Brighton & Hove City Council

Health & Wellbeing Overview & Scrutiny Committee

Title:	**Health & Wellbeing Overview & Scrutiny Committee**
Date:	**26 November 2014**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Rufus (Chair)C Theobald (Deputy Chair), Bennett, Bowden, Cox, Marsh, Meadows, Sykes **Co-optees:** Jack Hazelgrove (OPC), Youth Council and Healthwatch
Contact:	**Kath Vlcek** 01273 290450 kath.vlcek@brighton-hove.gov.uk

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AGENDA

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To consider

(a) Declaration of Substitutes

(b) Declaration of Interest

(c) Declaration of Party Whip, and

(d) Exclusion of Press and Public

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

18 Chair's Communications

19 Care Quality Commission inspection of BSUH sites **11 - 44**

The Chief Executive of Brighton and Sussex University Hospitals Trust (BSUH) and senior officers will update members on the findings from the Care Quality Commission inspection of the Trust. Two inspectors from the Care Quality Commission will tell members how the inspection takes place and what is assessed. Handouts from the presentation will be available at the committee meeting.

Contact Officer: *Kath Vlcek, Scrutiny Support Officer* *Tel: 01273 290450*

Ward Affected: *All Wards*

20 Update on PLACE assessments of BSUH **45 - 54**

Report from BSUH on their recent Patient-Led Assessments of the Care Environment (PLACE) surveys.

Contact Officer: *Kath Vlcek, Scrutiny Support Officer* *Tel: 01273 290450*

Ward Affected: *All Wards*

21 Update on 3T Redevelopment Scheme **To Follow**

Presentation from BSUH on the update with the 3T hospital redevelopment programme – handouts will be available at the committee.

Contact Officer: *Kath Vlcek, Scrutiny* *Tel: 01273 290450*

	Support Officer	
Ward Affected:	*All Wards*	

22 Stroke Services in Brighton and Hove **55 - 64**

Report from BSUH about proposed changes to Sussex-wide stroke services.

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

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Meeting papers can be provided, on request, in large print, in Braille, on audio tape or on disc, or translated into any other language as requested.

For further details and general enquiries about this meeting email scrutiny@brighton-hove.gov.uk

Date of Publication 18 November 2014

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 10 SEPTEMBER 2014

BANQUETING SUITE, HOVE TOWN HALL

MINUTES

Present: Councillor Rufus (Chair)

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

Other Members present: Healthwatch and Youth Council co-optees

PART ONE

9 PROCEDURAL BUSINESS

A Declaration of Substitutes

Councillor Gill Mitchell was substituting for Councillor Anne Meadows.

B Declarations of Interest

Councillor Gill Mitchell works for the Acute Trust.

Robert Brown, co-optee, is Chair of Trustees for Trust for Developing Communities.

C Declaration of Party Whip

None

D Exclusion of Press and Public

As per the agenda

10 MINUTES OF PREVIOUS MEETING

10.1 There was an outstanding item at 5.6; Ms Hoban from the CCG said that she would follow it up and send it to the Youth Council.

The minutes were agreed.

11 CHAIR'S COMMUNICATIONS

11.1 The Chair of HWOSC said that the Care Quality Commission has reported back on its inspection of BSUH. HWOSC attended and contributed at the Quality Summit discussing the findings. The Trust has been rated as overall 'requires improvement' with a 'good' rating at the locations for Hove Polyclinic and the renal satellite unit in Bexhill. HWOSC will have a full report and discussion at the November meeting but in the meantime, the report had been emailed to members. The Trust has been rated as overall 'requires improvement' with a 'good' rating at the locations for Hove Polyclinic and the renal satellite unit in Bexhill.

11.2 The Ambulance Service has asked all local HOSCs for feedback on reconfiguring their call handling services. The proposals do not need statutory consultation but the service is keen to engage with everyone and is seeking responses about what would be exemplary engagement. The letter will be circulated to members and asking for feedback.

11.3 The CCG is holding two events, to meet CCG leaders and update on work. The first is on 18 September 2-3.30, the second 2nd October 6-7.30. Please try and attend if you can.

11.4 Apologies had been received from Jack Hazelgrove, on behalf of the Older People's Council.

12 HEALTH & WELLBEING BOARD RESTRUCTURE

12.1 HWOSC members received a verbal update from Geraldine Hoban from the CCG and Pinaki Ghoshal, Executive Director of Children's Services, Brighton & Hove City Council, updating HWOSC members on the restructure of the Health and Wellbeing Board (HWB). It has recently been reviewed and revised after its first year.

The HWB is now much more strategic, overseeing health priorities across the city. The CCG and the Council are now both equitable in the number of Board members that they have. There are also changes in the members on the Board, including the Chair of the Local Safeguarding Children's Board.

12.2 There has been a change in the HWB support mechanisms including a new larger stakeholder group; this is still to be set up but will include a variety of stakeholders across the city who are not currently represented on the Board. There is also a Chief Executive group which brings the highest level people from organisations on the HWB to discuss the issues in detail.

12.3 Ms Hoban said that the newly constituted HWB has now met twice and feels different; the intention is to make it more of a force for changing service delivery. It aims to be a leader for the city, bringing together partners who are able to provide high level city wide endorsement and commissioning. The HWB has an equivalent status to the existing P&R committee, and is chaired by the Chief Executive of the Council.

Mr Ghoshal added that this restructure is a much closer bringing together of health and local authority partners, making it a mechanism for real decision making. It needs to embrace the wider wellbeing agenda. The new arrangement covers a large amount of the work that was previously covered by the Adult Social Care Committee, and the wellbeing functions of the Children's committee. The remaining Children's Committee work now covers education and early years work.

12.4 There is a clear link between the HWB and HWOSC; the roles are to complement each other rather than duplicate work. There is more cross- development work to be carried out in the future

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12.5 Members asked questions about the HWB:

Q – Are the priorities still the same now that the board has restructured?

Ms Hoban said that the priorities had come from the HWB strategy which had not changed, so the priorities remained the same.

Q – Members commented that they were pleased that it was a partnership; a recent LGA peer review said that the council could work more closely in partnership so hopefully this is a step in the right direction.

Mr Ghoshal said that in his year at the council, he had seen some very strong partnerships and we needed to maximise on this. The council was lucky that it was co-terminus with the CCG as this helped strengthen the partnerships; this was not always the case.

Q- Members asked what actual powers the HWB had; it had involvement in some key areas including the Better Care Fund, the CQC inspection of BSUH and also looking at cancer screening rates in the city.

Ms Hoban said that the HWB was not just a formality; it had the power to send back commissioning plans if they were not considered robust enough. This had happened in the past.

Ms Hoban also commented that the HWB had to be careful not to take over the scrutiny role, this was HWOSC's place and there was no need to duplicate roles. HWB needed to have oversight of things rather than close inspection at all stages.

The Chair of HWOSC said that it was impossible to prescribe the various HWB and HWOSC roles for all situations, it needed to be an ongoing conversation.

12.6 There was also a lengthy discussion across the committee about whether any number of committees or boards could help to avoid a situation similar to the child exploitation that had been uncovered in Rotherham. Mr Ghoshal said that there were a number of mechanisms in place to help assure against such a situation developing- HWOSC and HWB are part of this. It is really important to have an open dialogue and challenge to other partners. Unfortunately child exploitation happens everywhere; the challenge is to seek it out and address it.

The Chair of HWOSC said that this was an important discussion to be had but he didn't want to detract from the wider discussion about the HWB. This was agreed.

12.7 Finally, the Chair commented that the minutes from the previous HWB meetings would be circulated to HWOSC members.

13 CHILDREN'S COMMISSIONING CHANGES

13.1 Pinaki Ghoshal, Executive Director of Children's Services, Brighton & Hove City Council and Geraldine Hoban from the CCG presented the report on the changes in commissioning children's services and answered members' questions.

13.2 The paper had been to the HWB in July and was coming to HWOSC for information. The existing commissioning arrangements had been developed at a time when the health system looked very different. Following a number of changes in health, it was considered an appropriate time for the arrangements to be reviewed.

The demise of the Children's Trust meant that directors had taken their attention away from children and young people to a certain extent. There was a need to strengthen leadership and joint commissioning of services and strengthen governance arrangements. There is now a clinical lead for Children and Young People.

13.3 Members commented and asked questions about the new arrangements.

Q- Members said that historically there had been a 'cliff edge' when young people came to 18, and transitioned from children's to adult services. HWOSC members hoped that the new arrangements will help to smooth the transition process.

Q - The Healthwatch representative questioned section 5 on page 16, how could communities expect to be consulted if consultation was not considered necessary?

Mr Ghoshal said that the paragraph in question related specifically to the decision to start the review; there has been significant consultation with a wide range of stakeholders.

Q - The Youth council representative asked where the gaps were, referred to in 3.7.

Mr Ghoshal said that across the system, a large amount of money was spent on young people with SEN and disabilities. Parents and carers constantly report having to repeat information again and again; there must be a more integrated system.

Ms Hoban said that there was also a gap in terms of mental health provision; Brighton & Hove is an outlier with regard to self-harm levels.

13.4 Agreed – that an update will come back to HWOSC after at least 6 months.

14 DEMENTIA CARE UPDATE

14.1 Simone Lane and Deirdre Prower from the CCG presented the report and answered members' questions. This report is a twelve month progress update; a lot of progress has been made in a number of areas including the Memory Assessment Clinics, and the new Emerald Unit at the hospital specifically for people with dementia.

This is currently based in the Barry building, but they are mindful of needing to move the ward due to the 3Ts proposal and have designed it to be as mobile as possible. For example, artwork is on movable screens. The Unit is designed to be as familiar as possible; it plays 1950s type music and has similarly dated decoration.

Ms Lane said that the JSNA had 37 recommendations, with more work coming from consultation events so there was still a lot more to be done.

The Trust for Developing Communities (TDC) has been involved in producing a guide as to how to make services dementia friendly. Mr Brown, Healthwatch representative, spoke in his role as Chair of Trustees for the TDC. He invited HWOSC members to attend the launch event; details would be circulated separately.

Denise D'Souza clarified one point – the care home in reach team works with all care homes. They take self-funded or local authority residents.

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14.2 HWOSC members welcomed the progress that had been made; the changes are going to make a huge difference to many lives.

Q – Who are the dementia champions? Ms Prowse said that they did not have to be GPs, it is not a medical role, it's a support role. They may come from the Alzheimer's Society or similar setting.

