Brighton & Hove City Council

Health & Wellbeing Overview & Scrutiny Committee

Title:	**Health & Wellbeing Overview & Scrutiny Committee**
Date:	**4 February 2015**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Rufus (Chair)C Theobald (Deputy Chair), Bennett, Bowden, Cox, Marsh, Meadows and Sykes **Co-optees:** Colin Vincent (OPC), Youth Council and Healthwatch
Contact:	**Kath Vlcek** 01273 290450 kath.vlcek@brighton-hove.gov.uk

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AGENDA

Part One **Page**

23 Procedural Business **1 - 2**

To consider

(a) Declaration of Substitutes

(b) Declaration of Interest

(c) Declaration of Party Whip, and

(d) Exclusion of Press and Public

24 Minutes of Previous Meeting **3 - 10**

25 Chair's Communications

26 Introduction to the Care Act **11 - 18**

Presentation from Philip Letchfield, Head of Modernisation and Performance

27 Adult Social Care Performance Monitoring **19 - 60**

Report of Philip Letchfield, Head of Modernisation and Performance

Contact Officer: *Philip Letchfield, Head of Contracts and Performance* *Tel: 01273 295078*

Ward Affected: *All Wards*

28 CCG Review into Premature Mortality **61 - 70**

Report from Public Health and the Clinical Commissioning Group

Ward Affected: *All Wards*

29 Healthwatch Brighton and Hove - achievements over the last twelve months **71 - 94**

Report from Frances McCabe, Chair of Healthwatch Brighton and Hove.

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Date of Publication 27 January 2015

Agenda Item 1

To consider the following Procedural Business:

A. Declaration of Substitutes

Where a Member of the Committee is unable to attend a meeting for whatever reason, a substitute Member (who is not a Cabinet Member) may attend and speak and vote in their place for that meeting. Substitutes are not allowed on Scrutiny Select Committees or Scrutiny Panels.

The substitute Member shall be a Member of the Council drawn from the same political group as the Member who is unable to attend the meeting, and must not already be a Member of the Committee. The substitute Member must declare themselves as a substitute, and be minuted as such, at the beginning of the meeting or as soon as they arrive.

B. Declarations of Interest

(1) To seek declarations of any personal or personal & prejudicial interests under Part 2 of the Code of Conduct for Members in relation to matters on the Agenda. Members who do declare such interests are required to clearly describe the nature of the interest.

(2) A Member of the Overview and Scrutiny Commission, an Overview and Scrutiny Committee or a Select Committee has a prejudicial interest in any business at a meeting of that Committee where –

(a) that business relates to a decision made (whether implemented or not) or action taken by the Executive or another of the Council's committees, sub-committees, joint committees or joint sub-committees; and

(b) at the time the decision was made or action was taken the Member was

(i) a Member of the Executive or that committee, sub-committee, joint committee or joint sub-committee and

(ii) was present when the decision was made or action taken.

(3) If the interest is a prejudicial interest, the Code requires the Member concerned:

(a) to leave the room or chamber where the meeting takes place while the item in respect of which the declaration is made is under consideration. [There are three exceptions to this rule which are set out at paragraph (4) below].

(b) not to exercise executive functions in relation to that business and

(c) not to seek improperly to influence a decision about that business.

(4) The circumstances in which a Member who has declared a prejudicial interest is permitted to remain while the item in respect of which the interest has been declared is under consideration are:

(a) for the purpose of making representations, answering questions or giving evidence relating to the item, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise, BUT the Member must leave immediately after he/she has made the representations, answered the questions, or given the evidence;

(b) if the Member has obtained a dispensation from the Standards Committee; or

(c) if the Member is the Leader or a Cabinet Member and has been required to attend before an Overview and Scrutiny Committee or Sub-Committee to answer questions.

C. Declaration of Party Whip

To seek declarations of the existence and nature of any party whip in relation to any matter on the Agenda as set out at paragraph 8 of the Overview and Scrutiny Ways of Working.

D. Exclusion of Press and Public

To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: Any item appearing in Part 2 of the Agenda states in its heading the category under which the information disclosed in the report is confidential and therefore not available to the public.

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls.

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE

4.00pm 26 NOVEMBER 2014

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Rufus (Chair)

Also in attendance: Councillor C Theobald (Deputy Chair), Bowden, Cox, Marsh, Sykes and Robins

Other Members present: Councillors

PART ONE

16 PROCEDURAL BUSINESS

16a Councillor Alan Robins was substitute for Councillor Anne Meadows

16b There were no declarations of interest.

16c There were no declarations of party whip.

16d There was no exclusion of press or public.

17 MINUTES OF PREVIOUS MEETING

17.1 These were agreed as an accurate record.

18 CHAIR'S COMMUNICATIONS

18.1 The Chair said that the agenda was focussed on the Hospital Trust, starting by looking at the Care Quality Commission report and about what the Trust is doing to address the issues highlighted. The committee would also hear about the results of the recent Patient Led Assessment of the Care Environment (PLACE), followed by an update on the progress of the 3Ts development, and lastly proposals for stroke services in the region.

19 CARE QUALITY COMMISSION INSPECTION OF BSUH SITES

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19.1 Terri Salt, Inspection Manager (Hospitals), Care Quality Commission, spoke to the committee about the role of CQC and how it operates. Its role is to work with providers but not to manage the Trusts.

BSUH was in the first cohort of the new inspection regime, which takes a risk based approach. There are CQC teams dedicated to analysing a range of data about a health provider to highlight risks.

19.2 During the BSUH inspection, 35 inspectors reviewed the services at four out of the 8 BSUH sites; Royal Sussex County Hospital, Princess Royal Hospital, Hove Polyclinic and Bexhill Renal Unit.

There are five key domain questions, is the provider safe; effective; caring; responsive; and, well-led? Each domain is given an overall rating ranging from outstanding; good; requires improvement; or inadequate. There was a deliberate decision not to have a 'satisfactory' option, the CQC wanted to be clear about the quality of service offered.

Most Trusts range between 'good' or 'requires improvement' in overall results. BSUH's final results were 'requires improvement' though some areas were given higher gradings.

19.3 Matthew Kershaw, Chief Executive, Brighton and Sussex University Hospitals Trust (BSUH) spoke to the committee about the inspection results. He said that the Trust had had a mixed performance, and the CQC had identified it as a medium risk trust. All of issues highlighted by the inspection had been ones that the Trust had known about and highlighted and some had existed for a number of years and had been working to address. A key factor in the Emergency Department inspection was that BSUH could not demonstrate that 95% of patients were seen within 4 hours; this preceded Mr Kershaw's appointment but was something that needed to be addressed.

As the committee had heard, the overall rating was 'requires improvement', but the Trust had been marked as 'good' in the domains of 'effective' and 'caring'. There had been one 'inadequate' score for one aspect out of 90 in total, for the emergency department pathway, which, as seen, was a known problem.

BSUH feels that the report is a fair and balanced one, there were no surprise issues in the report. There had been some positive comments but also a number of areas where improvements could be made. The hospital had drawn up a detailed action plan to address the various areas that needed to be improved. Mr Kershaw was happy to share this with the committee if they would like.

19.4 The committee members then asked Ms Salt, Mr Kershaw and Sherree Fagge, Chief Nurse, about the inspection and outcomes.

Before beginning the questions, the HWOSC chair thanked Mr Kershaw and Ms Fagge for their ongoing openness and willingness to engage. The CQC had recognised this and it had always been apparent at HWOSC too.

- What does CQC see as the direction of travel for BSUH? The same concerns have been raised before, so how can it be managed in a long term manner.

  Ms Salt said that it was difficult to compare previous CQC inspection reports with the current one as the inspection process has changed significantly. However in terms of what will be done from now on, the CQC will closely monitor the action plan; they have a Lead Inspector who works with the Trust and the CCG.

  Some of the negative comments were due to the lay out of the building and the age of some of the hospital including the Barry Building. The Inspectors knew that the 3Ts proposal will aim to address a lot of this but it has to assess the Trust on what it sees at the time of inspection.

  Ms Salt also confirmed that CQC had no serious overriding concerns; in particular mortality rates are better than comparator Trusts.

- Members asked how do you maintain the ongoing good practice as well as introducing improvements?

  Ms Fagge said that the CQC inspection had recognised that the Trust was maintaining maintain positive work – 64 areas of work had been assessed as 'good', including end of life care, which was uniformly recognised as a good across all five domains.

  There were regular internal meetings amongst senior Trust staff to look at how to improve other areas, this was discussed in training and appraisals etc. There is a member of Executive Team responsible for each workstreams associated with the action plan.

  Mr Kershaw commented that even areas that had been assessed as 'good' were not complacent, they were looking to see how they could move to 'outstanding'. He added that the Trust expected the follow up CQC inspection to take place in summer 2015, depending on the CQC's capacity.

- Members asked whether patients should be concerned by the Trust's safety assessment – 'requires improvement'. How much of a worry was this? They also asked how the Eye Hospital was categorised in the CQC inspection- in the PLACE inspections it had its own category.

  Mr Kershaw said that the CQC look at the Brighton sites as one, including the Eye Hospital and the Royal Alexandra Childrens Hospital. Locally there is an excellent cataract service. The results of the CQC safety assessments were linked to unscheduled care.

  Ms Salt said that every inspection decision is carefully scrutinised by the CQC before the final decision, and that they are entirely based on evidence not just opinion. In the

case of mortality data, the information is reported by department and can now be reported under individual surgeon's names.

In cases where 'requires improvement' is the final assessment, it means that most people are getting good care, but a few are not receiving the same level of care so it is inconsistent.

- Members asked whether the CQC report had a negative effect on staff morale?

  Mr Kershaw said that it was a fair and balanced report for both staff and patients. If it had not been fair, it would have had a negative impact on staff. Ms Fagge added that staff were keen for the CQC to come to their individual wards – and that the one 'inadequate' rating has galvanised people to take action.

- Members commented that the report was not very understandable to the layperson – it felt that it was by professionals, for professionals.

  Mr Kershaw said he agreed, which is why it was key for BSUH to have some clear headline messages and these have been communicated widely.

- Members asked about the budgetary implications – does BSUH have to make savings elsewhere to deliver the actions needed?

  Mr Kershaw said that most areas did not require additional cost but just a different way of doing things. However some areas for example staffing and improving the environment have costs.

  Mr Kershaw gave an example of one of the new initiatives being put into place regarding discharges from hospital. One area was to identify appropriate patients to discharge early in the mornings, and there was also a drive to build closer links with partners including Adult Social care. The CCG had an initiative 'Discharge to assess' which will help to support people who do not need hospital care to be discharged back home with further support.

- Members asked about staff sickness levels; Ms Fagge said that they were at a reasonable level, and under the national threshold targets. However there were still some hotspots including the Emergency Department.
- The Healthwatch representative asked how the Trust and CQC engaged with Healthwatch. Ms Salt said that the CQC had listening events to which Healthwatch was invited. CQC also used local Healthwatch reports on topics such as discharge planning.

  It was agreed that Healthwatch and CQC would arrange to meet up at a later date.

- Members asked for the rationale behind the international recruitment drive. The Trust said that there were currently up to 200 vacancies across nursing, due to increased investment in nursing. Every internationally recruited member of staff had a high level of English. The Trust also ran local and national recruitment drives in a multi-pronged approach. There had only been a low number of applicants locally to date.

19.5 The HWOSC Chair brought the item to a close- there had been an hour and a half discussing the item and there was still a huge amount more to cover. HWOSC need to understand how the Trust is monitored going forward, especially with regard to 3Ts and Trust status.

The Chair proposed that there be an opportunity to have an additional public workshop looking at the CQC report and work going forward as well as additional reports to future committee meetings. Mr Kershaw said that he would be happy for the Trust to take part in a workshop of this kind, suggesting that East and West Sussex colleagues also be invited to share the learning. Ms Salt said that the CQC would also be happy to take part.

The workshop was agreed by all members.

The Chair thanked everyone for attending and taking part in the discussion.

20 UPDATE ON PLACE ASSESSMENTS OF BSUH

20.1 Ms Fagge introduced the PLACE report to members; there were mixed results across the Trust. The assessment was based on what is actually seen on the assessment day – some of the results were unexpected for example the lower cleanliness records at RACH.

The Trust was very grateful to all of the assessors who took part. Revisits will take place in March 2015, all HWOSC members were welcome to take part in the training.

20.2 Members commented and asked questions

- Councillor Marsh has taken part in the assessments on a number of occasions; she was always amazed at what could be achieved within old substandard buildings. Staff do their best to make the environment as positive as possible.

- Members queried the drop in results for the Sussex Eye Hospital. Steve Gallagher, Operational Director Facilities and Estates, said that there had been a period of minor improvements to the Eye Hospital but it needed a major facelift- there was a £3 million programme planned for February- September 2015. This would include reconfiguring outpatients and orthoptics and replacing the roof and windows.

  Some members said that they found the Eye Hospital chaotic with long delays to be seen. Mr Kershaw said that the appointment booking system had been recognised as an area that needed to be improved urgently – this would be prioritised.

  Toys in the Eye Hospital had been replaced with washable ones - a cleaning rota had been implemented too.

- Members asked about the lower results for the Royal Alexandra Children's Hospital particularly in light of it being a new building. Mr Gallagher said that there had been a recurring problem with the glass atrium which leaked. On the day of the PLACE

inspection there had been heavy rainfall leading to rain coming through the atrium. It has since been repaired, under the PFI contract – and the Trust felt more confident that it would withstand the winter weather.

There is also a long term solution involving replacing the roof with a higher pitched one – this would be replaced next summer by the PFI contractors as part of the contract arrangements. The contract has penalty mechanisms which have already been applied; the contract is closely monitored every month.

- Members asked about the Sussex Orthopaedic Treatment Centre results. Karon Goodman, Compliance Manager, BSUH said that there will be clearer rotas for changing cubicle curtains.

- Mr Kershaw commented that cleaning is managed for the Trust by Sodexho – they work together to maintain standards. They will continue to monitor the results closely until the Trust is happy with the standards throughout. The Trust can make changes to the contract requirements as necessary and is looking at all options going forward.

  Mr Kershaw also added that the visual appearance of a building would not affect its infection control system – the Trust was very successful at infection control.

20.3 The Chair thanked everyone for their input. It was an interesting topic, though it was always important to be mindful of the subjectivity of assessors. HWOSC would continue to monitor this going forward.

21 UPDATE ON 3T REDEVELOPMENT SCHEME

21.1 Professor Passman gave a presentation to HWOSC members. He said that he was keen to address members' concerns. He noted that there was an urban myth that some services will be discontinued at the Trust during the 3Ts development process; Professor Passman stressed that this was not, and never had been the case. A significant amount of money will be spent on temporary accommodation for the services which is known as the "decant" schemes and which he has briefed the HOSC upon at previous meetings.

Major construction was due to begin in earnest in late 2015. The Trust has submitted its Full Business Case to central Government and anticipated final further questions before Christmas. The key unknown was in the HM Treasury approval. The aim of the Trust and it's partners is to secure approval before the general election.

The Trust is going to review the title '3Ts – Teaching Trauma and Tertiary' after the Full Business Case is granted as it was felt that this did not reflect the very substantial element of the project which related to local DGH services, which translates into 56% of the overall floor area of the project.

Professor Passman also noted that there is a recurring myth that the Trust will be too specialist at the expense of local services. He noted that, currently, 7% of activity at the RSCH is specialist. This increase to 9% when 3Ts is complete, but this increase is

related to repatriating activity from London and the shift of some local activity into community setting as part of the proposals for the Better Care Fund.

It was noted that the Trust has decided to keep rheumatology and physiotherapy on the County site during the works process. The original proposal was to move these to Brighton General, but this had been reconsidered following previous discussions at the HOSC and with the staff concerned.

Professor Passman stressed that the risks of not carrying the work out are far greater than the risks of doing it.

21.2 The Chair said that HWOSC would always focus on the risks, but noted Professor Passman's comments.

- Members asked how infection control would be managed in the new building; Professor Passman said that 65% of the new Barry Building would be single rooms with toilets which should help with Infection Control, but rigorous attention to hygiene by clinical staff will always be paramount.

- Members heard that the Thomas Kemp tower will host a helipad which will operate in daylight hours only. The Trust will continue its discussions with local neighbours through the Hospital Liaison Group.

- Members heard that the Trust had pledged to put a blue plaque on the front of the replacement for the Barry Building (Stage 2) to commemorate its history, which had been an informative arising from discussion at the Planning Committee in January 2012
- Members commented that any decant or move of services would come with associated disruption for patients and families. How had this been reflected in plans?

  Professor Passman said that the intention from the beginning of the planning process and been to keep relocated services in places where they are most accessible.

  It was noted that the current proposals to relocate acute neurosurgical services (and the associated proposal to centralise services for patients who suffer a fractured neck of femur at the Princess Royal Hospital) support the major trauma centre services whilst 3Ts is being built. It was noted that fractured neck of femur services are currently provided at both Trust sites and the proposal to centralise them would provide opportunities for consistent care and for a focus on early rehabilitation and discharge.

  Members suggested that perhaps there could be a workshop on risk planning and the action plans.

- Mr Kershaw said that the fact remained that there needed to be a major trauma centre in Brighton or other services would be affected too. He believed that one single pathway will be better for fractured neck of femur patients- currently patients are moved to PRH for rehab but now they will be there for the whole service.

- Professor Passman concluded by saying that there were different sections of work, in February/ March 2015 neurosurgery will be moving to RSCH. There is a deliberate plan

to space out r significant service moves over time – to reduce the risk of undertaken too many moves at one time.

21.3 Members thanked Professor Passman for his update and said that they fully supported BSUH in its plans.

22 STROKE SERVICES IN BRIGHTON AND HOVE

22.1 Dr Nicola Gainsborough updated HWOSC members on plans for stroke services in the region.

Currently services are run on two sites, RSCH and PRH.The service scores well on national audit results but improved scoring is predicated on improved staffing levels. The building layout in RSCH also adds pressure, with stroke patients having to be taken in three lifts to access services. There is also a real prssure to provide a 24/7 service.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

Care Act 2014

Overview

Overview

- Significant Change (Part 1 Care Act)
- Consolidates / modernises existing law
- New law to support existing policy
- New in law and practice
- Regulation and guidance
- Phased Implementation

Some key changes April 2015

- National eligibility criteria
- Carers eligibility
- Safeguarding
- Independent Advocacy
- Deferred payments
- Assessment process

Funding of Care

- Cap on Care Costs
- Care Account
- Eligible needs/assessment
- General living costs
- Usual cost Council would pay
- Thresholds
- Appeals

Implementation

- Modernisation Board
- Programme Manager
- Enabling work streams
- Specific workstreams ; themed
- National & Regional Support
- National Stocktakes
- 'Deep Dives'

Finance

- Financial modelling 2015-16 costs
- Financial modelling funding reform
- £125,000 one off support 14/15
- Regional funding 2014-15
- Funding in Better Care Programme
- New burdens funding

What are we doing ; Information & advice

- Review existing provision
- Dedicated Plan
- National Best Practice
- Regional events
- Involving citizens and people who use services
- Working in partnership

What are we doing ; Information & advice

- Improving the on line offer
- Revising Leaflets / policy
- Redesign of processes in Assessment services
- Engaging commissioners re contracted services
- Staff training and development
- Accredited independent financial advice

What are we doing ? Advocacy

- Estimating the likely additional demand for independent advocacy
- Working with regional colleagues
- Engaging existing advocacy providers re capacity
- Referencing commissioning guidance
- Staff training and development

What are we doing ?Assessment

- Business process mapping and redesign
- Document and reporting redesign
- Managing additional demand
- Supported assessment
- Role of qualified staff
- Impact of national eligibility criteria
- Planning transitional year 2015-16
- Learning & Development for staff

What are we doing ? Charging

- Deferred payments schemes
- Charging Policy
- Carers services
- Self Funders
- Review business processes

Workforce

- Dedicated enabling group
- National support / skills for care
  - Analysis
  - Support tools
- Regional joint work / funding
- Learning & Development pathway

What are we doing ? Communication

- National Communication Strategy in 2 Phases
- National resource bank / tool kit
- Local strategy aligned to local strategy
- Interim activity
  - Presentations
  - Workshops
  - Bulletins
  - Newsletters

Health & Wellbeing Overview & Scrutiny Committee	Agenda Item 27 Brighton & Hove City Council

Subject:		**Adult Care Performance 2013-14**
Date of Meeting:		**February 4 2015**
Report of:		**Executive Director Adult Services**
Contact Officer:	**Name:**	**Philip Letchfield** **Tel: 29-5078**
	Email:	**philip.letchfield@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The purpose of the report is to provide a summary of the developing adult care performance framework and specific benchmarked information against national performance indicators in 2013-14.

1.2 The information is intended to support the Committee in its overview and scrutiny functions.

2. RECOMMENDATIONS:

2.1 That the Committee considers any recommendations it would wish to make in relation to the performance of adult care services.

2.2 That the Committee considers any recommendations it would wish to make regarding the local arrangements to implement the national performance framework.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The national performance framework in adult social care is going through a period of significant change. The previous framework was characterised by Inspections and Annual Reviews by the national regulator, extensive self-assessment, 'star ratings' for Councils and 'league tables' for each performance indicator. This has been replaced by a model of sector led improvement outlined from 3.2 below onwards .This period of change will continue in the coming years, driven by the requirements of the Care Act and the Better Care Programme. In addition a 'zero based review' of all national data reporting has been completed and a new data reporting framework introduced in 2014/15.

