close to them in decisions about their care and treatment. Patients confirmed that they felt involved in decision-making and medical and nursing staff shared enough information to support their decision-making. However: Outpatients 69 Brighton and Sussex University Hospitals NHS Trust Inspection report 08/01/2019

• The patient led assessment of the care environment result for dignity, scored significantly worse than the national average in two of the outpatient areas assessed.

Is the service responsive? Same rating: Requires improvement —– Our rating of responsive stayed the same. We rated it as requires improvement because:

• Patients could not always access the service when they needed it. Overall waiting times from referral to treatment were worse than the national average.

• Patients referred on a cancer pathway were not always treated within 62 days of referral from their GP. The trust was performing worse than the England average in this area.

• The service did not always take account of people's individual needs. The patient led assessment of the care environment audits for dementia and disability scored significantly worse than the national average across four outpatients areas that were assessed. The trust wide dementia strategy did not have any outpatient related actions.

• Department waiting times for individual clinics were not recorded or collected by the services. This meant that the service did not have oversight of patient waiting times within the department.

• Clinics were sometimes cancelled with less than six-weeks' notice. This was not in line with the trust's Patient Access Policy and the amount of cancellations had increased since our last inspection.

• The service treated concerns and complaints seriously, investigated them and learned lessons from the results. However, trust wide, not all complaints were responded to within the timeframe set in the trust guidelines.

However:

• Patients referred on a two week wait pathway for suspected cancer could expect to see a specialist within two weeks of referral from their GP and the trust was performing better than the England average in this area.

• Once a decision to treat had been made for a patient with a cancer diagnosis, they could expect to be treated within the operational standard of 31 days, and the trust was performing better than the England average in this area.

• The service took account of patients' individual needs. The main outpatient departments were signposted, and volunteers were situated in the main hospital entrance and offered patients assistant to find a clinic if required.

• The service received more compliments than complaints over the previous 12 months.

Is the service well-led? Same rating - Requires improvement —– Our rating of well-led stayed the same. We rated it as requires improvement because:

• Whilst the service had managers with the right skills and abilities to run a service providing high-quality and sustainable care, there were key vacancies in the division, and the management structure had not yet been embedded, nor was it known or understood to all staff. Staff did not feel that the divisional leadership team were visible on this site, and some had never met face to face. Outpatients 70 Brighton and Sussex University Hospitals NHS Trust Inspection report 08/01/2019

• There was a new governance structure in place across the trust which indicated that governance fed from the departments up through the divisions and to board level. However, there were no discussions of governance at the team meetings within the outpatient department, which meant that governance issues may be missed at a divisional and senior level.

• The service had a vision for what it wanted to achieve. A new clinical strategy had been created since our last inspection and we were told that this had involved in depth discussions with divisions and services and had been aligned to the trust strategic objectives. However, we were unable to see the strategy due to it not being approved or ratified, and staff we spoke with had not been involved or engaged with this process.

• There were improvement projects being run within the department, however key staff from the departments were not included as part of this.

• Action plans were not in place following poor performance in three areas of the Patient Led Assessment of the Care Environment audits and no evidence to suggest the service was going to make any changes in response to the audits.

However:

• Since our last inspection, the central administrative service and outpatients had been merged as a standalone directorate. This meant that the majority of outpatient services were under one directorate, which would enable better oversight and management of key performance figures such as mandatory training.

• Staff felt well supported at a local level by the department manager and individual line managers. • The culture of the staff in the department was positive and open. Staff put patients at the centre of their work.

• The service demonstrated a commitment to improvement and innovation. There had been a significant improvement in the friends and family response rates and the successful roll out of the e-referral system.

Actions the trust SHOULD take to improve:

• The trust should ensure that patient records are audited for quality.

• The trust should ensure that only registered nurses carry medicines keys. • The trust should ensure that the waiting area and environment in phlebotomy is safe for staff and patients using it.

• The trust should ensure that staff in outpatients receive training in the Mental Health Act.

• The trust should ensure that outpatient services are included as part of the dementia strategy.

• The trust should ensure that action plans are put in place and monitored following poor performance in three areas of the Patient Led Assessments of the Care Environment scores.

• The trust should continue to develop the leadership and governance functions of outpatients. Staff should be appropriately involved in all areas of performance. Performance monitoring activities undertaken by staff should be meaningful and focused on improving performance.

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 40 Brighton & Hove City Council

Subject:		**Cancer Screening and Treatment**	
Date of Meeting:		**20 March 2019**	
Report of:		**Executive Lead for Strategy, Governance & Law (Monitoring Officer)**	
Contact Officer:	**Name:**	**Giles Rossington**	**Tel: 01273 295514**
	Email:	**giles.rossington@brighton-hove.gov.uk**	
Ward(s) affected:		**(All Wards);**	

FOR GENERAL RELEASE

Glossary

- **BHCCG: Brighton & Hove Clinical Commissioning Group –** commissions most healthcare services for the city
- **BSUH: Brighton & Sussex University Hospitals Trust –** local acute trust and main provider of cancer treatment for BH residents
- **PHE: Public Health England –** responsible for national screening programmes (bowel, cervical and breast)
- **NHSE: NHS England –** NHS body responsible for specialist commissioning (including rare cancers) and for some oversight of local NHS organisations
- **IAF: Improvement & Assessment Framework –** NHSE framework for performance improvement
- **LTP: NHS Long Term Plan –** recently published five year vision for the NHS
- **ICS: Integrated Care System –** formal alliances of health and care commissioners and providers required by LTP
- **STP: Sustainability & Transformation Partnership –** sub-regional NHS planning footprint (i.e. Sussex & East Surrey)
- **PCN: Primary Care Network –**primary and community care services based around clusters of GP practices – also required by LTP

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 This report provides details of the performance of the local health system in terms of screening for and treating cancer.