Councillor Cox said that he had become a dementia friend following a training event. He found the event invaluable and recommended that everyone take part. It was agreed that enquiries would be made on behalf of the whole HWOSC.

Q – where will patients who cannot fit into the Emerald Unit be housed?

Ms Prowse said that the JSNA highlights housing as an issue, some people will be housed in sheltered care or better care. The Better Care pilot will focus on dementia, joining social and medical care.

Q – How do we look after carers? They shoulder a lot of the burden.

Ms Prowse said that there are several aspects of carer support in place. When someone attends the Memory Assessment Clinic, their carer is given a year's support. However work needs to be done to continue the work after that year until the end of the illness. Their considerations will include respite care.

The Healthwatch representative commented that sometimes a carer would have a different GP from the person they care for and the GP might not know that they have a

carer's role. It would be useful for as much communication as possible to go between the various parties in these instances.

14.3 The HWOSC Chair concluded by saying that he wanted to add his voice to those welcoming the report and the progress made. It was very encouraging to see the steps that had been made.

15 MENTAL HEALTH SERVICES - UPDATE ON MODEL OF CARE

15.1 John Child, Service Director at Sussex Partnership Foundation Trust, presented the report updating members on mental health services in the city, the current provisions and proposals to reinvest money back into services.

He summarised the position since the ward had been permanently closed; 45 patients had been placed out of area since then, as well as some people being placed in the Priory or elsewhere in Sussex. The demand is mainly for male beds; the Priory also has other demands on its bed capacity. Length of stay out of area could range between a day to two weeks.

At section 3.8 of the report, four recommendations for reinvestment had been outlined. Mr Child hoped that HWOSC would support the proposals.

15.2 HWOSC members commented on the report and raised questions.

Q –the proposals were all welcomed and it was hoped that they would reduce A&E attendance.

Mr Child commented that one of the consequences of increased mental health services at A&E is an increase in people presenting with mental health problems. The clinicians have to deal with them more quickly.

He clarified that the number of people not known to mental health services when they presented is far higher in Brighton and Hove than in any other Sussex unit. This may be to do with a combination of the transient population, drug and alcohol issues and homelessness amongst other things.

Q – members queried the psychology service specifically for people with psychosis.

Mr Child said that there was a lot of psychological provision for other mental health services,. There has been a national drive to support people with lower level mental health issues eg anxiety and depression ; this has had a knock on effect of reducing support for people with psychosis.

15.3 The Chair of HWOSC concluded that HWOSC members supported the proposals; they were starting to drill down to the additional support needed. He asked for updates to come back to HWOSC as appropriate.

The meeting concluded at 6.00pm

Signed Chair

Dated this day of

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 19 Brighton & Hove City Council

Subject:		**Care Quality Commission inspection of BSUH sites**		
Date of Meeting:		**26 November 2014**		
Report of:		**Assistant Chief Executive**		
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel:**	**29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**		
Ward(s) affected:		**All**		

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The Care Quality Commission carried out a thorough inspection of services provided by Brighton and Hove University Hospitals Trust in May 2014 and published their findings report in August 2014. The report details areas for improvement as well as areas of good practice. This report covers the report findings, key actions to be taken by BSUH and governance arrangements.

1.2 The Care Quality Commission presentation is also attached to this report, which outlines their inspection process and assessments.

2. RECOMMENDATIONS:

2.1 That HWOSC members consider and comment on the CQC inspection findings.

2.2 That members consider and comment on BSUH's action plan and monitoring arrangements.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The Care Quality Commission (CQC) conducted an announced inspection of the Trust on 21-23 May 2014. 35 inspectors visited four of the Trust's eight registered hospital sites and conducted further unannounced spot checks in late May. Information on the characteristics of each CQC rating level can be found at **Appendix One.**

3.2 The final reports were published on 8 August 2014. They can be accessed through . http://www.bsuh.nhs.uk/about-us/performance-and-data/cqc-reports-and-statement-of-purpose/care-quality-commission-cqc-inspection-august-2014

BSUH's action plan was reviewed internally and with external partners prior to being submitted to the CQC on 15 September 2014. The action plan focussed on the actions the Trust must take to improve quality and safety, linked to Compliance Actions (Regulations). The Trust Board paper includes the action plan and can be accessed through: http://www.bsuh.nhs.uk/about-us/the-trust-board/trust-board-meeting-papers/september-2014-board-meeting-papers/?assetdet8792229=524557

3.3 The new programme of inspections included the introduction of ratings for healthcare organisations to support the process of regulation. Ratings are at service level, hospital level, domain level (relating to five key questions) and Trust level. This is on a 4-point scale:

Outstanding	Good	Requires Improvement	Inadequate

The five key questions focussed on the quality and safety of care, based on the things that matter to people: Is it safe? Is it effective? Is it caring? Is it responsive to people's needs? Is it well led?

3.4 The CQC inspects and rates the following 8 clinical areas and pathways identified as priorities for all Trusts by the Chief Inspector of Hospitals: Medical care (including older people's care); outpatients; services for children and young people/Paediatrics; maternity; surgery; Critical Care/ Intensive Care; A&E; and End of Life care.

Each service was given a rating of outstanding, good, requires improvement or inadequate in relation to each of the five questions above. For the sites the CQC visited during the inspection, there were overall 90 ratings: 64 Good; 25 Requires Improvement and 1 Inadequate.

3.5 The Trust received an overall rating of 'requires improvement'. RSCH and PRH sites were given a 'requires improvement' rating, Bexhill Renal satellite Unit and Hove Polyclinic and Community Services for children, young people and their families were given 'good' ratings.

The Trust received overall ratings for the whole Trust in relation to the five questions:

Are the services at this trust safe?	Requires improvement
Are the services at this trust effective?	Good
Are the services at this trust caring?	Good
Are the services at this trust responsive?	Requires improvement
Are the services at this trust well-led?	Requires improvement

3.6 Outstanding areas noted were:

- *The Trust was exceptionally open and engaged with the inspection*
- *Awareness of staff of the work on values and behaviours was almost universal.*
- *Care for patients with dementia was good in both Royal Sussex and Princess Royal Hospitals, where staff had been innovative and creative in order to provide a safe and stimulating environment for people.*
- *The critical care teams at the Royal Sussex and Princess Royal Hospitals were strong, committed and compassionate.*

- *The feedback from patients was overwhelmingly positive*.

3.7 There were eight compliance actions which focused around areas which had been identified by the Trust prior to the CQC visit. These included patient flow; the central booking 'hub'; staffing; learning lessons and feedback to staff on incidents; cultural issues; and the hospital environment.

3.8 Key actions to address the challenges fell into a number of categories:

Unscheduled care, flow and Emergency Department (ED) performance - These include:

- creation of a surgical assessment unit
- focus on earlier and greater numbers of discharges each day
- creation of additional/flexible capacity including for 72 hours stay
- 'cohorting' policy and full capacity protocol ['cohorting' refers to the trust's procedures for managing patients who arrive by ambulance at very busy times]
- continued work within ED and with downstream wards [wards to which patients presenting at A&E may be admitted] on all pathway issues and flow

Central booking 'hub' [this is the trust's new booking system for outpatient appointments. Although the new model works very successfully in other trusts, there have been some issues with its introduction into BSUH] **-** A plan is in place to improve performance which includes:

- Hub and spoke model in high volume specialties to provide local support and access for clinicians
- Patient Access Managers based in the hub
- Flexing of staff to answer the phones to ensure times with busiest call volumes are adequately covered
- Continuation of dedicated email address for raising concerns (checked daily and responded to within 24 hours)
- Work with primary care on referral patterns

Cultural issues - The "Foundations for Success" programme within the Trust is engaging the workforce to address long-standing issues. The programme includes:

- establishing a Values and Behaviours plan including workstreams on race equality and empowerment, accountability and performance management which have now been developed
- a new clinical structure
- Appointment of new Director of Strategy and Change
- Focus on increased communication, engagement, training and appraisal

Staffing – A number of actions are being implemented to support the staff including:

- a £3 million investment in nursing including increased nurse to patient ratios and supernumerary Ward Sisters/Charge Nurses
- Improvements to efficiency of recruitment processes and prioritisation of nursing recruitment in line with the new recruitment strategy
- Clinical restructure includes a lead nurse in each new clinical directorate with overall responsibility for nurse staffing issues

Environment, Cleaning and Food - The actions related to the environment longer term will be addressed by the 3Ts redevelopment of Royal Sussex County Hospital. Ahead of this there is a capital investment programme to maintain existing estate/facilities to the highest possible standards and improve where necessary. There has also been the creation of Lead Nurse as link between ward areas and Sodexo [Sodexo is the contractor responsible for RSCH cleaning and catering] to receive and action issues raised and proactively identify and drive improvement.

3.9 The success of actions relating to the above will be regularly reviewed by BSUH in internal meetings, in partnership meetings with the CCG and NHS England Area Team, and will be overseen by the CQC and the Trust Development Authority

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

None for this cover report. Financial implications for the action plan will be considered separately by the Trust.

Legal Implications:

None for this cover report. Legal implications for the action plan will be considered separately by the Trust.

Equalities Implications:

None for this cover report. Equality implications for the action plan will be considered separately by the Trust.

SUPPORTING DOCUMENTATION

Appendices:

1. Care Quality Commission characteristics of each rating

2. Report from BSUH.

Characteristics of each rating level

We have developed characteristics to describe what outstanding, good, requires improvement and inadequate care looks like in relation to each of the five key questions. These are set out below.

These characteristics provide a framework, which, when applied using professional judgement, guide our inspection teams when they award a rating. They are not to be used as a checklist or an exhaustive list. The inspection team use their professional judgment, taking into account best practice and recognised guidelines.

Not every characteristic has to be present for the corresponding rating to be given. This is particularly true at the extremes. For example, if the impact on the quality of care or on people's experience is significant, then displaying just one element of the characteristics of inadequate could lead to a rating of inadequate. Even those rated as outstanding are likely to have areas where they could improve. In the same way, a service or provider does not need to display every one of the characteristics of 'good' in order to be rated as good.

Safe

People are protected from abuse* and avoidable harm.

* Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Outstanding 

People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.

There is a genuinely open culture in which all safety concerns raised by staff and people who use service are highly valued as integral to learning and improvement.

