Who are we?

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

Where and when is the Board meeting?

This next meeting will be held in the Council Chamber, Hove Town Hall on Tuesday 24 March 2020, starting at 4.00pm. It will last about two and a half hours.
There is limited public seating available for those who wish to observe the meeting. Board meetings are also available to view on the council's website.

What is being discussed?

There are 5 main items on the agenda

- Directorate of Public Health – Annual Report;
- Joint Health and Wellbeing Strategy Outcome Measures;
- Better Lives, Stronger Communities;
- Commissioning Strategy – Health and Adult Social Care;
- Brighton and Hove Healthwatch GP review, Patients Experiences of Primary Care in Brighton and Hove During 2019

Health & Wellbeing Board
24 March 2020
4.00pm
Council Chamber, Hove Town Hall

Who is invited:

B&HCC Members: Moonan (Chair), Appich (Deputy Chair), Shanks (Opposition Spokesperson), Bagaeen (Group Spokesperson) and Nield

CCG Members: Dr Andrew Hodson (Deputy Chair), Lola BanJoko, Malcolm Dennett, Dr Jim Graham and Ashley Scarff

Non-Voting Co-optees: Geoff Raw (CE - BHCC), Deb Austin (Acting Statutory Director of Chidlren's Services), Rob Persey (Statutory Director for Adult Care), Alistair Hill (Director of Public Health), Graham Bartlett (Safeguarding Adults Board), Chris Robson (Local Safeguarding Children Board) and David Liley (Healthwatch)

Contact: **Penny Jennings**
Secretary to the Board
Democratic Services Officer01273 291065
penny.jennings@brighton-hove.gov.uk

Date of Publication - Monday, 16 March 2020

This Agenda and all accompanying reports are printed on recycled paper

AGENDA

Formal matters of procedure

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

Page

58 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

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

59 MINUTES **9 - 36**

To consider and approve the minutes of:

(a) The meeting of the Board held on 28 January 2020 (copy attached); and

(b) The Special meeting of the Board held on 6 February 2020 (copy attached)

60 CHAIR'S COMMUNICATIONS

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

61 FORMAL PUBLIC INVOLVEMENT

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

(a) Petitions – to consider any petitions received by noon on 17 March 2020;

(b) Written Questions – to consider any written questions received by 17 March 2020;

(c) Deputations – to consider any Deputations received.

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62 FORMAL MEMBER INVOLVEMENT

To consider any of the following:

(a) Petitions;

(b) Written Questions;

(c) Letters;

(d) Notices of Motion

63 DIRECTORATE OF PUBLIC HEALTH - ANNUAL REPORT 37 - 68

Report of the Director of Public Health (copy attached)

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

64 JOINT HEALTH AND WELLBEING STRATEGY OUTCOME MEASURES 69 - 74

Report of the Director of Public Health (copy attached)

Contact: *Kate Gilchrist* *Tel: 01273 290457*
Ward Affected: *All Wards*

65 BETTER LIVES, STRONGER COMMUNITIES 75 - 92

Report of the Executive Director, Adult Health and Social Care (copy attached)
Contact: Grace Hanley *Tel:0127329928*

Ward Affected: *All Wards*

66 COMMISSIONING STRATEGY -HEALTH AND ADULT SOCIAL CARE 93 - 116

Report of the Executive Director Adult Health and Social Care (copy attached)

Contact: *Andy Witham* *Tel: 01273 291498*
Ward Affected: *All Wards*

67 BRIGHTON AND HOVE HEALTHWATCH GP REVIEW, PATIENTS EXPERIENCES OF PRIMARY CARE IN BRIGHTON AND HOVE DURING 2019 117 - 228

Report detailing the review carried out by Healthwatch (copy attached)
Ward Affected: *All Wards*

Health & Wellbeing

WEBCASTING NOTICE
This meeting may be filmed for live or subsequent broadcast via the Council's website. At the start of the meeting the Chair will confirm if all or part of the meeting is being filmed. You should be aware that the Council is a Data Controller under the Data Protection Act 1998. Data collected during this web cast will be retained in accordance with the Council's published policy (Guidance for Employees' on the BHCC website).

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Electronic agendas can also be accessed through our meetings app available through www.moderngov.co.uk

For further details and general enquiries about this meeting contact Democratic Services, 01273 2910656 or email democratic.services@brighton-hove.gov.uk

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

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

Hove Town Hall has facilities for people with mobility impairments including a lift and wheelchair accessible WCs. However, in the event of an emergency use of the lift is restricted for health and safety reasons please refer to the Access Notice in the agenda below.

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

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If the fire alarm sounds continuously, or if you are instructed to do so, you must leave the building by the nearest available exit. You will be directed to the nearest exit by council staff. It is vital that you follow their instructions:

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

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

Health & Wellbeing

1. Procedural Business

(a) Declaration of Substitutes: Where Members of the Board are unable to attend a meeting, a designated substitute for that Member may attend, speak and vote in their place for that meeting.

(b) Declarations of Interest:

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

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

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

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

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

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

HEALTH AND WELLBEING BOARD	Agenda Item 59 (a) Brighton and Hove City Council

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING BOARD

4.00pm 28 JANUARY 2020

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillors Moonan (Chair), Appich (Deputy Chair), Shanks (Opposition Spokesperson), Bagaeen (Group Spokesperson) and Nield
Brighton and Hove CCG: Dr Andrew Hodson (Chair of the CCG and Co-Deputy Chair), Lola Banjoko, Malcolm Dennett ad Ashley Scarff

Also in Attendance: Geoff Raw, Chief Executive; Deb Austin, Acting Statutory Executive Director, Children's Services; Rob Persey, Statutory Director for Adult Social Care; Alistair Hill, Director of Public Health and David Liley, Brighton and Hove Healthwatch

PART ONE

38 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

38(a) Apologies

38.1 Apologies were received from Graham Bartlett, Brighton and Hove Local Safeguarding Adults Board and Chris Robson, Brighton and Hove Local Safeguarding Children Board

38(b) Declarations of Substitutes, Interests and Exclusions

38.2 There were none.

38c Exclusion of press and public

38.3 28.3 In accordance with Section 100A of the Local Government Act 1972 ("the Act"), the Health and Wellbeing Board considered whether the public should be excluded from the meeting during consideration of any item of business on the grounds that it is likely in view of the business to be transacted or the nature of the proceedings, that if members of the public were present during it, there would be disclosure to them of confidential information as defined in Section 100A (3) of the Act.

38.4 It was noted that Item 47 contained exempt information which would have needed to be considered whilst the press and public were excluded from the meeting. It had been agreed however that in view of the late release of this item it would now be considered at a special meeting of the Board the details of which would be confirmed as soon as possible.

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

38.6 The Chair explained that this meeting although being webcast would not be available to watch live, although once uploaded would be available for repeated future viewing.

39 MINUTES

39a Minutes of Special Meeting, 5 November 2019

39.1 **RESOLVED -** That the Chair be authorised to sign the minutes of the special meeting held on 5 November 2019 as a correct record.

39b Minutes of Meeting, 12 November 2019

39.2 **RESOLVED -** That the Chair be authorised to sign the minutes of the meeting held on 12 November 2019 as a correct record.

40 CHAIR'S COMMUNICATIONS

Better Care Fund

40.1 The Chair, Councillor Moonan, explained that she wished to update the Board on one item which did not require a formal report that day. The Better Care Fund included a section 75 agreement which supported the joint working. In September we had been informed that the agreement would need to be formally extended when the funding had been agreed with national government. The Chair was able to confirm that this agreement had now been formally signed off and a formal report on the targets and outcomes would come to the Board's next scheduled meeting in March.

Draft Sussex Health & Care – Response to the NHS Long Term Plan

40.2 The draft Sussex Health & Care response to the NHS Long Term Plan had been presented to the November special meeting and it was understood that the draft response had now been submitted. Whilst there had been some feed-back this had not been finalised as yet. Work had started on the delivery plan to support the response. The scrutiny of the NHS Long Term Plan would sit with the Health Overview and Scrutiny Committee.

Flu Jab/Vaccination

40.3 The Chair also wished to highlight that that it is not too late for anyone to receive a Flu Jab. Many people often thought that as it is after Christmas and in new year it was too late to bother but locally we were only just starting to hit our peak levels.

Wuhan Novel Coronavirus

40.4 The Chair stated that everyone was aware of the novel coronavirus which had been identified recently which appeared to have originated in Wuhan, China. This situation was evolving rapidly and was being monitored carefully, but based on the available evidence, Public Health England had advised that the current risk to the UK population was low. The BHCC Public Health team were liaising closely with Public Health England and CCG colleagues to ensure that we were able to respond appropriately and quickly to any situational changes. NHS England had cascaded detailed information on managing suspected cases to all front-line NHS staff. The link to the latest information is set out below:

Based on the available evidence, Public Health England advise that the current risk to the UK population is low.