3.2 The Adult Social Care Outcomes Framework (ASCOF) is a national set of indicators grouped under 4 outcome headings. Several of these indicators are derived from a standard annual survey of people using services and a biennial survey of informal carers with a focus on outcomes for people. The Health & Social Care Information Centre (HSCIC) provide annual public reports on the benchmarked performance of individual Councils. A copy of the most recent ASCOF report for the city is appended at **appendix 1**.

3.2.1 Performance in relation to the ASCOF indicators in 2013/14 was broadly positive in relation to trends and benchmarked performance. Key user survey outcomes (quality of life, choice and control, social activity, safety) all improved from 2012/13 and the Council was the highest performer in its comparator group on 3 of these outcomes. Overall satisfaction levels were also above average.

3.2.2 Performance in relation to key indicators regarding delayed transfers of care and long term admissions into residential care also improved significantly.

3.2.3 In relation to reablement / intermediate care services the percentage still living at home 91 days after discharge from the service continues to fall and is now below average. However the number of older people offered this type of service following admission to hospital remains the highest in our comparator group.

3.2.4 The results from the first survey of carers in 2012 were disappointing, an action plan was put in place and the survey for 2014 is now complete. The results are pending and we will be analysing these once available.

3.3 A second annual engagement event ('City Summit') was completed in 2014; these seek to gather local people's views on our performance and enable dialogue about priorities for improvement and the progress the Council is making. In 2014 the event was centred on a week of themed days based at the Jubilee library supported by social media activity. This was well attended and enabled a wider audience to be reached than previous events, specifically people not yet using services.

3.4 The Council remains an active member of the Making It Real (MIR) programme. This is a national programme (part of the Think Local Act Personal consortium) which is user / carer led and is seeking to promote the 'personalisation' of care and support services. The programme has developed a series of 'I' statements grouped under 6 headings which capture what people want to see and experience from personalised services.

3.5 The third annual 'Local Account' was produced in 2014 and was widely distributed, including on the Council website - . http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/5126%20ASC%20Local%20Account%202014%20-%20r21FINAL.pdf.

This is an annual 'account' of our performance and is developed in partnership with key voluntary sector partners in the city. It draws on the engagements events, Making It Real markers, annual surveys and other feedback mechanisms to highlight priorities, improvement actions and challenges. It is constructed around the MIR markers such as Information and Advice, active and supportive communities and support that is flexible and integrated. The content draws on local people's experiences as well as performance data.

3.6 The outcomes from the City Summits, Surveys and the Local Account are reported into key forums and are used to inform our business planning. The model is one based on a 'you said ', 'we did' approach.

3.7 Peer Review is another element of sector led improvement; to date we have been the subject of one peer review by officers from other councils and have supported peer reviews of other councils. The peer review in the city focused upon people receiving direct payments and safeguarding matters; the improvement actions were included in the Safeguarding Boards annual plans. A new programme of 'Director to Director' peer review has also recently commenced.

3.8 The Personal Outcomes Evaluation Tool (POET); is a nationally approved annual 'survey' we are considering commencing in 2015 to benchmark the impact personal budgets are having on people's lives.

3.9 Apart from the statutory ASCOF information the remaining elements of the sector led improvement model are voluntary, although Councils are strongly encouraged to participate. Brighton & Hove has responded positively and engaged with the full programme of sector led improvement.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The report is essentially providing the Committee with information to support its overview and scrutiny function. Adult Care is subject to a national performance framework and local performance arrangements need to take account of this.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 The report provides information regarding community engagement through the mechanisms of the City Summit and Local Account.

6. CONCLUSION

6.1 Overview and scrutiny of adult care services performance is a key function of the Committee and this report is seeking to support the Committee in carrying out that function.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 The performance and benchmarking information is used alongside unit costs (available through the Personal Social Services Expenditure Report PSSEX1) to inform budget strategies and is monitored through the targeted budget management process.

Finance Officer Consulted: Anne Silley *Date: 23/12/14*

Legal Implications:

/The national and legislative requirements underpinning the information in this Report on adult care performance framework and benchmarking is specifically referred to in the body of the Report. There are no additional specific legal or Human Rights Act Implications arising from this report.

7.2

Lawyer Consulted: Sandra O'Brien *Date: 24/12/2014*

Equalities Implications:

7.3 The information gathered through the performance arrangements described within this report is used to inform business planning and equalities impact assessments in adult care.

Sustainability Implications:

7.4 There are no specific sustainability implications in the report.

Any Other Significant Implications:

7.5 There are no other significant implications in the report.

SUPPORTING DOCUMENTATION

Appendices:

1. ASCOF Comparator Report 2013-14
2.

Background Documents

1. Local Account 2014 'How are we doing ..' Available on Council website http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/5126%20ASC%20Local%20Account%202014%20-%20r21FINAL.pdf
2.

Health & Social Care Information Centre

National Adult Social Care Intelligence Service (NASCIS)

Measures from the Adult Social Care Outcomes Framework (ASCOF): Comparator Report 2013-14

Brighton and Hove (816)

NASCIS Standard Report 8
This report is based on final data

Published 9th December 2014

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Report based on final data

Contents

Introduction

This report is one of a range of standard reports available from the National Adult Social Care Intelligence Service (NASCIS). The report shows measures from the Adult Social Care Outcomes Framework (ASCOF) for Brighton and Hove (816) in the context of data for 15 comparable councils.

Comparable councils are selected according to the Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbour Model, which identifies similarities between authorities based upon a range of socio-economic indicators. Further information about the Nearest Neighbour Model can be found on the CIPFA web site at:
http://www.cipfastats.net/resources/nearestneighbours

Notes

Comparator Groups
The comparator group average is based on this council plus the 15 comparator councils. Comparator groups are not available for City of London (714) and Isles of Scilly (906).

Sources
This report is based on final 2013-14 data. Chart sources include:

Adult Social Care Combined Activity Return (ASC-CAR) - charts 1E, 1G, 2A, 2B

Personal Social Services Adult Social Care Survey (Adult Social Care Survey (ASCS)) - charts 1A, 1B, 1I part1, 3A, 3D, 4A, 4B

Delayed Transfers of Care (DToC) - chart 2C

Hospital Episode Statistics (HES) - chart 2B

Mental Health Minimum Data Set (MHMDS) - charts 1F, 1H

Mid-year population estimates, Office for National Statistics (ONS) - charts 2A, 2C

Referrals, Assessments and Packages of Care (RAP) - chart 1C

Carers Survey
Measures 1D, 1I part2, 3B, 3C and 3D part2 are based solely on the Carer's survey. This is a biennial survey which took place for the first time in 2012-13. Therefore no data are available for these measures for 2013-14, 2011-12 and 2010-11.

References

Adult Social Care Outcomes Framework (ASCOF)
More information and a handbook of definitions (Nov-13) are available from:
https://www.gov.uk/government/publications/the-adult-social-care-outcomes-framework-2013-to-2014

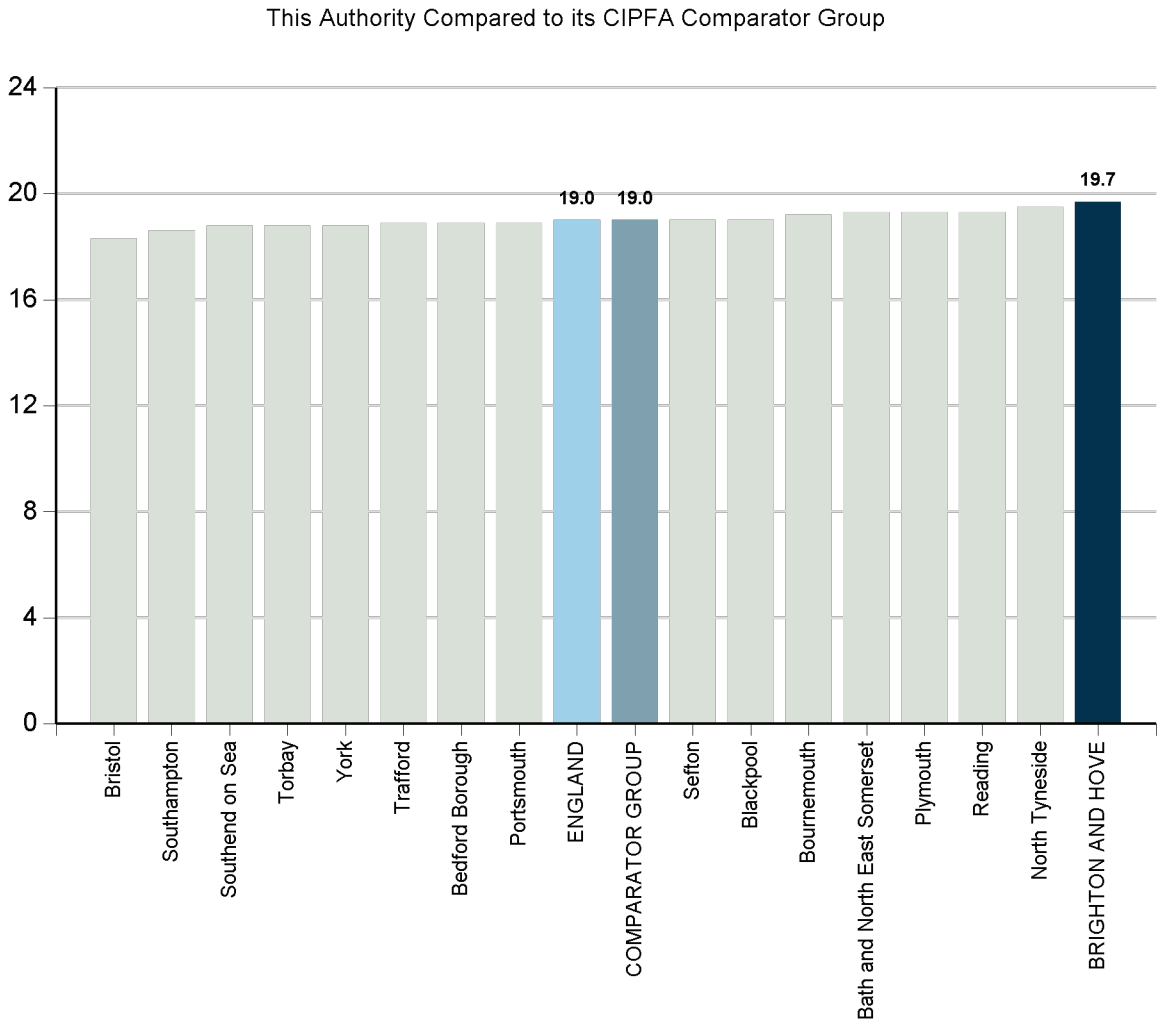
Adult Social Care Outcomes Toolkit (ASCOT)
The ASCOT measure (1A) is designed to capture information about an individual's social care-related quality of life (SCRQoL). ASCOT is the source for the questions in the ASCS. Users wishing to make commercial use of ASCOT materials should contact the ASCOT team (ascot@kent.ac.uk) who will be put in touch with Kent Innovation and Enterprise, as registration is required.
http://www.pssru.ac.uk/ascot/

ASCOF Measure Summary

Indicator	BRIGHTON AND HOVE	COMPARATOR GROUP	ENGLAND
1A	19.7	19.0	19.0
1B	81.6	77.6	76.8
1C1	78.0	61.8	61.9
1C2	22.4	16.8	19.1
1E	13.7	7.3	6.7
1F	5.6	6.5	7.0
1G	80.1	75.7	74.9
1H	53.0	57.2	60.8
1I1	51.1	44.7	44.5
2A1	10.5	15.5	14.4
2A2	723.3	758.8	650.6
2B1	80.1	82.9	82.5
2B2	7.1	3.5	3.3
2C1	6.9	10.0	9.6
2C2	1.2	3.6	3.1
3A	68.2	66.2	64.8
3D1	74.7	75.2	74.5
4A	75.5	66.8	66.0
4B	84.5	79.2	79.1

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

1A - Social care related quality of life score, 2013-14

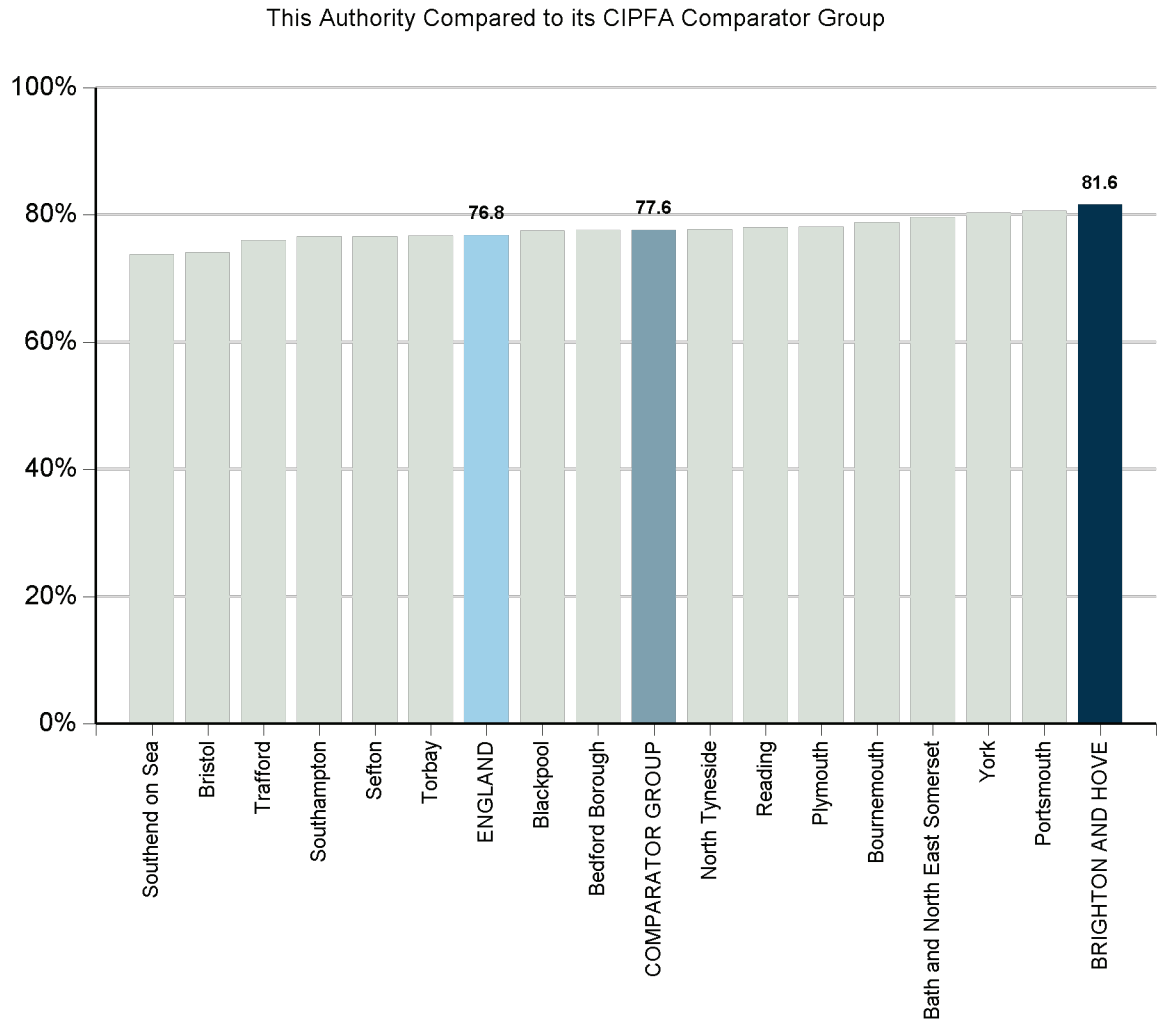


This measure gives an overarching view of quality of life of users based on outcome domains of social care related to quality of life.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator and denominator: ASCS.
Data for 2013-14 is based on final data.

1B - The proportion of people who use services who have control over their daily life, expressed as a percentage, 2013-14



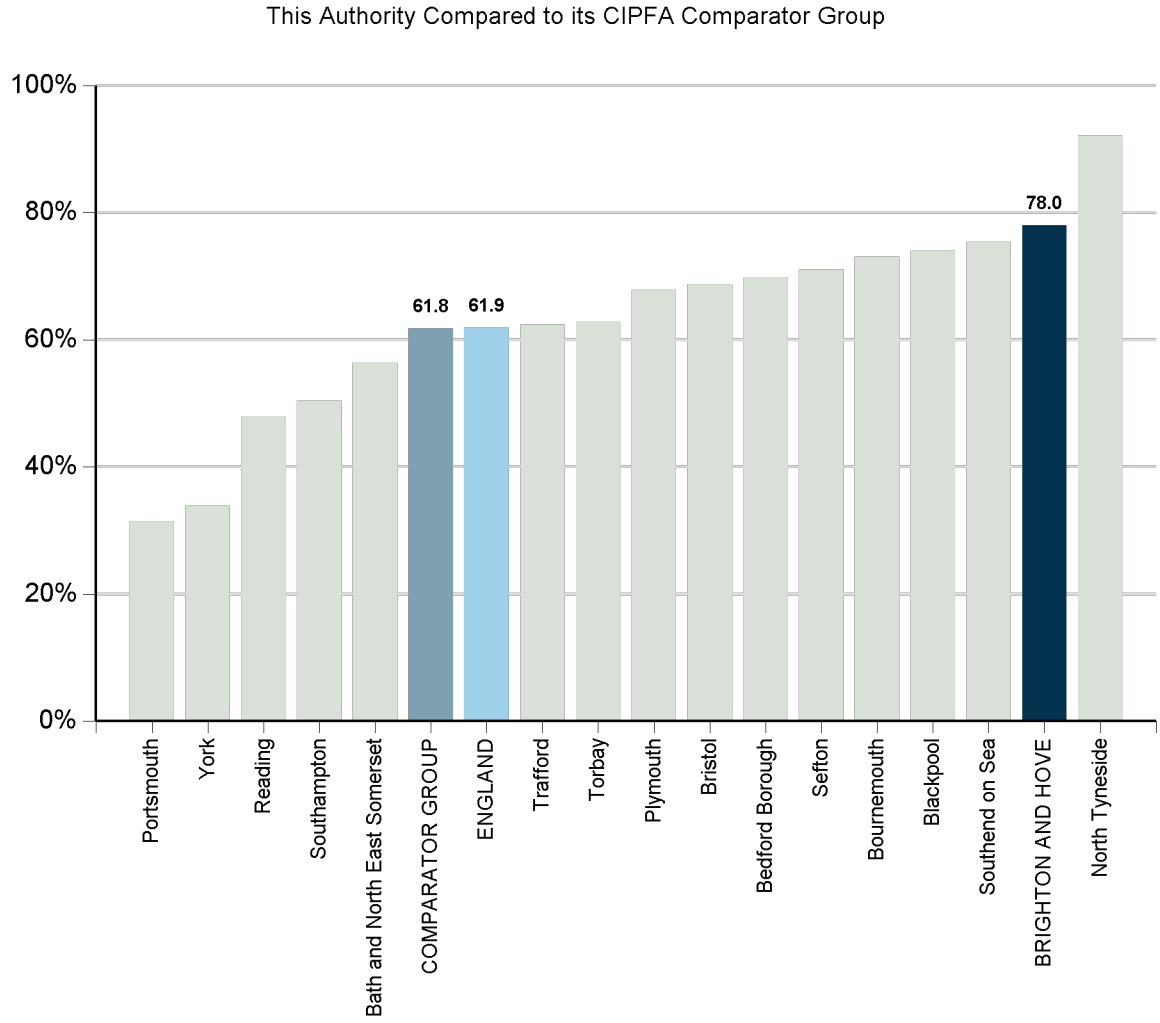
Control is one of the key outcomes derived from the policy of personalisation. This measure is a means of determining whether that outcome is being achieved.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator and Denominator: ASCS.

Data for 2013-14 is based on final data.