All staff are open and transparent, fully committed to reporting incidents and near misses. The level and quality of incident reporting shows the levels of harm and near misses, which ensures a robust picture of quality. There is ongoing, consistent progress towards safety goals reflected in a zero-harm culture.

Learning is based on a thorough analysis and investigation of things that go wrong. All staff are encouraged to participate in learning to improve safety as much as possible, including participating in local, national and, where relevant, international safety programmes.

There is a comprehensive 'safety management system', which takes account of current best practice models. The whole team is engaged in reviewing and improving safety and safeguarding systems. Innovation is encouraged to achieve sustained improvements in safety and continual reductions in harm.

A proactive approach to anticipating and managing risks to people who use services is embedded and is recognised as being the responsibility of all staff. People who use services and those close to them are actively involved in managing their own risks.

Other external organisations are actively engaged in assessing and managing anticipated future risks.

Good 

People are protected from avoidable harm and abuse.

When something goes wrong, people receive a sincere and timely apology and are told about any actions taken to improve processes to prevent the same happening again.

Openness and transparency about safety is encouraged. Staff understand and fulfil their responsibilities to raise concerns and report incidents and near misses; they are fully supported when they do so. Monitoring and reviewing activity enables staff to understand risks and gives a clear, accurate and current picture of safety.

Performance shows a good track record and steady improvements in safety. When something goes wrong, there is an appropriate thorough review or investigation that involves all relevant staff and people who use services. Lessons are learned and communicated widely to support improvement in other areas as well as services that are directly affected. Opportunities to learn from external safety events are also identified. Improvements to safety are made and the resulting changes are monitored.

There are clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. These:

- Are reliable and minimise the potential for error
- Reflect national, professional guidance and legislation
- Are appropriate for the care setting
- Are understood by all staff and implemented consistently
- Are reviewed regularly and improved when needed.

Staff have received up-to-date training in all safety systems.

Safeguarding vulnerable adults, children and young people is given sufficient priority. Staff take a proactive approach to safeguarding and focus on early identification. They take steps to prevent abuse from occurring, respond appropriately to any signs or allegations of abuse and work effectively with others to implement protection plans. There is active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations.

Staffing levels and skill mix are planned, implemented and reviewed to keep people safe at all times. Any staff shortages are responded to quickly and adequately. There are effective handovers and shift changes, to ensure staff can manage risks to people who use services.

Risks to people who use services are assessed, monitored and managed on a day-to-day basis. These include signs of deteriorating health, medical emergencies or behaviour that challenges. People are involved in managing risks and risk assessments are person-centred, proportionate and reviewed regularly.

Staff recognise and respond appropriately to changes in risks to people who use services.

Risks to safety from service developments, anticipated changes in demand and disruption are assessed, planned for and managed effectively. Plans are in place to respond to emergencies and major situations. All relevant parties understand their role and the plans are tested and reviewed.

Requires improvement 

There is an increased risk that people are harmed or there is limited assurance about safety.

People do not always receive a timely apology when something goes wrong and are not consistently told about any actions taken to improve processes to prevent the same happening again.

Information about safety is not always comprehensive or timely. Safety concerns are not consistently identified or addressed quickly enough.

There is limited use of systems to record and report safety concerns, incidents and near misses. Some staff are not clear how to do this or are wary about raising concerns.

When things go wrong, reviews and investigations are not always sufficiently thorough or do not include all relevant people. Necessary improvements are not always made when things go wrong.

Systems, processes and standard operating procedures are not always reliable or appropriate to keep people safe. Monitoring whether safety systems are implemented is not robust. There are some concerns about the consistency of understanding and the number of staff who are aware of them.

Safeguarding is not given sufficient priority at all times. Systems are not fully

embedded, staff do not always respond quickly enough or there are gaps in the system of engaging with local safeguarding processes.

There are periods of understaffing or inappropriate skill mix, which are not addressed quickly. The way that agency, bank and locum staff are used does not ensure that people's safety is always protected.

The approach to assessing and managing day-to-day risks to people who use services is sometimes focused on clinical risks and does not take a holistic view of people's needs.

The risks associated with anticipated events and emergency situations are not fully recognised, assessed or managed.

Inadequate 

People are unsafe or at high risk of avoidable harm or abuse.

When something goes wrong, people are not always told and do not receive an apology. Staff are defensive and are not compassionate.

Safety is not a sufficient priority. There is limited measurement and monitoring of safety performance. There are unacceptable levels of serious incidents or never events.

Staff do not recognise concerns, incidents or near misses. Staff are afraid of, or discouraged from, raising concerns and there is a culture of blame. When concerns are raised or things go wrong, the approach to reviewing and investigating causes is insufficient or too slow. There is little evidence of learning from events or action taken to improve safety.

Safety systems, processes and standard operating procedures are not fit for purpose. There is wilful or routine disregard of standard operating or safety procedures.

Care premises, equipment and facilities are unsafe.

There is insufficient attention to safeguarding children and adults. Staff do not recognise or respond appropriately to abuse.

Substantial or frequent staff shortages or poor management of agency or locum staff increases risks to people who use services.

Staff do not assess, monitor or manage risks to people who use the services. Opportunities to prevent or minimise harm are missed.

Changes are made to services without due regard for the impact on people's safety. There are inadequate plans in place to assess and manage risks associated with anticipated future events or emergency situations.

Effective

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Outstanding 

Outcomes for people who use services are consistently better than expected when compared with other similar services.

There is a truly holistic approach to assessing, planning and delivering care and treatment to people who use services. The safe use of innovative and pioneering approaches to care and how it is delivered are actively encouraged. New evidence-based techniques and technologies are used to support the delivery of high quality care.

All staff are actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review, accreditation and research are proactively pursued. High performance is recognised by credible external bodies.

The continuing development of staff skills, competence and knowledge is recognised as being integral to ensuring high quality care. Staff are proactively supported to acquire new skills and share best practice.

Staff, teams and services are committed to working collaboratively and have found innovative and efficient ways to deliver more joined-up care to people who use services.

There is a holistic approach to planning people's discharge, transfer or transition to other services, which is done at the earliest possible stage. Arrangements fully reflect individual circumstances and preferences.

The systems to manage and share the information that is needed to deliver effective care are fully integrated and provide up to the minute information across teams and services.

Consent practices and records are actively monitored and reviewed to improve how people are involved in making decisions about their care and treatment. Engagement with stakeholders, including people who use services and those close to them, informs the development of tools and support to aid informed consent.

Good

People have good outcomes because they receive effective care and treatment that meets their needs.

People's care and treatment is planned and delivered in line with current

evidence-based guidance, standards, best practice and legislation. This is monitored to ensure consistency of practice.

People have comprehensive assessments of their needs, which include consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. The expected outcomes are identified and care and treatment is regularly reviewed and updated.

Where people are subject to the Mental Health Act (MHA), their rights are protected and staff have regard to the MHA Code of Practice.

Information about people's care and treatment, and their outcomes, is routinely collected and monitored. This information is used to improve care. Outcomes for people who use services are positive, consistent and meet expectations.

There is participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services, benchmarking, peer review and service accreditation. Accurate and up-to-date information about effectiveness is shared internally and externally and is understood by staff. It is used to improve care and treatment and people's outcomes.

Staff are qualified and have the skills they need to carry out their roles effectively and in line with best practice. The learning needs of staff are identified and training is put in place to meet these learning needs. Staff are supported to maintain and further develop their professional skills and experience.

Staff are supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal. Relevant staff are supported through the process of revalidation. There is a clear and appropriate approach for supporting and managing staff when their performance is poor or variable.

When people receive care from a range of different staff, teams or services, this is coordinated. All relevant staff, teams and services are involved in assessing, planning and delivering people's care and treatment. Staff work collaboratively to understand and meet the range and complexity of people's needs.

When people are due to move between services their needs are assessed early, with the involvement of all necessary staff, teams and services. People's discharge or transition plans take account of their individual needs, circumstances, ongoing care arrangements and expected outcomes. People are discharged at an appropriate time and when all necessary care arrangements are in place.

Staff can access the information they need to assess, plan and deliver care to

people in a timely way; particularly when people move between services or during transition. When there are different systems to hold or manage care records, these are coordinated. People understand, and have a copy, if possible, of the information that is shared about them.

Consent to care and treatment is obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004. People are supported to make decisions and, where appropriate, their mental capacity is assessed and recorded. When people aged 16 and over lack the mental capacity to make a decision, 'best interests' decisions are made in accordance with legislation. The process for seeking consent is appropriately monitored. The use of restraint is understood and monitored, and less restrictive options are used where possible.

Deprivation of liberty is recognised and only occurs when it is in a person's best interests, is a proportionate response to the risk and seriousness of harm to the person, and there is no less restrictive option that can be used to ensure the person gets the necessary care and treatment .The Deprivation of Liberty Safeguards, and orders by the Court of Protection authorising deprivation of a person's liberty, are used appropriately.

Requires improvement

People are at risk of not receiving effective care or treatment.

Care and treatment does not always reflect current evidence-based guidance, standards and best practice. Implementation of evidence-based guidance is variable. Care assessments do not consider the full range of people's needs.

Outcomes for people who use services are below expectations compared with similar services. The outcomes of people's care and treatment is not always monitored regularly or robustly. Participation in external audits and benchmarking is limited. The results of monitoring are not always used effectively to improve quality.

Not all staff have the right qualifications, skills, knowledge and experience to do their job. The learning needs of staff are not fully understood. Staff are not always supported to participate in training and development or the opportunities that are offered do not fully meet their needs.

There are gaps in management and support arrangements for staff, such as

appraisal, supervision and professional development.

Multi-disciplinary teams do not include all necessary staff, are not coordinated or do not meet frequently enough to provide effective care. Discharge and transition planning is undertaken but is not timely or does not consider all of the person's needs. There may be delays or poor coordination when people are referred or discharged or when they transition to other services. There are delays in sharing information about people's care when they are discharged, this information has some gaps or staff are not clear what information should be shared.

Staff do not always have the complete information they need before providing care and treatment. Systems to manage and share care records and information are cumbersome or uncoordinated.

Consent is not always obtained or recorded in line with relevant guidance and legislation. There is a lack of consistency in how people's mental capacity is assessed and not all decision-making is informed or in line with guidance and legislation. Decision-makers do not always make decisions in the best interests of people who lack the mental capacity to make decisions for themselves, in accordance with legislation. Restraint and deprivation of liberty are not always recognised, or less restrictive options used where possible. Applications to authorise a deprivation of liberty are not always made appropriately or in a timely manner to the Court of Protection or by using the Deprivation of Liberty Safeguards.