1.2 The report was requested by HOSC members because of concerns about cancer performance. **Appendix 1** to this report contains information from BHCCG, BSUH and the council's Public Health team (however please note that screening for cancers is the responsibility of Public Health England/NHS England rather than local authority public health teams).

1.3 The HOSC has a statutory role in ensuring that NHS-funded healthcare for local people is delivered to an acceptable standard, and the HOSC should hold providers to account for the quality of their provision. However, where the HOSC finds systemic performance or quality issues, it may wish to make a referral to the Health & Wellbeing Board, which is responsible for commissioning services across the local health and care system.

2. RECOMMENDATIONS:

2.1 That the Committee notes the contents of this report.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 NHS England assesses the performance of all CCGs using an Improvement & Assessment Framework (IAF). The IAF includes four measures relating to cancer:

- cancers diagnosed at an early stage (i.e. via screening rather than by diagnosis of symptoms);
- people with an urgent GP referral for cancer having definitive treatment within 62 days;
- one year survival from all cancers;
- cancer patient experience.

In addition, NHS providers are assessed against targets for:

- a two week wait between GP referral and an initial outpatient appointment; and
- 31 days between diagnosis and commencing treatment for all cancers.

3.2 The local health system has consistently struggled with the majority of these measures. Details of performance and of NHS improvement planning in response are included in **Appendix 1**.

3.3 Cancer is a priority in the NHS Long Term Plan and the LTP makes a number of commitments to improve cancer diagnosis and services. These include Primary Care Networks addressing local early diagnosis rates by 2023/24 and aligning cancer alliance areas with STP and/or Integrated Care System footprints.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The report recommendation is to note. However, the Committee has the option to refer this report to the HWB if members feel that there is a systemic issue of performance/quality which is not adequately addressed in the action planning outlined in **Appendix 1**.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None directly, although members may wish to note that one of the major quality measures for cancer is cancer patient experience (Brighton & Hove performs at the national average).

6. CONCLUSION

6.1 Members are asked to note information on quality and performance relating to cancer diagnosis and treatment.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this report for information.

Legal Implications:

7.2 There are no legal implications to this report.

Lawyer Consulted: Elizabeth Culbert Date: 01/02/2019

Equalities Implications:

7.3 None directly. Members may wish to note that particular cancers may have a disproportionate impact on some protected groups; and also that cancer screening programmes may be less effective amongst certain groups than across the population as a whole. In both instances, members may be interested in the steps being taken by commissioners and providers to address these issues.

Sustainability Implications:

7.4 None directly.

Any Other Significant Implications:

7.5 None identified

SUPPORTING DOCUMENTATION

Appendices:

1. Information jointly provided by BH CCG, BSUH and by BHCC Public Health

Documents in Members' Rooms
None

Background Documents
None

Cancer: Improvement Assessment Framework (IAF) Ratings 17/18

Context

NHS England (NHSE) has a statutory duty under the Health and Social Care Act (2012) to conduct an annual assessment of all Clinical Commissioning Groups (CCGs) within England. The Improvement and Assessment Framework (IAF) was introduced in 2016/17 to facilitate this assessment. The assessment provides a framework that aligns key objectives and priorities, while also informing the way NHSE manages relationships with CCGs.

Cancer is one of the areas under the IAF Better Care domain and it measures four indicators.

Indicator	National Benchmark	Brighton and Hove
Cancers diagnosed at early stage 62% by 2020	53.5	49.8
People with urgent GP referral having definitive treatment for cancer within 62 days	85	75.3
One-year survival from all cancers * 75% by 2020	72.4	70.5
Cancer patient experience **	8.7/10	8.7/10

*Data from 2015 **data from 2016

National Policy Context

Nationally and locally there is a commitment to improve the outcomes of people affected by cancer. The NHS Long Term Plan highlights cancer as a priority, with the National Cancer Strategy *Achieving Word Class Outcomes for Cancer 2015-2020: A Strategy for England Independent Cancer Taskforce Review*, outlining six priority areas for cancer; Prevention, Early Diagnosis, Patient Experience, Living with and Beyond Cancer, Modernising Cancer Services and Commissioning, Accountability and Provision.

Locally, work is being carried out across the Sussex and East Surrey Commissioning Alliance (SES) to meet the national recommendations set out in the NHS Long Term Plan and National Cancer Strategy. Delivering on these recommendations requires coordination and integration between key organisations, particularly Providers, Public Health England, Local Authority's, County Council's, CCGs, Cancer Alliances and NHSE.

IAF Indicators and CCG's response

Cancer diagnosed at an early stage (62% by 2020)

This IAF indicator monitors the percentage of patients that receive a cancer diagnosis at an early stage.

Early diagnosis is highlighted in both the Cancer Strategy and the NHS Long Term Plan as a priority, as it is strongly evidenced that patients diagnosed at an early stage have a higher rate of survival than those diagnosed at a later stage.

The CCG are working in collaboration with key stakeholders to increase the number of people being diagnosed at an early stage and are working to shift from detection as a result of symptoms, to detection as a result of screening programmes, communication and engagement with patients and the public and, providing greater GP access to diagnostics.