Re-procurement of Substance Misuse Service

40.5 contracts for:
(i) In-patient detoxification; and
(ii) Community recovery service

It was noted that at the meeting of the Board held on 29 January 2019 delegated authority had been granted for the Executive Director of Health and Adult Social Care (HASC) to undertake procurement by tender and award of contracts for substance misuse services for a term of five years with the provision for a further two year extension. The re-procurement process is now complete and the contracts have been awarded as follows:

For Lot 1: inpatient detoxification services, the contract has been awarded to Vale House Stabilisation Services.

For Lot 2: community recovery service, the contract has been awarded to Change, Grow, Live (CGL)

The contract documents were now in preparation and the planned start date for the new services was 1 April 2020.

Deferral of Consideration of Consideration of Report(s) 47 and 50 – Commissioning of a Supported Living Service for People With Cognitive Impairments

40.6 The Chair explained that after consulting with colleagues and other members of the Board she had taken the decision to hold back the report(s) on commissioning a supported living service for people with cognitive impairments. Once the existing service provider had given notice everyone had known that fulfilling the required procurement

process and mobilising a new service to protect service users would be extremely challenging. We had also had to compare the preferred bid accurately with an in-house offer. As a result this report could not fit neatly into the timings of the Board meetings which were set a year in advance.

40.7 Members considered that they had, had insufficient time to read through and fully understand the implications of the report in time to make a considered decision that day. The Chair went on to explain that the decision could not be delayed for long in view of the need to protect as the wellbeing of the existing service users and the timescales to award the contract. Her preference was for this report to be brought back to a special meeting of the Board the following week, the timings for which were to be confirmed. The recommendations for the Board remained that the service be outsourced to an external provider who could provide a high quality specialist service for the best value to the council.

40.8 **RESOLVED –** That the content of the Chair's Communications be received and noted.

Callover

40.9 All items on the agenda were reserved for discussion with the exception of Item 46, details as set out below:

Item 46 – "Annual Review of Adult Social Care Charging Policy 2020"

40.10 The officer recommendations set out in the above report were agreed without debate.

41 FORMAL PUBLIC INVOLVEMENT

41a Petition(s)

41.1 There were none.

41b Written Question(s)

41.2 It was noted that five written questions had been received, four of which related to the roll-out of 5G technology and the other to social prescribing. Three of those who had submitted questions were not in attendance at the meeting, the Chair confirmed however that details both of the question(s) themselves and the responses given would be set out in the minutes. The questions submitted and the responses provided by the Chair are set out below:

Accountability for Future Health Issues Related to 5G – Mr Manderlay

41.3 The Chair, Councillor Moonan, invited Mr Manderlay to put his question which is set out below:

"Who is going to be held accountable for any future health issues in either individuals or groups of people related to 5G?

Is it not true that the person or persons held responsible will be the one (or ones) whose signature (or signatures) appear on the permits?"

41.4 The Chair, responded in the following terms:

"The report which the Board is considering today sets out the role of the Council in relation to the roll-out of 5G in the context of its planning powers. The Council should follow the National Planning Policy Framework when considering planning applications and this states that local planning authorities should not "set health safeguards different from the International Commission guidelines for public exposure." The Council is therefore expected to rely on the International Commission guidelines which have been reviewed by Public Health England (PHE). Further, in most cases, as set out in the report no planning applications are required because of permitted development rights and the Council therefore has limited powers in dealing with proposals to which these rights apply."

41.5 Mr Manderlay had given prior notification of a supplementary question and this is set out below:

"In your "response to petition to halt the roll-out of 5G" you state that you (and the government) take the advice from Public Health England. On their website PHE refer to research and studies regarding the safety of RF, including Non-Ionising Radiation. My question is, what are these researches and studies and, most importantly, who conducted them? Thousands of doctors and scientists the world over have drawn attention to hundreds, if not thousands, of peer reviewed papers to the total lack of independent studies about the long term effects of non-ionising radiation in humans (not to mention wildlife). If PHE claim the studies have been done, they need to state who did them and why as well as their lengths and specific remits. Shouldn't a decision which potentially affects the health and wellbeing of many generations to come be based on thorough, independent research and studies?"

41.6 The Chair's response is set out below:

"I will need to refer you to Public Health England as they are the lead body on reviewing the evidence base from all areas. They provide the guidance which local bodies then use. I should stress that Public Health England is different from our local public health team. Public Health England (PHE) is an executive agency of the Department of Health and Social Care (DHSC) which is the expert national public health agency.

Refusal of Major Insurers to Insure Their Policies Against Negative Health Impacts of wi-fi Technologies Including 5G- Ms Hidalgo

41.7 Ms Hidaglo was invited to put her question which is set out below:

"If 5G is so safe, how come that leading insurers the world over, including Lloyds of London refuse to insure in their policies against any negative health effects caused by wi-fi technologies including 5G"

41.8 The Chair, responded in the following terms:

"insurance companies operate as independent commercial entities, unlike Council's which are required to follow the International Commission Guidelines. I cannot comment on the stance taken by insurance companies but I would like to reiterated that the Council will always carefully consider any planning application which does come forward that relates to 5G and there is the opportunity for people to put forward their comments in relation to those applications which will be given careful consideration in each case."

41.9 Mr Hidaglo had given prior notification of a supplementary question and this is set out below:

"What about the increasing number of people already sensitive to EMF? I know someone who is and their life has exponentially got worse ever since the launch of 3 and 4G. Nausea, headaches, dizziness and nerve pain on a daily basis. With 5G on top of this life will become intolerable to these people. And, as I have said their numbers are increasing."

41.10 The Chair, responded in the following terms:

As I have set out above, any concerns or objections that are raised in relation to individual planning applications will be carefully considered, including any health concerns."

Classification of Impact on Wildlife as an Emerging Issue- Ms Blosse

41.11 The following question had been notified by Ms Blosse:

"The European Commission's Scientific Committee on Health, Environmental and emerging Risks (SCHEER), assessed potential effects on wildlife from increases in electromagnetic radiation. 5G technology was classified as an "emerging issue" and given the highest ranking as an environmental hazard. It highlighted the concern that since health and safety issues remain unknown, it leaves the possibility of unintended biological consequences to the environment. The EKLIPSE report "The Impacts of EMR on Wildlife" confirms the harm from EMR on wildlife. Bees are at greater risk and in decline. What is the Health and Wellbeing Board planning to do to protect our city?"

41.12 The Chair's response is set out below:

"The County Ecologist has been consulted on this issue. None of the main government departments and agencies (The Environment Agency, DEFRA, Natural England) and or leading advocacy groups (RSPB and Bug Life) have information or guidance on this issue and do not direct us to any research. However, the issue was raised in the House of Commons' during questions and at that time (June 2019), Margot James gave the following response on behalf of the Government:-

"Electromagnetic radiation (EMR) has the potential to impact the movement of insects and some species of animals, but there is currently no evidence that human-made EMR, at realistic field level impacts on (a) plants, (b) animals or (c) insects."

The guidance we do have is that there is no known impact on human health (the remit of Health and Wellbeing Board) and, as we have already heard, there are planning and

legal limitations on how the city council can act as a local planning authority. As I have set out above, any concerns or objections that are raised in relation to individua planning applications will be carefully considered and if there is guidance or relevant research that comes forward this can considered alongside those concerns and objections."

Limitations of ICNIRP-Ms Gomez/Ms Edgell

41.13 The following question had been notified by Ms Gomez/Ms Edgell:

The ICNIRP does not guarantee the correctness, reliability, or completeness of the information published on its website for guideline purposes. The content is provided for information only. ICNIRP do not assume any responsibility for any damage, including direct or indirect loss suffered by users or third parties in connection with the website and the information it contains including any technical data, recommendations, or specification available and an insurance company (Swiss Re) has listed 5G as a "high impact risk". Their white paper wording as follows:

"existing concerns regarding potential negative health effects from electromagnetic fields (EMF) are only likely to increase. An uptake in liability claims could be a potential long term consequence. https://es-ireland.com/2019/06/17may-2019-swiss re-classifies-5g-as-high-impact-emerging-risk-in-whitepaper/

Therefore if an insurance company will not take the risk then why would Brighton and Hove risk the health and lives of the residents of Brighton and Hove. Who is taking responsibility for damages caused by forcing me to be tortured by 5G pollution against my will?"

41.14 The Chair's response is set out below:

"Again I refer back to my previous responses and to the information set out in the report. I cannot comment on the position taken by insurance companies but the Council is clear about its responsibilities in relation to determining planning applications in accordance with the National Planning Policy Framework. This does require policies citing the International Commission guidelines to be treated as material when considering electronic communications development proposals. Once again I would like to reiterate that much of the development connected with the roll out of 5G will benefit from permitted development rights. The Council will carefully consider every individual planning application that it does receive, including any objections or comments received."

Social Prescribing – Mr Kapp

41.15 The Chair, Councillor Moonan, invited Mr Kapp to put his question which is set out below:

"Why isn't improvement in health included in the Council's 3 year plan (published in the "Argus" on 18 January 2020), when £454 million of public money is devolved from central government to the Clinical Commissioning Group this year, which together with £126mpa makes £580mpa for health and social care, which will probably rise next year

to £600mpa, the dispersion of which should be decided by all councillors at the budget meeting on 27 February 2020?"