1C part 1 - Number of adults, older people and carers receiving self-directed support in the year to 31 March as a percentage of all clients receiving community based services and carers receiving carer specific services, 2013-14



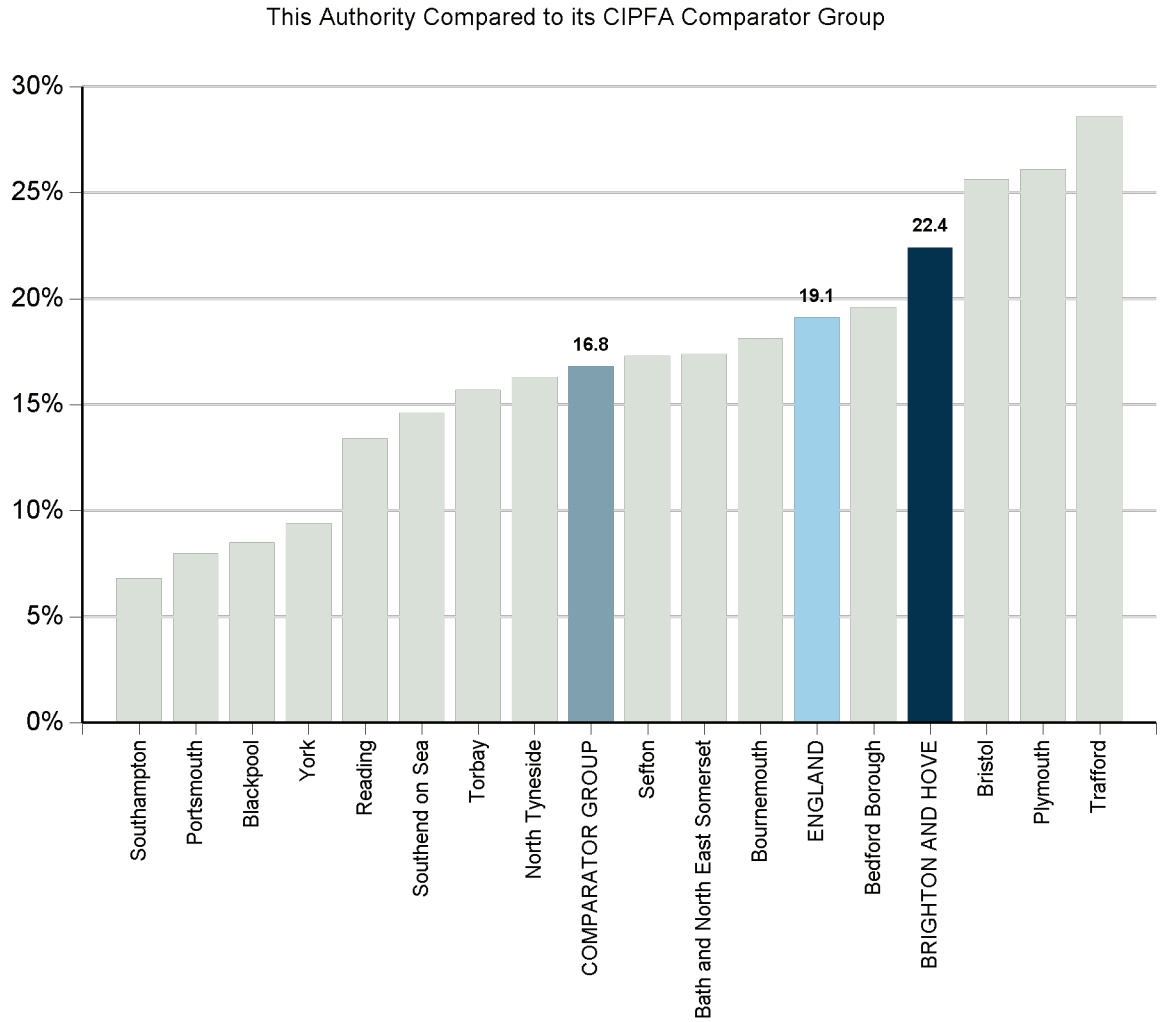
Research has indicated that personal budgets have a positive effect in terms of impact on wellbeing, increased choice and control, cost implications and improving outcomes.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator and denominator: RAP.

Data for 2013-14 is based on final data.

1C part 2 - Number of adults, older people and carers receiving self-directed support via a direct payment in the year to 31 March as a percentage of all clients receiving community based services and carers receiving carer specific services, 2013-14



Studies have shown that direct payments make people happier with the services they receive and are the purest form of personalisation.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator and denominator: RAP.

Data for 2013-14 is based on final data.

1D - Carer-reported quality of life score, 2013-14

This Authority Compared to its CIPFA Comparator Group

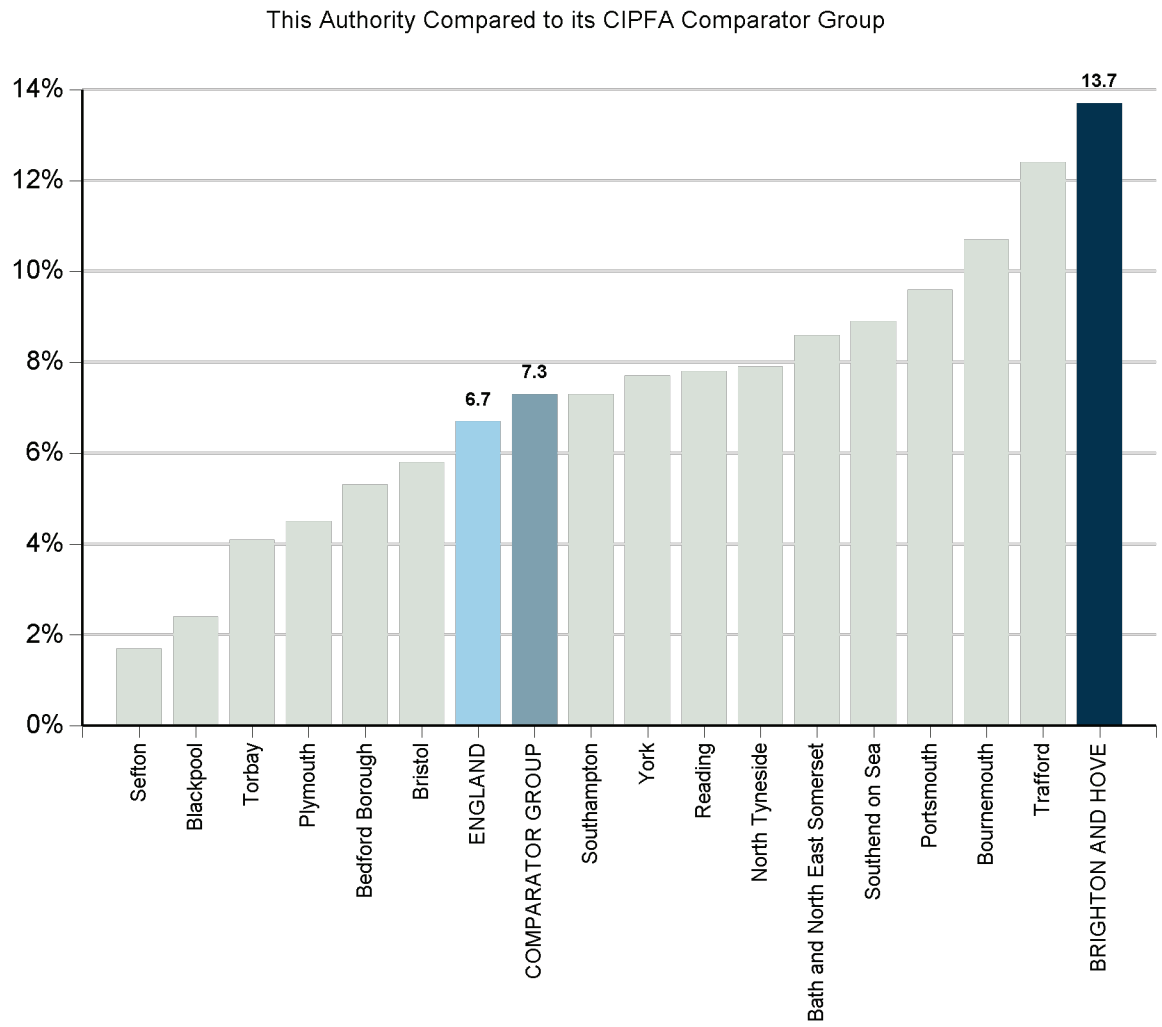
No Data Available

Outcome measure 1D is not calculated for 2013-14, as it is basedsolely on the Carer's survey. This is a biennial survey which took place for the first time in 2012-13. Therefore no data are available for this measure for 2013-14, 2011-12 and 2010-11.

This measure gives an overarching view of the quality of life of carers based on outcomes identified through research by the Personal Social Services Research Unit. This is the only current measure related to quality of life for carers available, and supports a number of the most important outcomes identified by carers themselves to which adult social care contributes.

Sources
Numerator and denominator: CS.

1E - Adults with a learning disability in paid employment, expressed as a percentage, 2013-14



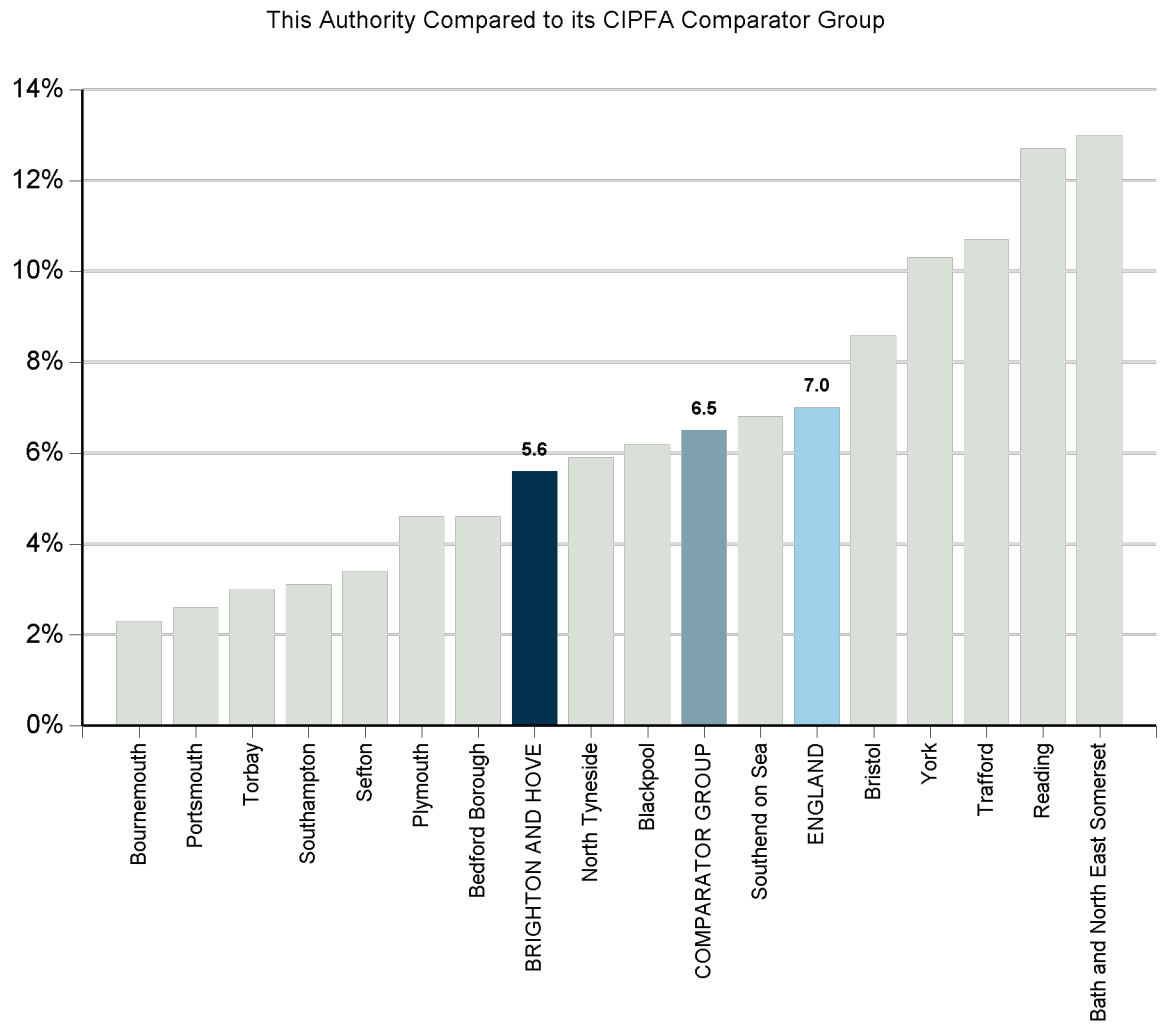
There is a strong link between employment and enhanced quality of life, including evidenced benefits for health and wellbeing and financial benefits.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator and denominator: ASC-CAR.

Data for 2013-14 is based on final data.

1F - Adults in contact with secondary mental health services in paid employment, expressed as a percentage, 2013-14



Employment outcomes are a predictor of quality of life, and are indicative of whether care and support is personalised. Employment is a wider determinant of health and social inequalities.

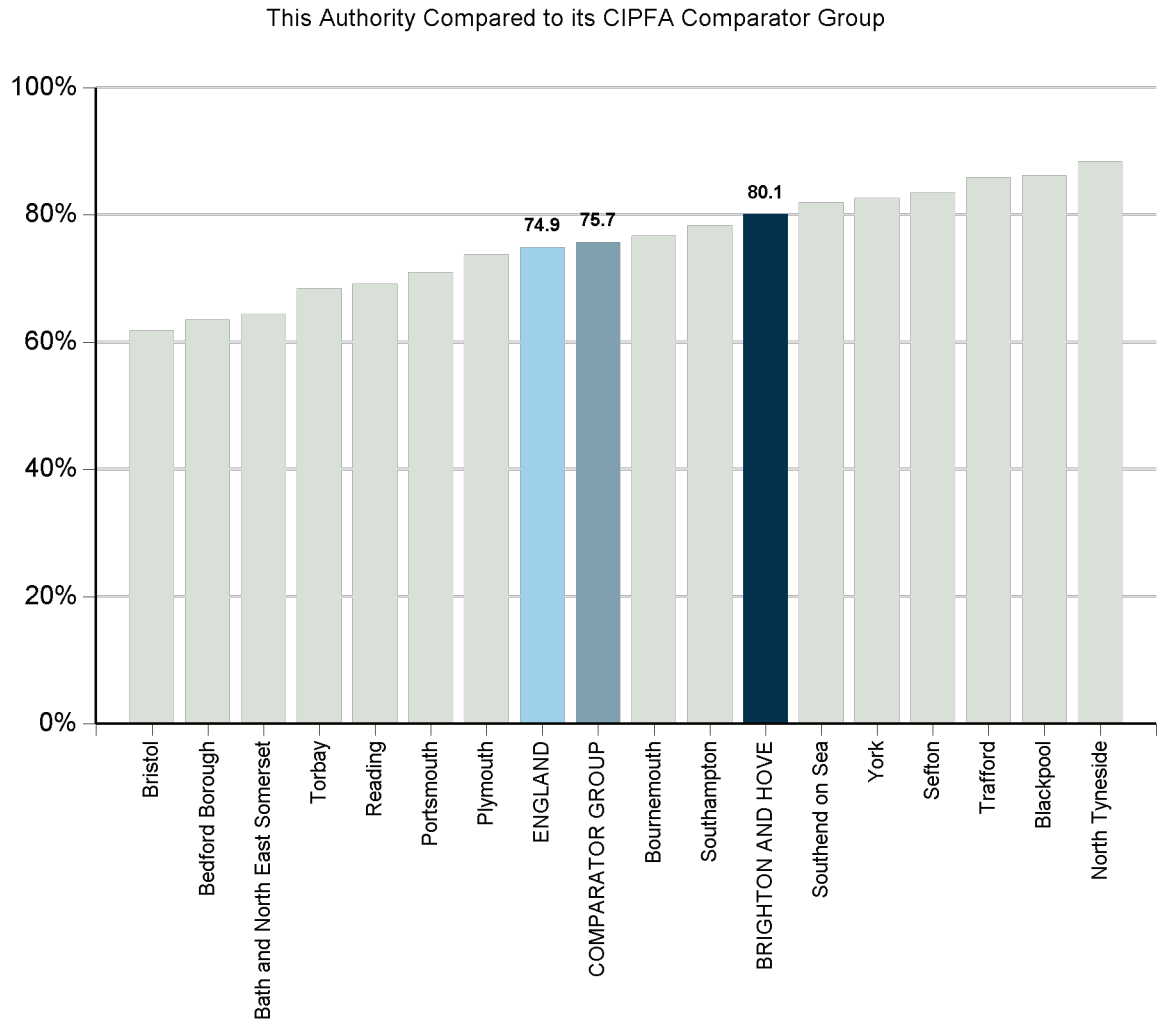
Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources - Numerator and denominator: MHMDS.

Please note: National totals are not the exact sum of all councils' data. In some instances it is not possible to attribute a service user to a council but these service users still form part of the national total.

Data for 2013-14 is based on final data.

1G - Adults with a learning disability who live in their own home or with family, expressed as a percentage, 2013-14



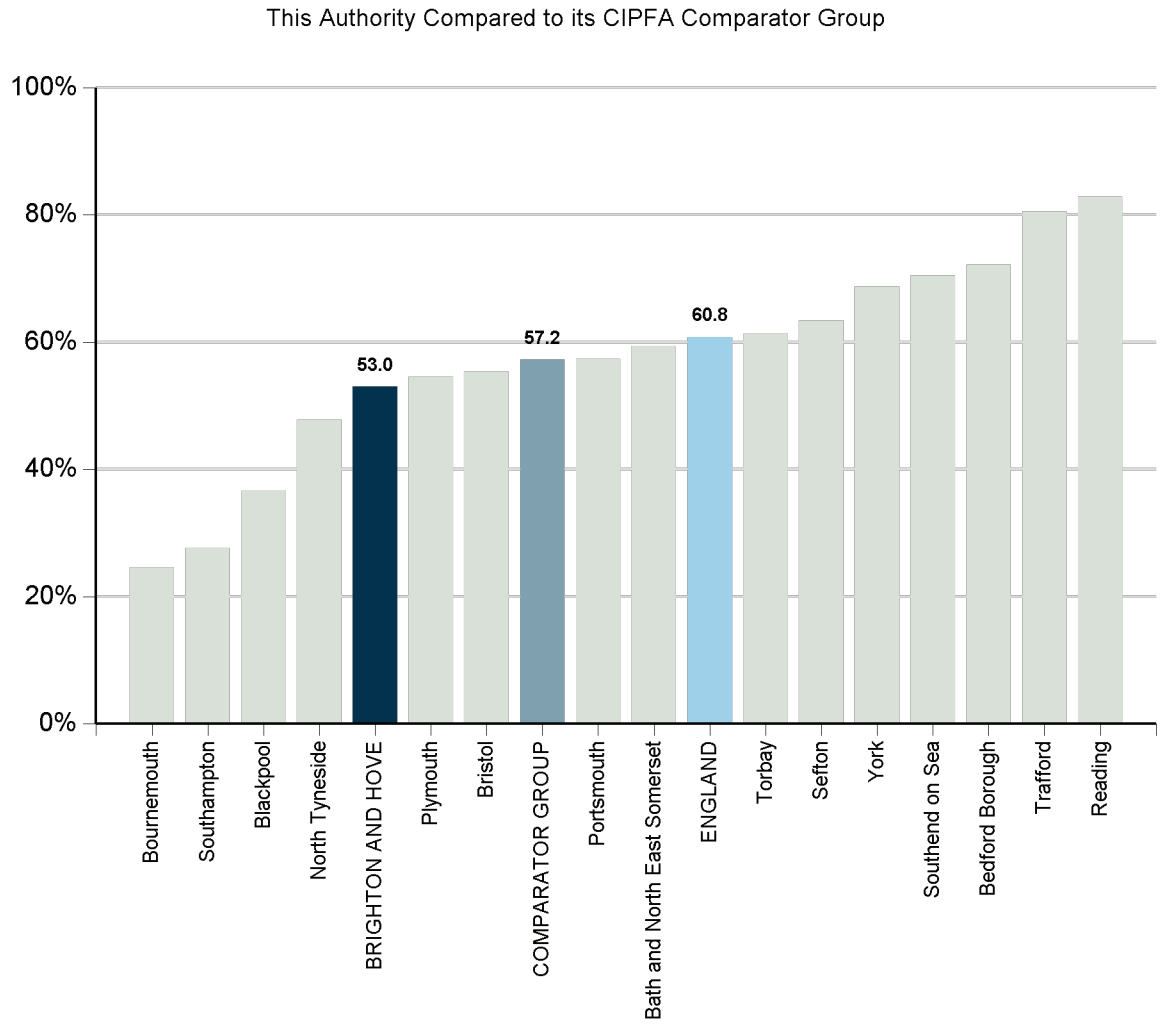
The nature of accommodation for people with a learning disability has a strong impact on their safety and overall quality of life and the risk of social exclusion.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator and denominator: ASC-CAR.

Data for 2013-14 is based on final data.

1H - Adults in contact with secondary mental health services living independently, with or without support, expressed as a percentage, 2013-14



Stable and appropriate accommodation is closely linked to improving safety and reducing the risk of social exclusion.

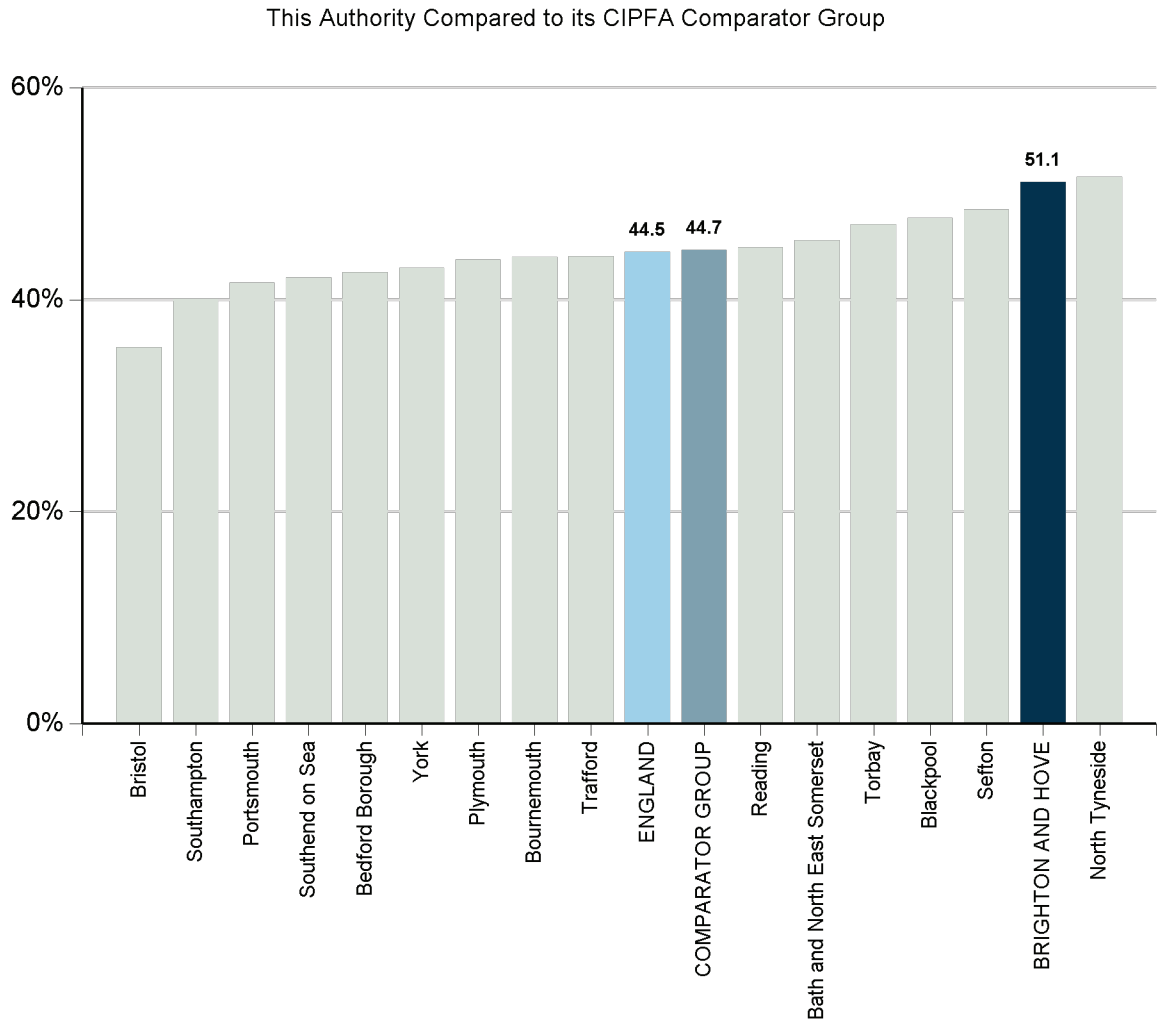
Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources - Numerator and denominator: MHMDS.