Inadequate 

People receive ineffective care or there is insufficient assurance in place to demonstrate otherwise.

People's care and treatment does not reflect current evidence-based guidance, standards and practice. Care or treatment is based on discriminatory decisions rather than an assessment of a person's needs. Staff fail to comply with the Mental Health Act Code of Practice or other legislation.

There is very limited or no monitoring of people's outcomes of care and treatment. People's outcomes are very variable or significantly worse than expected when compared with other similar services. Necessary action is not taken to improve people's outcomes.

People receive care from staff who do not have the skills or experience that is needed to deliver effective care. Staff so not develop the knowledge, skills and experience to enable them to deliver good quality care. Staff are not supervised or managed effectively. Poor performance is not dealt with in a timely or effective way.

Staff and teams provide care in isolation and do not seek support or input from other relevant teams and services. There are significant barriers to effective joint working between teams.

The information needed to plan and deliver effective care to people is not available at the right time. Information about people's care is not appropriately shared.

There plans for people's discharge or transition are incomplete or they do not reflect their needs. There are significant delays to discharge or this occurs without ongoing care arrangements being in place.

Consent to care and treatment has not been obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004. There are instances where care and treatment is not provided in line with consent decisions. Where appropriate, people's mental capacity has not been assessed and recorded. When people aged 16 and over lack the mental capacity to make a decision, 'best interests' decisions have not been made in accordance with legislation. Restraint and deprivation of liberty are not recognised and no attempts are made to find less restrictive options to provide necessary care and treatment.

Applications to authorise a deprivation of liberty are not made appropriately or in a timely manner to the Court of Protection or by using the Deprivation of Liberty Safeguards.

Caring

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Outstanding 

People are truly respected and valued as individuals and are empowered as partners in their care.

Feedback from people who use the service, those who are close to them and stakeholders is continually positive about the way staff treat people. People think that staff go the extra mile and the care they receive exceeds their expectations.

There is a strong, visible person-centred culture. Staff are highly motivated and inspired to offer care that is kind and promotes people's dignity. Relationships between people who use the service, those close to them and staff are strong, caring and supportive. These relationships are highly valued by staff and promoted by leaders.

Staff recognise and respect the totality of people's needs.. They always take people's personal, cultural, social and religious needs into account.

People who use services are active partners in their care. Staff are fully committed to working in partnership with people and making this a reality for each person. Staff always empower people who use the service to have a voice and to realise their potential. They show determination and creativity to overcome obstacles to delivering care. People's individual preferences and needs are always reflected in how care is delivered.

People's emotional and social needs are highly valued by staff and are embedded in their care and treatment.

Good 

People are supported, treated with dignity and respect, and are involved as partners in their care.

Feedback from people who use the service, those who are close to them and stakeholders is positive about the way staff treat people. People are treated with

dignity, respect and kindness during all interactions with staff and relationships with staff are positive. People feel supported and say staff care about them.

People are involved and encouraged to be partners in their care and in making decisions, with any support they need. Staff spend time talking to people, or those close to them. They are communicated with and receive information in a way that they can understand. People understand their care, treatment and condition. People and staff work together to plan care and there is shared decision-making about care and treatment.

Staff respond compassionately when people need help and support them to meet their basic personal needs as and when required. They anticipate people's needs. People's privacy and confidentiality is respected at all times.

Staff help people and those close to them to cope emotionally with their care and treatment. People's social needs are understood. People are supported to maintain and develop their relationships with those close to them, their social networks and community. They are enabled to manage their own health and care when they can, and to maintain independence.

Requires improvement 

There are times when people do not feel well supported or cared for.

Some people who use the service, those who are close to them and stakeholders have concerns about the way staff treat people.

People are sometimes not treated with kindness or respect when receiving care and treatment or during other interactions with staff. Staff do not see people's privacy and dignity as a priority. Staff may focus on the task rather than treating people as individuals. Staff do not always respect people's confidentiality.

There is a paternalistic approach to providing care. Some staff do not consider involving people as an important part of care. People say that staff do not always explain things clearly or give them time to respond or help them to understand. Some people are not supported to understand information they are given about their care and condition. People are not given information, access to advocacy or helped in other ways to be involved in their care and treatment.

People's emotional and social needs are not always viewed as important or reflected in their care and treatment. People are not encouraged to manage their own care.

Inadequate 

People are not involved in their care and are not treated with compassion. They feel vulnerable and isolated.

People do not feel cared for and feedback about staff interactions is negative.

Staff are rude, impatient, judgmental or dismissive of people using their services or those close to them. People do not know how to seek help or are ignored when they do. People's privacy, dignity and confidentiality is not respected. Their basic needs are not met.

People do not know or do not understand what is going to happen to them during their care. People do not know who to ask for help. They are not involved in their own care or treatment.

People's preferences and choices are not heard or acted on.

People feel isolated and disconnected from their lives. They do not receive support to cope emotionally with their care and condition.

Responsive

By responsive, we mean that services are organised so that they meet people's needs.

Outstanding 

Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.

People's individual needs and preferences are central to the planning and delivery of tailored services. The services are flexible, provide choice and ensure continuity of care.

The involvement of other organisations and the local community is integral to how services are planned and ensures that services meet people's needs. There are innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs.

There is a proactive approach to understanding the needs of different groups of people and to deliver care in a way that meets these needs and promotes equality. This includes people who are in vulnerable circumstances or who have complex needs.

People can access services in a way and at a time that suits them.

There is active review of complaints and how they are managed and responded to, and improvements are made as a result across the services. People who use services are involved in the review.

Good 

People's needs are met through the way services are organised and delivered.

Services are planned and delivered in a way that meets the needs of the local population. The importance of flexibility, choice and continuity of care is reflected in the services.

The needs of different people are taken into account when planning and delivering

services (for example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation).

Care and treatment is coordinated with other services and other providers.

Reasonable adjustments are made and action is taken to remove barriers when people find it hard to use or access services.

Facilities and premises are appropriate for the services being delivered.

People can access the right care at the right time. Access to care is managed to take account of people's needs, including those with urgent needs.

The appointments system is easy to use and supports people to make appointments.

Waiting times, delays and cancellations are minimal and managed appropriately. Services run on time. People are kept informed of any disruption to their care or treatment.

It is easy for people to complain or raise a concern and they are treated compassionately when they do so. There is openness and transparency in how complaints are dealt with. Complaints and concerns are always taken seriously, responded to in a timely way and listened to. Improvements are made to the quality of care as a result of complaints and concerns.

Requires improvement

Services do not always meet people's needs.

The needs of the local population are not fully identified or understood or taken into account when planning services, or there are shortfalls in doing this. There are shortfalls in how the needs of different people are taken into account, for example on the grounds of age, disability, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.

Services are not always planned in conjunction with other local services. Services are not delivered in a way that focuses on people's holistic needs. Services are delivered in a way that is inconvenient and disruptive to people's lives.

People find it hard to access services because the facilities and premises used are not

appropriate for the services being provided and action is not taken to address this.

Some people are not able to access services for assessment, diagnosis or treatment when they need do. There are long waiting times, delays or cancellations. Action to address this is not timely or effective.

People do not find it easy to or are worried about raising concerns or complainants. When they do, they receive a slow or unsatisfactory response. Complaints are not used as an opportunity to learn.

Inadequate 

Services are not planned or delivered in a way that meets people's needs

Minimal effort is made to understand the needs of the local population. Services are planned and delivered without consideration of people's needs.

The facilities and premises used do not meet people's needs or are inappropriate.

People are unable to access the care they need. Services are not set up to support people with complex needs or people in vulnerable circumstances.

People are frequently and consistently not able to access services in a timely way for an initial assessment, diagnosis or treatment. People experience unacceptable waits for some services.

People who raise concerns and complaints are not taken seriously and feel ignored. Complaints and concerns are handled inappropriately. There is a defensive attitude to complaints and a lack of transparency in how they are handed. People's concerns and complaints do not lead to improvements in the quality of care.

Well-led

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Outstanding 

The leadership, governance and culture are used to drive and improve the delivery of high quality person-centred care.

The strategy and supporting objectives are stretching, challenging and innovative while remaining achievable.

A systematic approach is taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.

Governance and performance management arrangements are proactively reviewed and reflect best practice.

Leaders have an inspiring shared purpose, strive to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies are in place to ensure delivery and to develop the desired culture.

There are high levels of staff satisfaction across all equality groups. Staff are proud of the organisation as a place to work and speak highly of the culture. There are consistently high levels of constructive engagement with staff, including all equality groups. Staff at all levels are actively encouraged to raise concerns.

There is strong collaboration and support across all functions and a common focus on improving quality of care and people's experiences.

Innovative approaches are used to gather feedback from people who use services and the public, including people in different equality groups.

Rigorous and constructive challenge from people who use services, the public and stakeholders is welcomed and seen as a vital way of holding services to account.

The leadership drives continuous improvement and staff are accountable for delivering change. Safe innovation is celebrated. There is a clear proactive approach to seeking out and embedding new and more sustainable models of care.

Good 

The leadership, governance and culture promote the delivery of high quality person-centred care.

There is clear statement of vision and values, driven by quality and safety. It has been translated into a credible strategy and well-defined objectives that are regularly reviewed to ensure that they remain achievable and relevant. The vision, values and strategy have been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others

Strategic objectives are supported by quantifiable and measurable outcomes, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.

Staff in all areas know and understand the vision, values and strategic goals.

The board and other levels of governance within the organisation function effectively and interact with each other appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.

Quality receives sufficient coverage in board meetings, and in other relevant meetings below board level.

The organisation has the processes and information to manage current and future performance. The information used in reporting, performance management and delivering quality care is accurate, valid, reliable, timely and relevant. Integrated reporting supports effective decision-making. A full and diverse range of people's views and concerns are encouraged, heard and acted on. Information on people's experience is reported and reviewed alongside other performance data.

There is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. Performance issues are escalated to the relevant committees and the board through clear structures and processes. Clinical and internal audit processes function well and have a positive impact in relation to

quality governance, with clear evidence of action to resolve concerns.

Financial pressures are managed so that they do not compromise the quality of care.