Specific interventions undertaken to improve cancers diagnosed at an early stage:

- Working with Public Health to raise awareness around healthy lifestyle factors and behaviours
- Working with Public Health to improve screening uptake through a jointly commissioned contract with Albion in the Community.
- Through a CCG locally commissioned service in GP practices addressing those areas where there are low cancer screening uptake through working with Cancer Research UK and CCG Clinical Leads and following up non-responders to screening.
- Utilising NHS Health Checks
- Implementation of Straight To Test (diagnosis)
- Implementation of NICE NG12 guidance (2015) for suspected cancer which lowered the thresholds for referrals
- Implementation of Nationally driven “Be Clear on Cancer” locally and other targeted interventions
- The CCG has a Macmillan Cancer Nurse in place who runs education and training programmes

People with urgent GP referral having definitive treatment for cancer within 62-days
This IAF indicator is a constitutional standard that monitors the percentage of patients that are receiving definitive treatment for their cancer within 62-days of being referred urgently by their GP.

This core delivery indicator spans the whole pathway from referral to first treatment. It monitors the length of time taken from urgent GP referral to first outpatient appointment, the decision to treat and finally first definitive treatment.

Shorter waiting times can help to ease patient anxiety and, at best, can lead to earlier diagnosis, quicker treatment, lower risk of complications, improved patient experience and overall improved cancer outcomes.

Specific Interventions undertaken by BSUH

Performance against the standards is compliant on the 31-Day standard but non-compliant for both 2WW and the 62-Day standards.

CANCER SERVICES DASHBOARD		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Cancer Waits Performance									
100	**Cancer: 2 week GP referral to 1st outpatient - 93%**	91.17%	93.03%	92.42%	85.61%	84.74%	80.80%	80.71%	85.81%
3.00	**Cancer: 31 day diagnosis to treatment for all cancers - 96%**	100.00%	99.14%	98.32%	99.17%	98.72%	97.49%	96.76%	96.50%
4.00	**Cancer: 62 days urgent GP referral to treatment of all cancers - 85%**	78.6%	80.2%	70.9%	70.9%	71.4%	74.1%	71.6%	75.2%

Actions being taken to improve secondary care cancer patient constitutional standards include the following:

- More regular review of all patients on a cancer pathway, undertaken daily, to progress patients next steps
- External review of cancer services at BSUH undertaken Summer 2018 whose report included a list of recommendations to improve care, outcomes and timeliness
- External support brought in to help implement recommendations, including an intensive breach avoidance programme to reset the service provisions
- Continued development to automate data and reports to enable service to live manage the patients under their care
- Demand and capacity work is being revisited to identify core gaps and short/medium/long term solutions to facilitate better flow through patients pathways including with surgical and outpatient capacity
- Review of Multi-Disciplinary Meeting functions, attendance and decision making to provide optimal discussions for patients that require it and stream delays where decision making can be more protocolised
- A review has been completed by the cancer alliance focused on the timed pathways of Colorectal, Prostate and Lung. The recommendations are being incorporated into the overarching cancer action and improvement plan.
- Delays in diagnostics remains a contributing factor to the delays seen in the cancer pathway. There is a specific diagnostic action and recovery plan to address this.

One-year survival from all cancers (75% by 2020)
This IAF indicator measures the number of adults diagnosed with any type of cancer who are still alive after one-year of diagnosis and is set out in the 2017-2019 NHS Operational Planning and Contracting Guidance as a priority.

The most up-to-date published international comparisons show that relative survival rate during 1995-2007 improved for breast, colorectal, lung and ovarian cancer patients in all jurisdictions. However, the

gap in survival between the highest performing countries (Australia, Canada and Sweden) and the lowest (England, Northern Ireland, Wales and Denmark) remains largely unchanged, except for breast cancer, where the UK is narrowing the gap. More recently, the survival gap has also started to close in stomach and rectal cancers, according to as yet unpublished data, however it remains significant in lung and colon cancers.

Specific Interventions undertaken take to improve the one-year survival rate of all cancers:

- The development of timed pathways to support the delivery for 28-days to diagnosis starting with the faster diagnostic pathways for lung, colorectal and prostate. As well as improved access to diagnostics for cancer patients including the development of a rapid diagnostic centre and vague symptom pathway in partnership with the Surrey and Sussex Cancer Alliance
- Implementation of STT for colorectal at BSUH
- Implementation of the ACE lung pathway at BSUH. The ACE Programme is an early diagnosis programme that supports the NHS outcome of 'preventing people from dying prematurely'. It is a unique initiative supported by Cancer Research UK and Macmillan Cancer Support and will run across England for 3 years.
- Working with the Surrey and Sussex Cancer Alliance to develop a vague symptom clinic and cancer and non-cancer diagnostic centre
- Implementation of Faecal Immonochemical Test for GPs (symptomatic investigation)
- Rapid Diagnostic centre planning
- Supporting diagnostics through a new Alliance group – The Diagnostic Collaborative

Cancer patient experience

This IAF indicator is focused with measuring the experience of cancer patients. Improving the experience of cancer patients (and quality of life) is outlined as a priority within the Cancer Strategy, with the Taskforce setting an ambition for continuous improvement in patient experience and to give it equal priority with clinical outcomes.