Please note: National totals are not the exact sum of every councils data. In some instances it is not possible to attribute a service user to a council but these service users still form part of the national total.

Data for 2013-14 is based on final data.

1I part 1 - The proportion of people who use services who reported that they had as much social contact as they would like, expressed as a percentage, 2013-14



There is a link between loneliness and poor mental and physical health. Self-reported levels of social contact act as an indicator of social isolation.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator and denominator: ASCS

Data for 2013-14 is based on final data.

1I part 2 - The proportion of carers who reported that they had as much social contact as they would like, expressed as a percentage, 2013-14

This Authority Compared to its CIPFA Comparator Group

No Data Available

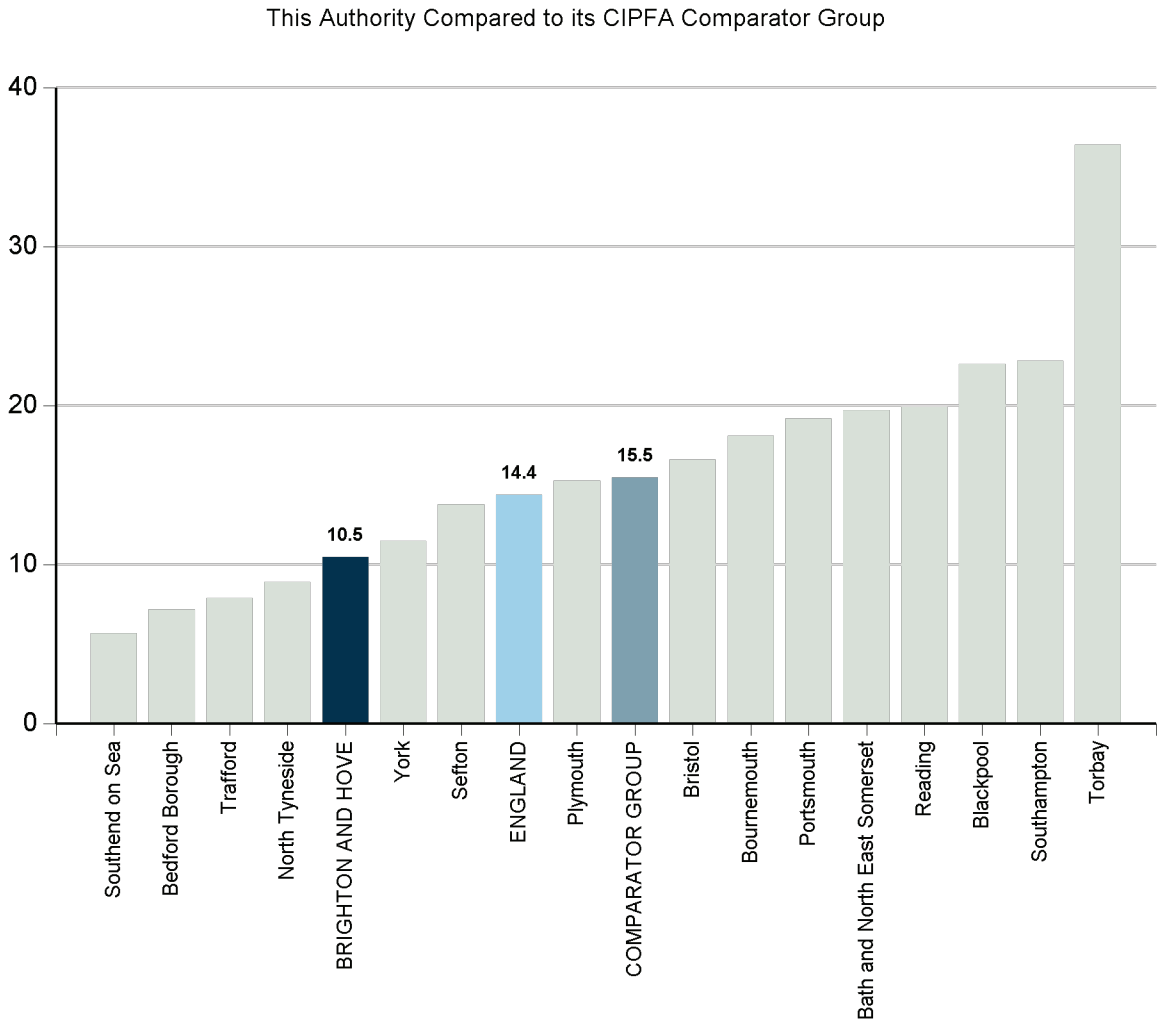
Outcome measure 1I part 2 is not calculated for 2013-14, as it is solely based on the Carers survey. This is a biennial survey which took place for the first time in 2012-13. Therefore no data is available for this measure for 2013-14, 2011-12 and 2010-11.

There is a link between loneliness and poor mental and physical health. Self-reported levels of social contact act as an indicator of social isolation.

Sources
Numerator and denominator: CS

Data for 2013-14 is based on final data.

2A part 1- Permanent admissions to residential and nursing care homes for younger adults (18-64), per 100,000 population, 2013-14



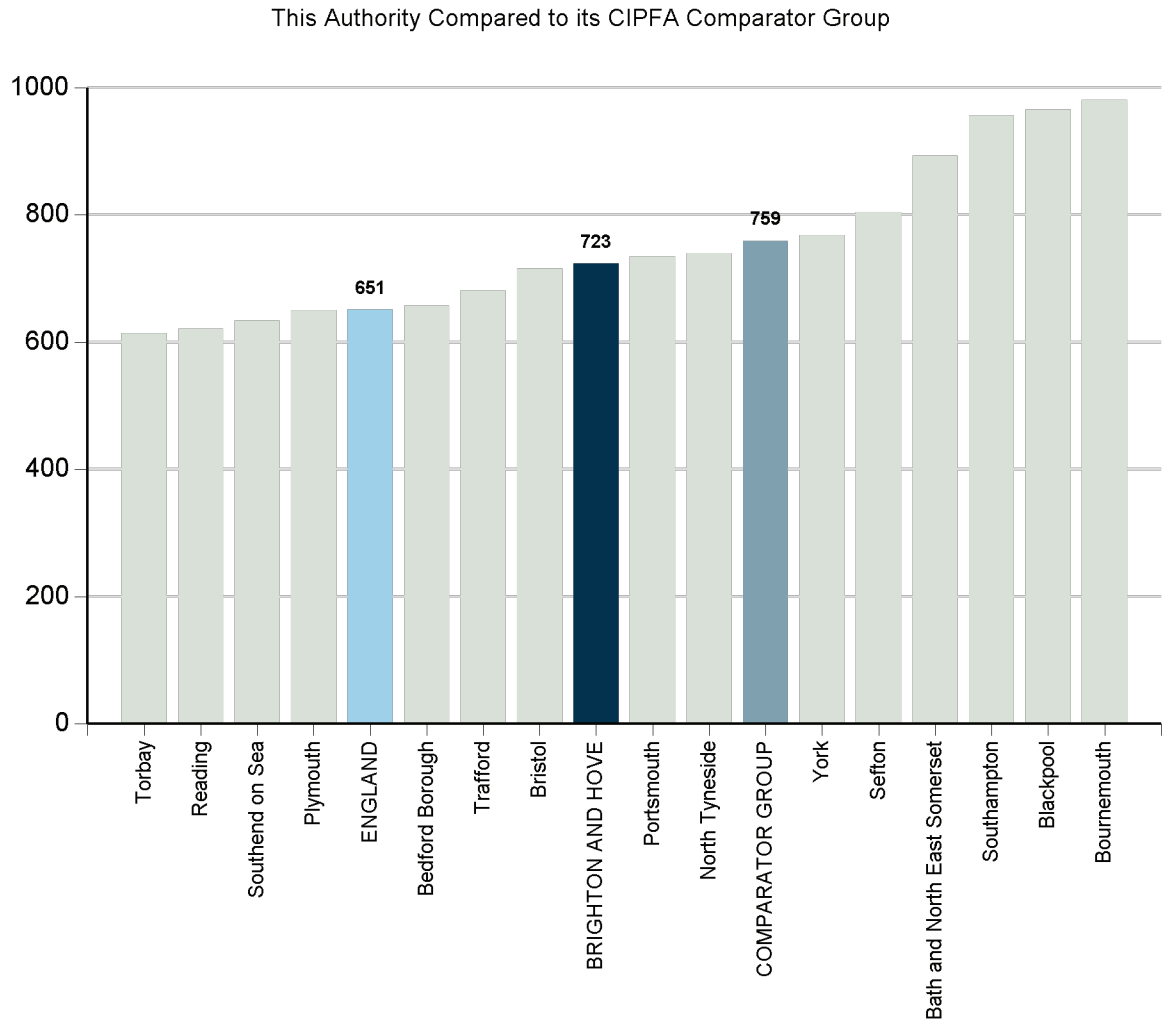
Avoiding permanent placements in residential and nursing care homes is a good indication of delaying dependency. Research suggests where possible people prefer to stay in their own home rather than move into residential care.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator: ASC-CAR.
Denominator: ONS 2013 mid-year population estimates (aged 18-64).

Data for 2013-14 is based on final data.

2A part 2 - Permanent admissions to residential and nursing care homes for older people (65 and over), per 100,000 population, 2013-14



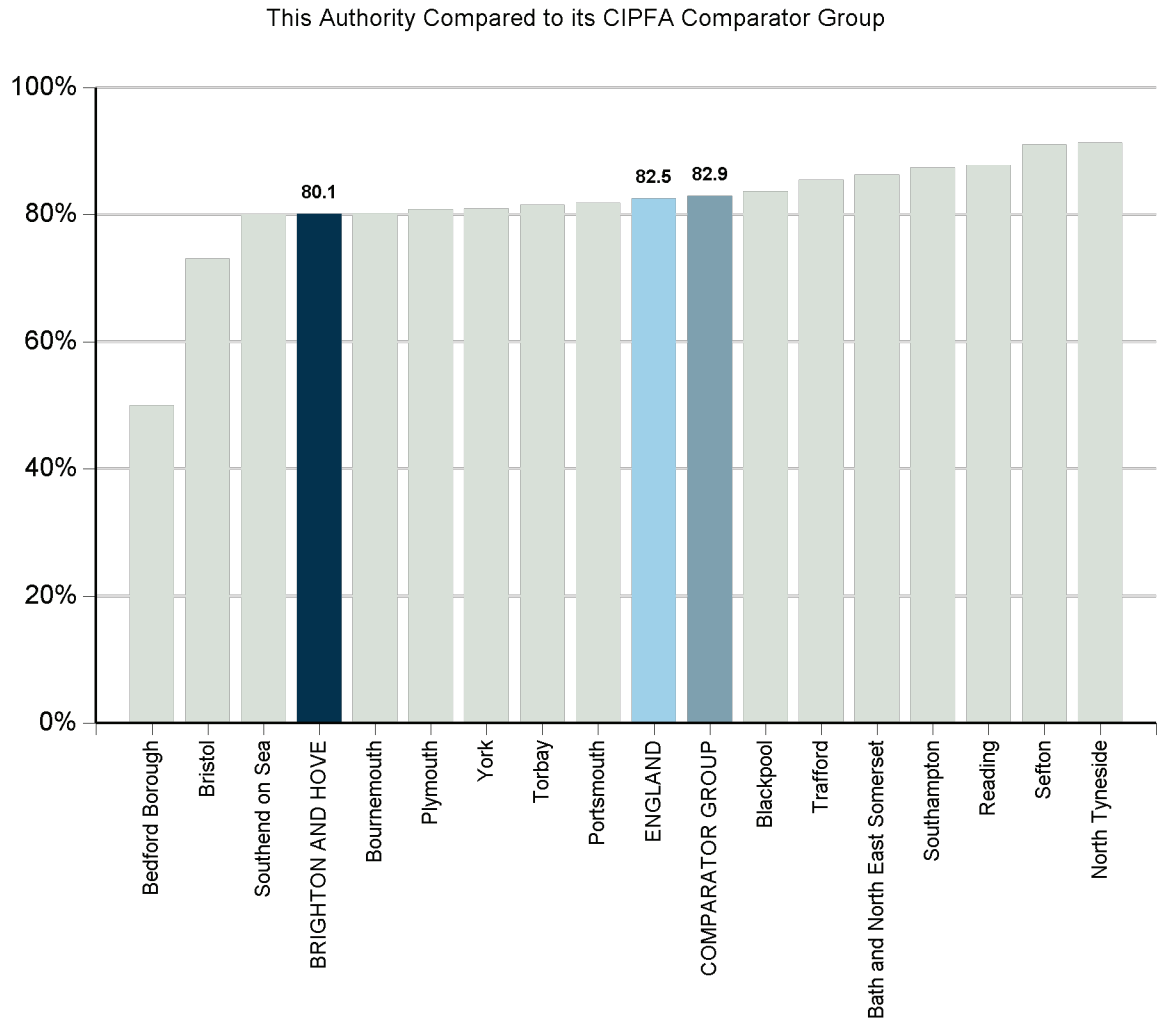
Avoiding permanent placements in residential and nursing care homes is a good indication of delaying dependency. Research suggests where possible people prefer to stay in their own home rather than move into residential care.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator: ASC-CAR.
Denominator: ONS 2013 mid-year population estimates (65 and over).

Data for 2013-14 is based on final data.

2B part 1 - Older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services, expressed as a percentage, 2013-14



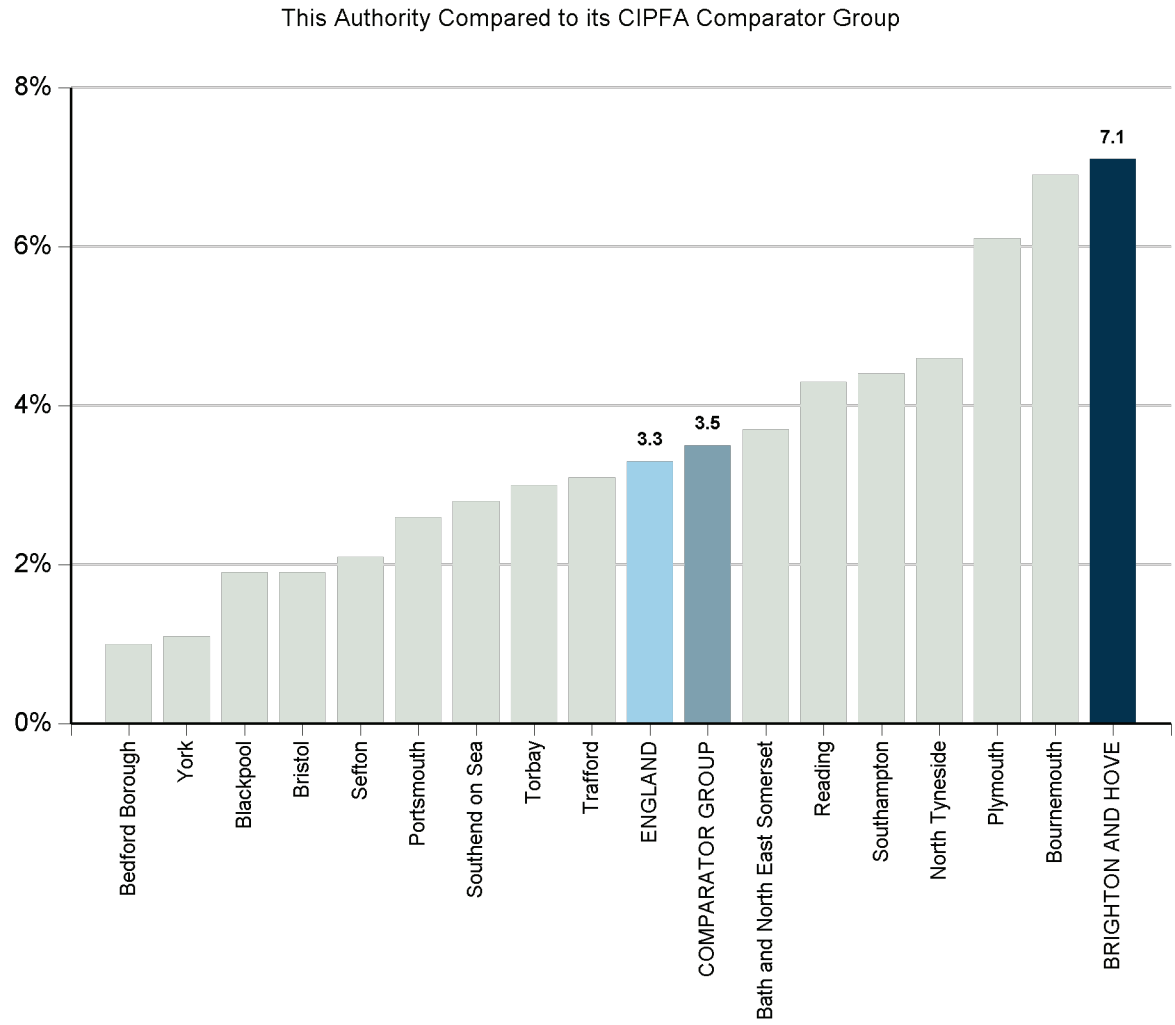
Remaining living at home 91 days following discharge is the key outcome for many people using reablement services.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator and Denominator: ASC-CAR.

Data for 2013-14 is based on final data.

2B part 2 - Older people (65 and over) who were offered reablement services following discharge from hospital, expressed as a percentage, 2013-14



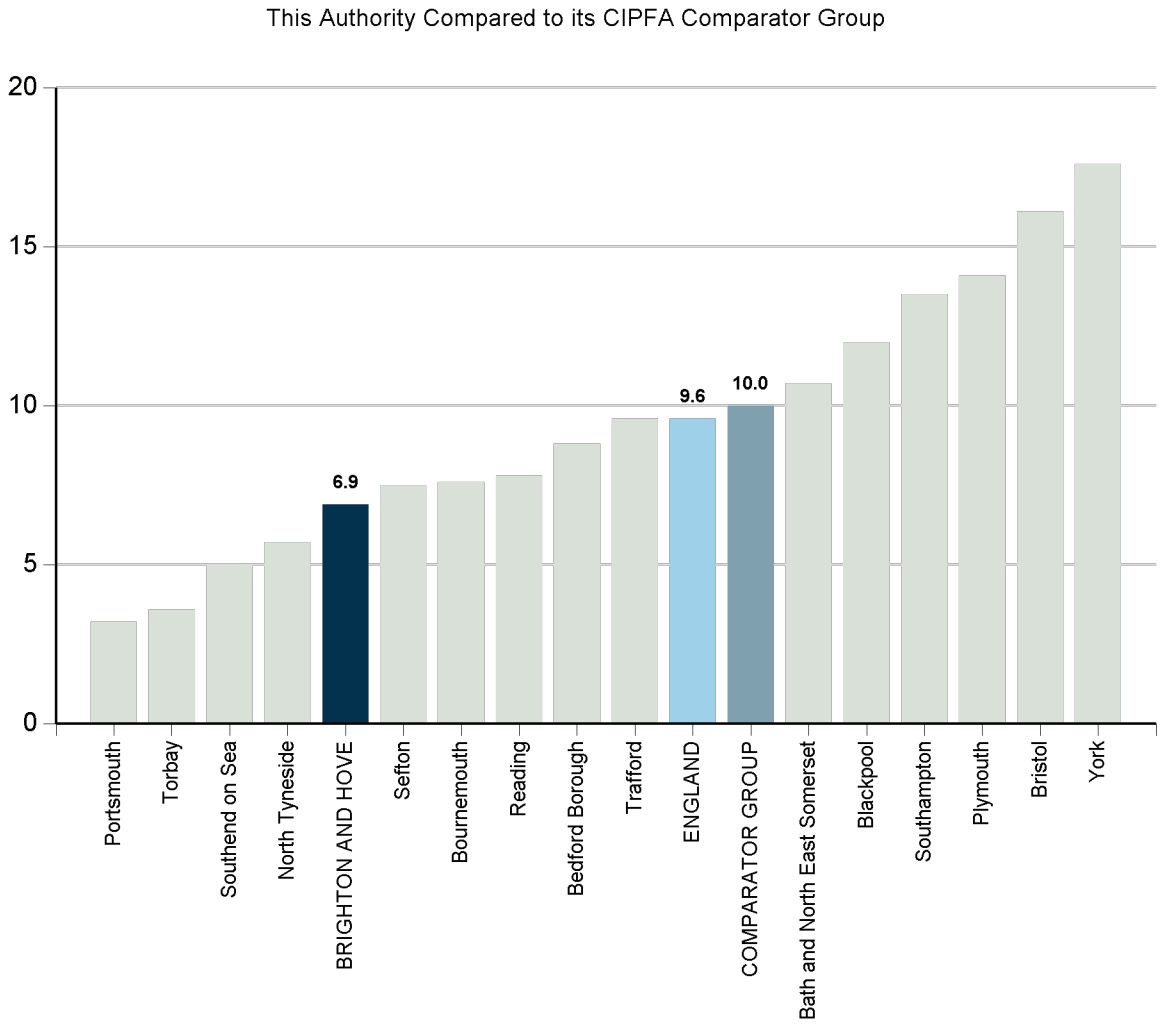
This measure indicates the volume of reablement offered.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator: ASC-CAR.
Denominator: HES.