The leadership is knowledgeable about quality issues and priorities, understands what the challenges are and takes action to address them. Performance information is used to hold management and staff to account.

The service is transparent, collaborative and open with all relevant stakeholders about performance.

The board has the experience, capacity and capability to ensure that the strategy can be delivered. The appropriate experience and skills to lead are maintained through effective selection, development and succession processes.

Leaders at every level prioritise safe, high quality, compassionate care and promote equality and diversity. Leaders model and encourage cooperative, supportive relationships among staff so that they feel respected, valued and supported.

The leadership actively shapes the culture through effective engagement with staff, people who use services and their representatives and stakeholders.

Candour, openness, honesty and transparency and challenges to poor practice are the norm. Mechanisms are in place to support staff and promote their positive wellbeing. Behaviour and performance inconsistent with the values is identified and dealt with swiftly and effectively, regardless of seniority.

There is a culture of collective responsibility between teams and services.

The service proactively engages and involves all staff and ensures that the voices of all staff are heard and acted on. The leadership actively promotes staff empowerment to drive improvement and a culture where the benefit of raising concerns is valued. Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated in a sensitive and confidential manner, and lessons are shared and acted upon.

Information and analysis are used proactively to identify opportunities to drive improvements in care. Service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care. Their impact on quality and financial sustainability is monitored effectively.

There is a strong focus on continuous learning and improvement at all levels of the organisation. Safe innovation is supported and staff have objectives focused on

improvement and learning. Staff are encouraged to use information and regularly take time out to review performance and make improvements.

Requires improvement

The leadership, governance and culture do not always support the delivery of high quality person-centred care.

The vision and values are not well developed and do not encompass key elements such as compassion, dignity and equality. The vision and the strategy are not aligned.

The arrangements for governance and performance management do not always operate effectively. There has been no recent review of the governance arrangements, the strategy, plans or the information used to monitor performance.

Risks, issues and poor performance are not always dealt with appropriately or in a timely way. The risks and issues described by staff do not correspond to those reported to and understood by leaders.

Not all leaders have the necessary experience, knowledge, capacity or capability to lead effectively. The need to develop leaders is not always identified or action is not always taken. Leaders are not always clear about their roles and their accountability for quality.

Staff satisfaction is mixed. Improving the culture or staff satisfaction is not seen as a high priority. Staff do not always feel actively engaged or empowered. There are teams working in silos or management and clinicians do not always work cohesively.

Staff do not always raise concerns or they are not always taken seriously or treated with respect when they do.

There is a limited approach to obtaining the views of people who use services and other stakeholders. Feedback is not always reported or acted upon in a timely way.

The approach to service delivery and improvement is reactive and focused on short term issues. Improvements are not always identified or action not always taken. Where changes are made, the impact on the quality of care is not fully understood in advance or it is not monitored.

The sustainable delivery of quality care is put at risk by the financial challenge.

Inadequate 

The delivery of high quality care is not assured by the leadership, governance or culture in place.

There is no credible statement of vision and guiding values. Staff are not aware of or do not understand the vision and values.

The strategy is not underpinned by detailed, realistic objectives and plans, and does not reflect the health economy in which the service works. Staff do not understand how their role contributes to achieving the strategy.

The governance arrangements and their purpose are unclear. There is no process in place to review key items such as the strategy, values, objectives, plans or the governance framework. Financial and quality governance are not integrated to support decision-making. The information that is used to monitor performance or to make decisions is inaccurate, invalid, unreliable, out of date or not relevant.

Data and notifications are not submitted to external organisations as required.

There is no effective system for identifying, capturing and managing issues and risks at team, directorate and organisation level. There is a lack of openness and transparency, which results in the identification of risk, issues and concerns being discouraged or repressed. Significant issues that threaten the delivery of safe and effective care are not identified or adequate action to manage them is not always taken.

Leaders do not have the necessary experience, knowledge, capacity, capability or integrity to lead effectively. Leaders are out of touch with what is happening on the front line. There is a lack of clarity about authority to make decisions and how individuals are held to account. Quality and safety are not the top priority for leadership. Meeting financial targets is seen as a priority at the expensive of quality.

There are low levels of staff satisfaction, high levels of stress and work overload. Staff do not feel respected, valued, supported and appreciated. There is poor collaboration or cooperation between teams and there are high levels of conflict.

The culture is top-down and directive. It is not one of fairness, openness, transparency, honesty, challenge and candour. There is bullying, harassment, discrimination or violence. When staff raise concerns they are not treated with respect. The culture is

defensive.

There is minimal engagement with people who use services, staff or the public. The service does not respond to what people who use services or the public say. Staff are unaware or are dismissive of what people who use the service think of their care and treatment.

There is little innovation or service development. There is minimal evidence of learning and reflective practice. The impact of service changes on the quality of care is not understood.

Brighton and Sussex University Hospitals NHS Trust

Report for Brighton & Hove Health & Wellbeing Overview and Scrutiny Committee,

Care Quality Commission Report for Brighton and Sussex University Hospital NHS Trust October 2014

1. Purpose

The purpose of this paper is to update the B&H HWOSC on the findings from the CQC reports published in August 2014 following their visit to Brighton and Sussex University Hospital NHS Trust in May 2014. It will also detail the key findings and actions, governance processes and subsequent monitoring arrangements to ensure compliance.

2. Background

The Care Quality Commission (CQC) conducted an announced inspection of the Trust on the 21-23rd May 2014. A team of 35 inspectors visited four of the Trust's eight registered hospital sites and conducted further unannounced spot checks on the 27th May and 30th May.

The CQC arranged the Quality Summit on 5th August 2014. It was attended by invited members of the Trust Board and external stakeholders, including commissioners, health overview and scrutiny committees, NHS England and the Trust Development Authority.

The final reports were published on 8th August 2014 and can be accessed through . http://www.bsuh.nhs.uk/about-us/performance-and-data/cqc-reports-and-statement-of-purpose/care-quality-commission-cqc-inspection-august-2014

The Trust's action plan arising from the recommendations from the report was reviewed internally and with external partners prior to being submitted to the CQC on 15th September 2014. The action plan focussed on the actions the Trust must take to improve quality and safety, linked to Compliance Actions (Regulations). The Trust Board paper includes the action plan and can be accessed through: http://www.bsuh.nhs.uk/about-us/the-trust-board/trust-board-meeting-papers/september-2014-board-meeting-papers/?assetdet8792229=524557

3. Report findings

The new approach used for the Chief Inspector of Hospital inspections identifies the key questions to ask about the quality and safety of care, based on the things that matter to people:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to peoples' needs?

- Is it well led?

The new programme of inspections included the introduction of ratings for healthcare organisations to support the process of regulation. Ratings are at service level, hospital level, domain level (relating to the 5 key questions) and Trust level. This is on a 4-point scale:

Outstanding	Good	Requires Improvement	Inadequate

The CQC inspected and rated the following 8 clinical areas and pathways identified as priorities for all Trusts by the Chief Inspector of Hospitals:

Medical care (including older people's care)	Outpatients	Services for children and young people Paediatrics	Maternity
Surgery	Critical Care/ Intensive Care	A&E	End of Life Care

Each of these services was given a rating of outstanding, good, requires improvement or inadequate in relation to each of the five questions above. For the sites the CQC visited during the inspection. There were overall 90 ratings which were: 64 Good 25 Requires Improvement 1 Inadequate

The Trust received an overall rating of 'requires improvement'. RSCH and PRH sites were given a 'requires improvement' rating, Bexhill Renal satellite Unit and Hove Polyclinic and Community Services for children, young people and their families were given 'good' ratings.

The Trust received overall ratings for the whole Trust in relation to the five questions:

Are the services at this trust safe?	Requires improvement
Are the services at this trust effective?	Good
Are the services at this trust caring?	Good
Are the services at this trust responsive?	Requires improvement
Are the services at this trust well-led?	Requires improvement

Outstanding areas noted within the reports were:

- *The Trust was exceptionally open and engaged with the inspection*
- *Awareness of staff of the work on values and behaviours was almost universal.*
- *Care for patients with dementia was good in both Royal Sussex and Princess Royal Hospitals, where staff had been innovative and creative in order to provide a safe and stimulating environment for people.*
- *The critical care teams at the Royal Sussex and Princess Royal Hospitals were strong, committed and compassionate.*
- *The feedback from patients was overwhelmingly positive*.

There were eight compliance actions which focused around areas which had been identified by the Trust prior to the CQC visit. These included patient flow, the central booking 'hub',

staffing, learning lessons and feedback to staff on incidents, cultural issues and the environment.

4. Key actions to address the challenges

4.1 Unscheduled care, flow and Emergency Department (ED) performance
The overall aim is to achieve and sustain 95% by internally developing mechanisms to better use the trusts capacity and respond to changes and spikes in demand. These include:

- creation of a surgical assessment unit
- focus on earlier and greater numbers of discharges each day
- creation of additional/flexible capacity including for 72 hours stay
- 'cohorting' policy and full capacity protocol
- continued work within ED and with downstream wards on all pathway issues and flow

It is also important to work with the Trust's partners on developing new approaches and tiers of support to address the changing environment. These include:

- alternatives to ED attendance with primary care and SECAMB
- 'discharge to assess'
- repatriation to secondary care providers
- Better Care Fund and frailty pathway
- onward care capacity to help reduce 'medically fit for discharge' list

4.2 Central booking 'hub'
A plan is in place to improve performance which includes:

- Hub and spoke model in high volume specialties to provide local support and access for clinicians
- Patient Access Managers based in the hub
- Flexing of staff to answer the phones to ensure times with busiest call volumes are adequately covered
- Continuation of dedicated email address for raising concerns (checked daily and responded to within 24 hours)
- Work with primary care on referral patterns

4.3 Cultural issues
The "Foundations for Success" programme within the Trust is engaging the workforce to address long-standing issues. The programme includes:

- establishing a Values and Behaviours blueprint and implementation plan including workstreams on race equality and empowerment, accountability and performance management which have now been developed
- a new clinical structure
- Appointment of new Director of Strategy and Change
- Focus on increased communication, engagement, training and appraisal

4.4 Staffing

There are a number of actions which are being implemented to support the staff which have included:

- a £3 million investment in nursing including increased nurse to patient ratios and supernumerary Ward Sisters/Charge Nurses
- Improvements to efficiency of recruitment processes and prioritisation of nursing recruitment in line new recruitment strategy
- Clinical restructure includes a lead nurse in each new clinical directorate with overall responsibility for nurse staffing issues

4.5 Environment, Cleaning and Food

The actions related to the environment longer term will be addressed by the 3Ts redevelopment of Royal Sussex County Hospital. However, ahead of this, there is a capital investment programme to maintain existing estate/facilities to the highest possible standards and improve where necessary including, for example, works to support service reconfiguration and refurbishment of PRH discharge lounge. There has also been the creation of Lead Nurse as link between ward areas and Sodexo to receive and action issues raised and proactively identify and drive improvement.