Specific Interventions undertaken to improve the experience of cancer patients:

- Improved patient experience through the implementation of risk stratified follow-up pathways for breast, colorectal and prostate
- Implementation of the Recovery Package
- BSUH – standardise process for Health Needs Assessment (HNA), 70% of HNA's to take place at breaking bad news for September/October 2018, develop of Health and Wellbeing events through peer evaluators and working with consultants on using a standardised template for treatment summaries.
- Standardised process at the CCG though Cancer Locally Commissioned Services
- Delivery of the Recovery Package including health needs assessments, treatment summaries, cancer care reviews and access to health and wellbeing events such as Albion in the community
- End of Life Care Vision - the implementation of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) across primary, community and secondary care

Cancer Screening Programmes – summary data

Screening programme	**Current position**	**Local target**	**Progress**	**National target, England Average and South East average for – Kent Surrey Sussex**
Bowel: coverage Persons 60-74, in last 5 years (%)	58.0%	52%	Target met with trend increasing	National Target: 52% Eng Ave: 59.6% South East: 61.2%
Breast: 50-70 year old women screened in last 3 years (%)	66.9%	70%	Target not met and trend decreasing	National Target: 70-80% Eng Ave: 72.2% South East: 71.6%
Cervical: eligible women (25-64) attending screening in last 3.5 years to 5.5 years (%)	68.2%	72%	Target not met and trend decreasing	National Target:80% Eng Ave: 71.7% South East: 68.2%

Data source: Public Health Outcomes Framework 2017/18 Cancer Services profiles

https://fingertips.phe.org.uk/profile/cancerservices/

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 41 Brighton & Hove City Council

Subject:		**Brighton & Hove Healthwatch Annual Report 2018**
Date of Meeting:		**20 March 2019**
Report of:		**Executive Lead, Strategy, Governance & Law**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 29-5514**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

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

1.2 Healthwatch is a co-opted member of both the Brighton & Hove HOSC and the Health & Wellbeing Board, and is this year presenting its annual report to both committees (the annual report is included as **Appendix 1**).

2. RECOMMENDATIONS:

2.1 That members note the Healthwatch annual report (**Appendix 1**).

3. CONTEXT/ BACKGROUND INFORMATION

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

3.2 Healthwatch Brighton & Hove is an independent Community Interest Company (CIC). Details of the activity of Healthwatch over the past year are included in the Healthwatch Annual Report (**Appendix 1**).

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

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

5 COMMUNITY ENGAGEMENT & CONSULTATION

5.1 The development of the Annual Report is based on the Healthwatch B&H's consistent approach to seeking to hear people's stories about their experiences of health and social care services. 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 to inform their work.

6. CONCLUSION

6.1 The Healthwatch annual report is presented for information.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this report as it is for information.

Legal Implications:

7.2 There are no legal implications to this report
Lawyer Consulted: Elizabeth Culbert; Date: 01/02/2019

Equalities Implications:

7.3 None identified.

Sustainability Implications:

7.4 None identified.

Any Other Significant Implications:

7.5 None

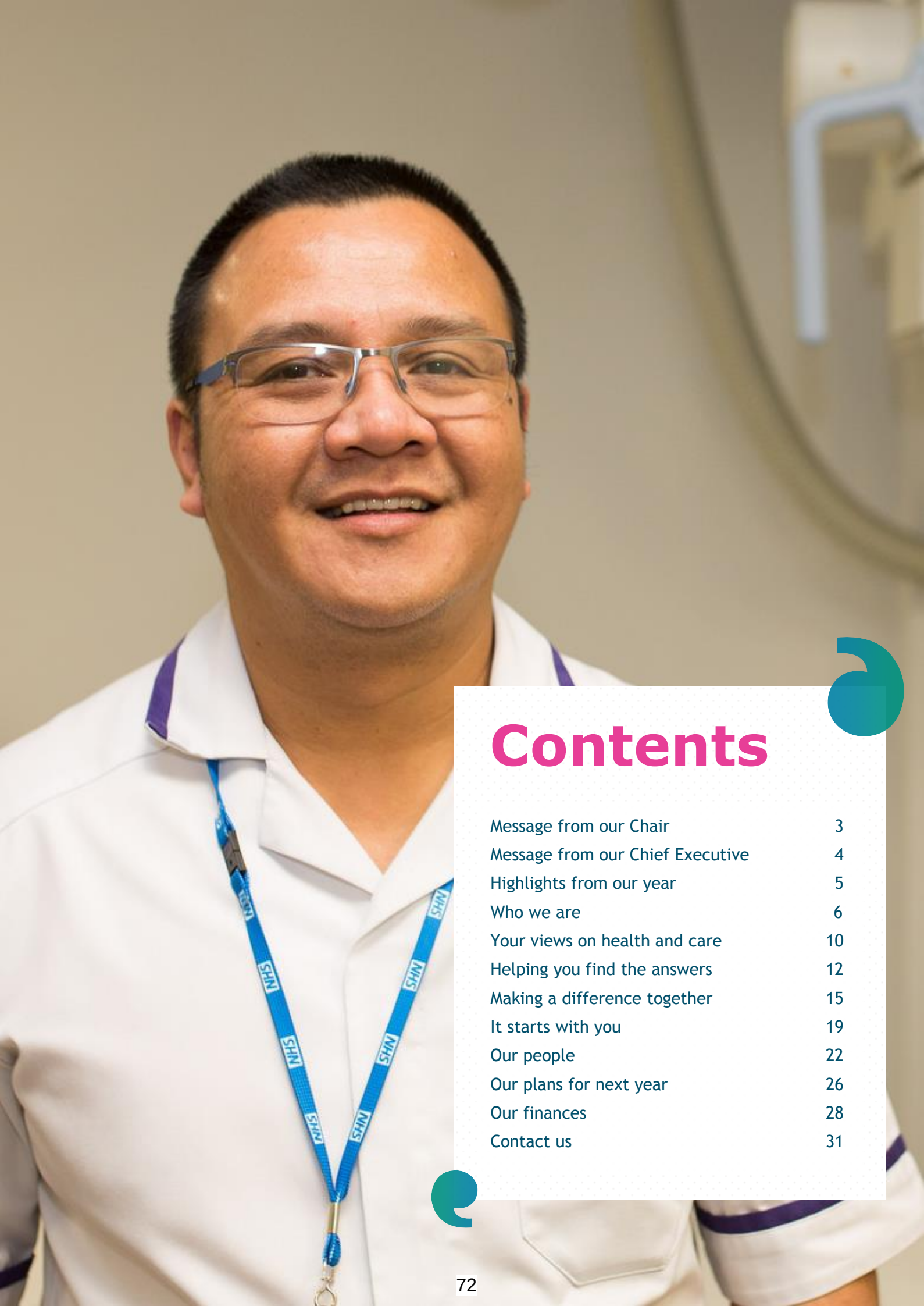
SUPPORTING DOCUMENTATION

Appendices:

1. Healthwatch Brighton & Hove Annual Report 2018

Healthwatch Brighton and Hove

Annual Report 2017/18



Contents

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

29

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

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

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.