Data for 2013-14 is based on final data.

2C part 1 - Delayed transfers of care from hospital, per 100,000 population, 2013-14



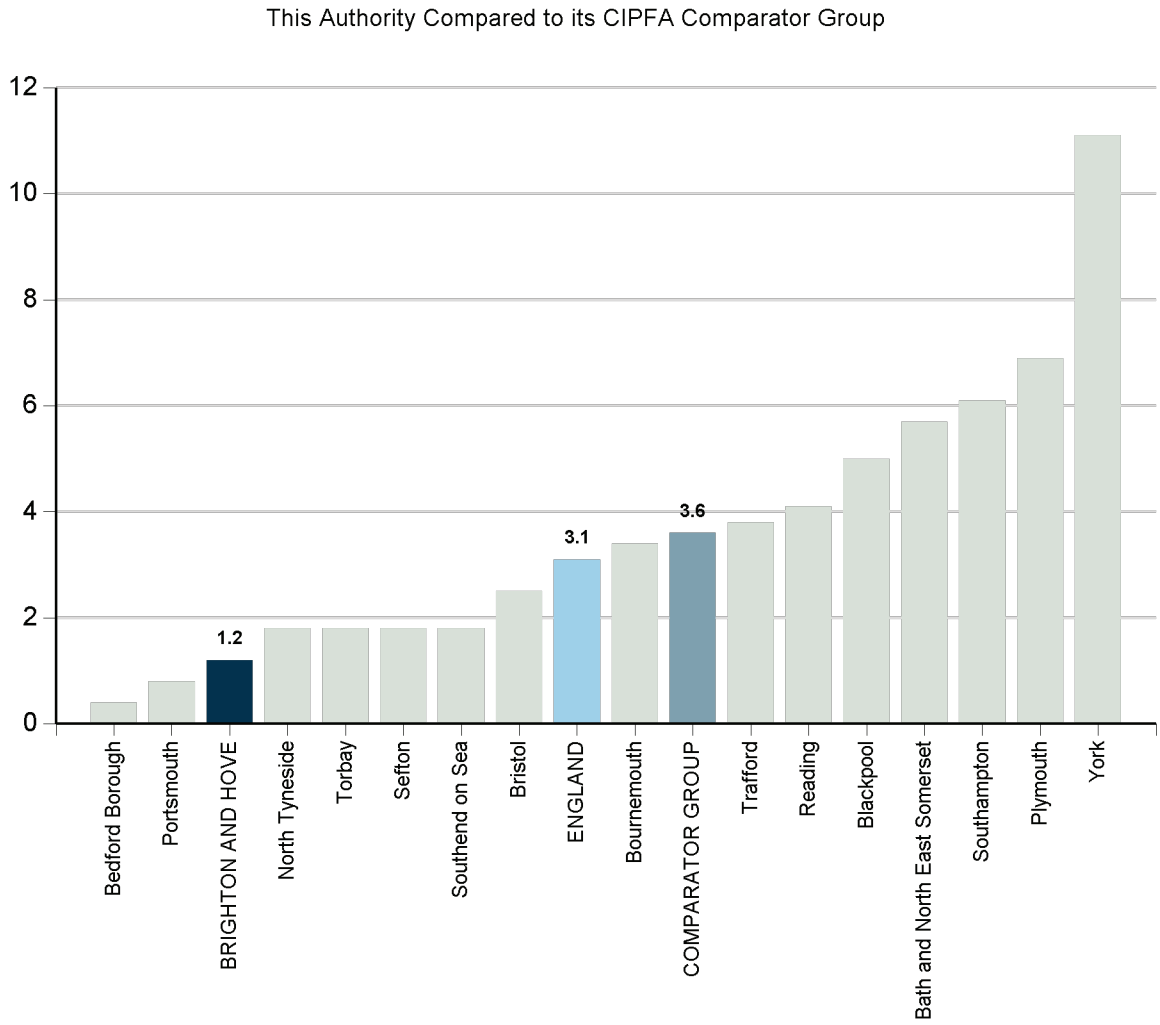
The impact of hospital services and community based care in facilitating timely and appropriate transfer from all hospitals for all adults.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator: DToC.
Denominator: ONS 2013 mid-year population estimates (18 and over).

Data for 2013-14 is based on final data.

2C part 2 - Delayed transfers of care from hospital which are attributable to adult social care, per 100,000 population, 2013-14



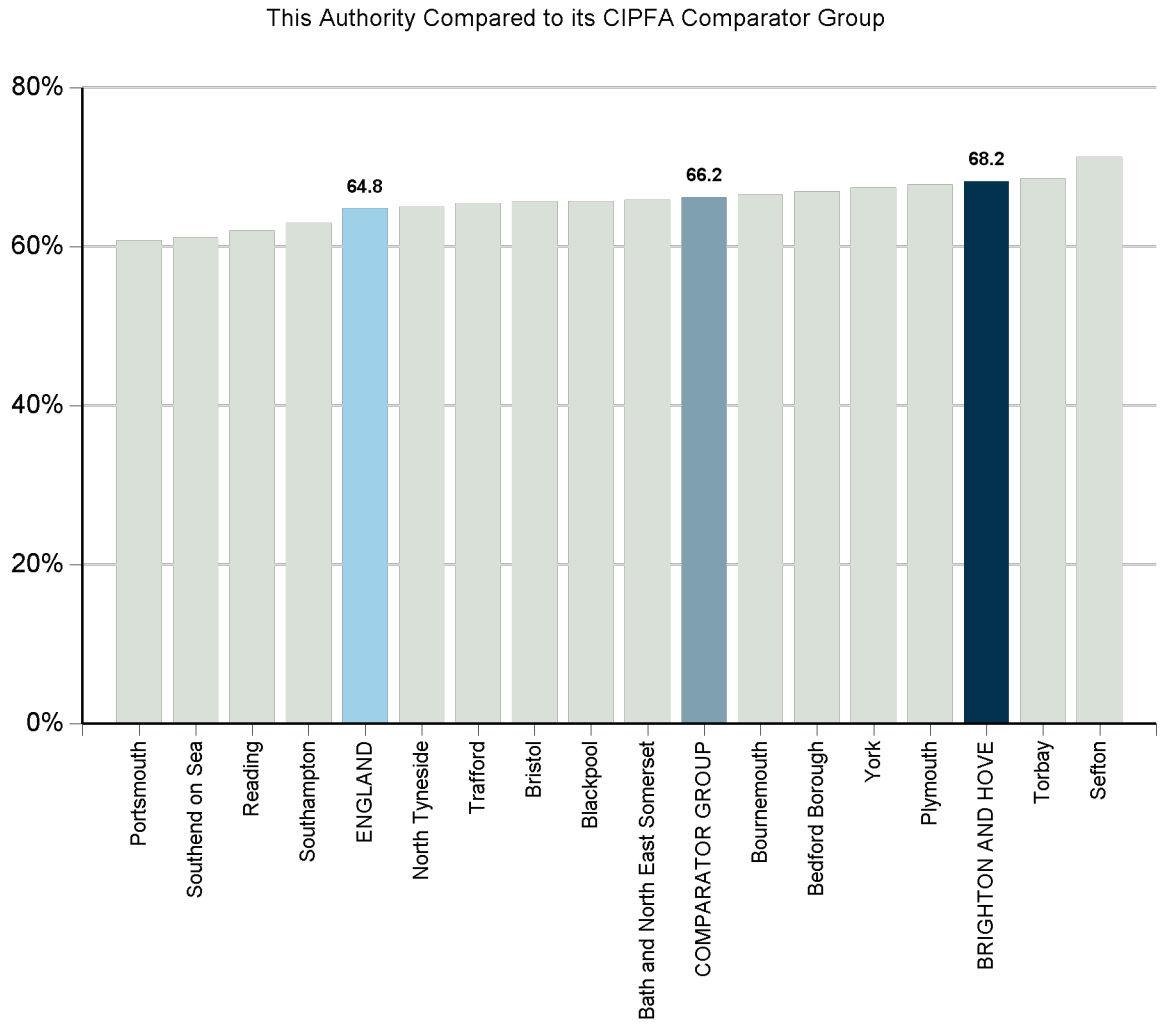
The impact of hospital services (acute, mental health and non acute) and community based care in facilitating timely and appropriate transfer from all hospitals for all adults.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator: DToC.
Denominator: ONS 2013 mid-year population estimates (18 and over).

Data for 2013-14 is based on final data.

3A - Percentage of adults using services who are satisfied with the care and support they receive, 2013-14



The satisfaction with services of people using adult social care is directly linked to a positive experience of care and support. Analysis of surveys suggests that reported satisfaction with services is a good predictor of the overall experience of services and quality.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator and denominator: ASCS.

Data for 2013-14 is based on final data.

3B - Overall satisfaction of carers with social services, expressed as a percentage, 2013-14

This Authority Compared to its CIPFA Comparator Group

No Data Available

Outcome measure 3B is not calculated for 2013-14, as it is solely based on the Carers survey. This is a biennial survey which took place for the first time in 2012-13. Therefore no data is available for this measure for 2013-14, 2011-12 and 2010-11.

The satisfaction with services of carers of people using adult social care is directly linked to a positive experience of care and support. Analysis of user surveys suggests that reported satisfaction with services is a good predictor of the overall experience of services and quality.

Sources
Numerator and denominator: CS.

3C - The proportion of carers who report that they have been included or consulted in discussion about the person they care for, expressed as a percentage, 2013-14

This Authority Compared to its CIPFA Comparator Group

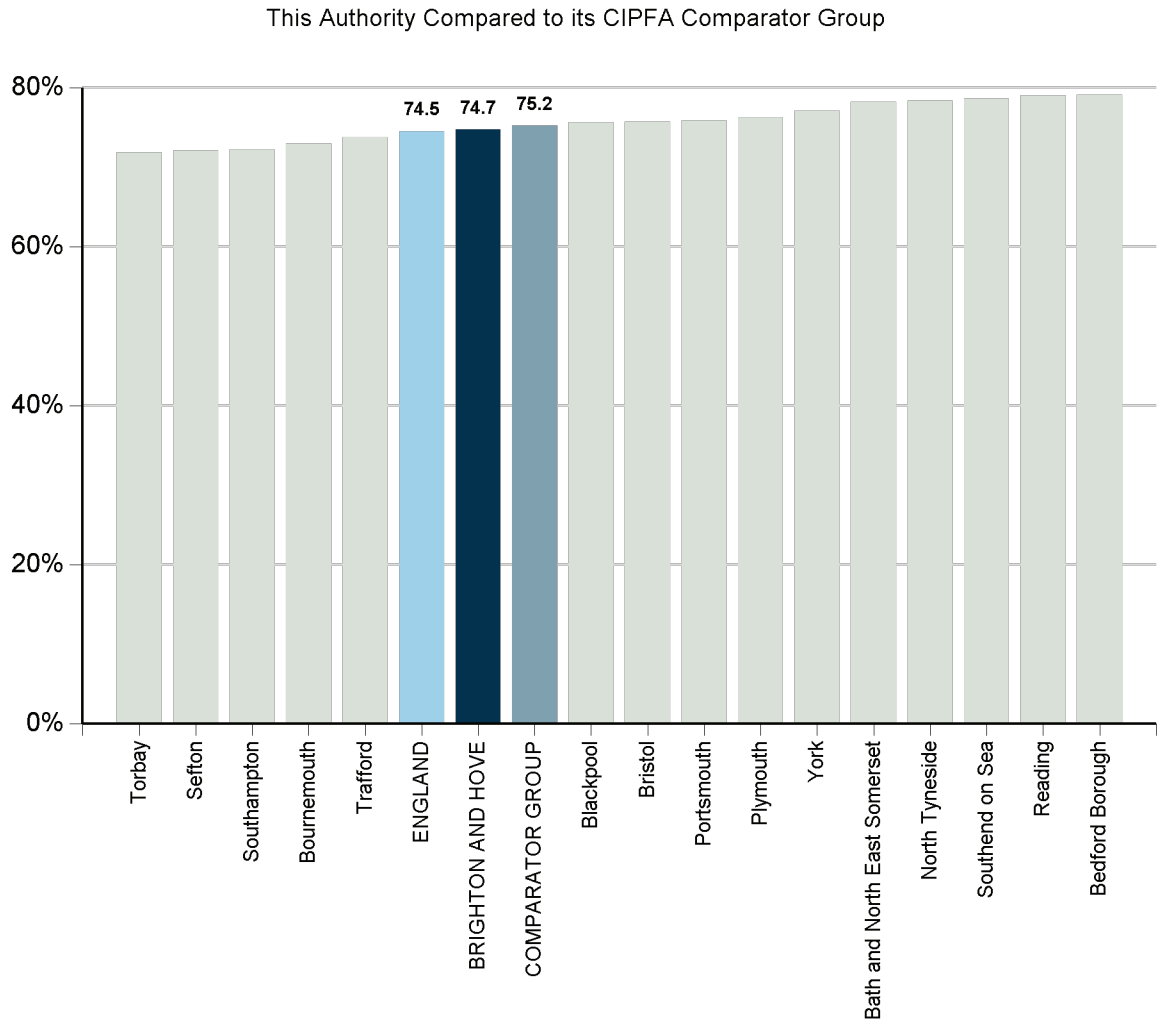
No Data Available

Outcome measure 3C is not calculated for 2013-14, as it is solely based on the Carers survey. This is a biennial survey which took place for the first time in 2012-13. Therefore no data is available for this measure for 2013-14, 2011-12 and 2010-11.

Carers should be respected as equal partners in service design for those individuals for whom they care – this improves outcomes both for the cared for person and the carer, reducing the chance of breakdown in care. This measure reflects the experience of carers in how they have been consulted by both the NHS and social care.

Sources
Numerator and denominator: CS.

3D part 1 - The proportion of people who use services who find it easy to find information about services, expressed as a percentage, 2013-14



This measure reflects social services users' experience of access to information and advice about social care in the past year. Information is a core universal service, and a key factor in early intervention and reducing dependency. Improved and/or more information benefits service users by helping them to have greater choice and control over their lives.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator and denominator: ASCS

Data for 2013-14 is based on final data.

3D part 2 - The proportion of carers who find it easy to find information about services, expressed as a percentage, 2013-14

This Authority Compared to its CIPFA Comparator Group

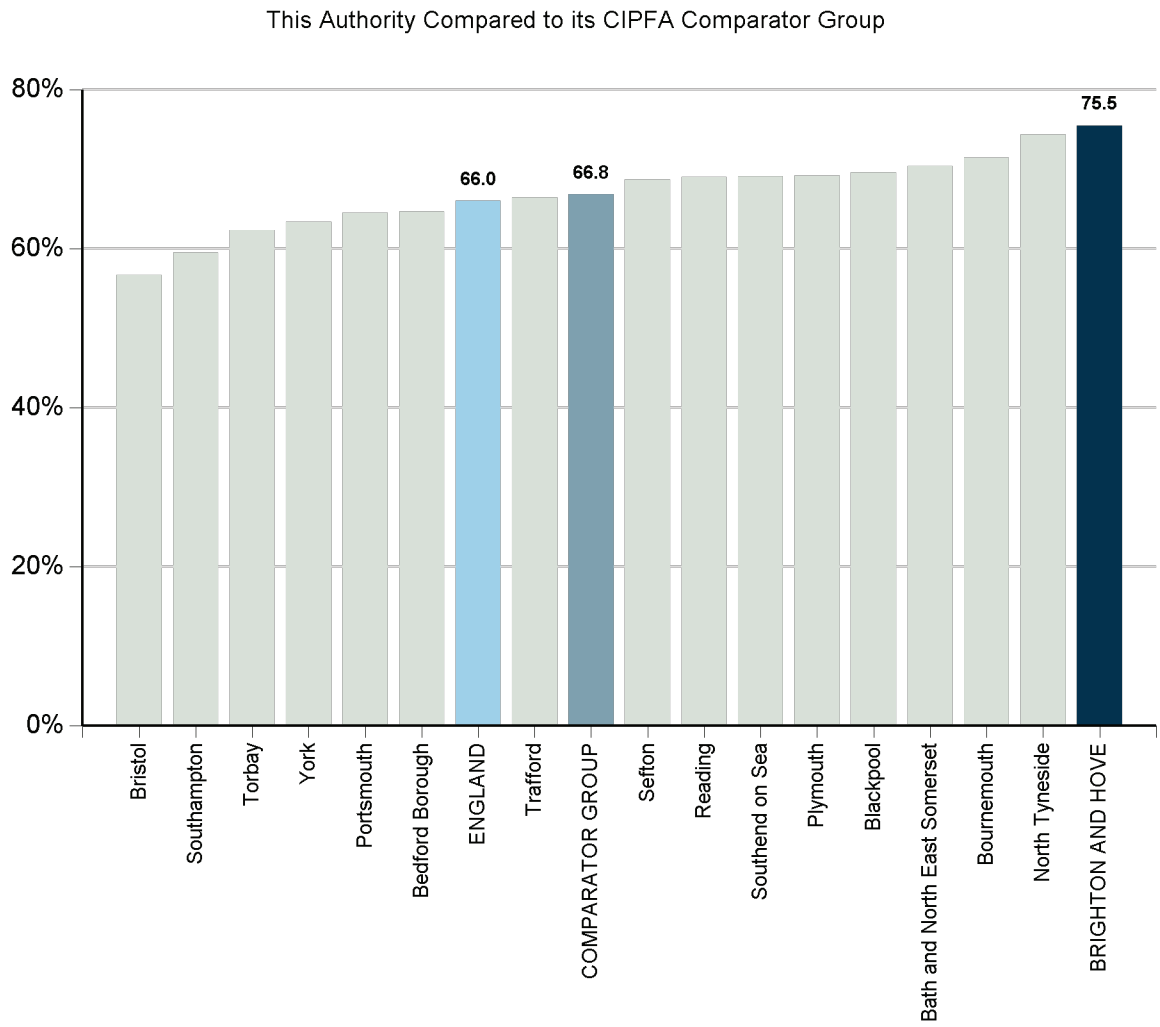
No Data Available

Outcome measure 3D part 2 is not calculated for 2013-14, as it is solely based on the Carers survey. This is a biennial survey which took place for the first time in 2012-13. Therefore no data are available for this measure for 2013-14, 2011-12 and 2010-11.

This measure reflects carers' experience of access to information and advice about social care in the past year. Information is a core universal service, and a key factor in early intervention and reducing dependency. Improved and/or more information benefits carers by helping them to have greater choice and control over their lives. This may help to sustain caring relationships through, for example, reduction in stress, improved welfare and physical health improvements. These benefits accrue only where information is accessed that would not otherwise have been accessed, or in those cases where information is obtained more easily.