5. Governance process for the CQC Action Plan

It has been agreed that internally the action plan will be monitored through the Clinical Management Board on a monthly basis by exception, the Quality and Risk Committee quarterly and bimonthly at the Trust Board.

Externally, the action plan will be monitored monthly at the integrated delivery meeting. The first part of the meeting will focus on the action plan and the CCGs and Area team will join the meeting. The meeting is chaired by the TDA.

The Improving Quality and Patient Experience Group will continue to coordinate the programme of monthly Quality visits and will review the evidence against compliance actions in more depth. The Quality visits in the future will focus on achievement of the fundamental standards which have been consulted on by the CQC and will come into force for all providers in April 2015. The quality visits also help the Trust to identify improvements in practice related to the action plan.

Elma Still
Associate Director of Quality
October 2014

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 20 Brighton & Hove City Council

Subject:		**PLACE Assessment Results for BSUH**	
Date of Meeting:		**26 November 2014**	
Report of:		**Assistant Chief Executive**	
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 All NHS Hospital Trusts are required to carry out an annual audit of their hospital environments called PLACE (Patient Led Assessments of the Care Environment).

1.2 The assessments took place between March to June 2014; members of HWOSC were invited to take part as they had been in previous years. The report provides detail of BSUH's results across the Trust and how they compare with the national average.

2. RECOMMENDATIONS:

2.1 That HWOSC members note and comment on the results.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 All NHS Hospital Trusts are required to carry out an annual audit of their hospital environments called PLACE (Patient Led Assessments of the Care Environment). The PLACE assessment falls into four broad categories:

- How clean the hospital environment is;
- Buildings and facilities - inside and outside of the building, fixtures and fittings, signage and car parking;
- Food and Hydration, the quality and availability of food and drinks; (the meal service to patients is observed and the assessors have an opportunity to taste the food);
- Privacy and Dignity, how well the environment supports this;

3.2 PLACE is not a patient survey although it is patient-led. PLACE assessors are required, as a team, to reach joint decisions based on what they see on the day of the assessment. In certain circumstances (for example checking whether an individual received the meal they ordered) they can speak to patients. Assessors gather information on their findings following a clearly defined checklist.

3.3 The results of the assessments are shared with the Care Quality Commission, who will use the information in their monitoring of provider compliance with the essential standards of quality and safety, and to inform inspection of relevant standards.

3.4 The patient assessors who conducted this year's assessments will be invited back to re-visit the areas that they assessed to see if they consider that improvements have been made.

3.5 During March to June 2014 the number of assessments nationally undertaken in Hospitals, Treatment Centres and Hospices was 1356 across 287 organisations compared to 1359 in 2013.

The scores for Brighton and Sussex University Hospitals Trust (BSUH) for the four sets of criteria with comparisons to 2013 and to the national average are as follows;

Site	Cleaning 2014	2013	Food/ Hydration 2014	2013	Privacy/ Dignity 2014	2013	Condition/ Appearance 2014	2013
Hurstwood Park	98.11%	99.82 %	97.81%	87.82%	83.62%	80.63 %	93.25%	94.31%
Royal Alexandra Children's Hospital	94.77%	95.52 %	96.85%	87.27%	87.98%	97.25 %	79.17%	92.51%
Princess Royal Hospital	96.25%	99.09 %	99.00%	87.93%	84.89%	91.03 %	85.52%	94.86%
Sussex Eye Hospital	87.46%	97.83 %	95.44%	89.09%	69.61%	80.12 %	71.22%	83.94%
Royal Sussex County Hospital	97.56%	95.44 %	96.04%	83.52%	83.99%	86.78 %	86.86%	80.81%
Sussex Orthopeadic Centre	95.41%	100%	97.62%	89.62%	96.75%	86.84 %	94.68%	92.17%
National Average 2014	*97.25%*		*88.79%*		*87.73%*		*91.97%*	

The scores for BSUH for 2014 showed mixed results. As a Trust they performed better than the national average for food and hydration (88.8%), with the highest score being 99%. The national average for cleanliness was 97.3% with the lowest score being 87.5%. The other two criteria Privacy, Dignity and Wellbeing and Condition, Appearance and Maintenance did not perform so well.

Long standing environmental issues which are impacting on the privacy and dignity scores in particular in the Barry Building and Sussex Eye Hospital at RSCH and at Hurstwood Park include issues such as spacing between beds, large enough reception areas in departments, sufficient space at reception desks so that conversations cannot be overheard, and also patients leaving consulting rooms without having to return through the general waiting area. In many instances, improvements are largely dependent on Trust's 3Ts redevelopment programme to achieve a permanent solution.

3 COMMUNITY ENGAGEMENT & CONSULTATION

4.1 Assessments are undertaken by patient assessors. The term patient assessor covers all people whose experience of the hospital is as a user rather than a provider. It encompasses relatives, carers, friends, patient advocates, and volunteers. The local Healthwatch and HWOSC members were also invited to participate; some members were able to take part.

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.

Any Other Significant Implications:

5.5 None to this cover report.

SUPPORTING DOCUMENTATION

Appendices:

1. BSUH PLACE report 2014

Brighton and Sussex University Hospitals NHS Trust

Brighton & Hove HOSC report

PLACE 2014.

Introduction

Patient-Led Assessments of the Care Environment (PLACE) are annual patient led audits to provide a snapshot of how a healthcare provider is performing against a range of non-clinical activities which impact on the patient experience of care. The criteria assessed are – Cleanliness; the Condition, Appearance and Maintenance of healthcare premises; the extent to which the environment supports the delivery of care with Privacy and Dignity; and the quality and availability of food and drink.

The programme aims to promote the following principles and values;

> A commitment to ensure that services are provided in a clean and safe environment that is fit for purpose.
> Striving to get the basics of quality of care right.
> Encouraging feedback from the public, patients and staff to help improve services
> Putting patients first.

The assessments focus on the areas which our patients say matter, and by encouraging and facilitating the involvement of patients, the public and other bodies with an interest in healthcare (e.g. Local Healthwatch) in assessing providers in equal partnership with NHS staff to both identify how they are currently performing against a range of criteria and to identify how services may be improved for the future.

Assessments

19 patient assessors took part in the BSUH PLACE audits in 2014 (11 at RSCH and 8 at PRH).

The week in which assessments are to be undertaken is determined by the Health and Social Care Information Centre (HSCIC) and individual organisations are given 6 weeks notice of the date by which assessments should be completed.

Final decisions on the wards or areas of the hospital which are to be assessed are not made until the day of the assessment. The areas chosen are a joint decision by the assessment team, although the hospital staff also have an important role to play in ensuring that the wards or areas chosen are reflective of the range of services and, where appropriate, the individual buildings that make up the hospital.

In each year, different areas should be selected (with the exception of A&E) so that over a period of time all areas of the hospital are assessed.

Results

At the end of the process, each individual site which has undertaken an assessment is provided with a result against the four set criteria which are: Cleanliness; Food and Hydration; Privacy, Dignity and Wellbeing; Condition, Appearance and Maintenance. The results are calculated by reference to the score (points) achieved; these are expressed as a percentage.

The scores are agreed by each team as they assess each chosen area. Final scores should be agreed at the conclusion of the assessment of that ward/department before moving on to the next. Once the selected areas on site have been audited, the patient assessors (Trust staff are not included) meet to complete a final summary sheet which should accurately reflect the hospital as a whole.

The results of the assessments are shared with the Care Quality Commission, who use the information in their monitoring of provider compliance with the essential standards of quality and safety, and to inform inspection of relevant standards. Other organisations such as the NHS Commissioning Board and the National Institute for Health and Clinical Excellence may also use the data in support of their own objectives.

The results also enable us as a Trust to identify what we are doing right and improve on things that we are not. Participating organisations and others who may use this data will be able to benchmark their performance or the performance of particular types of organisations.

Key Findings in 2014.

During March to June 2014 the number of assessments nationally undertaken in Hospitals, Treatment Centres, Hospices) was 1'356 across 287 organisations compared to 1'359 in 2013.

The national average scores compared to BSUH for the four sets of criteria with comparisons to 2013 are as follows;

Site	Cleaning 2014	Cleaning 2013	Food/ Hydration 2014	Food/ Hydration 2013	Privacy/ Dignity 2014	Privacy /Dignity 2013	Condition / Appearance 2014	Condition /Appearance 2013
HWPNC	**98.11%**	**99.82%**	**97.81%**	**87.82%**	**83.62%**	**80.63%**	**93.25%**	**94.31%**
RACH	**94.77%**	**95.52%**	**96.85%**	**87.27%**	**87.98%**	**97.25%**	**79.17%**	**92.51%**
PRH	**96.25%**	**99.09%**	**99.00%**	**87.93%**	**84.89%**	**91.03%**	**85.52%**	**94.86%**
S.E.H	**87.46%**	**97.83%**	**95.44%**	**89.09%**	**69.61%**	**80.12%**	**71.22%**	**83.94%**
RSCH	**97.56%**	**95.44%**	**96.04%**	**83.52%**	**83.99%**	**86.78%**	**86.86%**	**80.81%**
S0TC	**95.41%**	**100%**	**97.62%**	**89.62%**	**96.75%**	**86.84%**	**94.68%**	**92.17%**
National Average 2014	***97.25%***		***88.79%***		***87.73%***		***91.97%***	

Key-
HWPNC – Hurstwood Park Neurological centre

RACH - Royal Alexandra Children's Hospital
PRH – Princess Royal Hospital
S.E.H – Sussex Eye Hospital
RSCH – Royall Sussex County hospital
S0TC – Sussex Orthopaedic Treatment centre

The scores for BSUH for 2014 showed mixed results. As a Trust we performed better than the national average for food and hydration (88.8%), with our highest score being 99%. The national average for cleanliness was 97.3% with our lowest score being 87.5%. The other two criteria Privacy, Dignity and Wellbeing and Condition, Appearance and Maintenance we did not perform so well.