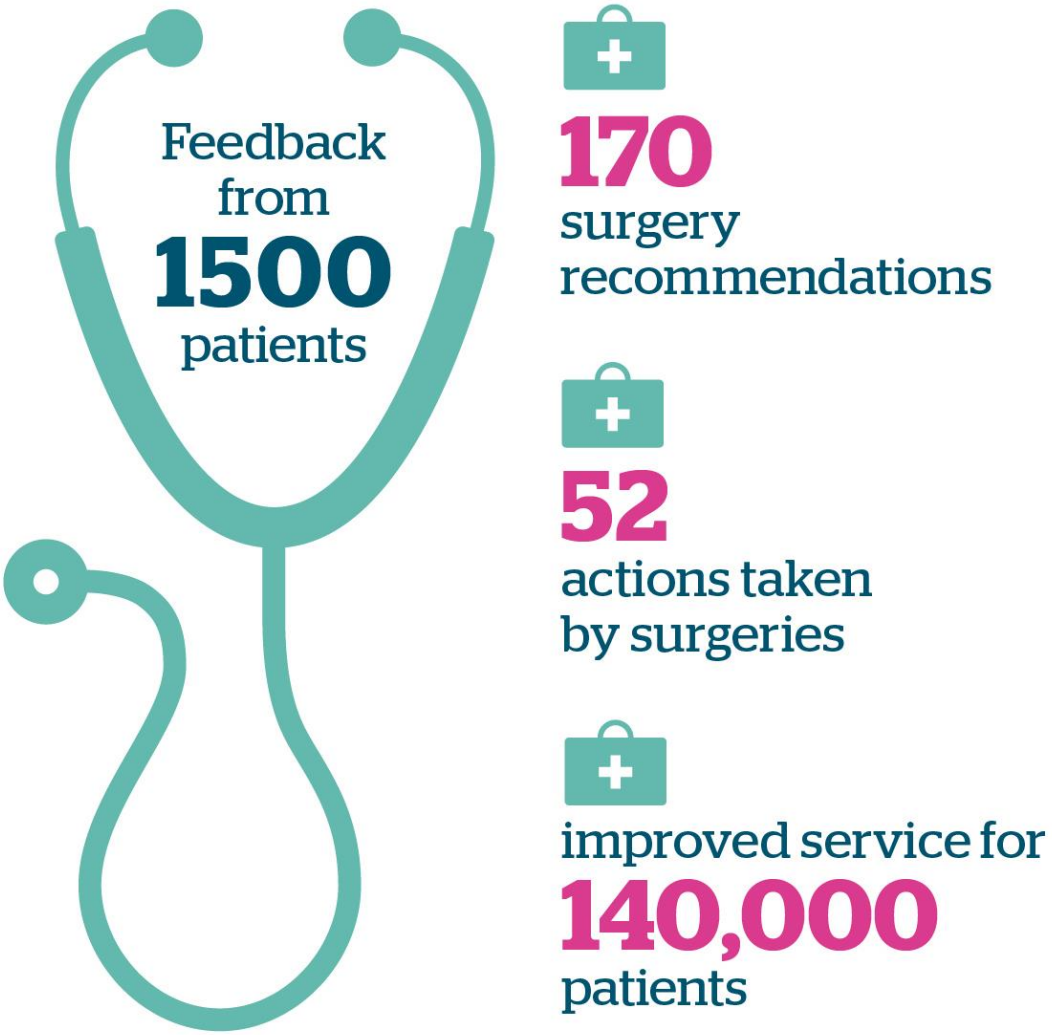
You can read the full GP Review at:
www.healthwatchbrightonandhove.co.uk/Reports/GP-Review-2018.pdf

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.