41.16 The Chair thanked Mr Kapp for his questions and responded in the following terms:

"I would like to correct you as the Council Plan has several pages covering "A Healthy and Caring City". However, the Council Plan is the Council Plan covering the things it can control. While it does include working with partners, such as the, pages covering "A Healthy and Caring City" the CCG while a partner is also an entity in its own right with its own control over its finances and priorities. The Council and the CCG have both agreed the Joint Health and Wellbeing Strategy to which we are both joint partners and is focused on health improvement for the city. We will continue to work with the CCG on joint priorities but there would need to be a significant change in national legislation for your proposal to be allowed in law."

41.17 Mr Kapp was invited by the Chair to ask a supplementary question if he had one and this and the Chair's response to it is set out below:

41.18 "We had information given to the July Board about social prescribing but not the detailed funding as to how it works. I have had similar emails from people who run various things like Nordic Walking wanting to know how they can get funding to run such services. However the Board is not the funding controller for social prescribing nor is the CCG – this comes from the national pocket. Will the Health and Wellbeing Board agree to take a paper raising the question of whether or not licensed social prescribing providers should be paid as pharmacists are paid for drugs?"

41.19 The Chair responded as set out below:

"At the outset I should explain that Social Prescribing is not the same as prescribing medication. NHSE had a detailed webpage covering which I would encourage people to look at. It is. however far too detailed to report all the information to you today so I have been selective but have attached the link to the detail and this will go in the minutes.https://www.england.nhs.uk/personalisedcare/social-prescribing/

Social Prescribing is a way for local agencies to refer people to a link worker. Link workers give people time, focusing on "what matters to me" and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support. Funding for the new social prescribing link workers became available to primary care networks (PCNs) from 1 July 2019 when the reformed GP contract began. This is the biggest investment in social prescribing by any national health system, and legitimises community-based activities and support alongside medical treatment as part of personalised care."

41.20 **RESOLVED –** That the questions submitted and the Chair's response to them be noted and received.

41c Deputations

41.21 There were none.

42 FORMAL MEMBER INVOLVEMENT

42a Petitions

42.1 There were none.

42b Written Questions

42.2 A question had been circulated by Councillor Nield. The text of which is set out below:

"I have been contacted, as I think all Members have, by a resident who wants to know why as a transgender man he is having to wait years to access hormone treatment in Brighton and Hove. His mental health is suffering as he waits.

He says:

"Brighton is a beacon of hope for transgender people across the UK in terms of social acceptance, but this doesn't appear to be reflected in the NHS services provided. We need hormone treatment provided in a reasonable timescale."

I am very interested to see this same issue raised in the Local Term Plan:

4.2.6 local priorities: trans locally commissioned service in primary care. Responding to issues raised by our population there is a recognised gap and level of need in services for supporting our transgender population. An audit of local GP practices showed there were significant difficulties for transgender and non-binary patients such as long waits to receive prescribed hormone treatment. Brighton and Hove CCG are developing initial service costings and plans to initiate a three-year pilot service to fill this gap and improve the services for this population cohort. If we succeed, we would be proud to be the first CCG to do this in the country."

"I would very much like to know more about these plans: particularly how soon we can expect this pilot to begin, and what will be its scale and scope."

42.3 The Chair, Councillor Moonan, responded in the following terms:

"Thank you for this question and for raising it on behalf of other members of this Board.

I have a response from the CCG. I should highlight that this response does not go into the details of the individual concerned as that would not be appropriate although I have been assured that provision is arranged. Before I give the CCG response, it is worth noting that the board and also HOSC have been aware of waiting times for referral to specialist gender identity services at Charing Cross hospital are long. We are also aware that all GPs do not have the experience required to intervene in ways which would mitigate the negative impact of the long wait for a specialist referral (e.g., by prescribing hormones).

The Council held a Trans Equalities Scrutiny Panel in 2015 and that Panel heard evidence and made recommendations on issues which do relate to the issues raised. Specifically, the Panel heard that there were long waits for referral to the Gender Identity Clinic at Charing Cross. The Panel did not make recommendations to improve the Gender Identity Clinic but did make recommendations for a much more robust assessment of local need (via a Trans Needs Assessment and other measures) so that the local NHS was in the best position possible to manage demand.

The Panel also heard evidence about the issue of GP expertise in dealing with Trans health issues and made a number of recommendations, including a recommendation that the CCG explored the potential to pilot enhanced gender identity healthcare services at a central Brighton GP practice–i.e., so that local trans people had timely access to a more expert service than GPs can typically provide.

In short, I think that the Council has shown an interest in precisely the issues raised by the complainant: (a) excessive waits for GIC; and (b) the need to develop a level of local specialism that might mitigate (a). However, despite the Council making recommendations to the CCG in 2015 -and the CCG agreeing to implement the recommendations – the problems have continued.

The CCG has made a formal response:
Currently there are a range of support initiatives in place. There is also a guide for GPs/General practice available on the CCG website:

https://www.gpbrightonandhoveccg.nhs.uk/supporting patients -accessing-gender-identity-services;

https://www.brightonandhoveccg.nhs.uk/gp-guide-supporting-trans-patients-launched

Also, a screening document for trans people has been produced because when a person's record is changed to reflect their identity, they will not automatically be called for screening programmes, i.e., someone who is female to male will not be called for cervical or breast screening even if they still have cervical or breast tissue

https://www.brightonandhoveccg.nhs.uk/your-health/screening

There is a pilot in development that is in the scoping stages which will mean that there will be a local satellite service available in the city. This work is underway and the CCG will update the Board about progress with this shortly.

42.6 **RESOLVED –** That the content of the submitted question and the Chair's response be noted and received.

42c Letters

42.7 There were none.

42d Notices of Motion

42.8 There were none.

43 INTERIM RESPONSE TO PETITION TO HALT THE ROLLOUT OF 5G

43.1 The Board considered a joint report of the Director of Public Health, the Executive Director, Health and Adult Social Care and the Executive Director, Economy Environment and Culture outlining the national guidance relating to the ability to the council to influence roll-out of mobile technology.

43.2 It was noted that at the meeting of Full Council held on 24 October 2019 a petition with 2,240 signatures had been presented requesting that the roll out of 5G technology be halted. A Green Group amendment recommending that the petition was noted and a report on the issue provided for consideration at the next available meeting of the Board was passed.

43.3 Public Health England (PHE) took the lead nationally and provided expert advice on public health matters associated with high frequency EMF and their recently updated guidance could be found in Appendix 1 to the report. The PHE's advice was based on comprehensive evidence reviews which had been prepared by expert scientists in the UK and around the world including the World Health Organisation (WHO) and the International Commission on Non-Ionizing Radiation Protection (ICNIRP). Their consensus was that there was no conclusive evidence of adverse health effects related to short term or long-term exposure to high frequency EMF or that EMF below certain safety thresholds was harmful to health.

43.4 The Assistant Director, City Development and Regeneration, Max Woodford, explained that the ability of councils to influence the roll-out of mobile technology was limited by central government regulations on permitted development rights (through the prior approval process) that allowed specified development to go ahead without planning permission. As a consequence planning policy could not be used to halt the roll out of 5G. The planning system did, however, require that any new installations were consistent with the international guidelines adhered to by PHE. Prior approval of the local planning authority was required for masts and certain other types of apparatus falling within permitted development rights, however, considerations were strictly limited to siting and appearance and the only applications refused by the council in respect of such equipment which had been successful at appeal had been on those grounds. Such applications had to be publicised and any representations received taken into account by the local planning authority in determining whether prior approval should be refused and planning permission required.

43.4 Councillor Nield referred to use of the "precautionary principle" referred to in the petitioners' submission, she understood that the council's powers under planning legislation were limited but sought clarification regarding any other powers which might be available.

43.5 The Head of Legal Services, Elizabeth Culbert, explained that there was no legal obligation or statutory duty for the local planning authority to apply the "precautionary principle". The Council as a local planning authority was in a different position to town council's that had expressed opposition to the roll out of 5G technology. All applications for planning permission needed to be determined on their own merits and the council would be open to allegations of predetermination if it adopted a policy position that the

precautionary principle should apply as this would fetter the discretionary power of the local planning authority to grant planning permission. It was highly likely that any such approach would be challenged in the courts.

43.6 Councillor Bagaeen sought clarification in respect of any masts situated on council land/buildings and the powers available to it in such circumstances.

43.7 The Assistant Director, City Development and Regeneration, Max Woodford, explained that although the majority of mast sites in the city would be allowed under permitted development rights, there were currently eight mast sites on council land which were leased to operators who might look to use those sites for 5G technology outside of those rights. Two masts on top of council buildings were used for telecommunications equipment, there were also six council owned sites in more remote locations, used for transmitting and receiving television signals and these due to their locations might be unsuitable for 5G given the short wavelength of the signals. Even if these sites were used they would form a very small part of the equipment that needed to be installed across the city, most of which would be permitted under existing development rights. All other applications would need to considered and determined on their individual merits.