Long standing environmental issues which are impacting on the privacy and dignity scores in particular in the Barry Building and Sussex Eye Hospital at RSCH and at Hurstwood Park include issues such as spacing between beds, large enough reception areas in departments, sufficient space at reception desks so that conversations cannot be overheard, and also patients leaving consulting rooms without having to return through the general waiting area. In many instances, improvements are largely dependent on Trust's 3Ts redevelopment programme to achieve a permanent solution.

Actions

All of the issues identified by the assessors were used to formulate an action plan for each of the six audit sites. The Estates department have rectified the majority of defects identified. This work started immediately after the PLACE assessments concluded.

All issues in relation to cleaning were raised with the Trust's soft FM provider, Sodexo. An action plan was put in place and the issues were rectified immediately.

Following the assessments, the reports were sent to divisional Matrons with regard ward items that needed replacement due to wear and tear i.e. torn chairs, broken bins, etc. These items have now been discarded and replaced.

A meeting has also been arranged for the beginning of October between the Facilities Compliance Manager and the Deputy Chief Nurse to discuss progress to date.

The patient assessors who conducted this year's assessments were invited back during September to review progress against the PLACE action plans. These meetings went very well and Healthwatch Brighton and Hove have agreed to a further follow up visit in early December.

During these meetings both Mid Sussex and Brighton and Hove Healthwatch were pleased with the fact that immediate attention had been given with regard the results of the visits. Plans for next year's PLACE audits have already been discussed and training dates have been arranged for new volunteers who are keen to participate in the 2015 assessments.

Below are the assessment summary's in relation to the six sites within BSUH that were audited.

Royal Alex Children's Hospital

>A modern building with good cleanliness, but some wards need better cleaning (level 8).
>Very pleased with the décor and treatment rooms, the size of the rooms are brilliant and great lighting.
>Some of the general seating needs replacement.
>Some of the linen was substandard with holes in the sheets.
>Better signage needed.
>Some Health and Safety issues with regard electrical sockets and cleaning equipment.
>The patients are treated with dignity and respect by brilliant staff. The staff are so wonderful and the care given is fantastic.
>Food was well above expectation.

Sussex Eye Hospital

>Security in some areas was poor where patients have access (keys left in clinical cupboards in Pre Assessment)
>Signage in the building needs to be improved and more defined
>There needs to be a professional review of the space in OPD and A/E with a view of utilising space better for patients and staff, some of the patients were having Eye tests in the corridor. Patients were also being seen in treatment rooms with the door open, this was due to the fact that the heating in this building is far too hot, (this has been reported).
>This building is difficult to keep clean because of its age and general poor maintenance which needs to be addressed urgently.
>Old metal windows are in a dangerous and unsafe condition throughout the building.
>The condition of much of the furniture was very old, some of the dilapidated chairs need a thorough review and replacement.
>Many old pieces of furniture which are inappropriate for a clinical environment (desks).
>Equipment in Orthoptics needs to be reviewed with a view to modern testing facilities.
>All window curtains need replacing in Orthoptics dept.
>Children's toys in the waiting room in Orthoptics need replacing, (they can apply through the Rockinghorse Appeal charitable funds).
>All remaining carpet needs replacement with Lino.
>Lots of the doors were scuffed including the Main Front doors.
>Overall Food good.

Royal Sussex County

>There are some modern buildings which are excellent and provide adequate privacy and dignity for all patients.
>We were extremely impressed with TMBU and the Post Natal ward. The staff were very welcoming and both units were beautifully clean and had a calm feel about them.
>Similar observations were made with the Renal unit and the Haematology/Oncology suite, the staff here were also very welcoming.
>Baily and Chichester ward were almost chaotically overcrowded and the nurses work station was unsuitably placed causing further chaos.
>Some of the elderly wards are very overcrowded and it would be very difficult to have any private conversations.

>There was a mixed response when patients were asked about the food, hot desserts are served at the same time as the hot meal.
>In the Sussex Cancer Centre the atmosphere was pleasant and welcoming, the building was spotlessly clean and very tidy. There were some minor issues with confusing signage but generally it was a place that patients should feel very comfortable in.

Princess Royal

>A modern building with varying standards of cleanliness.
>Issue with general storage on wards.
>We were very impressed with the upgrade to the entrance and the car park which is much improved.
>Poynings ward is not at all well signposted and therefore finding this ward is very difficult.
>The patient care on all the wards/departments visited seemed to be excellent.
>Patients are treated with dignity and respect.
>The food service is very good.

Sussex Orthopaedic Treatment Centre

>A modern building with standards close to a centre of excellence, and well maintained.
>The staff were happy and caring and the patients are treated with dignity and respect.
>Food service was generally very good with a massive range of both hot and cold, excellent.
>There were a few areas which need attention with regard to cleanliness. All of the sink waste outlets were dirty and the flooring was generally dull looking.
>We felt that the high back chairs in the waiting area should be reserved for patients that need them (children sitting on them at the time of the assessment).
>Throughout the building there was no evidence of a curtain changing schedule in place, nurses were not aware of when they were last changed.
>Externally the pathway leading from the car park to the SOTC is inaccessible for wheelchair users with no drop kerb, the pathway was also uneven.
>Signage was poor both leading to the building and on the actual frontage of the building itself.

Hurstwood Park

>This is a very old building and does require some external maintenance which includes, painting of the patio areas at the back of the building and general maintenance to the windows.
>Good standards of cleanliness
>Good patient care is supported and well led.
>Food on offer to patients is very good.

PLACE 2015

When received, the dates of next year's audits will be sent to Healthwatch, HOSC, patient user groups and other local groups that wish to join us for the assessments.

The Trust's PLACE lead is Karon Goodman, Facilities Compliance Manager.

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 22 Brighton & Hove City Council

Subject:		**Stroke Services in Brighton and Hove**	
Date of Meeting:		**26 November 2014**	
Report of:		**Assistant Chief Executive**	
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 BSUH has identified in its clinical strategy that improvements to stroke care are a key priority for the organisation.

1.1 The report outlines current provision and potential future plans in Brighton and Hove, and more widely across Sussex.

2. RECOMMENDATIONS:

2.1 That HWOSC members note the issues with the current provision of stroke care and comment on potential changes to services.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 A stroke is a blood clot affecting the brain that can cause permanent disability or death. Each year, 110,000 people in England, have a stroke and 900,000 people are living with the effects of stroke. Following stroke onset, the most critical period for intervention is the first 4.5 hours where thrombolysis (clot busting) treatment can potentially be delivered.

3.2 Acute stroke services require specific organisation and designation and are subject to specific national standards. CCGs in Sussex have established a collaborative team to look at how best to commission very acute services such as stroke care, where changes in one CCG area frequently have an impact on others. In January 2014, there was unanimous agreement for a Sussex-wide review of stroke services across the whole pathway including prevention, acute phase and rehabilitation taking whilst into account co-dependent services.

3.3 In 2012-13 in Sussex there were 2,000 acute stroke admissions. Patients attend one of six acute stroke units. BSUH has around 700 confirmed stroke admissions yearly, split 70/30 between RSCH and Princess Royal Hospitals.

The BSUH acute service comprises 2 multidisciplinary units – 22 beds at RSCH and 10 at PRH. Complex neuro-rehabilitation is provided at the Sussex Rehabilitation Centre at PRH. Transient ischaemic attack (TIA) clinics are provided within the stroke unit at RSCH. In June 2014 RSCH introduced a 7 day TIA service which can be referred into for urgent review by senior stroke doctors.

3.4 The latest clinical audit data shows that the RSCH stroke unit scores highly for immediate CT scanning, thrombolysis rates, stroke unit processes, early specialist assessments, and discharge, but is challenged to provide sufficient early specialist rehabilitation due to low therapy staffing or the ideal of 7 day working for all staff. More detail can be found in **Appendix One.**

3.5 There are a number of strategic challenges for BSUH including:

- *Immediate access to acute stroke beds, partly a factor of the general pressure on beds faced at RSCH, although the RSCH direct admission rate is above the national mean at 59.2% (National 58%)*

- *Insufficient specialist staff, including senior nurses, therapists, psychologists and doctors to deliver the standards of care we aspire to. There are national shortages in staff in these groups who have the specific training required for acute stroke care. This impacts on :*
    - *Providing a uniform service 24 hours a day, 7 days a week*
    - *Providing all the therapeutic interventions stroke patients need*

- *Lack of responsive Early Supported Discharge (ESD) for East Sussex patients, impacting on East Sussex patients' length of stay and our ability to rapidly discharge home with community rehabilitation. This impacts on the overall availability of stroke beds. In contrast the Brighton and Hove ESD is very responsive*

- *Currently the service is not resourced to deliver 6 monthly patient reviews by the whole stroke team. At present we undertake a six-monthly follow up phone call by our senior stroke co-ordinator and bi-monthly multi-disciplinary evening sessions to invite patients and carers back to RSCH to review any urgent issues. In addition all patients are seen in outpatients post discharge. Patients perceive a 'gap in care' when they go home and the reality of life post stroke is more apparent. We are discussing this area of provision with local CCGs.*

- *The challenge of running acute stroke units on two sites and providing equitable 24/7, 7/7 per week care*

3.6 BSUH has identified in its clinical strategy that improvements to stroke care are a key priority for the organisation. They believe significant re-organisation of services will be required to achieve this including possibly re-organisation to a single as the best approach. However, this will be a significant change to service provision which will require extensive consultation and the support of clinically-led commissioners.

At the present time, BSUH believes it is best to do this in partnership with all of the CCGs and providers of stroke care across Sussex. Changes to provision at BSUH could adversely affect other systems, so it is important to plan to improve stroke care on a larger footprint.

However, should changes not go ahead on a Sussex basis, BSUH will need to formally consider the case for change of its own service configuration in the near future. The sole and over-riding basis in such a consideration will be improving the quality of care for patients.

The Trust will need to consider the 'fit' of stroke services with other specialised care such as neurosurgery and vascular surgery, and also the impact of any changes on how it manages the limited supply of inpatient bed space at both acute sites. Any proposed changes will be duly consulted on.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 This report comes at the start of any change to service provision for stroke services in Brighton and Hove. No decisions have been made as to what the future service might look like; currently no options have been discounted. HWOSC has been assured that all possible options will be fully considered in due course.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 As part of the further development of plans for stroke services, proposed change will need to be discussed with commissioners, patients and the public and this will be done through the relevant consultation processes.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 There are no current financial implications. This will be considered by BSUH and wider when plans are developed further.