Sources
Numerator and denominator: CS

4A - The proportion of people who use services who feel safe, expressed as a percentage, 2013-14



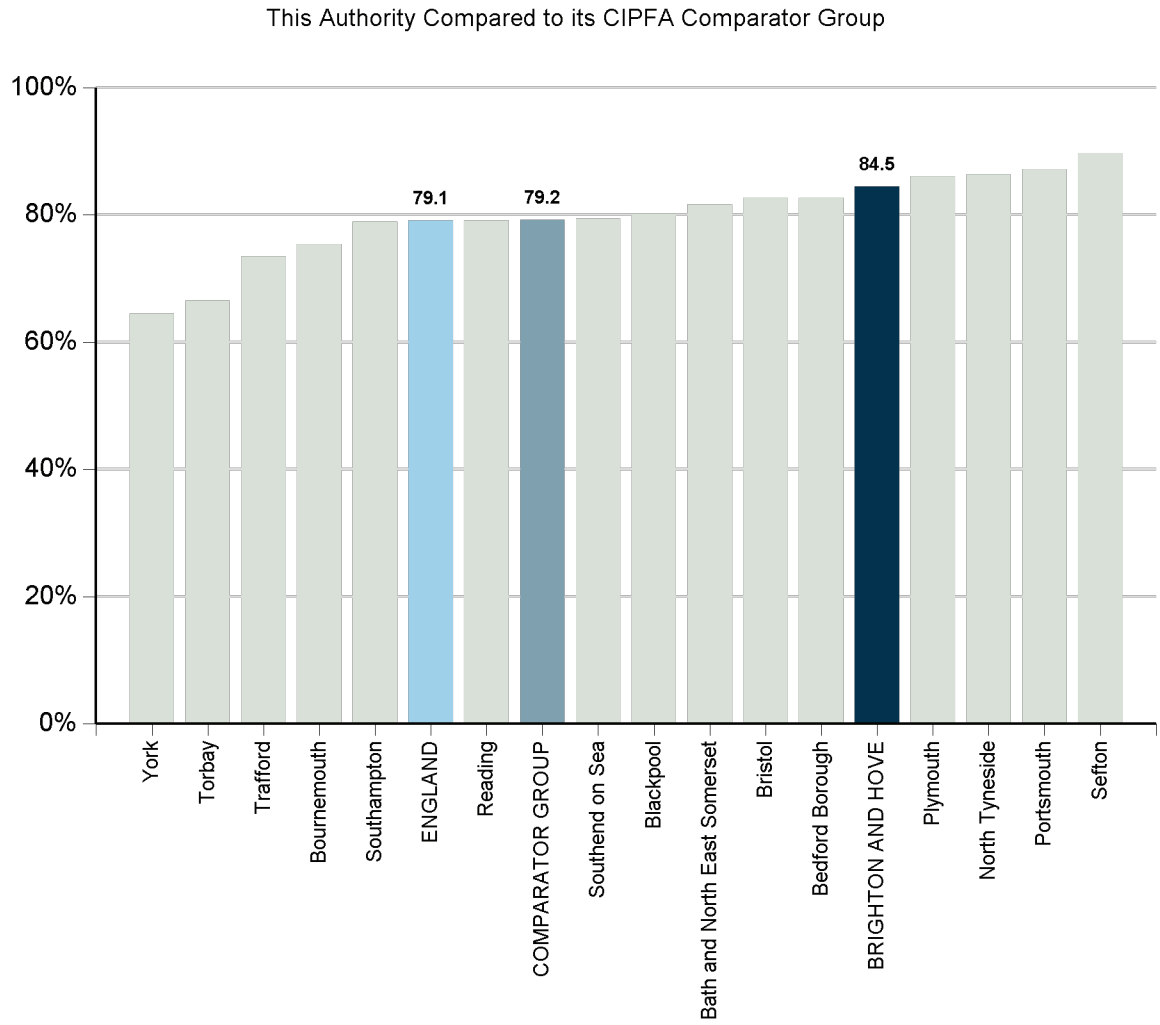
Safety is fundamental to the wellbeing and independence of people using social care (and others). There are legal requirements about safety in the context of service quality. There is also a vital role of being safe in the quality of the individual's experience.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator and denominator: ASCS.

Data for 2013-14 is based on final data.

4B - The proportion of people who use services who say that those services have made them feel safe and secure, expressed as a percentage, 2013-14



Safety is fundamental to the wellbeing and independence of people using social care (and others). There are legal requirements about safety in the context of service quality.

Where council measures are not shown, data are either unavailable or have been suppressed by HSCIC.

Sources
Numerator and denominator: ASCS.

Data for 2013-14 is based on final data.

Appendix 1: Data sources, numerators, denominators and NASCIS guidance

The charts and tables featured in this report are listed in the table below, with sources for the numerators and denominators and how to find them in the On-Line Analytical Processor (OLAP) on NASCIS. To access the OLAP, visit the NASCIS website:
https://nascis.hscic.gov.uk

To obtain data using the OLAP, where the *total* of a dimension is required, ensure that totals are displayed by selecting the view totals button at top left

For further guidance on using the OLAP, please consult the OLAP user guidance:
https://nascis.hscic.gov.uk/Portal/OLAPGuidance.pdf

The annexes to the ASCOF, Carers Survey and Adult Social Care Survey publications provide additional data which are not available via the OLAP. Please consult the HSCIC publications catalogue at http://www.hscic.gov.uk/searchcatalogue for the data annexes to the following publications:

Measures from the Adult Social Care Outcomes Framework - England
Personal Social Services Adult Social Care Survey - England
Personal Social Services Survey of Adult Carers in England

Indicator	Numerator(s)	Denominator(s)
1A - Social care-related quality of life score The quality of life of users based on outcome domains of social care related quality of life. The maximum positive score for the outcome is 24.	**Adult Social Care Survey:** 1. Sum of the scores for respondents who have answered all Qs 3a to 9a and Q11. **OLAP:** Adult Social Care Survey is not available via OLAP.	**Adult Social Care Survey:** 1. Total number of respondents who answered all the Qs 3a to 9a and 11. **OLAP:** Adult Social Care Survey is not available via OLAP.
1B - The proportion of people who use services who have control over their daily life, expressed as a percentage	**Adult Social Care Survey:** 1. Number of respondents who answered "I have as much control over my daily life as I want" and "I have adequate control over my daily life" to Q3a. **OLAP:** Adult Social Care Survey is not available via OLAP.	**Adult Social Care Survey:** 1. Total number of respondents to Q3a. **OLAP:** Adult Social Care Survey is not available via OLAP.

1C part 1 - Number of adults, older people & carers receiving self-directed support in the year to 31 March as a percentage of all clients receiving community based services and carers receiving carer specific services	**RAP return:** 1. SD1, line 10, column 5 2. SD3, line 6, column 5. **OLAP:** 1. RAP SD1, Ageband dimension: Total 18 and over; SDS status dimension: Total (including 'not self directed support' - direct payments. 'Self directed support' – direct payments, CASSR services, or both). 2. RAP SD3, Carer Ageband dimension: Total all ages; SDS status dimension: Total (same as RAP SD1).	**RAP return:** 1. P2f, page 1, line 11, column 1 2. P2f, page 3, line 11, column 1 3. C2, page 1, line 5, column 1. **OLAP:** 1. RAP P2f, client type dimension: Total clients; Service dimension: Total Services (Ageband dimension: total 18 and over). 2. RAP C2, Carer Ageband dimension: Total all ages; Services dimension: services only.
1C part 2 - Number of adults, older people & carers receiving self-directed support via a direct payment in the year to 31 March as a percentage of all clients receiving community based services and carers receiving carer specific services	**RAP return:** 1. SD1, line 10, columns 1+2+4 2. SD3, line 6, columns 1+2+4. **OLAP:** 1. RAP SD1, Ageband dimension: Total 18 and over; SDS status dimension: 'not self directed support' - direct payments, 'self directed support' - direct payments, or both direct and CASSR. 2. RAP SD3, Carer Ageband dimension: Total all ages; SDS status dimension: same as RAP SD1.	**RAP return:** 1. P2f, page 1, line 11, column 1 2. P2f, page 3, line 11, column 1 3. C2, page 1, line 5, column 1. **OLAP:** 1. RAP P2f, client type dimension: Total clients; Service dimension: Total Services (Ageband dimension: total 18 and over). 2. RAP C2, Carer Ageband dimension: Total all ages; Services dimension: services only.
1D - Carer-reported quality of life score	**Carers Survey:** 1. Sum of the scores for respondents who have answered all Qs 7 to 12. **OLAP:** Carers Survey is not available via OLAP.	**Carers Survey:** 1. Total number of respondents who answered all the Qs 7 to 12. **OLAP:** Carers Survey is not available via OLAP.
1E - Adults with a learning disability in paid employment, expressed as a percentage	**ASC-CAR return:** 1. L1, line 1 to 5, column 9. **OLAP:** ASC-CAR L1, Worker status dimension: Total working as a paid employee (first five categories); Services dimension: Total services.	**ASC-CAR return:** 1. L1, line 9, column 9. **OLAP:** ASC-CAR L1, Worker status dimension: Total number of Adults of Working Age (18-64); Services dimension: Total services.

1F - Adults in contact with secondary mental health services in paid employment, expressed as a percentage	**Mental Health Minimum Data Set:** 1. Number of adults aged 18-69 who are receiving secondary mental health services and who are on the Care Programme Approach recorded as being in employment. The most recent record of employment status during the previous twelve months is used. **OLAP:** The Mental Health Minimum Dataset is not available in OLAP.	**Mental Health Minimum Data Set:** 1. Number of adults aged 18-69 who are receiving secondary mental health services and who were on the Care Programme Approach at the end of the month. **OLAP:** The Mental Health Minimum Dataset is not available in OLAP.
1G - Adults with a learning disability who live in their own home or with family, expressed as a percentage	**ASC-CAR return:** 1. L2, line 21, column 3. **OLAP:** ASC-CAR L2, Accommodation type dimension: Total settled accommodation.	**ASC-CAR return:** 1. L2, line 22, column 3. **OLAP:** ASC-CAR L2, Accommodation type dimension: Total (working age known to the council).
1H - Adults in contact with secondary mental health services living independently, with or without support, expressed as a percentage	**Mental Health Minimum Data Set:** 1. Number of adults aged 18-69 who are receiving secondary mental health services who are on the Care Programme Approach recorded as living independently (with or without support). The most recent record of whether or not the person is in settled accommodation during the previous twelve months is used. **OLAP:** The Mental Health Minimum Dataset is not available in OLAP.	**Mental Health Minimum Data Set:** 1. Number of adults aged 18-69 who are receiving secondary mental health services and who were on the Care Programme Approach at the end of the month. **OLAP:** The Mental Health Minimum Dataset is not available in OLAP.
1I part 1 - The proportion of service users who are satisfied with their level of social contact, expressed as a percentage	**Adult Social Care Survey:** 1. Number of respondents who answered 'I have as much social contact as I want with people I like' to Q8a. **OLAP:** Adult Social Care Survey is not available via OLAP.	**Adult Social Care Survey:** 1. Total number of respondents to Q8a. **OLAP:** Adult Social Care Survey is not available via OLAP.

1I part 2 - The proportion of carers who are satisfied with their level of social contact, expressed as a percentage	**Carers Survey:** 1. Number of respondents who answered 'I have as much social contact as I want with people I like' to Q11. **OLAP:** Carers Survey is not available via OLAP.	**Carers Survey:** 1. Total number of respondents to Q11. **OLAP:** Carers Survey is not available via OLAP.
2A part 1- Permanent admissions to residential and nursing care homes for younger adults (18-64), per 100,000 population	**ASC-CAR return:** 1. S3, page 1, line 14, columns 1+2+3. **OLAP:** ASC-CAR S3, Ageband dimension: Age 18 to 64; Client type dimension: Total clients; Residential type dimension: Total - Residential care and Nursing care only (Age 18 to 64 Total).	**Population data:** 1. ONS mid-year population estimates. Total Aged 18-64 2. (numerator/population estimate) *100,000. **OLAP:** Per 10k and Per 100k population measures are available on OLAP. ONS mid-year population estimates are not available in OLAP.
2A part 2 - Permanent admissions to residential and nursing care homes for older people (65 and over), per 100,000 population	**ASC-CAR return:** 1. S3, page 1, line 15, columns 1+2+3. **OLAP:** ASC-CAR S3, Ageband dimension: Age 65 and over; Client type dimension: Total clients; Residential type dimension: Total - Residential care and Nursing care only (Age 65 and over Total).	**Population data:** 1. ONS mid-year population estimates. Total Aged 65+ 2. (numerator/population estimate) *100,000. **OLAP:** Per 10k and Per 100k population measures are available on OLAP. ONS mid-year population estimates are not available in OLAP.
2B part 1 - Older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services, expressed as a percentage	**ASC-CAR return:** 1. I1, lines 1, column 9. **OLAP:** ASC-CAR I1 - Discharge Data Dimension: Number of discharges in denominator where person was still at home 91 days later (Numerator) Measure – Number of discharges.	**ASC-CAR return:** 1. I1, lines 2, column 9. **OLAP:** ASC-CAR I1 - Ageband dimension: Total (65 and over) Measure – Number of discharges.

2B part 2 - Older people (65 and over) who were offered reablement services following discharge from hospital, expressed as a perecntage	**ASC-CAR return:** 1. I1, lines 2, column 9. **OLAP:** ASC-CAR I1 - Ageband dimension: Total (65 and over) Measure – Number of discharges.	**Hospital Episode Statistics:** 1. The number of people discharged alive from hospitals in between 1 October and 31 December in reporting year. This includes all specialties and zero-length stays. **OLAP:** HES Data is not available via OLAP.
2C part 1 - Delayed transfers of care from hospital, per 100,000 population	**Delayed Transfers of Care (DToC):** 1. Total number of delayed discharges (aged 18 and over). This is the average of the 12 monthly snapshots collected in the monthly reports. **OLAP:** Delayed Transfers of Care (DToC) data is not available via OLAP.	**Population data:** 1. ONS mid-year population estimates. Total Aged 18 and over 2. (numerator/population estimate) *100,000. **OLAP:** Per 10k and Per 100k population measures are available on OLAP. ONS mid-year population estimates are not available in OLAP.
2C part 2 - Delayed transfers of care from hospital which are attributable to adult social care, per 100,000 population	**Delayed Transfers of Care (DToC):** 1. Total number of delays attributable to Social Care or jointly to Social Care and the NHS (aged 18 and over). This is the average of the 12 monthly snapshots collected in the monthly reports. **OLAP:** Delayed Transfers of Care (DToC) data is not available via OLAP.	**Population data:** 1. ONS mid-year population estimates. Total Aged 18 and over 2. (numerator/population estimate) *100,000. **OLAP:** Per 10k and Per 100k population measures are available on OLAP. ONS mid-year population estimates are not available in OLAP.
3A - Percentage of adults using services who are satisfied with the care and support they receive	**Adult Social Care Survey:** 1. Number of respondents who answered 'I am extremely satisfied', 'I am very satisfied', 'I am very happy with the way staff help me' to Q1. **OLAP:** Adult Social Care Survey is not available via OLAP.	**Adult Social Care Survey:** 1. Total number of respondents to Q1. **OLAP:** Adult Social Care Survey is not available via OLAP.

3B - Overall satisfaction of carers with social services, expressed as a percentage	**Carers Survey:** 1. Number of respondents who answered 'I am extremely satisfied' or 'I am very satisfied' to Q4. **OLAP:** Carers Survey is not available via OLAP.	**Carers Survey:** 1. Total number of respondents who answered Q4. Minus those who answered 'we haven't received any support'. **OLAP:** Carers Survey is not available via OLAP.
3C - The proportion of carers who report that they have been included or consulted in discussion about the person they care for, expressed as a percentage	**Carers Survey:** 1. Number of respondents who answered 'I always felt involved / consulted' or 'I usually felt involved / consulted' to Q15. **OLAP:** Carers Survey is not available via OLAP.	**Carers Survey:** 1. Total number of respondents who answered Q15. Excluding those who answered 'there have been no discussions'. **OLAP:** Carers Survey is not available via OLAP.
3D part 1 - The proportion of people who use services who find it easy to find information about services, expressed as a percentage	**Adult Social Care Survey:** 1. Number of respondents who answered 'Very easy to find', 'Fairly easy to find' to Q12. **OLAP:** Adult Social Care Survey is not available via OLAP.	**Adult Social Care Survey:** 1. Total number of respondents to Q12, minus / excluding those who answered 'I've never tried to find information or advice'. **OLAP:** Adult Social Care Survey is not available via OLAP.
3D part 2 - The proportion of carers who find it easy to find information about services, expressed as a percentage	**Carers Survey:** 1. Number of respondents who answered 'Very easy to find', 'Fairly easy to find' to Q13. **OLAP:** Carers Survey is not available via OLAP.	**Carers Survey:** 1. Total number of respondents to Q12, minus / excluding those who answered 'I have not tried to find information or advice in the last 12 months'. **OLAP:** Carers Survey is not available via OLAP.
4A - The proportion of people who use services who feel safe, expressed as a percentage	**Adult Social Care Survey:** 1. Number of respondents who answered 'I feel as safe as I want' to Q7a. **OLAP:** Adult Social Care Survey is not available via OLAP.	**Adult Social Care Survey:** 1. Total number of respondents to Q7a. **OLAP:** Adult Social Care Survey is not available via OLAP.
4B - The proportion of people who use services who say that those services have made them feel safe and secure, expressed as a percentage	**Adult Social Care survey:** 1. Number of respondents who answered 'Yes' to Q7b. **OLAP:** Adult Social Care Survey is not available via OLAP.	**Adult Social Care Survey:** 1. Total number of respondents to Q7b. **OLAP:** Adult Social Care Survey is not available via OLAP.

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HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 28 Brighton & Hove City Council

Subject:		**Preventing premature mortality audit (PPMA)**	
Date of Meeting:		**4 February 2015**	
Report of:		**Monitoring Officer**	
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The purpose of the report is to provide HWOSC with an overview of an audit, commissioned by the Clinical Commissioning Group, looking at premature mortality in three diseases (cardio-vascular disease (CVD), chronic obstructive pulmonary disease (COPD) or diabetes). The study aims to find potentially preventable risk factors and look at how to address them in future.

1.2 The CCG has managed to engage with all GP practices in the city, which is a first for this type of work in the country. Findings from the audit will be shared with colleagues regionally and nationally.

2. RECOMMENDATIONS:

2.1 That HWOSC members consider the information in the audit and comment on the preliminary findings.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Brighton & Hove has significantly poorer (higher) mortality rates for causes considered preventable than other regions of England and the South East, and in particular higher under 75 mortality from respiratory disease. Around one third of all deaths in the city are in those aged 18-74 years and for many people under 75 years, deaths related to three key diseases (cardio-vascular disease (CVD), chronic obstructive pulmonary disease (COPD) or diabetes) can be prevented or averted.

3.2 The study aimed to determine potentially preventable risk factors for premature death from these conditions including:

- identification of disease
- quality of care
- lifestyles
- links between secondary and primary care

In order to look at what could be done in the future to prevent further ‘premature’ deaths.

3.3 Deaths from cancer were specifically not looked at (unless the patient had COPD or diabetes) as there had been a recent audit of cancer deaths in the city.

3.4 All GP practices across the city signed up to be part of the audit, a first for this type of work across the country which meant the CCG could provide a comprehensive analysis across the city. It has been requested by Public Health England that the work be highlighted at regional workshops around England on Primary Care and Health Inequalities.

3.5 The methodology included linking data from death registration records, primary care registers and lifestyles data, and secondary care admissions/attendance in the two years prior to death of 651 patients who died prematurely (aged 18-74 years) from or with the three conditions.

These deaths accounted for 32% of deaths of those aged 18-74, or 10% of all deaths in the city over the three year period from October 2010 to September 2013, totalling 6,546 years of life lost under the age of 75.

3.6 The work is in two phases; phase one is the data analysis described above – this has been completed. Phase two is an in-practice audit of medical notes for the patients in question.

3.7 Initial key findings can be grouped as follows. More information on each of these headings is in the appendix:

- **Age, gender and deprivation:** The majority of deaths were in patients aged 55-74 years and males and there is a relationship with deprivation but it is not the whole story. The rate in the east locality is almost double that in the central locality, and is significantly higher than the overall premature mortality rate for the city. Rates were significantly higher in Queen's Park, East Brighton, Hollingdean and Stanmer, and Moulsecoomb and Bevendean wards.

- **Lifestyles:** Rates of smoking, alcohol consumption above recommended levels and overweight/obesity were much higher than in the general adult population aged 18-74 years and those who were still smoking and drinking above recommended levels died significantly younger than ex or non-smokers and those drinking below recommended limits. There was little recording of advice or referral for lifestyles issues.

- **Practice disease registers:** Practices organise care for specific patients by maintaining disease registers of both those patients with established disease and those with risk factors and by providing systematic care to reduce risks, for example by managing blood pressure and cholesterol levels and by supporting patients to give up smoking. Around a third of patients dying from CVD were not on a related disease register in primary care and whilst most patients dying with COPD or Diabetes were, around a third were excepted from registers and may have been missing out on preventive care (patients can be excepted from registers for a number of reasons including patients not attending a review after three invitations, patients with terminal illness, newly registered patients, patients on maximum doses of medication or unable to take medication). The care of those who were on disease registers and not excepted was generally good. A

high percentage of patients on relevant disease registers were also on a depression register.

- **Secondary care:** Contact with secondary care services was high with the majority of patients having had at least one hospital inpatient admission in the two years prior to their death (60%), this was much higher for patients who died with COPD (81%) or diabetes (80%). This emphasizes the importance of this audit not just in terms of preventing death, but also time spent in ill health. There were patients not on disease registers in primary care who had had hospital admissions coded for the disease and so should have potentially been investigated further in primary care and placed on registers – the in-practice audit is looking at the details of these cases. A sizeable percentage of admissions were alcohol related, tying in with the findings from the primary care records and emphasising the need to support people with chronic conditions and alcohol issues better in the city.

- **Other emerging themes from the in-practice audit include:** Isolated patients; Alcohol; Complex medical problems; Obesity; Missed treatment; Sudden deaths; Multi-morbidity; End stage disease; Cancer and specifically lung cancer; Mental wellbeing and Housing.

3.8 Some action has already been taken to address the findings. The Public Health team and Clinical Commissioning Group have each committed to funding three extra FTE Health Trainers (a total of 6 - taking the team from 4 to 10 FTEs) to work with GP practices to be able to provide more coordinated support for individuals with chronic conditions to improve their health behaviours. The health trainer programme is a cost effective and well evidenced approach to reducing health inequalities and improving health outcomes. It works with individuals to take action across multiple health behaviours.

3.9 The findings are also being used in meetings with clusters of practices to share learning and to draw together suggestions for practice across the city.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 None to this cover report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this cover report.

Legal Implications:

5.2 None to this cover report.

Equalities Implications:

5.3 None to this cover report.

Sustainability Implications:

5.4 None to this cover report.

Crime & Disorder Implications:

5.5 None to this cover report.

Risk and Opportunity Management Implications:

5.6 None to this cover report.

Public Health Implications:

5.7 The findings of the report will help to address premature mortality in the city.

Corporate / Citywide Implications:

5.8 None to this cover report.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 None to this cover report, which is presenting information.