43.8 The Chair, Councillor Moonan, thanked officers for the report which set out clearly the council's position and detailed its limited ability to influence the roll-out of mobile technology and the reasons that was so.

43.9 **RESOLVED –** That the contents of the report be noted.

44 BRIGHTON AND HOVE HEALTH AND WELLBEING STRATEGY 2019-2030, DELIVERY PLAN

44.1 The Board considered a joint report of the Director of Public Health, the Executive Director, Health and Adult Social Care and the Executive Managing Director, Brighton and Hove Clinical Commissioning Group detailing the Brighton and Hove Health and Wellbeing Strategy 2019- 2030 and seeking approval of the initial Health and Wellbeing Strategy Delivery Plan which made recommendations for areas it would like to consider in the 2020/21 programme.

44.2 It was noted that Health and Wellbeing Boards had a duty to prepare a Joint Health and Wellbeing Strategy in order to meet needs identified in the Joint Strategic Needs Assessment. The Brighton and Hove Health and Wellbeing Strategy 2019-30 had been approved by the Board at its meeting in March 2019 and this paper presented an initial delivery plan to deliver the aspirations of the strategy. Board Members would provide system leadership to enable the delivery and further development of the Plan.

44.3 It was noted that the following amendment to the recommendations had been received from the Green Group proposed by Councillor Shanks and seconded by Councillor Nield.

"To add the recommendation 1.2:

That the Board agrees to invite relevant Heads of Service of the Council to attend the Board at different meetings throughout the year to report on how their department is

fulfilling the Strategy and to explain their detailed plans to the Board, e.g., the Head of Transport to report on how the City's Transport Strategy will comply with the requirements of the Health and Wellbeing Strategy."

44.4 Councillor Shanks stated that she fully supported the Plan but considered that it was very important to ensure that there was effective reporting back on work to/of all partners in order to keep the strategy rolling forward. Councillor Nield also concurred in that view stating that she had seconded the amendment on that basis.

44.5 Councillor Bagaeen stated that he also supported the proposed amendment which would help to ensure that the cross-cutting approach advocated was carried forward effectively.

44.6 Councillor Shanks referred to the social prescribing which in cases where that was considered to be appropriate could ease the pressure on busy GP practices as did measures already in place to encourage earlier intervention and to enable patients to speak to/be seen by other suitably qualified staff other than solely by their GP.

44.7 Councillor Appich referred to the measures in place to ensure that those with learning disabilities were aware of and had access to a full range of services. Councillor Appich had attended a Partnership Board meeting at which these issues had been discussed the previous day and the available data was very worrying.

44.8 The Chair, Councillor Moonan, welcomed the proposed amendment which would help to ensure that the Board were kept updated regarding roll-out across council departments and the interface between that work its interface with other partners.

44.9 As no further matters were raised in respect of this item the Chair then took a vote on the proposed amendment. A vote was taken, the amendment was carried and was then voted on as a substantive repot recommendation.

44.10 **RESOLVED –** (1) That the Board approves the initial Health and Wellbeing Strategy Delivery Plan and makes recommendations for areas it would like to consider in its 2020/21 programme; and

(2) That the Board agrees to invite relevant Heads of Service of the Council to attend the Board at different meetings throughout the year to report on how their department is fulfilling the Strategy and to give the Board their detailed plans, e.g., the Head of Transport to report on how the City's Transport Strategy will comply with the requirements of the Health and Wellbeing Strategy.

NB: The Board were in agreement that the Strategy needed to be incorporated into all areas of council decision making, for other areas of the council to report back on issues relating to the Strategy (as referred to in 2 above); for feedback on progress to start with starting well and dying well and then to move on to the other two wells. Yearly updates on progress of the Plan will be given to the Board from June 2021.

45 PROPOSED FEES FOR ADULT SOCIAL CARE PROVIDERS 2020 -21

45.1 The Board considered a report of the Executive Director, Health and Adult Social Care setting out the proposed fees for Adult Social Care Providers 2020/21.

45.2 It was explained that the paper set out the recommended fee levels and uplifts to be paid to Adult Social Care Providers from April 2020. The services that were considered in the report were integral to the proper functioning of the wider health and care system which included managing patient flow in and out of hospital. It was recognised that public finances were under increasing pressure but that this needed to be balanced with the need to manage and sustain the provider market to support the increasing complexity and demand to comply with the duties placed on the Council by the Care Act 2014 to meet the needs of those requiring care and support and to seek to ensure provider sustainability and viability. As there had been no uplift for the 2019/20 financial year supporting and sustaining the provider market was of particular significance for 2020/21 financial year.

45.3 Councillor Shanks noted that that the living wage was paid to those working for adult social care providers. Councillor Shanks enquired regarding mechanisms in place to ensure that was the case, any ongoing monitoring carried out to ensure that remained the case and, whether contracts entered into contained a specific clause/clauses requiring that to be the case. Councillor Shanks also enquired regarding whether a review process existed to check that provision was being managed in accordance with the contracts entered into and that staff were paid in line with what had been agreed, stating that she would have expected that to be evidenced. Councillor Shanks stated that she did not consider that the information provided was sufficient for her to agree the report recommendations. Councillor Nield concurred in that view.

45.4 Councillor Bagaeen queried why an uplift of 2% had been recommended in a number of instances, particularly as figures in relation to some provision appeared to change month on month. It was explained that this figure was in line with that for the general Council budget which ensured that the fees set could be paid from the budget provision available, plus any addition element which might also be payable.

45.5 Councillor Appich stated that she met with officers to discuss some of the figures provided in more detail and the approach which had been taken was a reasonable one in her view. It should be noted that a wider review of commissioning strategies currently in place was to be undertaken for the following financial year and would be reflected in the recommendations put forward then.

45.6 No further matters were raised and the Chair therefore moved on to the vote and the recommendations set out in the report were agreed on a vote of 4 with 5 abstentions.

45.7 **RESOLVED –** (1) That the Board agrees to the recommended fee increases as set out in the table below. The underpinning background to the fee changes is set out in the main body of the report.

Tables of Fees

Service	Current fee 2019-20	New fee 2020-21	% uplift

Service	Current fee 2019-20	New fee 2020-21	% uplift
Care Homes and Care Homes with Nursing			
In city care homes – set fees per week	£571	£582	2%
In city care homes with nursing – set fees per week	£736.56 Includes FNC at £165.56	£747.56 Includes FNC at £165.56 *NB this may change as 2020-21 rate not yet set by NHS*	2%
In city Learning Disability care homes not on set rates (individually negotiated)	Variable	Variable	Variable
In city care homes not on set rates (individually negotiated)	Variable	Variable	Variable
In city care homes with nursing not on set rates (individually negotiated)	Variable	Variable	Variable
Block Contract Arrangements	Variable	Variable	Variable
Out of City Care Home and Care Home with Nursing Placements			
Out of city care homes on set rates	Host Authority Rates	Host Authority Rates	• Match set rates for new placements. • 2% to existing placements
Out of city care homes with nursing on set rates	Host Authority Rates	Host Authority Rates	• Match set rates for new placements. • 2% to existing placements
Out of city care homes individually negotiated	Variable	Variable	Variable
Out of city care homes with nursing individually negotiated	Variable	Variable	Variable
Supported Living & Community Support: Learning & Physical Disabilities, functional mental health			
Supported Living for people with learning disabilities	Variable	Variable	2%
Supported Living for adults with Physical and/or Sensory Disabilities and Acquired Brain Injury	Variable	Variable	Variable
Community support for people with learning disabilities	Variable	Variable	2%
Community support for adults with Physical and/or Sensory Disabilities and Acquired Brain Injury	Variable	Variable	2%
Community support for adults with functional mental health issues	Variable	Variable	variable
Home Care			
Home care main area/back up provider – core fee	£17.83	£18.19	2%
Home care main area/back up provider – enhanced fee	£19.83	£20.23	2%
Dynamic Purchasing System Approved	Variable	Variable	variable

Service	Current fee 2019-20	New fee 2020-21	% uplift
Provider Packages			

Direct Payments			
Direct Payments Monday to Friday hourly rate for those employing Personal Assistants	£10.80	£11.00	2%
Direct Payments Weekend hourly rate for those employing Personal Assistants	£11.80	£12.00	2%
Other Direct Payment agreements	Variable	Variable	2%
Shared Lives			
Shared Lives Management Fee	Variable	Variable	2%
Shared Lives fee to carers	Variable	Variable	2% to care element
Day Support			
Day support for people with Learning Disabilities	Variable	Variable	2%
Day support for people with Acquired Brain Injury	Variable	Variable	2%

Note: Councillors Nield and Shanks wished it to be recorded that they had abstained from voting in respect of the report recommendations.