Legal Implications:

7.2 There are no current legal implications. This will be considered by BSUH and wider when plans are developed further.

Sustainability Implications:

7.3 None are known at present.

SUPPORTING DOCUMENTATION

Appendices:

1. Information from BSUH

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Brighton and Hove HOSC report

Stroke Services, November 2014

Executive Summary

- Stroke is a medical emergency. Stroke medicine and patient outcomes have changed beyond recognition in the last 15 years. The consequences of stroke cost the NHS £3 billion per year[1]
- Any patient presenting with a stroke like symptoms needs rapid assessment at a stroke unit capable of providing thrombolysis
- Following the recent presentation of the MRFIT trial stroke units are also likely to have to provide more specialised intra arterial thrombolysis
- To provide high quality, equitable stroke care for patients across Sussex some changes to services may be required which are being taken forward by the Sussex Collaborative Delivery Team Stroke Reference Group
- Clinical outcomes of stroke care at the Royal Sussex County Hospital are currently excellent with a relatively high proportion of patients discharged home, low length of stay, low mortality and high patient satisfaction.
- However, we believe the service could be improved further and we are supporting the Sussex-wide review work to secure these improvements

Introduction

A stroke is a blood clot affecting the brain that can cause permanent disability or death. Each year, 110,000 people in England, have a stroke and 900,000 people are living with the effects of stroke. Most strokes are age related –75% occur in those > 65 years, 1:4 who experience stroke are < 65 and 1:10 are < 55. It is the third commonest cause of death in the UK and costs £8 billion pa (£3 billion NHS costs)[1]

Following stroke onset, the most critical period for intervention is the first 4.5 hours where thrombolysis (clot busting) treatment can potentially be delivered. Time is brain, with 2 million neurones damaged per minute. Direct admission to the stroke unit within 4 hours, early expert multidisciplinary assessments and treatment, intravenous fluids, nutrition and treatment with aspirin and statins all contribute to improved stroke outcomes. To achieve this requires organised, expert units providing 7 day, 24/7 services. The acute clinical pathway should provide:

- Immediate access to imaging for all patients
- Thrombolysis – clot-busting drugs – for those stroke victims where this is clinically appropriate
- completion of all investigations and treatments to reduce the risk of stroke for transient ischaemic attacks (TIAs or 'mini-strokes') within 1 week or within 24 hours for high risk cases

1 National Audit Office. Progress in improving stroke care. London: NAO, 2010.

- an acute vascular surgical service (i.e. surgeons who operate on blood vessels) to perform further tests and interventions where necessary

Acute stroke services therefore require specific organisation and designation and are subject to specific national standards. CCGs in Sussex have established a collaborative team to look at how best to commission very acute services such as stroke care, where changes in one CCG area frequently have an impact on others. In January 2014, at a Sussex Collaborative quarterly strategy meeting, there was unanimous agreement for a Sussex-wide review of stroke services across the whole pathway including prevention, acute phase and rehabilitation taking whilst into account co-dependent services.

Current Brighton and Hove stroke provision

In Sussex, 2012–13 there were 2,000 acute stroke admissions (SUS data). Patients attend one of six acute stroke units. BSUH has around 700 confirmed stroke admissions pa, split 70/30 between RSCH and Princess Royal Hospital.

The BSUH acute service comprises 2 multidisciplinary units - Donald Hall/Solomon wards, RSCH (22 beds) and Ardingly ward, PRH (10 beds). Complex neuro-rehabilitation is provided at the Sussex Rehabilitation Centre at PRH. Transient ischaemic attack (TIA) clinics are provided within the stroke unit at RSCH.
In June 2014 RSCH introduced a 7 day TIA service which can be referred into for urgent review by senior stroke doctors.

SSNAP (Sentinel Stroke National Audit Programme) audit, key outcomes for stroke and how we compare nationally

The SSNAP audit is an aspirational national audit of stroke care run by the Royal College of Physicians It consists of a biannual audit of the organisation of care and a continual ongoing review looking at the care of all stroke inpatients. 74,307 records have been analysed to date (April 13 - Mar 14)

The 2014 acute organisational audit score is based on combined Domains looking at all aspects of the organisation of services and is summarised in Appendix A. BSUH's performance is summarised below.

	RSCH	PRH
Summary of domain scores		
D1 Acute care*	B 87.5	D 50.0
D2 Specialist roles	C 70.0	E 40.0
D3 Interdisciplinary services	D 45.8	E 41.7
D4 TIA/Neurovascular clinic	A 100.0	A 100.0
D5 Quality improvement, training & research	A 100.0	D 60.7
D6 Planning & access to specialist support	A 100.0	B 85.9
Organisational audit total score	B 83.9	D 63.0

The latest data from the clinical audit shows that the RSCH stroke unit scores highly for immediate CT scanning, thrombolysis rates, Stroke unit processes, early specialist assessments, and discharge, but is challenged to provide sufficient early specialist rehabilitation due to low therapy staffing or the ideal of 7 day working for all staff. Review of the BSUHT data shows improvement in overall SSNAP scores on both sites across the quarters. Whilst the 'D' overall is challenging, 71% of national units currently achieve a D or E. Where stroke services have undergone significant reorganisation and financial investment in London, standards are generally A or B. This supports the case for Sussex-wide review of the model of care.

	SSNAP level (Q1 2014)	Patient Numbers (Q1 2014)	SSNAP Score (level) Jul-Sept 2013 (Q2)	SSNAP Score (level) Oct-Dec 2013 (Q3)	SSNAP Score (level) Jan-March 2014 (Q4)	SSNAP Score (level) Apr-June 2014 (Q1)
RSCH	D	131	41.5 (D)	45.6 (D)	54.2 (D)	57.9 (D)
PRH	D	61	38.8 (E)	35.7 (E)	45.0 (D)	53.0 (D)

Strategic Challenges for BSUH

Whilst the service provided for stroke patients at RSCH performs well, it faces a number of challenges.

- Immediate access to acute stroke beds, partly a factor of the general pressure on beds faced at RSCH, although the RSCH direct admission rate is above the national mean at 59.2% (National 58%)

- Insufficient specialist staff, including senior nurses, therapists, psychologists and doctors to deliver the standards of care we aspire to. There are national shortages in staff in these groups who have the specific training required for acute stroke care. This impacts on :

    - Providing a uniform service 24 hours a day, 7 days a week
    - Providing all the therapeutic interventions stroke patients need

- Lack of responsive Early Supported Discharge (ESD) for East Sussex patients, impacting on East Sussex patients length of stay and our ability to rapidly discharge home with community rehabilitation. This impacts on the overall availability of stroke beds. In contrast the Brighton and Hove ESD is very responsive

- Currently the service is not resourced to deliver 6 monthly patient reviews by the whole stroke team. At present we undertake a six-monthly follow up phone call by our senior stroke co-ordinator and bi-monthly multi-disciplinary evening sessions to invite patients and carers back to RSCH to review any urgent issues. In addition all patients are seen in outpatients post discharge. Patients perceive a 'gap in care' when they go home and the reality of life post stroke is more apparent. We are discussing this area of provision with local CCGs.

- The challenge of running acute stroke units on two sites and providing equitable 24/7, 7/7 per week care

The way forward

BSUH has identified in its clinical strategy, that improvements to stroke care are a key priority for the organisation.

We believe significant re-organisation of our services will be required to achieve this. In order to make the improvements against national standards that will benefit patients, we believe re-organisation to a single site may be the best approach. However, this will be a significant change to service provision which will require extensive consultation and firstly and most importantly, the support of our clinically-led commissioners.

At the present time, we believe it is best that we do this in partnership with all of the CCGs and providers of stroke care across Sussex. Changes to provision at BSUH could adversely affect other systems, so it is important to plan to improve stroke care on a larger footprint.

However, should changes not go ahead on a Sussex basis, BSUH will need to formally consider the case for change of its own service configuration in the near future. The sole and over-riding basis in such a consideration will be improving the quality of care for patients. However, the Trust will need to consider the 'fit' of stroke services with other specialised care such as neurosurgery and vascular surgery, and also the impact of any changes on how it manages the limited supply of inpatient bed space at both acute sites. In any event proposed change will need to be discussed with commissioners, patients and the public and this will be done through the relevant consultation processes.

Dr Nicola Gainsborough, November 2014

Appendix A

Summary of domain scores

RSCH scores are highlighted in bold in the table

Summary of domain scores	A	B	C	D	E	RSCH
D1 Acute care*	21 sites (11%) scored 90-100%	**15 sites (8%) scored 80-89%**	45 sites (25%) scored 65-79%	86 sites (47%) scored 50-64%	16 sites (9%) scored <50%	**B 87.5**
D2 Specialist roles	45 sites (25%) scored 90-100%	40 sites (22%) scored 80-89%	**51 sites (28%) scored 65-79%**	39 sites (21%) scored 50-64%	8 sites (4%) scored <50%	**C 70.0**
D3 Interdisciplinary services	7 sites (4%) scored 85-100%	42 sites (23%) scored 70-84%	45 sites (25%) scored 60-69%	**65 sites (36%) scored 45-49%**	24 sites (13%) scored <40%	**D 45.8**
D4 TIA/Neurovascular clinic	**88 sites (48%) scored 90-100%**	45 sites (25%) scored 80-89%	37 sites (20%) scored 70-79%	5 sites (3%) scored 60-69%	8 sites (4%) scored <60%	**A 100.0**
D5 Quality improvement, training & research	**55 sites (30%) scored 85-100%**	30 sites (16%) scored 75-84%	48 sites (26%) scored 65-74%	26 sites (14%) scored 50-64%	24 sites (13%) Scored <50%	**A 100.0**
D6 Planning & access to specialist support	**94 sites (51%) scored 90-100%**	37 sites (20%) scored 75-89%	15 sites (8%) scored 60-74%	12 sites (7%) scored 50-59%	25 sites (14%) scored <50%	**A 100.0**
Organisational audit total score	12 sites (7%) scored 90-100	**46 sites (25%) scored 80-89%**	61 sites (33%) scored 70-79%	44 sites (24%) scored 60-69%	20 sites (11%) scored <60%	**B 83.9**