SUPPORTING DOCUMENTATION

Appendices:

1. Update from the CCG

Brighton & Hove Preventing premature mortality audit (PPMA) - HWOSC briefing February 2015

Kate Gilchrist, Head of Public Health Intelligence and
Katie Stead, GP lead for primary care quality and public health

Background

Brighton & Hove has significantly poorer (higher) mortality rates for causes considered preventable than England and the South East, and in particular under 75 mortality from respiratory disease – though it is average compared with comparator areas.

Around one third of all deaths in the city are in those aged 18-74 years and for many people under 75 years, deaths related to three key diseases (cardio-vascular disease (CVD), chronic obstructive pulmonary disease (COPD) or diabetes) can be prevented or averted.

This study aimed to determine potentially preventable risk factors for premature death from these conditions including:

- identification of disease
- quality of care
- lifestyles
- links between secondary and primary care

In order to look at what could be done in the future to prevent further 'premature' deaths.

Deaths from cancer were specifically not looked at within this audit (unless the patient had COPD or diabetes) as there had been a recent audit of cancer deaths in the city.

All GP practices across the city signed up to be part of the audit, a first for this type of work across the country which meant we could provide a comprehensive analysis across the city. It has been requested by Public Health England that the work be highlighted at regional workshops around England on Primary Care and Health Inequalities.

What we did

Data were linked from death registration records, primary care registers and lifestyles data, and secondary care admissions/attendance in the two years prior to death of 651 patients who died prematurely (aged 18-74 years) from or with the three conditions. These deaths accounted for 32% of deaths of those aged 18-74, or 10% of all deaths in the city over the three year period from October 2010 to September 2013, totalling 6,546 years of life lost under the age of 75 and so focusing on preventing/averting these deaths could have a significant impact on premature death rates and inequalities across the city.

There are two phases of the work: analysis of the data extracted and an in-practice audit being undertaken by a clinical facilitator who is further reviewing notes held in-practice. Phase one is complete and phase two is currently in progress (some emerging themes are given here but they should be treated with caution at this stage).

Key early findings (these are expanded in pages 3-5):

- **Age, gender and deprivation:** The majority of deaths were in patients aged 55-74 years and males and there is a relationship with deprivation but it is not the whole story. The rate in the east locality is almost double that in the central locality, and is significantly higher than the overall premature mortality rate for the city. Rates were significantly higher in Queen's Park, East Brighton, Hollingdean and Stanmer, and Moulsecoomb and Bevendean wards.
- **Lifestyles:** Rates of smoking, alcohol consumption above recommended levels and overweight/obesity were much higher than in the general adult population aged 18-74 years and those who were still smoking and drinking above recommended levels died significantly younger than ex or non-smokers and those drinking below recommended limits. There was little recording of advice or referral for lifestyles issues.
- **Practice disease registers:** Practices organise care for specific patients by maintaining disease registers of both those patients with established disease and those with risk factors and by providing systematic care to reduce risks, for example by managing blood pressure and cholesterol levels and by supporting patients to give up smoking. Around a third of patients dying from CVD were not on a related disease register in primary care and whilst most patients dying with COPD or Diabetes were, around a third were excepted from registers and may have been missing out on preventive care (patients can be excepted from registers for a number of reasons including patients not attending a review after three invitations, patients with terminal illness, newly registered patients, patients on maximum doses of medication or unable to take medication). The care of those who were on disease registers and not excepted was generally good. A high percentage of patients on relevant disease registers were also on a depression register.
- **Secondary care:** Contact with secondary care services was high with the majority of patients having had at least one hospital inpatient admission in the two years prior to their death (60%), this was much higher for patients who died with COPD (81%) or diabetes (80%). This emphasizes the importance of this audit not just in terms of preventing death, but also time spent in ill health. Though small in number, there were patients not on disease registers in primary care who had had hospital admissions coded for the disease and so should have potentially been investigated further in primary care and placed on registers – the in-practice audit is looking at the details of these cases further. A sizeable percentage of admissions were alcohol related, tying in with the findings from the primary care records and emphasising the need to support people with chronic conditions and alcohol issues better in the city.
- **Other emerging themes from the in-practice audit include:** Isolated patients; Alcohol; Complex medical problems; Obesity; Missed treatment; Sudden deaths; Multi-morbidity; End stage disease; Cancer and specifically lung cancer; Mental wellbeing and Housing

Resulting action:

On the basis of the findings from the first stage of the analysis, the Public Health team and Clinical Commissioning Group have each committed to funding three extra FTE Health Trainers (a total of 6 - taking the team from 4 to 10 FTEs) to work with GP practices to be able to provide more coordinated support for individuals with chronic conditions to improve their health behaviours.

The health trainer programme is a cost effective and well evidenced approach to reducing health inequalities and improving health outcomes. It works with individuals to take action across multiple health behaviours.

Next steps:

- The clinical facilitator is continuing to conduct the next phase of the audit and will work with practices to use the audit to look for missed opportunities to reduce preventable premature mortality within the services that had contact with these patients.
- Some of this will be done at practice level, but the information is also being used in meetings with clusters of practices to share learning and to draw together suggestions for practice across the city.
- At the city level the steering group will look for gaps in services and make recommendations for new or different services. It will also look at how effective the services were in delivering care and whether additional support or re-organisation would be recommended.

More detailed early findings:

Age, gender and deprivation

- The majority of deaths were of people aged 55-74 years (85%) and two thirds were of males.
- Across the city's practices, the premature mortality rate from causes included in the audit was 10.9 per 100,000 patients aged 18-74 years.
- There is significant variation across the city and a link with deprivation: the rate in the east locality is almost double that in the central locality, and is significantly higher than the overall premature mortality rate for the city. Rates were significantly higher in Queen's Park, East Brighton, Hollingdean and Stanmer, and Moulsecoomb and Bevendean wards.
- Deprivation might be an explanation for some of the differences in premature mortality rates across the city; but it is not the whole story. The audit looked at other factors which might help explain the level of variation in premature mortality across the city.

Lifestyles:

- Most patients did have recording of key lifestyles factors in their primary care records, with the exception of physical activity levels. Key contributory lifestyle factors in the premature deaths identified within the audit included:
- The general smoking prevalence in the city is 24% but for those who died prematurely from the conditions considered in the audit it was 46%, and for patients dying prematurely with COPD 56%.
- Whilst 42% of residents self-report a BMI classified as overweight/obese, 61% of those who died prematurely were overweight or obese, and 75% of those who died prematurely with diabetes.
- For all 18-74 year olds in the city 18% report drinking at increasing or high risk levels (>14 units per week for females and >21 units for males) compared with 29% of those dying prematurely of the conditions considered in the audit. Those dying with COPD (31%) and of CVD (28%) had the highest recorded rates of increasing/high risk drinking.
- Whilst all patients within the audit died under the age of 75 years, the median age at death is statistically significantly younger for patients with a coding for alcohol dependence at 58 years and for those drinking at increasing or higher risk levels (61 years) compared with 67 for those whose last recorded alcohol consumption was lower risk and 66 for non-drinkers.
- There was no association between alcohol consumption and deprivation.
- The median age at death is also statistically significantly younger for patients who are current smokers at 63.5 years than for ex-smokers (68 years) and those who have never smoked (66 years)
- Smoking rates were significantly higher in patients resident in the most deprived areas of the city.
- Those drinking at increasing or high risk levels were significantly more likely to smoke (68% were current smokers) than those drinking at lower risk (40%) or non-drinkers (37%).
- There was low recording of advice/referral for these lifestyles issues – this is being looked at further in the in-practice audit

Practice disease registers

- Disease registers in primary care were formalised as part of the new GP contract in 2004. Once patients with particular conditions have been identified, registers enable them to be monitored and

their condition and treatment reviewed more easily. Practices organise care for specific patients by maintaining disease registers of both those patients with established disease and those with risk factors and by providing systematic care to reduce risks, for example by managing blood pressure and cholesterol levels and by supporting patients to give up smoking.

- Around one in three people dying from CVD were not on a related disease register. This raises the question whether some CVD deaths could have been prevented or postponed had the patients been on a disease register and that some may have been missing out on preventive care. This is being explored further in the in-practice audit.
- For those dying from CVD or Stroke the median age of death was younger for those not on a related register than those who were.
- Identification was much higher for COPD and diabetes. However, around a third of patients with COPD and diabetes were excepted from registers and therefore potentially not being reviewed/monitored regularly – the high rates of patients being excepted is of concern and is being looked at as a key area in the in-practice audit.
- One possible reason for exceptions was that patients were on a palliative care register near the end of life and so excepted from other registers. Whilst this is still relevant for the audit it could explain high exceptions rates. However for most conditions few patients were on a palliative care register.
- We used a tool called attrition triangles to look at the care received within general practice for those on related registers and not excepted – focussing on key QOF indicators. With the exception of FeV1 for COPD and foot checks for diabetes most patients on registers, and not excepted, were receiving relevant checks and good quality care.
- A high percentage of patients on relevant disease registers were also on a depression register. Across the city 6% of adult patients are on a depression register but for those dying prematurely included in the audit, the figures were between a quarter and a third of patients (higher for those with diabetes and COPD than CVD)

Secondary care

- Contact with secondary care services was high which emphasizes the importance of this audit not just in terms of preventing death, but also time spent in ill health:
    - The majority of patients had at least one hospital inpatient admission in the two years prior to their death (60%), this was much higher for patients who died with COPD (81%) or Diabetes (80%)
    - 52% (338) had at least one emergency inpatient admission (range 0-26 admissions)
    - 34% (224) had at least one elective admission (range 0-49 admissions)
    - 69% (449) had at least one A&E attendance (range 0-44 attendances)
    - 69% (452) has at least one outpatients appointment (range 0-130 appointments)
- In total, the 651 patients included in the audit had 1,752 inpatient admissions (1,141 emergency and 611 elective), 1,761 A&E attendances and 5,610 outpatients appointments in the two years prior to their deaths

- These admissions equate to the following total number of bed days for each condition (please note patients could be included in more than one group so the total number of bed days for all patients is not the sum of these figures):
    - CVD – 6,417 bed days
    - Stroke – 1,641 bed days
    - COPD – 3,941 bed days
    - Diabetes – 5,693 bed days
- There was a large percentage of admissions which were alcohol related, tying in with the findings from the primary care records and emphasising the need to support people with chronic conditions and alcohol issues better in the city.
- There were cases where people were not on disease registers in primary care but had had an admission to hospital in the two years prior to their death with the disease coded – this is a key area being considered in the in-practice audit as potentially some of these patients should have been placed on disease registers although this is not necessarily the case and requires the in-practice audit work before more can be garnered from this.

Other emerging themes from the in-practice audit:

Four surgeries have been reviewed to date totalling 58 patients. Each death, the causes and circumstances leading up to this point have been reviewed. Each retrospective review has explored the patient's surgery notes and by examining the narrative seen in consultations and letter communications it is possible to follow the care patients received prior to their death.

A small number of patients had very little clinical data and it is likely that these patients might have only recently registered with a surgery. There is also missing contemporaneous data from post mortem's which might have shed light on the events leading up to death. Taking these issues away still leaves a large collection of data and clinical information which has allowed us to summarise the care and treatment patients received prior to their premature death. Key themes emerging so far are:

- Isolated patients
- Alcohol related death
- Complex medical problems
- Obesity
- Missed treatment
- Sudden deaths
- Multi-morbidity
- End stage disease
- Cancer / lung cancer
- Mental wellbeing

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 29 Brighton & Hove City Council

Subject:		**Healthwatch Brighton and Hove - achievements over the last twelve months**
Date of Meeting:		**4 February 2015**
Report of:		**Monitoring Officer**
Contact Officer:	**Name:**	**Kath Vlcek** **Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The purpose of the report is to provide HWOSC with an overview of Healthwatch Brighton and Hove's progress and achievements over twelve months

2. RECOMMENDATIONS:

2.1 That HWOSC members consider the information and comment on how HWOSC could work more closely with Healthwatch going forward.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Healthwatch Brighton & Hove began on 1 April 2013.

Healthwatch organisations:

- have the power to enter and view services
- influence how services are set up and commissioned by having a seat on the local Health and Wellbeing Board
- produce reports which influence the way services are designed and delivered
- provide information, advice and support about local services
- pass information and recommendations to Healthwatch England and the Care Quality Commission

3.2 Healthwatch Brighton and Hove (HWBH) is run by a Board of Directors with a number of paid members of staff and 30 volunteers.

The volunteers carry out a range of key roles- 6 Enter and View Authorised Representatives; 8 Healthwatch Representatives; 4 Helpline Volunteers; 4 Engagement and Communications Assistants; 3 Hospital Complaints Peer Reviewers; 3 Research and Intelligence Committee Members; 1 Media Monitor; 1 Admin Assistant. There are also 12 volunteers known as Papermates who help distribute the Healthwatch magazine.

3.3 HWBH has carried out several investigations on a range of local health issues including hospital discharge procedures, local CAMHS services; Eaton Place Surgery closure and other issues. Their investigations include discussions with service users, patient surveys, enter and view visits and discussions with community and voluntary sector partners.

3.4 HWHB plan to visit a further 2 services which have focuses on learning disabilities, dementia and older people. In addition to these, they have visited the Royal Sussex County Hospital Discharge Lounge, as referenced above. HWHB are developing their Enter and View methods and are currently collaborating with East Sussex Healthwatch.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 Healthwatch Brighton and Hove carry out community engagement and consultation as part of their every day work.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this cover report.

Legal Implications:

5.2 None to this cover report.

Equalities Implications:

5.3 None to this cover report.

Sustainability Implications:

5.4 None to this cover report.

Crime & Disorder Implications:

5.5 None to this cover report.

Risk and Opportunity Management Implications:

5.6 None to this cover report.

Public Health Implications:

5.7 Healthwatch's work help address public health issues for all local residents.

Corporate / Citywide Implications:

5.8 None to this cover report.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 None to this cover report, which is presenting information.

SUPPORTING DOCUMENTATION

Appendices:

1. Healthwatch report.

healthwatch
Brighton and Hove

Healthwatch Brighton and Hove
Report on Year 2 to Brighton and Hove Health and Wellbeing Overview and Scrutiny Committee (HOSC)

April 2014 to January 2015

Contents

Background

Healthwatch Brighton and Hove began work on the 1st April 2013. There is a local Healthwatch organisation in every local authority area in England. They take the experiences people have of local care and use them to help shape local services.

Healthwatch organisations:

- have the power to enter and view services
- influence how services are set up and commissioned by having a seat on the local Health and Wellbeing Board
- produce reports which influence the way services are designed and delivered
- provide information, advice and support about local services
- pass information and recommendations to Healthwatch England and the Care Quality Commission

How does local Healthwatch differ from LINks?

Local Healthwatch organisations have taken over the work previously done by the Local Involvement Networks (LINks), but with additional functions. Many of the strengths of LINks will apply just as much as local Healthwatch organisations, however, there are a number of key differences between the two organisations:

- LINks only had a remit for adult health and social care services. Local Healthwatch is responsible for capturing the health and social care users' voices of adults and children; a crucial difference reflecting the ongoing need for the views of all users to be taken into account.
- Local Healthwatch has a statutory place on their local health and wellbeing boards for the first time.
- A national network will be put in place to support the development of local Healthwatch organisations, from their start-up to being fully functional.
- The local Healthwatch can reach an opinion on the local service and how they can be improved.
- Local Healthwatch will signpost patients to services where there is good practice and a strong reputation.
- Local Healthwatch can feed those views and any recommendations to Healthwatch England to action at a national level.

Healthwatch Statutory Functions

The 8 functions of local Healthwatch are determined by statute:

1. Promoting and supporting the involvement of local people in the commissioning, the provision and scrutiny of local care services.

2. Enabling local people to monitor the standard of provision of local care services and whether and how local care services could and ought to be improved.
3. Obtaining the views of local people regarding their needs for, and experiences of, local care services and importantly to make these views known.
4. Making reports and recommendations about how local care services could or ought to be improved. These should be directed to commissioners and providers of care services, and people responsible for managing or scrutinising local care services and shared with Healthwatch England.
5. Providing advice and information about access to local care services so choices can be made about local care services. Helpline and Engagement
6. Formulating views on the standard of provision and whether and how the local care services could and ought to be improved; and sharing these views with Healthwatch England.
7. Making recommendations to Healthwatch England to advise the Care Quality Commission to conduct special reviews or investigations (or, where the circumstances justify doing so, making such recommendations direct to the CQC); and to make recommendations to Healthwatch England to publish reports about particular issues.
8. Providing Healthwatch England with the intelligence and insight it needs to enable it to perform effectively.

The Independent Complaints Advocacy Service (ICAS) is sub-contracted to a local organisation Impetus. This service helps empowers anyone who wishes to resolve a complaint about healthcare commissioned and/or provided by the NHS in England:
http://www.bh-impetus.org/projects/independent-complaints-advocacy-service-icas/

Healthwatch England

Healthwatch England is not a regulatory body such as the Care Quality Commission and does not have direct responsibility to change practices. However, the organisation does have a statutory remit to collate evidence of service shortfalls and issues nationally and to ensure the regulators, other arms length bodies, and government departments, respond accordingly. Through the Healthwatch network, Healthwatch England will ensure the voices of people who use health and social care services are heard by the Secretary of State, the Care Quality Commission, the Monitor and every local authority in England. Healthwatch England provides leadership, support and advice to local Healthwatch organisations so they can become strong ambassadors for local people. They will gather and analyse information provided by local Healthwatch organisations and others to identify key issues and trends.

Who We Are

Staff

From May 2014 to November 2014 there were 2 part time job share managers: Jane Viner – responsible for performance management, operations, finance, line managing 3 staff members.

Claire Jones – responsible for Healthwatch representatives, engagement and communication and line managing 1 member of staff.

Kerry Dowding – Research and Projects Co-ordinator (full time), collates and analyses information received by Healthwatch from our helpline, engagement activities, information received from Trusts and Brighton and Hove City Council. Writes reports on behalf of Healthwatch and co-ordinates enter and view activities.

Magda Pasiut –Engagement and Communications Co-ordinator(4 days a week), produces the monthly Healthwatch magazine, manages the website and social media and media communications. Engages with local groups and citizens.

Elaine Elliott - Helpline and Information Co-ordinator (4 days a week) responds to helpline enquiries and manages volunteers who help respond to helpline calls. Steve Turner – Volunteer Co-ordinator (4 days a week) recruits, inducts and trains our pool of volunteers, directly manages most of them, and supports other members of staff in their work with volunteers.

Board

Healthwatch Brighton and Hove has a Board of Directors (formerly known as the Governing Body). They lead the strategic direction of Healthwatch Brighton and Hove and ensure that it effectively delivers on its important role. They meet on a monthly basis and most act as representatives at other Boards or meetings, for instance, Patient Participation Groups (PPGs), Patient Experience Panels and other patients' participation fora. The Chair receives a small stipend for one day a week, but the rest of the role is voluntary, along with other Board members.

The Board has been in place for one year. The expectation has been that the organisation should be a Community Interest Organisation. Setting up a new organisation with all that entails has taken place in parallel with developing a programme of work in a highly volatile and political environment. The potential agenda is enormous and determining priorities remains a constant challenge, as does raising the profile of HWBH, so that the people of Brighton and Hove are able to communicate to us their ideas and concerns.

At the strategic level, one of the main aims of the last nine months has been to develop honest relationships with Chief Officers in Brighton and Hove City Council and the Health Service. This has been particularly successful in the Clinical Commissioning Group (CCG) and with Brighton Sussex University Hospital NHS Trust (BSUH) and working relationships have been made at different levels in other organisations. A challenge has been to ensure HWBH has sufficient people with the right support to attend all priority meetings and to ensure the intelligence received informs our activities.

Frances McCabe – Chair

Frances has been Chair since November 2013 and appointed the rest of the Board. For over 40 years, she worked in health and social care: as a nurse and health visitor, managing social services to Director level, In senior posts in charities, the Social Services Inspectorate and leading national health and social care projects at the Department of Health. Frances has Masters degrees in Geriatric Medicine and Life History Research(on GPs). For 3 years, she was the Chair of Age UK Brighton and Hove and remains a trustee. She has 3 children, two step-children, two of whom are local and 5 grandchildren.

Bob Deschene

Bob has 15 years of experience in senior NHS Management in East & West Sussex working in a doctor's surgery, Primary Care Group, Primary Care Trusts and acting as a lead in Older People's Services, Children & Young People's Services, and Mental Health. He has also spent 23 years in the private sector in Canada and the UK in senior financial roles. As well, he has done some volunteer work for Age UK and was a board member of the LINk Steering Group.

Clare Tikly

Clare's experience stems from 50 years of teaching in schools and teacher education. As a Mother and Grandmother she understands how families are affected by social and cultural changes, and gain from supportive communities. She is active in a patient group and a Local Action Team. Healthwatch is planned to let all people have a say in health and social care in Brighton and Hove. Clare is pleased to be able to work with professionals in these areas and to encourage other people to become involved.

Doris Ndebele

Doris has a health background later graduating with a BSc (Hons) in Health Studies. She is passionate about BME issues, being actively involved with projects both at Trustee level and paid worker for 16 years. She is currently the Chief Officer at BMECP where she has been for the past 13 years working to develop BMECP Centre. Her work has included: nursing, research, workforce

planning, community learning and secretarial work. Doris holds an MSc in Managing Voluntary Organisations, a Grad. Cert. in Social Enterprise and a mental health nursing qualification. Doris was a former LINk Steering Group member.

John Davies

John is a Professor of International Health Promotion at the University of Brighton. He has worked as an academic and practitioner in health promotion, health education and social care at local, national and international levels for over 40 years. Now semi-retired, John sees the work of Healthwatch as being based on the Health for All principles of equality and empowerment and intends to work with the people of Brighton and Hove and service providers to deliver the best health and social care possible.