46 ANNUAL REVIEW OF ADULT SOCIAL CARE CHARGING POLICY 2020

46.1 This item was not called for discussion and the report recommendations were agreed without discussion.

46.2 **RESOLVED –** (1) That the Board agrees (with effect from 6 April 2020) that the council continues with the current charging policy for care and support services which includes an individual financial assessment to determine affordability and complies with the requirements of Section 17 of the Care Act 2014. The charging policy is set out at Appendix 1 to the report; and

(2) The Board agrees an increase of charges as shown in the tables of charges set out below that with effect from 6 April 2020:

Maximum Charges	2019-20	**2020 - 2021**
Means Tested Charges		
In-house home care/support	£25 per hour	**£26 per hour**
In–house day care	£39 per day	**£40 per day**
In-House Residential Care	£123 per night	**£126 per night**
Fixed Rate Charges		
Fixed Rate Transport	£4.00 per return	**£4.10 per return**

Fixed Meal Charge /Day Care	£4.80 per meal	**£4.90 per meal**

To agree an increase to Carelink charges as follows:

Standard Carelink Plus service	£18.90 per month	**£19.30 per month**
Enhanced Carelink Service	£22.70 per month	**£23.15 per month**
Exclusive Mobile Phone Service	£24.50 per month	**£25 per month**

To agree an increase to miscellaneous fees as follows:

Deferred Payment set up fee (see 2.13)	£523 one-off	**£533 one-off**
Initial fee for contracting non-residential care for self- funders	£276 one-off	**£281 one-off**
Ongoing fee for contracting for non-residential care for self- funders	£85 per year	**£87 per year**

To continue with the existing policy not to charge carers for any direct provision of support to carers.

47 COMMISSIONING OF SUPPORTED LIVING SERVICE FOR PEOPLE WITH COGNITIVE IMPAIRMENT (ACQUIRED BRAIN INJURY)

47.1 Consideration of this report was deferred, it would be the subject of a specially convened meeting for its sole consideration. The date, time and venue for that meeting to be confirmed as soon as possible.

47.2 **RESOLVED –** That the position be noted.

48 FUTURE USE OF KNOLL HOUSE RESOURCE CENTRE

48.1 The Board considered a report of the Executive Director, Adult Social Care and Health relating to the future use of Knoll House Resource Centre.

48.2 It had been agreed at the meeting of the Board held on 10 September 2019 that a business case and options appraisal would be produced for the use of Knoll House as: (a) high level supported step-down accommodation for adults with mental health needs; or (b) lower level supported accommodation for adults with a mental health condition to enable independent living (c) both of the above options would be considered within the business case and options appraisal. It was recognised that in Brighton and Hove too many people were placed in residential and nursing placements in comparison with comparable authorities and that in many cases this was due to a lack of suitable alternative accommodation/provision.

48.3 The outline business case was detailed in the report and had looked at the two groups requested by the Board but had also included a third group in relation to physical

disabilities and acquired brain injury (ABI). Following consideration of all three options it was recommended that Option C be pursued for the reasons set out in the report, but that a final decision about whether to provide a Council run or outsourced service be made at the scheduled June meeting of the Board following

48.4 The Chair welcomed the report noting that the report to be brought forward to the June meeting of the Board would include detailed costings in respect of each option. The Chair was also pleased to note that it was intended that a Guardianship scheme would be put in place at the property.

48.5 Councillor Shanks stated that she was satisfied that this further report provided a well weighted consideration of all the options, noting that residents' concerns had been addressed and a meeting held with the residents' association. It was confirmed that the meeting had been valuable as it had been possible to give reassurance regarding the available options and that being pursued which was preferred for the reasons set out in the report.

48.6 Councillor Bagaeen sought clarification of the running/staffing costs in respect of Option B.

48.7 Councillor Appich referred to the fact that there were currently 5 Court of Protection cases for this cohort where the Court had specifically asked the Council what alternatives were being commissioned locally to enable moves asking whether/what interim arrangements would be made to ensure that these individuals needs and vulnerabilities were protected.

48.8 It was explained that cases were referred to the Court of Protection where people, lacking mental capacity to make decisions about their care, objected to their current care arrangements, for example they may have been placed out of area or in a care home setting with people from a different age group or with different needs to them. The Council was frequently expected to explain to the Court what steps they were taking to improve local provision given its Care Act duty to promote a diverse market of care providers in an area and to provide choice to clients in need of care.

48.9 The Board then moved to the vote agreeing the recommendations set out in the report.

48.10 **RESOLVED –** That the Board agree:

(i) Option C: Supported Living Service for people with Physical Disabilities and Acquired Brain Injury is taken forward as the preferred option;

(ii) that a final decision about the model and whether to provide a Council run or outsourced service is made at the June Health and Wellbeing Board meeting once further detailed work has taken place to identify the viability and model for each option;

(iii) To consider Options A & B: Services for people with Mental Health needs within the Commissioning Strategy; and

(iv) To put in placed a Guardian Scheme at the property.

49 WHAT HAPPENS WHEN A GP SURGERY CLOSES OR MERGES OR THERE IS OTHER SERIOUS PATIENT DISRUPTION

49.1 The Board considered a report of the Clinical Commissioning Group (CCG), Director of Partnerships, detailing the arrangements put into place when a GP surgery closed or merged with another surgery or when there was other serious patient disruption.

49.2 It was noted that the report had been requested by Board Members at their meeting on 10 September 2019, following the announcement that the Matlock Road surgery would be merging with the one in Beaconsfield Road. At that time the CCG had been asked to provide background information regarding the processes which the CCG had in place and undertook at a time of GP change. The paper provided for the Board that day detailed those steps and also sought to set them into the context of the wider CCG programme aimed at increasing practice resilience. A more detailed paper setting out the information in this report but also including details in relation to the development of PCNs, had been received by the Health Overview and Scrutiny Committee (HOSC). Brighton General Practices experienced pressures in common with the rest of the country in respect of practice closures, on-going cross workforce shortage and the increasing number of GP retirements. The Director of Partnerships at the CCG, Ashley Scarff, was accompanied by the Deputy Director of Primary Care at the CCG, Hugo Luck who was in attendance to answer Board Members questions.

49.3 The following addition/amendment to the recommendations had been received from the Green Group proposed by Councillor Nield and seconded by Councillor Shanks.

"To add the recommendation 1.2:

That the Board requests a further report which maps the geographical spread of GP practices in Brighton and Hove, shows where surgeries have been lost through closure or merger since 2015, and where surgeries may be in danger of closure or merger (for example through GP retirement) by 2030. This report is to explain the forward plan for ensuring that residents in all areas of Brighton and Hove are provided with primary care which is both local and accessible to them."

49.4 Councillors Nield and Shanks stated that their amendment had been put forward to seek to ensure that Board Members were fully informed in respect of this matter, if however, they considered information in response to questions by Board Members in addition to that set out in the report support was sufficient, they would withdraw their amendment.

49.5 The Director of Partnerships, Ashley Scarff, referred to the flow–diagrams which had been circulated to Board Members which were intended to set out in simple terms how the process worked. Although GP surgeries operated independently of the NHS it was recognised that upheaval could be experienced by some patients when a practice was closed or merged with another and it was important therefore to mitigate upheaval as far as practicable, to try and reduce pressures and to provide opportunities to create new skills. As some aspects of this service linked into primary care, it was important to address gaps and to look at how services could be provided most appropriately. There were circumstances in which a patients needs could be better addressed by other services than by attending a GP practice.

49.6 Councillor Nield explained that she wished to understand how the process worked and how patients were made aware of changes in advance of them occurring. Often gaps occurred and in the case of the Matlock surgery closure some elderly residents had found the process bewildering and that their concerns had not been considered. In the case of the Matlock Road surgery closure the greatest concern had been that the nearest surgery was not located on a direct bus route.

49.7 The Deputy Director of Primary Care, Hugo Luck, explained that it was important to recognise that the structure of GP practices had changed little since 1948 when the NHS had been set up. In consequence this element of the service had not kept part and it was important to provide the right care in the right place. Whilst all that had been said in respect of the Matlock surgery were noted, the changes there and in respect of other closed/merged surgeries had been welcomed by some patients. When small surgeries closed it provided the opportunity a have access to a broader range of services and facilities than could be provided at a smaller surgery, for example access to nursing services and the ability to have an annual health review. The downside was that the nearest surgery might be some distance further away from the patient's home Details had been provided to those registered at the surgery and the options available to them had been detailed. As far as practicable, patients were notified of changes in order to enable them to digest that information and to decide the option most appropriate to their needs.

49.8 It was a fact of life that closures and mergers would happening as GP's would retire or move on. Patients had differing needs and it was not possible to map every bus route to in view of the surgeries across the city, however, patients were advised regarding other surgeries in closest proximity to their home. Information was also provided on the surgery website.

49.9 Councillor Shanks asked for clarification as she understood it, a patient was compelled to sign up to the surgery located nearest to their home address and that if they requested to sign up to one further away that they would not be accepted onto the register for that surgery. She wished to understand how the commissioning arrangements in place worked and what degree of flexibility existed. It was explained that a range of contracting and commissioning arrangements were in place. GP services were contracted nationally with additional services commissioned at local level by individual CCG's. As the city was compact and densely populated there was a considerable overlap of/between surgery boundaries so in reality this did not generally represent a problem.