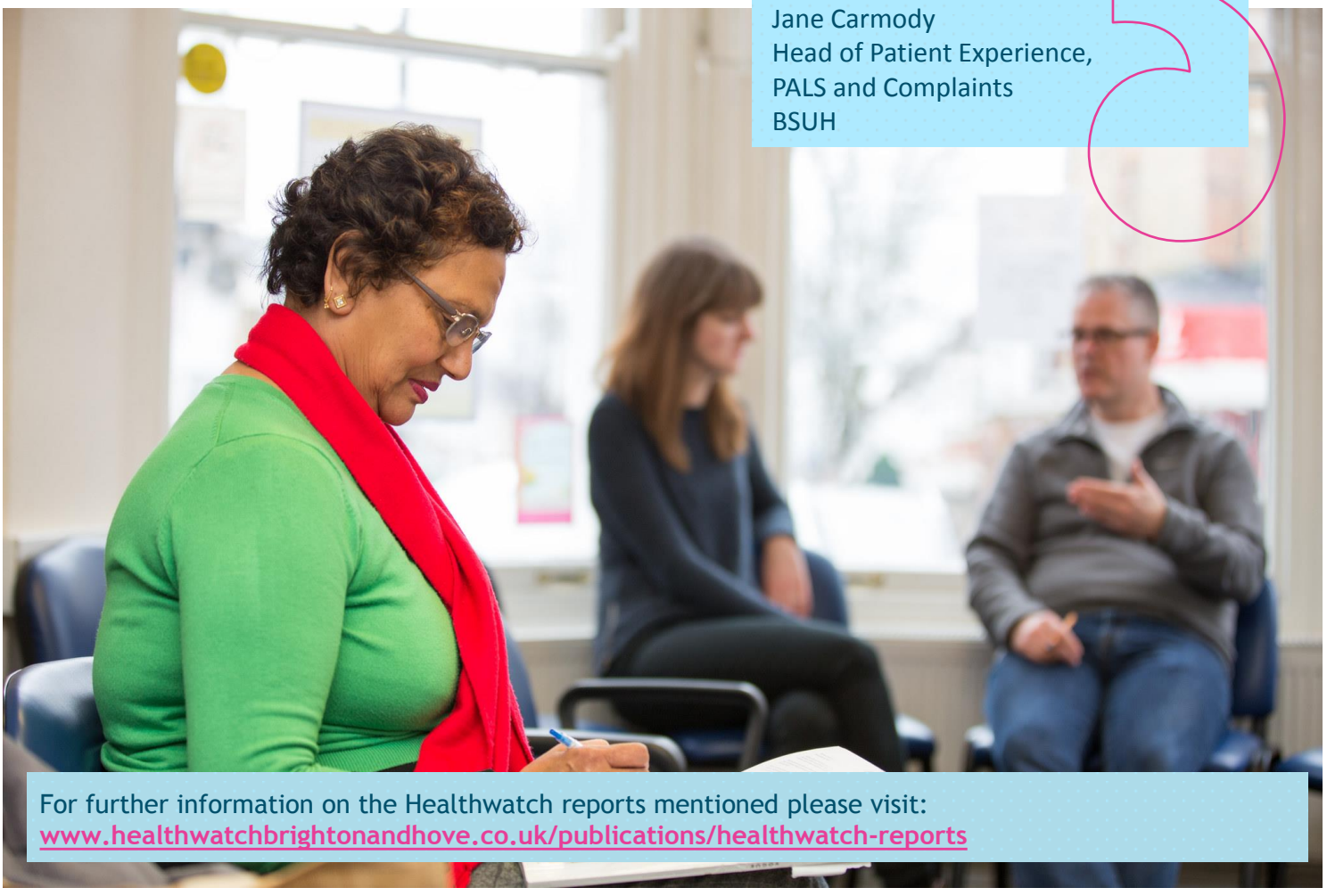
This year we incorporated nationally recognised standards into our work notably the Patients Association: Good Practice standards for NHS Complaints Handling (2014); My Expectations for raising concerns and complaints (2013); the revised NHS Complaints policy (2017), and Parliamentary and Health Service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


Tell us
what yo
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hear your vie
and care serv
chislington.co.u

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.

> ***"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

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."

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:
www.healthwatchbrightonandhove.co.uk/publications/healthwatch-reports

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

Contact us

Healthwatch Brighton and Hove

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113 Queen's Road
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BN1 3XG

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office@healthwatchbrightonandhove.co.uk
healthwatchbrightonandhove.co.uk

Young Healthwatch Brighton and Hove

YMCA DownsLink Group
Reed House
47 Church Road
Hove
BN3 2BE

01273 222 550
reed.house@ymcadlg.org
ymcadlg.org

Independent Health Complaints Advocacy Service (IHCAS)

Brighton & Hove Impetus
65-67 Western Rd
Hove
BN3 2JQ

01273 229 002
info@bh-icas.org
impetus.org/projects/independent-health-complaints-advocacy-service-ihcas

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.

If you require this report in an alternative format please contact us at the address above.

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HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 42 Brighton & Hove City Council

Subject:		**Healthwatch Report on Older Patients' Experience of Hospital Discharge**
Date of Meeting:		**20 March 2019**
Report of:		**Executive Lead for Strategy, Governance & Law (Monitoring Officer)**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 01273 295514**
	Email:	**giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**(All Wards);**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 Healthwatch Brighton & Hove has recently published “Let’s Get You Home”: The experiences of older people being discharged from the Royal Sussex County Hospital, Brighton from July to September 2018. “Let’s Get You Home” is included as **Appendix 1** to this report.

1.2 An action plan, detailing steps being taken to implement the Healthwatch report recommendations, is being formulated by the city council, Brighton & Hove CCG and by Brighton & Sussex University Hospitals Trust. The draft action plan is included for information as **Appendix 2**.

2. RECOMMENDATIONS:

2.1 That the Committee notes the Healthwatch report on older patients’ experience of discharge from the Royal Sussex County Hospital; and

2.2 That the Committee agrees to monitor the implementation of the Healthwatch report recommendations.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 In February 2019 Healthwatch Brighton & Hove published “Let’s Get You Home”, a report on older patients’ experience of being discharged from RSCH. The report is based on interviews with 80 patients.

3.2 “Let’s Get You Home” makes a series of recommendations around improving communication, personalising care, reducing delays in discharge, encouraging independence and following-up on patients post-discharge.

3.3 “Let’s Get You Home” has been welcomed by health and care commissioners and providers and an action plan to implement the report recommendations is being formulated. Parallel to the Healthwatch report, a peer review of city hospital to home services was undertaken in early March. The findings of this review will

be reported to the HOSC, and the committee may wish to monitor the implementation of any actions arising from this review alongside the Healthwatch report action plan.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Members could opt not to monitor the implementation of the action plan detailing implementation of the Healthwatch report recommendations, relying instead on Healthwatch Brighton & Hove alerting the HOSC to any specific delays in implementation.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None directly.