Karin Janzon

Karin has 40 years experience in adult social care where she has worked in research, planning and management for local authorities and as a consultant. Listening to service users has been a strand through all her work. Having joined Healthwatch as a governor, she is particularly interested in joining the debate about how social and health care services can support people in maintaining well-being and quality of life as they grow older. Karin, who originally comes from Sweden, thinks there is great value in being open to new ideas and solutions, including best practice in other European countries.

Sophie Reilly

Sophie is the Chair of the Federation for Disabled People.

Mick Lister

Mick retired 11 years ago as a Telecommunications Manager and started voluntary work as a fund raiser with NSPCC. Working in the voluntary sector soon brought him into contact with people involved in local healthcare, so he joined the South Downs Patient and Public Involvement Forum (PPIF). Local Involvement Networks (LINks) replaced the PPIFs, so he joined the LINk and was involved as Vice Chair with its transition to Healthwatch. Mick has real perspective of patient and public issues concerning local health and social care.

Volunteering

Healthwatch Brighton and Hove is an organisation led by and for local people, we involve local people as volunteers in our work for the following reasons:

- to ensure public involvement, ownership and leadership of Healthwatch work;
- to ensure patient voice and experience is at the centre of Healthwatch work;
- to enable Healthwatch to involve and reach a wide range of diverse people from different backgrounds and communities and of different ages;
- to help Healthwatch to have credibility with different communities in the city;
- to increase Healthwatch capacity to fulfil its functions and its work;
- to benefit from a variety of perspectives and a range of skills and knowledge;
- to utilise information and knowledge about health and social care services; and
- to ensure Healthwatch is open and transparent, has an independent voice, and is championed by local people for local people.

Currently, we have 30 volunteers in the following roles:

6 Enter and View Authorised Representatives
8 Healthwatch Representatives
4 Helpline Volunteers
4 Engagement and Communications Assistants
3 Hospital Complaints Peer Reviewers
3 Research and Intelligence Committee Members
1 Media Monitor
1 Admin Assistant

There are also 12 volunteers known as Papermates who help us distribute the Healthwatch magazine

Since April 2014 we have trained 35 volunteers in the following areas (figures in brackets refer to number of volunteers attending sessions):

Enter and View (6)
Volunteer induction (26)
Awareness session (24)
Being a Healthwatch representative (8)

Governance

Community Interest Company (CIC)
We became a CIC on the 14th October although Healthwatch Brighton and Hove does not officially become completely independent until 1st of April 2015 when it will employ its own staff etc.

From April 2014 we agreed the following policies:

- Code of Conduct
- Complaints Procedure
- Confidentiality Policy
- Criminal Records Policy
- Declaration of Interest Form
- Enter and View Policy
- Equality and Diversity Policy
- Finance Policy
- Helpline Policy
- Media Policy
- Social Media Policy
- Volunteer Policy
- Volunteer Expenses Policy

Policies can be found at: http://www.healthwatchbrightonandhove.co.uk/policies

Influencing Services

We have a trained pool of Healthwatch representatives who have received our 42 page information pack to enable them to participate more effectively.

We are members on the following:

- Quality Surveillance Group
- South East Healthwatch Group
- Health and Wellbeing Board
- Health and Wellbeing Board Executive Officer Group
- City Needs Assessment
- Health and Wellbeing Overview and Scrutiny Committee
- Healthwatch Brighton and Hove contract
- Clinical Commissioning Group Engagement Steering Group
- Clinical Commissioning Group leads
- Brighton and Hove NHS 111 Clinical Governance
- Commissioning Short Term Services (CSTS) Board
- Integrated Care Board

- System Resilience Group (formerly Urgent Care Working Group)
- Brighton and Hove Pharmaceutical Needs Assessment Steering Group
- Palliative Care and End Of Life Steering Group
- Patient Participation Network
- Extended Primary Integrated Care (EPiC) Citizens' Board
- Sussex Community NHS Trust Patient Experience Group
- Sussex Community NHS Trust Healthwatch and Patient Representative Group
- Brighton and Hove community mental health governance team for Sussex Partnership NHS Trust
- South East Coast Ambulance Service (SECAmb) Healthwatch Group

Our Chair also attends monthly meetings with the CEO of Brighton and Sussex University Hospitals NHS Trust (BSUH).

Hospital Complaints Peer Reviewers

We have 3 trained Hospital Complaints Peer Reviewers who help Brighton and Sussex University Hospital NHS Trust (BSUH) to review samples of complaints and BSUH's responses to the concerns raised, then give feedback to BSUH as a 'critical friend', suggesting how responses might be improved. They have helped the Trust by providing useful comments about the tone and approach of responses the Trust has made to complaints. These have been fed back to the individual complaints managers and to the wider team.

General Medical Council (GMC)

We organised a focus group on changes to the sanctions that GMC gives to doctors when they fail to meet professional standards. The event was attended by 23 members of the public and helped contribute to the new GMC sanctions guidance for doctors.

Dentistry

We received many calls through our helpline relating to NHS dentistry, firstly around finding an NHS dentist, and secondly issues around unnecessary referrals to private dental treatment. We made the NHS England Surrey and Sussex Area Team aware of both issues, and they informed us it was something they considered a priority. We also informed the public about their rights regarding NHS dentistry through our engagement and communications, and mapped NHS dentists who were accepting new patients, to find the majority of these were in central Brighton. Whilst access to dentistry was found to be a more locality specific issues, the issue of private referrals we found to be a national one. We contacted 'Which?' Magazine at the start of their national research on private dentistry referrals and shared our anonymised information to influence

their questions. We promoted the resulting survey, and are currently awaiting our localised results when the survey closes.

CAMHS

A range of sources including first person accounts from parents alerted us to potential issues in the Child and Adolescent Health Service. We wrote a report which took a journey through typical experiences of the service from joining it to moving on to adult services. This incorporated all recent community and voluntary group's research on this issue, as well as our own research. The report was timed with the recruitment of a new CAMHS commissioner to the Clinical Commissioning group, to ensure they had all the relevant information going in to post. We are planning to hold an event shortly which highlights to young people their rights and options when receiving mental healthcare.

The full report is available here:
http://www.healthwatchbrightonandhove.co.uk/sites/default/files/final_draft_with_responses_-_26.11.14_final.pdf

Hospital Discharge

We noticed through Royal Sussex County's PALS data and other sources that some people felt that they were being discharged from hospital too early, and with limited information about the next steps. We conducted some wide ranging research which included complaints data, a patient survey and an enter and view visit, to highlight the main issues from a patient's perspective. We also involved local community and voluntary sector partners to look in detail at the role of carers in the process, and the experiences of people with mental health issues in more detail. Since the report the hospital is preparing medications 24 hours in advance of discharge, and have reviewed and reprinted their discharge booklet. We also highlighted the lack of hot water in the discharge lounge, which is now being prioritized. We aim to use the information we have gathered on the discharge lounge to influence the future redesign of the space, and have been consulted by the CCG in new plans around the discharge process.

The full report is available here:
http://www.healthwatchbrightonandhove.co.uk/sites/default/files/final_report.pdf

Eaton Place Surgery Closure

We have been heavily involved in raising the concerns of patients. In September. we found out informally that the doctors were leaving and by October when it was announced that the surgery was closing, HWBH received two Helpline calls, but also had concerns raised from the community. HWBH has written a number of times to the Area Team, the Chair raised concerns with Councillors and the MPs (all parties), the CCG and was involved in public meetings. Most people spoken

to want a GP practice to remain in the area of Eaton Place and HWBH is supporting the patients in their views. The result of deliberations are awaited.

Visits to Services

Healthwatch has a legal right to enter and view health and social care premises funded by public money. This year we are running a programme of visits with a focus on social activities and occupation in Adult Social Care services, following on from evidence provided by our predecessor, Brighton and Hove LINk. To date we have visited:

- Somerset Day Centre: an older people's day centre http://www.healthwatchbrightonandhove.co.uk/sites/default/files/somerset_day_centre_healthwatch_report_final_.pdf
- Rottingdean Care Home: An older people's care home with nursing (report due in January)
- Preston Park Recovery Centre: A recover centre for people with mental health needs. (report Due in January)
- Active Aspirations Learning Disability Day Centre (Completed in January)

We plan to visit a further 2 services which have focuses on learning disabilities, dementia and older people. In addition to these, we have visited the Royal Sussex County Hospital Discharge Lounge, as referenced above. We are developing our methods with Enter and View and are currently collaborating with East Sussex Healthwatch.

Patient-Led Assessments of the Care Environment (PLACE) Visits

Our volunteers and staff have also participated in 3 patient-led assessments of the care environment (PLACE) visits. One visit was to the Eye hospital and volunteers identified serious problems ranging from faulty windows in all areas which meant damp and cold came in and rooms could not be used to uncomfortable chairs, poor flooring and decor and arrangements for patients. This was affecting the service for patients and staff who were working their best in a difficult environment. The Chief Executive was informed and took immediate action and a comprehensive funded plan of major works is in place and should be completed by the autumn. When volunteers did a follow up visit in December, some changes were already in place- new flooring, new blinds, new equipment. When we visit again at the end of the year, we expect the Eye Hospital environment to be revolutionised.

Using our data to improve services

- We provided the Care Quality Commission with key data and reports in advance of their inspections to Sussex Partnership Foundation Trust, The Sussex Community Trust, and The Brighton and Sussex University Hospital

Trust and GP practices. We also encourage members of the public to report their experiences directly to them and forward anonymised cases of interest.

- We work closely with our Local Clinical Commissioning group by sharing soft and quantitative intelligence on all services, and providing specific information for reviews and areas of interest.
- Sharing our data with Healthwatch England to help them to represent patients at a national level in their project work
- We provide data and research to all of our representatives, including all relevant local media in advance of meetings, to ensure patient's voices are being accurately represented and are influencing at a strategic level.

Improving Patient/User Information

- We helped make the Community Short Term Service leaflet more user friendly by providing feedback.
- We provided feedback on the 111 factsheet to help ensure the information is user friendly.
- We contacted NHS Choices to alert them to the difficulty in searching for data on hospitals, they subsequently changed the wording on the website to make it easier for the public to search for information.
- We listened to GP Out of Hours answerphone messages and gave individual feedback to make the messages clearer and more comprehensive for patients
- We made NHS England and our local CCG aware of the GP practices in our area which have yet to create a websit

Questions To Providers/Commissioners and Recommendations

	Total to date	Late/unanswered	Open
Clinical Commissioning Group	51	0	1
Hospital Trust	20	12	0
Community Trust	14	0	0
Mental Health Trust	6	0	0
Ambulance Trust	0	0	0
Brighton and Hove City Council	1	0	0
Social Care Services	14	1	9
OVERALL TOTALS	106	13	10

Working in Partnership

Working with Healthwatch England (HWE)
We gave feedback on the national escalation policy to ensure it is useful and accessible to all Healthwatch. We have attended the HWE national conference, webinars and participate in its social media group.

Working with local Healthwatch
We set up and organised a Sussex-wide meeting on mental health with the local mental health Trust and other Healthwatch to promote joint working and identify possible collaborative projects. We have recently started working with East Sussex Healthwatch on some forthcoming enter and view visits.

Care Quality Commission
We now meet with the area managers quarterly to share soft intelligence and maintain communication.

Community and Voluntary Sector
We have worked with a large cross section of the community and voluntary sector partners to gain specialist knowledge and increase the reach of our reports. This year we have worked with The Carer's Centre, Mind LIVE, Amaze, MASCot and The Lighthouse Recovery Support.

Engagement

Monthly Magazine

This is our main mechanism for informing residents about what Healthwatch is doing, providing opportunities to have a say about issues related to health and social care services in the city, and informing people about changes to health and social care services and policies. Every Magazine includes themes that have been identified as gaps through the Helpline and other intelligence work, such as guides for health and social care services during Christmas time or for NHS complaints services. The Magazine also suggests ways for people to improve their well-being and contains sections dedicated to children and young people, people from the Lesbian Gay Transgender and Bi-sexual community, carers, disabled people and older people. It currently has 1,445 readers although the distribution is much higher. Copies are shared by the City's main health and social care stakeholders and their clients and members of staff e.g. the Sussex Community NHS Trust (5,000 readers), some GP surgeries, Outpatients Department in Royal Sussex County Hospital (RSCH), Cardiac Outpatients in RSCH, various voluntary organisations and charities (such as Samaritans, Interact, Brighton and Hove Speak Out).

Community Groups and Events

Members of the public have been given the opportunity to have their say about health and social care services at a variety of groups, events and venues across the City. Healthwatch has directly reached approximately 2,980 members of the public.

We have had stalls, giving out information and capturing people's views at the following events:

- B.fest 2014 Launch Event
- BME Wellbeing Stakeholder Event
- Refugee week event
- Whitehawk Community Festival,
- Trans Pride weekend
- Brunswick Festival
- Hangleton Community Festival
- World Suicide Prevention Day
- BUPA Wellbeing event
- Community Works Summer and Autumn Conference
- Fresher's Fair at the Sussex University
- Health event in Moulsecoomb,
- Community Fair at the Sussex University
- "Best of Health", the event was free and aimed at all adults with a learning disability, family & paid carers, and anyone else interested in finding out more about ways for people with a learning disability to be healthy.
- "LifeLines – keep happy and healthy at 50+" Open Morning at Patching Lodge.
- Brighton and Hove Black History Month 2014, free fun family day for all ages.
- Jubilee Library and Hove Library.
- Diabetes Information Event
- Carers Summit, which was held on Carers Rights day 2014.
- Amaze Info Fair & AGM
- The Hangleton and Knoll 50+ October Event 2014

The Healthwatch Brighton and Hove website

www.healthwatchbrightonandhove.co.uk includes regular updates on changes to local and national policies, changes to health and social care services, consultations, and events. It has had 3,012 of visitors over the past year, 54.9% new visitors, 45.1% returning visitors.

Facebook

The Healthwatch Facebook account was primarily developed to engage with a younger audience, and is used to keep our Facebook 'Friends' up-to-date with Healthwatch activities, changes to local and national policies, changes to health and social care services, consultations and events. It also helps us to keep up-to-date with other organisations' health and social care related activities and engage with them. As of the end of December 2014 Healthwatch Brighton and Hove had 237 "Friends".

Twitter

The Twitter account was developed to link us with the key health and social care organisations, health professionals and younger audiences in Brighton and Hove. On this platform we share information about Healthwatch activities, changes to local and national policies, changes to health and social care services, consultations and events. As of the end of December 2014 Healthwatch Brighton and Hove had 826 Followers.

Media coverage:

20 of local newspapers/magazines/newsletters have mentioned Healthwatch Brighton and Hove.

Our Chair has been interviewed on the Latest TV station and Juice FM radio station.

We have issued 8 press releases:

- Press Release: Brighton and Hove people are not informed enough about out-of-hours services
- Healthwatch Brighton and Hove Annual Report 2013-2014
- Hospitals Trust rated "Requires Improvement" by the Care Quality Commission (CQC
- Healthwatch reports that it is so difficult to raise concerns about care that most people don't complain.
- Hospital discharge process leaves many people unprepared to return home
- Local CAMHS put young people in vulnerable position
- One year on from the urgent care report
- Somerset Day Centre - an example of best practice

Healthwatch Brighton and Hove Helpline

Healthwatch Brighton and Hove operates a Helpline Monday to Friday from 10am to 12 noon each day. Email: help@healthwatchbrightonandhove.co.uk

Tel: 01273 23 40 40

From April 2014 the Healthwatch Helpline dealt with enquiries from 220 individuals and 23 organisations (on behalf of clients). We provided people with information and signposting about local health and social care services. This included how to access them and what to do if things were going wrong. We mostly helped with queries related to local NHS services, including those provided by GPs/family doctors, dental surgeons, pharmacists and opticians. If people wished to make a complaint about an NHS or social care service we put them in touch with advocacy services. We developed a very close working relationship with Impetus, which provides the statutory Independent Complaints Advocacy Service.

Most of the enquiries we dealt with about primary health care were related to GP/dental surgeries – there were not as many about pharmacies and opticians. In most cases these involved liaising with the Practice Manager (with the patient's consent) to achieve a mutually satisfactory outcome. Sometimes people didn't know that they could speak with the Practice Manager themselves, lacked the confidence to do so, or may have had a disagreement with the practice in the past and felt unable to handle the conversation themselves. Our liaison sometimes resulted in patients receiving specific types of treatment/referrals that they felt they should be having and were not.
With dental practices we often had to clarify patients' entitlement to the various types of treatment covered by the NHS and costs for such courses of treatment.

We had several enquiries regarding patients being referred to private treatment unnecessarily. Many of the people we spoke with preferred to try to resolve issues amicably with their GP/dentist rather than have to change practice, although we pointed out that this was possible - the main reason for their wishing to stay with their current GP/dentist was that they had been there for years (sometimes decades) and felt that their regular practitioner knew them and their medical/dental history well. In some cases however we had to find out about a practice's complaints procedure and relay this to the patient, also ensure that they were aware of the NHS escalation process and possible advocacy support from ICAS.

Enquiries that were not primary care related were referred to the appropriate NHS Trust's Patient Advice and Liaison Service. Even if we passed issues on, we still recorded them on our database and maintained 'ownership' until we had

confirmation of action taken. Many of these related to length of time taken for referral appointments with consultants, and the PALS teams were often able to have these accelerated with departments. The occasional out of area enquiry we received was passed on to the appropriate Healthwatch (usually East or West Sussex), but also recorded on our system.

The amount of help given to individuals varied depending on the needs they disclosed. Some people could be given a phone number/e-mail address/website to contact the service provider/PALS team themselves, while others needed us to do more liaison on their behalf and report back to them. Depending on the person's physical or mental health needs, we also offered information about possible local or national support groups and referred people to these, e.g. Mind in Brighton and Hove and Age UK. This is something that adds value to the Helpline and which may not have happened as much with the previous Primary Care Trust PALS service – our project management of the Information Prescriptions website also complements this side of our service. To help improve services, anonymised data from the Helpline was fed back to the organisations responsible for the planning, commissioning and delivering of local health and social care services.

There is a steady flow of people with a diagnosis of mental illness (current or in the past), anxiety etc. contacting the helpline, either for support around their own issues, or e.g. parents/carers with mental health issues on behalf of family members with other problems. Many of these people have other complex physical needs as well. This can result in very lengthy and difficult phone conversations/e-mail correspondence which also involve a degree of emotional support for the enquirer and subsequent in-depth liaison with service providers/commissioners, e.g. with Sussex Partnership Foundation NHS Trust PALS team about specific clients where appropriate (and only with their consent).

Most people who contact us are patients of various health services across the city, however we also receive (and welcome) enquiries from concerned relatives/carers as well as professionals who may be working with people with health or social care issues. Some of the individuals we now assist have contacted our helpline previously, and we are pleased to say that they feel they can call upon us to help with follow-on or completely new issues that arise for them.

We also liaised with many different service providers and commissioners, e.g. NHS England and Brighton & Hove CCG (Clinical Commissioning Group), on behalf of patients/relatives to assist with their issues. To help us to develop our helpline skills and service further, the whole Healthwatch Brighton and Hove team attended a very successful and inspiring Helpline Development Day in August 2014. Other helpline staff and volunteer training has covered suicide alertness, mental health awareness, safeguarding and child protection, dealing with first disclosures of sexual abuse/violence, and NHS complaints advocacy,

also briefings from Age UK and Amaze. One of the Healthwatch managers and the Helpline and Information Co-ordinator also spoke to a groups of Sussex Interpreting Services (SIS) advocates about Healthwatch, Better Care and our helpline service. Our first helpline volunteer is now coming in once a week, and we are also in the process of training another three new people. They are studying Social Sciences at the University of Brighton and have chosen to complete their volunteer placements with Healthwatch Brighton and Hove between now and April 2015.

Future Activities

- Staff recruitment of a CEO for Healthwatch
- Inviting community organisations and individuals to become members of the Community Interest Company;
- Recruitment of additional Governing Body members;
- Transfer of staff from Community Works (former CVSF) to Healthwatch Brighton and Hove; taking over full management of the budget; and developing an income generation plan to assist the sustainability of Healthwatch Brighton and Hove
- Working with Community Spokes, voluntary organisations in order to improve our partnership activities and information base.
- Increasing the helpline hours and extend our activities in providing information to the public and patients.
- Increasing our activity on Enter and View visits and observation visits.
- Increasing our partnership activities with organisations with similar interests in order to optimise the impact we can make on service improvement
- Extending and enhancing the profile and reach of HWBH
- Continue to develop relationships with key stakeholders in the statutory sector in order to influence strategy and service delivery from the patient's and public's perspective.
- Improve HWBH's impact on the Health and Wellbeing Board and the Health and Wellbeing Overview and Scrutiny Committee (HOSC).

Key Figures April 2014- January 2015

Performance Measures (approx.)	HWBH
Number of Magazine subscribers	1445 (pls see also p.15 as distribution is wider)
Number of active volunteers (exc. Board members)	30
Number of Board members	8
Number of Requests for Information made	70
Number of Enter & View Visits undertaken	5
Number of Reports produced	7
Number of Recommendations made	36
Number of meetings attended	147
Number of helpline enquiries	266
Number of community events attended	45

Contact Healthwatch Brighton and Hove

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Facebook: www.facebook.com/healthwatchbrightonandhove

Helpline

Helpline telephone: 01273 234040 (10am-12pm, Monday to Friday)
Helpline email: help@healthwatchbrightonandhove.co.uk

Healthwatch Brighton and Hove CIC is a registered Community Interest Company. Company No. 9263937