49.10 Councillor Nield enquired regarding the facility for patients who were unable to attend a surgery to be visited in their own homes and asked how easy it was for a patient to receive a home visit if they needed one. The Co Deputy Chair, Dr Hodson, CCG, responded that this was resource driven, patients were visited in their own homes where that was required in response to a reasonable request. Generally, it was better for the patient and there was less delay if they visited the surgery directly, it was more efficient time wise for all.

49.11 The Chief Executive of Brighton and Hove Healthwatch, David Liley stated that feedback they had received indicated that GP mergers across the city had been well organised. A recent review of GP practices across the city had indicated that when

mergers had occurred the majority of patients did not consider that they had been disadvantaged as a result and that the general level of service provided was very high. Research carried out two years ago had identified a small group who did have problems accessing a local surgery and had sought to find more effective means of reaching those individuals. Overall however, this did not appear to represent a significant problem.

49.12 Councillor Appich referred to the level of GP support via the Primary Care Network, in particular the support given to care homes. In some instances, residents had needed to be admitted to A & E due to lack of more suitable care. It was noted that the measures were in place to address such issues and that the CCG could and did work with NHS and voluntary sector organisations to encourage them to work with GPs to address any potential problems for which they could provide assistance.

49.13 Councillor Bagaeen stated that having considered the data provided he was of the view that details of the percentage of locum GPs compared with salaried and partner GPs would have been useful. Also, details in relation to anticipated reduction in capacity and maps indicating surgery boundaries. It was explained that although detailed data was available, there were caveats when seeking to draw conclusions in that although it provided raw data as to numbers it did not indicate “what” services/advice they were qualified to provide for patients. In larger surgeries nurses were able to assist by taking appointments which freed up the GP to deal with more complex patient needs. The boundaries between the different surgery areas were fairly fluid given the concentration of the city’s population.

49.14 As no further matters were raised in respect of this item the Chair moved to the vote. Councillor Nield stated she wished to withdraw her proposed amendment in view of the update/information which had been given.

49.15 **RESOLVED –** That the content of the report be noted.

The meeting concluded at 6.25pm

Signed Chair

Dated this day of

HEALTH AND WELLBEING BOARD	Agenda Item 59 (b) Brighton and Hove City Council

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING BOARD

10.00am 6 FEBRUARY 2020

THE RONUK HALL, PORTSLADE TOWN HALL - PORTSLADE TOWN HALL

MINUTES

Present : Councillors Moonan (Chair), Appich (Deputy Chair), Shanks (Opposition Spokesperson), Bagaeen (Group Spokesperson) and Nield

CCG Members: Malcolm Dennett, Ashley Scarff and Katie Jackson

Non-Voting Co-Optees: Rob Persey, (Statutory Director of Adult Social Care) and Dr Lester Coleman (Healthwatch)

PART ONE

51 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

51(a) Apologies

51.1 Councillor Bagaeen sent his apologies. Apologies were also received from Dr Andrew Hodson, Chair of the CCG and Co-Deputy Chair of the Board; Lola Banjoko (CCG); Dr Jim Graham (CCG); Geoff Raw, Chief Executive (BHCC); Deb Austin, Acting Statutory Director, Children's Services (BHCC); Alistair Hill, Director of Public Health (BHCC); Graham Bartlett, Local Safeguarding Adults Board; Chris Robson; Local Safeguarding Children Board and David Liley; Healthwatch.

51(b) Declarations of Substitutes, Interests and Exclusions

52.2 Katie Jackson (CCG) was in attendance in substitution for Dr Andrew Hodson and Dr Lester Coleman was in attendance in substitution for David Liley of Healthwatch.

51(c) Exclusion of Press and Public

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

52.4 The Chair, Councillor Moonan, referred to the additional information contained in the report at Item 56 on the agenda. This report had been circulated to solely to members and was exempt under category 3 of Section 100A of the Local Government Act 1972. If Board Members wished to discuss any of the information contained therein any press and public who were present would need to be excluded from the meeting. Consideration of those matters would then take place in closed session.

52.5 **RESOLVED** - That the public be not excluded from any item of business on the agenda, unless discussion is to take took place in respect of information contained in Item 56 which was exempt under category 3, at which point any press and public who were present would be required to leave the meeting.

52.6 **Note:** Ultimately, all matters were discussed and determined whilst the press and public were present and it was unnecessary for them to be excluded from the meeting.

Webcasting

52.7 The Chair explained that on this occasion it had not been possible to webcast the meeting and would not therefore be available for future viewing.

52 CHAIR'S COMMUNICATIONS

Corona Virus Update

52.1 The Chair, Councillor Moonan explained that whilst there would not usually be any Chair's Communications for a special meeting of the Board she wanted to take the opportunity to confirm that Public Health England were taking the lead on this matter. The current risk remained low and the latest information which was updated at 2pm daily could be accessed at www.gov.uk/coronavirus.

52.2 **RESOLVED -** That the position be noted.

53 FORMAL PUBLIC INVOLVEMENT

53a Petitions

53.1 There were none.

53b Written Questions

53.2 There were none.

53c Deputations

53.3 There were none.

54 FORMAL MEMBER INVOLVEMENT

54a Petitions

54.1 There were none.

54b Written Questions

54.2 There were none.

54c Letters

54.3 There were none.

55 COMMISSIONING OF SUPPORTED LIVING SERVICE FOR PEOPLE WITH COGNITIVE IMPAIRMENT (ACQUIRED BRAIN INJURY)

By reason of the special circumstances, and in accordance with section 100B(4)(b) of the 1972 Act, the Chair of the meeting has been consulted and is of the opinion that this item should be considered at the meeting as a matter of urgency for the following reason that a decision to award the contract was required.

Note: The special circumstances for non-compliance with Council Procedure Rule 3, Access to Information Procedure Rule 5 and Section 100B(4) of the Local Government Act 1972 (as amended), (items not to be considered unless the agenda is open to inspection at least five days in advance of the meeting) were that the end of the procurement exercise could not be completed prior to the deadline for publication of the agenda. The item's report was published in advance of the previous Health and Wellbeing Board meeting on 28 January 2020 and that meeting resolved to consider the item at a special meeting that date and time of which was to be confirmed.

55.1 The Board considered a report of the Executive Director of Health and Adult Social Care which provided an update on the procurement of a supported living service for adults with cognitive impairments in Brighton and Hove which recommended that an external provider be procured due to the specialist nature of the provision required. It was noted that a part two confidential report containing more detailed information in respect of the preferred bid and the directly provided service had been circulated to members of the Board separately.

55.2 The following Labour/Green Group amendment was put forward:

To add new recommendation1.3 as shown below in ***bold italics*** proposed by Councillor Appich and seconded by Councillor Nield***:***

1.3 ***That the contract be reviewed at the end of its second year to help build capacity to develop a potential in-house model of delivery for such services in the***

future and the review be reported to the Health and Wellbeing Board prior to any extension or re-tender.

55.3 The Chair, Councillor Moonan, stated that she had accepted the late amendment put forward as she was of the view that doing so would facilitate the Board's discussion and decision making in respect of this matter. This was important as it was necessary to make a timely decision and there were special circumstances why the report had not been available within the usual timeframe due to the complex procurement process.

55.4 Councillor Appich spoke in support of her amendment stating that whilst she understood the necessity to make a decision regarding provision of this service at the present time, she was also firmly of the view that the proposed amendment was necessary to enable that to be reviewed at an appropriate point in the future. To do so provided the capacity for the decision taken to be reviewed when it was timely to do so, particularly as it would enable potential capacity for an in-house model to be developed. Councillor Nield stated that she concurred in that view and therefore supported the amendment.

55.4 The Head of Commissioning, Andrew Witham and the Commissioning and Performance Manager, Anne Richardson-Locke, updated in respect of the process which had been undertaken and the rationale for the report recommendations. Following service of notice by the current service provider in July 2019 alternative arrangements had needed to be made for the 3 existing tenants who no longer had need of the accommodation and had provided the opportunity for these flats to be used to provide supported living options for adults with cognitive impairments. It had not been possible to find alternative accommodation for one resident who would continue to live there until an alternative support provider had been found. The Supported Living Service would provide 24 hour support to 4 people with cognitive impairments which included learning disabilities, autism and cognitive impairments due to brain injury or other neurological conditions. It was intended that the support services would be shared across all four flats.

55.5 Unfortunately, the report had come forward as a late item as the period between the end of the procurement exercise and the date of the nearest Board meeting had not allowed for the usual pre-Board timescales. It was necessary for a decision to be made in order to ensure that delays in starting the service were kept to a minimum as the service was needed urgently and there would be a financial cost to the Council of delays. The Commissioning and Performance Manager, Anne Richardson-Locke, explained that although there had been 8 expressions of interest, only 3 tenders had been submitted ultimately which indicated the complexity needs to be supported and the very small number of specialist providers who were able to provide that level of care. The timescales to be met were very tight and the tender process had been conducted in compliance with the provisions of the Public Contract Regulations 2015. There would be no saving if the Council provided support directly at this time and could result in a delay in service provision.