6. CONCLUSION

6.1 Members are asked to note the findings and recommendations of the Healthwatch report on older patient experience of discharge from the RSCH and to monitor the implementation of the report's recommendations.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this report for information

Legal Implications:

7.2 There are no legal implications to this report.

Lawyer Consulted: Elizabeth Culbert Date: 27/02/19

Equalities Implications:

7.3 The Healthwatch report focuses on older people, both because there are many vulnerable people within this group and because over 65s form a majority of hospital in-patients. More discussion of equality issues is contained in the Healthwatch report (**Appendix 1**).

Sustainability Implications:

7.4 None identified.

Any Other Significant Implications:

7.5 None identified.

SUPPORTING DOCUMENTATION

Appendices:

1. "Let's Get You Home": The experiences of older people being discharged from the Royal Sussex County Hospital, Brighton from July to September 2018

2. Joint BHCC/CCG/BSUH Action Plan to implement "Let's Get You Home" recommendations.

Documents in Members' Rooms
None

Background Documents
None

healthwatch Brighton and Hove

“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

Contents

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.

[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

[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.

[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]

PRIVATE AND CONFIDENTIAL
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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

[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*

> *[The staff] have been fantastic.*
> *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.

> *[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."*

[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]

[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.

[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).

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.

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

[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'.*

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."*

> *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*

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 **13.8** days
7-20 days	26	44%	
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 **24.6** days
7-20 days	29	49%	
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

				Total Respondents			
Age Group	Hospital Interviews	Home Interviews	Online Survey	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

				Total Respondents			
Gender	Hospital Interviews	Home Interviews	Online Survey	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

				Total Respondents			
Disability	Hospital Interviews	Home Interviews	Online Survey	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

Appendix 2

Let's get You Home

Summary of Recommendations and agreed actions for improvement

Healthwatch identified recommendations in four key areas:

1. Communication
2. Personalised care
3. Delayed Transfers of Care
4. Independent Living

	Recommendation	Agreed action	responsible officer	impact / date of delivery
1.	**Communication** **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.**			
1.a	Discharge Planning should start within 24 hours of admission	• Work has already started on discharge planning for all patients within 24 hours after admission. • One document covering patient advice is now being		

		piloted in draft form in key areas. • Existing stock of 'Planning Your Discharge from Hospital' is available on the wards whilst production of the new document is completed. • A continuation of education and coaching on the wards and acute floor is underway with a link role in the Discharge Coordinator Team for Education, and the appointment of a Matron for Integrated Discharge to support the Safety and Quality agenda around Hospital Discharge, whilst supporting the team managerially and operationally, successful candidate is expected to take up post beginning of June 2019.	Head Nursing of Discharge Head Nursing of Discharge	May 2019 Ongoing

		• Engagement with senior nursing network planned at Nursing Midwifery Management Board 13/3. • Plan with Head of Nursing for Practice Development to consider the Discharge Planning Document when reviewing all current Admission and Discharge documentation, which will include a prompt to date and sign that the initial discussion around discharge has taken place and documentation has been given to patient/family/carer • There is 7 day HASC social work presence in RSCH to support early discharge planning.	Head Nursing of Discharge Head Nursing of Discharge And Head of Nursing Practice Development Assistant Director, HASC	March 2019
1.b	Written Discharge Planning should be provided to all patients	• The current 'Planning You Discharge from	Head Nursing of Discharge	May 2019

		Hospital' document along with the separate 'Let's get you Home' booklet is currently being provided to patients and families. • The new document will combine these two documents.		
1.c	Communication should be consistent for all patients	• The content structure of the above document (1.b) is consistent		
1.d	Every patient should receive one document covering all patient advice	• One document covering patient advice is now being piloted in draft form in key areas.		
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.**			
		• Established Board Rounds on each ward, which invites all Multidisciplinary Team members to participate and assign actions for the day. • The Discharge Team is now covering 7 days a week since	All divisions Heads of Nursing , Head of Discharge and NHSI support team. lead by COO	Commenced February 2019 Commenced February 2019

		December 2018 and working closely with the community trust to facilitate and communicate around discharge plans. Speak with patients and their families regarding the expectations, wishes and process. • Community In-Reach Team are provided by Sussex Community Foundation Trust and work within BSUH NHS Trust and are very much an integral part of the Integrated Discharge Team 7 days a week • Close working partnership with adult social care partners. • Daily Multi Agency Teleconference held Mon-Fri where every patient who is medically ready for discharge, information shared	Head of Nursing - Discharge	Commenced February 2019

		and actions assigned. • Multi Agency events have been held since 2016 in various forms to review all inpatients at specified Lengths of Stay, currently a new process has just been launched supported by NHS Improvement's Emergency Care Intensive Support Team where all patients over the length of stay of 21 days are reviewed, themes and actions are recorded and each ward will be receiving a report with their own performance illustrated along with the Hospital's overall performance. • In 2018 a clinical review took place supported by the S&Q Team at B&H CCG of a number of	All divisions Heads of Nursing , Head of Discharge and NHSI support team. lead by COO	

		cases where discharge did not go well when discharged to local Intermediate Care Units, this was interesting and gave understanding of some limitations in community care settings and also raised some themes that have been able to improve on. • There is regular HASC social worker involvement in daily board rounds and in teleconferences.	Assistant Director, HASC	
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.			
		• The discharge documentation is being reviewed and this will be taken into consideration. • Discharge Planning meetings currently are documented but not shared with the patient and family, this is a clear gap in the communication and is relatively simple to resolve. • Best Interest Meetings are a formal process where there is a formal chair and minute taker therefore meeting notes are taken and shared with the patient and family. • The Continuing healthcare Process includes a consent section which initiates a conversation between the Discharge	Head Nursing of Discharge Head Nursing of Discharge with Education Team	Immediate Ongoing supported by Safeguarding, dementia and discharge teams

		coordinator/Patient/ Family around the expectations and specific discharge process. • Work to focus on the ward Led Simple Discharges and documentation around these conversations. • HASC, SCFT and BSUH are currently working to develop a joint discharge leaflet.	Senior Nursing Network and Education Team	June 2019