55.6 Councillor Shanks stated that she fully supported the amendment. Whilst recognising the need to make a decision in order to avoid any hiatus in service delivery to vulnerable individuals she was also concerned that the ability existed to revisit it. She was concerned that pay scales had not been specified although the preferred bidder had indicated that they would set attractive pay rates. In her view the fact that the Council was committed to paying the living wage could set it at a disadvantage and that it was

not therefore an entirely like for like comparison. Councillor Shanks asked whether an external provider could be compelled to pay the living wage as requirement of their acceptance of their bid and it was confirmed that could not be done. Over time if in-house capacity could be developed there could be cost savings and other advantages which were not currently apparent.

55.7 Councillor Nield was in agreement with Councillor Shanks stating that if the Council paid staff properly arguably it could never be competitive. It was also important to focus of what values you wished to apply and what you waned to achieve, that needed to be factored in too.

55.8 Councillor Appich stated that she was disappointed that it had not been possible to let this contract in-house, at the present. She recognised the need for an urgent decision to be made which represented a good compromise for clients who were in desperate need reiterating however, that it was important to have the capacity to look at that afresh in the future.

55.9 There was no further discussion and in consequence, the Chair, Councillor Moonan, put the proposed amendment to the Board and on a vote of 4 with 3 abstentions it was accepted. The Chair then moved to a second vote which included the amendment in the substantive report recommendations. The substantive report recommendations were agreed on a vote of 4 with 3 abstentions.

NB: The Resolutions set out below incorporate the amended recommendations as agreed at the meeting and include a new recommendation 3 as shown below:

55.10 **RESOLVED** - (1) That Board agrees to award a three-year contract to the Service Provider that has been evaluated as providing the most economically advantageous tender;

(2) To grant delegated authority to the Executive Director of Health and Adult Social Care (HASC) to extend the contract at the end of the three-year term for a further period or periods of up to two years in total subject to satisfactory performance and available budget; and

(3) That the contract be reviewed at the end of its second year to help build capacity to develop a potential in-house model of delivery for such services in the future and the review to be reported to the Health and Wellbeing Board prior to any extension or re-tender.

56 COMMISSIONING OF SUPPORTED LIVING SERVICE FOR PEOPLE WITH COGNITIVE IMPAIRMENT (ACQUIRED BRAIN INJURY) - EXEMPT CATEGORY 3

56.1 The Board considered and determined the report recommendations without the need to go into closed session, discussion and determination took place whilst the press and public were present.

57 PART TWO PROCEEDINGS

57.1 The Board considered and determined the report recommendations without the need to go into closed session, discussion and determination took place whilst the press and public were present. Therefore, it was decided that none of the business of the meeting would remain exempt from disclosure to the press and public.

The meeting concluded at 10.30am

Signed Chair

Dated this day of

Item 63

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

Title:	Public Health Annual Report	
Date of Meeting:	24 March 2020	
Report of:	Alistair Hill, Director of Public Health, Health and Adult Social Care	
Contact:	Alistair Hill	Tel: 01273 296560
Email:	alistair.hill@brighton-hove.gov.uk	
Wards Affected:	All	

FOR GENERAL RELEASE

Executive Summary

Directors of Public Health are required to produce an independent annual report on the state of local public health. There are no specified requirements as to the content or format of the report.

This year's report, Making Health Your Business, focuses on the strong relationship between work and health.

The Director of Public Health will make a presentation on the report.

1. Decisions, recommendations and any options

1.1 That the Board note the report.

2. Relevant information

2.1 This year's Annual Report of the Director of Public Health examines the important relationship between work and health in Brighton & Hove.

2.2 The report starts by looking at why being in 'good work' benefits our health. Good paid work includes earning a decent living wage and enjoying good working conditions – and not all jobs have these characteristics.

2.3 There is a persuasive economic argument for investing in the health and wellbeing of all our communities. A healthy workforce is the bedrock of a productive and thriving economy. It is important that our economy is based on 'inclusive growth', so that local people and organisations benefit from prosperity in the city.

2.4 The report adopts the life course approach of our Health and Wellbeing Strategy, including starting, living and ageing well.

2.5 Helping children and young people to start well in life helps them to get ready for a good working life. It's one of the reasons why tackling inequality in educational outcomes is so important. The world of work is changing rapidly, and so lifelong learning is more important than ever in helping people gain skills and knowledge to adapt to these changes.

2.6 People who are unable to work are at increased risk of poor health. This disproportionately affects some of our most disadvantaged neighbourhoods and residents, including people with mental health conditions and disabled people. The report highlights some of the innovative local projects that are supporting people into work and making our workplaces more inclusive.

2.7 Musculoskeletal conditions and mental health remain the most common reasons for sickness absence and employers can do a lot to prevent these conditions as well as support their employees to manage them and to be health promoting employers. The report includes some top tips for local employers to highlight what they can do to create a healthier workplace.

2.8 The NHS has a valuable role to play by ensuring that support to keep people in work is a key goal of managing long-term health conditions.

2.9 Looking to the future, we will be spending more years in work and there will be an increasing number of older people in the workforce. Employers and workplaces will need to adapt to these changes to ensure they are age friendly. The NHS also has a role to play to ensure that helping people to stay in work is a key goal of managing long-term health conditions.

2.10 The report closes with nine recommendations, identifying where organisations across the City can make a difference by delivering action to support health, wellbeing and work. These recommendations will support the delivery of both the Health & Wellbeing Strategy, Economic Strategy and NHS Long Term Plan.

Recommendations

1. Continue to tackle the gaps in school readiness and educational outcomes, and support personal progression in order to reduce income, employment and health inequalities in later life. (BHCC, nurseries, schools and colleges, health services, community and voluntary sector, families)
2. Promote the importance of good work across the City, for example through the Living Wage Campaign. (Economic Partnership partners including Chamber of Commerce).
3. Use evidence-based resources to improve health and wellbeing and prevent ill health at work. (BHCC, employers)
4. Consider how health at work can be improved for those working in small businesses and at home. (BHCC and partners including Chamber of Commerce)
5. Establish a healthy workplace scheme for Brighton & Hove. (BHCC, employers)
6. Ensure that helping people to stay in work is a key aim of managing physical and mental health long term conditions. (NHS, employers, BHCC, CVS)
7. Develop the role of health and care services as local 'anchor institutions' to build community wealth and provide access to good work for local people. (NHS, BHCC and other local organisations)
8. Join up health and employment support for groups finding it hardest to access employment. (DWP, CVS, BHCC, NHS, communities)
9. Use the age friendly employer's toolkit to help employers become more age-friendly, promote health at work, help staff in mid-life to plan for their future, and support more older workers to remain in good work for longer. (BHCC, CCG, employers)

2.11 Health and Wellbeing Board members are invited to consider how they can contribute to the delivery of the recommendations.

2.12 The Public Health team will be relaunching its Healthy Workplace programme later in 2020. This will include action to progress recommendations 3, 4 and 5, including the establishment of a healthy workplace scheme for the city.

3. Important considerations and implications

Legal:

3.1 The NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires Directors of Public Health to write an annual report on the health of their local population. The Council has a duty to publish the report. The content and structure can be determined locally.

Lawyer consulted: Elizabeth Culbert Date: 25/02/20

Finance:

3.2 There are no direct financial implications from the recommendations in this report. The total Public Health budget for financial year 2019/20 is £20.785m of which £19.559m comes from the ring-fenced Public health grant, other funding comes from agreed carry forward of grant from 2018/19 and some non-grant funding.

Finance Officer consulted: Sophie Warburton Date: 25/02/2020

Equalities:

3.3 The report presents analysis relating to local inequalities in health and work. There are key recommendations to continue to tackle the gaps in school readiness and educational outcomes, and supporting personal progression in order to reduce income, employment and health inequalities in later life, to promote the importance of good work across the City, for example through the Living Wage Campaign and to join up health and employment support for groups finding it hardest to access employment.

Equalities Manager consulted: Anna Spragg Date: 25/02/2020

Supporting documents and information

Appendix1: REPORT CURRENTLY WITH DESIGN TEAM – TO BE APPENDED

Making health your business

Annual Report of the Director of Public Health
Brighton & Hove 2019

Brighton & Hove City Council

ACKNOWLEDGEMENTS

Thank you to everyone who has contributed to the report, including providing the case studies. In particular we would like to thank our lead authors and steering group members.

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Nicola Rosenberg
Caroline Parker
Sarah Podmore
Gemma Scambler
Sam Simmonds
Dr Peter Wilkinson
Becky Woodiwiss

To find out more about Public Health in Brighton & Hove please go to www.brighton-hove.gov.uk/public-health

The references for the report are also available at the link above.

CONTENTS

MY ANNUAL REPORT THIS YEAR FOCUSES ON THE IMPORTANT RELATIONSHIP BETWEEN WORK AND HEALTH

‘Good work’ benefits our health and wellbeing. Good paid work includes earning a decent living wage and enjoying good working conditions.

Many jobs lack these, as illustrated by national debates about the ‘gig economy’ and zero hours contracts, and there are more people in work who are living in poverty than ever before.

There is a persuasive economic argument for investing in the health and wellbeing of all our communities. A healthy workforce is the bedrock of a productive and thriving economy. Our local Economic Strategy puts improving community participation and inclusion at its heart, recognising that everyone should be able to benefit from new economic opportunities. Our goal is to build community wealth so that local people and organisations benefit from prosperity in the city.