4.	**Personalised Care: 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.**			
		• If a patient is admitted from home every effort is made to discharge them to their home if safe to do so. If the discharge is considered simple, either no care required on discharge or a re-start of their previous package of care, this is led by the wards and the ward or Hospital Rapid Discharge Team will liaise with the patients/families/carers. This is often not happening early enough in someone's admission – so is part of the work to be undertaken		ongoing

		around simple discharges and will be addressed through the development of standard work with board rounds and If the discharge is more complex and the patient will require some support to return home this is discussed with the patient and family and planned around their level of need. • If home is not possible or recommended straight from hospital, Letters have been produced to inform patients and family members that perhaps a period of rehabilitation has been recommended or transfer to our sub-acute ward in Newhaven is necessary. The		

		letters invite the patient and family to discuss any concerns with staff members or Discharge Team. • HASC social workers form part of the discharge team	Assistant Director, HASC	
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.**			
	Our Hospital Rapid Discharge Team work in the Emergency Department, Acute Floor and Care of the Elderly Wards, screen everyone who meets their criteria, the screening document initiates an initial conversation about what support the patient previously had and is documented on a specific screening tool. This is not used widely as is quite comprehensive and the standard admission document covers patients less likely to have complex discharge situations. In April 2019 we are launching new nursing documentation which will be less detailed but prompts initiation of the conversation. HASC social workers form a key part of the rapid discharge team. HASC social workers provide support and formal assessment for carers where required.			
6.	**Reduction of delayed transfers of care (DToC) :The hospital should identify and implement workable actions that reduce the number of stranded patients, particularly for this age group (65 years old plus).**			
		Multi-agency DToC summit held with ongoing weekly meetings since August. Focus is reducing DToC For 'stranded' patients: • ASC support with weekly in-patient review • Daily Multi Agency Teleconference which reviews each medically ready patient, defines what we are waiting for and what the next step is. Also records whether	CE of system including BSUHT, CCG and B&HCC All system partners	reduction in DToC from 6% to 3.2& by December 2018 Ongoing

		the patient is considered an actual Delayed Transfer of care – this is in discussion with all on the call. A set of DTOC principles have been produced in line with the National Guidance to support the clarification of DTOC's, e.g. Timeframes from referral to assessment, confirmation that referrals have been received, Has all internal assessments and information been provided? If the Discharge Plan was initiated that day, is there anything that would prevent the patient from being discharged, if the answer is no, then they are a Delayed Transfer of Care. • A robust database is kept which is used in the background on the Daily Multi Agency Teleconference and generates a daily report	Head Nursing of Discharge	Ongoing

		which shares the updates and actions for and a performance dashboard indicating the DTOC figure for the day, Discharges facilitated from the medically Ready caseload and also informing of what services and localities patients are delayed waiting for.		
		• This daily report will then feed into the weekly sitrep reporting process which is reported to NHS England.	Head Nursing of Discharge	Reviewed and reported weekly
		• The target of 3.2% has been achieved and held consistently with an occasional variance.		
		• A heightened focus on weekend discharges with community and Adult Social care support is hoped will drive the number of medically ready and pts who are delayed down even further with a consistent daily approach rather than 5 days a week	All system partners	Under on-going review

		service. • New Superstranded process supported by ECIST in the implementation with an aim to reduce the number of superstranded (LOS 21+ days) considerable and identify themes to resolve that can prevent future delays. • Regular and Accurate Information being provided by community partners informing the acute trust which patients have been referred to their services and what capacity is available is vital in the preparing patients for transfer and discharge.	All system partners All system partners	Weekly reviews undertaken and evaluated
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.**			
		The desire and ability to provide a 7 day discharge service has improved somewhat with Discharge Coordinator, Hospital Rapid Discharge Team also covering the weekends,		

		along with community partners and adult social care cover. To provide 7 days service in all specialities would involve a high level of investment and services are examining how they can re-organise their services without severely compromising weekday activity		
8.	**Independent Living: 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 the Home First model is implemented where patients are discharged home and assessed within their own home rather than being assessed in hospital. (This pathway is primarly funded by the CCG.) When care capacity allows this is an excellent model, however capacity has been reduced and we now see patients waiting in hospital for Home First Discharges. First and Foremost Hospital Discharge is always aimed to return the patient to their home and encourage independence as much as	SCFT/ASC and B&H CCG	

		possible. Where possible we utilise Age UK and Red Cross Hospital Discharge Services to support the patients discharge.		
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.**			
		All patients now receive advice on nutrition and hydration and accessing community groups. BSUH are providing information that will go into the new Discharge Information. The current stock of hospital documentation is being used in conjunction with the Lets Get You Home leaflets until stocks are used. Whilst the new documents are being completed and produced.	Head Nursing of Discharge	May 2019
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.**			
		The new discharge document will include useful contacts if a problem arises.	Head Nursing of Discharge Sara Allen	May 2019

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