Helping people get ready for a good working life needs to start early. It’s why tackling inequality in educational outcomes is so important. Further and higher education and apprenticeships also play vital roles. The world of work is changing rapidly, and lifelong learning is important in helping people gain skills and knowledge to adapt to these changes.

People who are unable to work are at increased risk of poor health. This disproportionately affects some of our most disadvantaged neighbourhoods and residents, including people with mental health conditions and people with disabilities or impairments.This report highlights some of the local projects that support people into work and make our workplaces more inclusive.

Looking to the future, we will be spending more years in work and there will be an increasing number of older people in the workforce. Employers and workplaces will need to adapt to these changes to ensure they are age friendly. The NHS also has a role to play to ensure that helping people to stay in work is a key goal of managing long-term health conditions.

This report also contains tips for local employers to create healthier workplaces. These include actions to prevent and manage musculoskeletal conditions (which affect joints, bones, muscles), and mental health, which remain the most common reasons for sickness absence. A distinctive feature of our local economy is the high proportion of people working in small businesses, who are self-employed and/or are home workers. We need to understand more about how health and wellbeing can be supported in these settings.

I hope this report will support action to make Brighton & Hove a leading city for both wellbeing and work.

Alistair Hill
Director of Public Health,
Brighton & Hove City Council

There is a persuasive economic argument for investing in the health and wellbeing of all our communities. A healthy workforce is the bedrock of a productive and thriving economy.

SECTION 1 THE CONNECTION BETWEEN WORK AND HEALTH

We all benefit from good health. It enables us to take part in family life, our local community and the economy. Health isn't just an absence of illness: it is also the extent to which a person can live a fulfilling and active life.

A healthy person is someone with the opportunity for meaningful work, secure housing, stable relationships, high self-esteem and healthy behaviours. Good health is a benefit:

- **Individually,** as people generally give more value to their health than they do their career, income or education[1]
- **Socially,** as good health allows people to play an active role in their community, and has been associated with higher levels of social cohesion[2]
- **Economically,** as areas of the UK experience quicker economic growth where there are high levels of good health.[3]

By thinking about the importance of good health within society as a whole, it enables us to focus on creating healthy environments rather than simply treating disease.[4]

Working people spend an average of a third of their waking hours at work[5]

What is good work?

Evidence shows that good work, including a good working environment, has a positive effect on the health of an individual and their whole family, and that bad work contributes to poor health.[5] 'The Marmot report: Fair Society, Healthy Lives' provides a description of what is considered to be good work:

- A living wage and job security
- Control over your work and job satisfaction
- Supervisor and peer support
- In-work development and learning
- Flexible working hours
- Protection from adverse and dangerous working conditions
- Ill health prevention and stress management strategies in the workplace
- Support to facilitate a return to work for those who have been ill.

SECTION 1 THE CONNECTION BETWEEN WORK AND HEALTH

How is good work beneficial to health?

For most people, being in work is good for their health and wellbeing.

Income is essential to meet basic human needs like shelter, warmth and food, as well as to afford a good quality of life.

Work plays an important role in an individual's identity, sense of purpose and social status.

Employment provides support for continuous learning and skill development, which is important for wellbeing.

Employees working long hours are two and a half times more likely to have a major depressive episode[6]

Volunteering

Volunteering or unpaid work can also be beneficial for health. It provides many of the interpersonal benefits of paid work, such as a sense of purpose, social connections and learning opportunities. For some people, this increase in skills or confidence can also create a route into employment.[8]

City Parks Rangers and volunteers harvesting posts for hedge laying

The Brighton & Hove Living Wage

Launched in 2012, the Brighton & Hove Living Wage campaign, led and managed by Brighton & Hove Chamber of Commerce, encourages local businesses to voluntarily pay all employees a good hourly rate. By 2020, 590 local employers had signed up to pay the Living Wage.

Set independently and updated annually, the Living Wage is calculated according to the basic cost of living in the UK and is the amount that allows a person to live, rather than just survive. The rate will be £9.30 per hour from 1 April 2020.

For more information, see **www.livingwagebrighton.co.uk**

Brighton & Hove City Council also supports a local campaign to end the practice of unpaid trial shifts in the city.

In the UK in 2015/16 an estimated 1.3million people suffered from a new or long-term illness that was related to their work[10]

How can work be harmful to health?

Jobs that are insecure, low-paid or fail to protect employees from stress and danger make people ill.[9]

The Joseph Rowntree Foundation[11] identifies four ways in which low paid work can have a negative effect on health:

1 **Material** – such as low paid work not providing enough income to afford heating, housing and adequate food

2 **Psychological** – inadequate income makes it more difficult to avoid stress and feel in control, both of which are important for good health

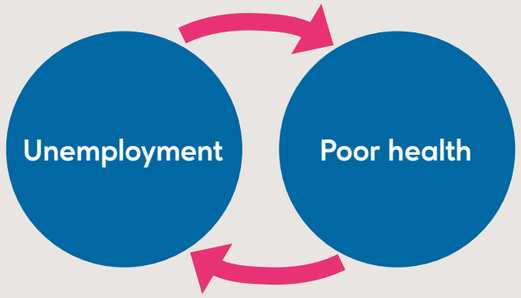
3 **Behavioural** – such as prioritising immediate gratification over the delayed gratification of long term health (eg smoking or drinking)

4 **Health selection** – being in poor health often acts as a barrier to higher paid work, which can create a negative cycle leading to even poorer health.

It is three times more expensive to get the energy we need from healthy foods than unhealthy foods[12]

How is unemployment harmful to health?

Being unemployed can lead to ill health, and being in poor health increases the likelihood of unemployment, which can lead to even poorer health.[13]



This is because financial problems result in lower living standards, but unemployment isn't just harmful to health because of money reasons, it is also because:

- Unemployment can trigger distress, anxiety and depression in the individual, but it can also occur in their partners and children. Families without a working parent are more likely to suffer persistent low income and poverty, and there is correlation between lower family income and poor health in children[14]
- Unemployment is associated with decreased physical activity and increased smoking and alcohol consumption[15]
- People who are unemployed suffer a range of heightened health risks including increased rates of limiting long-term illness, mental illness and cardiovascular disease. It has also been associated with an increase in overall death rates and particularly suicide[13]

For those who are unemployed but able to work, gaining employment in a role that provides good work generally leads to improved health outcomes.

WORK AND HEALTH CONCLUSION

The relationship between work and health is significant.

Supporting those able to work back into paid employment and ensuring the work that is available for them, and for those already working, is good quality work with good pay, is an important public health goal.

This will lead to improved health outcomes across our city, will benefit the local economy and ensure all those working in our city can share in the wealth they are helping to create.

SECTION 2 WORK IN BRIGHTON & HOVE

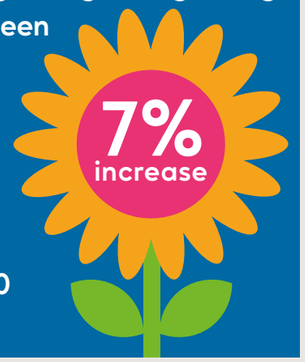
SECTION 2 WORK IN BRIGHTON & HOVE

This section uses data to provide a picture of the local population, our workforce, those not in work and local businesses.

Population

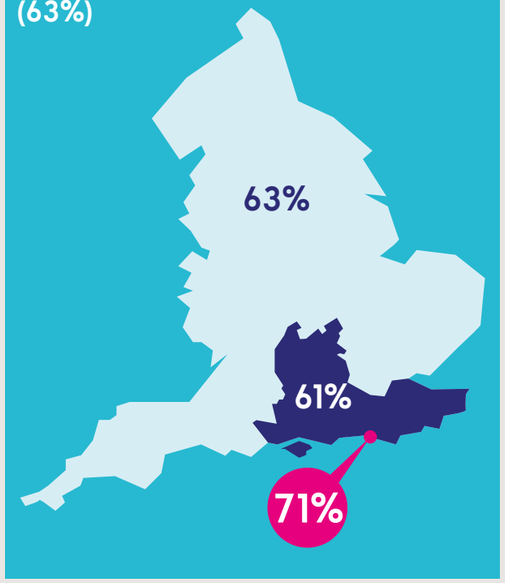
Brighton & Hove's resident population is growing, and growing quicker than seen nationally[1]

It is projected to rise from 290,400 people in 2018 to 311,500 by 2030 (7%)



Brighton & Hove has a higher proportion of residents of traditional working age[1]

71% (206,500) of people are aged 16-64, higher than the South East 61% and England (63%)



Employment

Not all people of working age work, some are in full-time education, are stay-at home parents or are unable to work due to health reasons and others cannot find work.

Brighton & Hove has a different economic profile to the South East and England with a lower employment rate and a higher unemployment rate.[4]

156,500 residents are employed, 97% of these are aged 16-64 years (year ending March 2019)

73% of working aged adults are in employment, which is lower than the South East (78%) and England (76%)

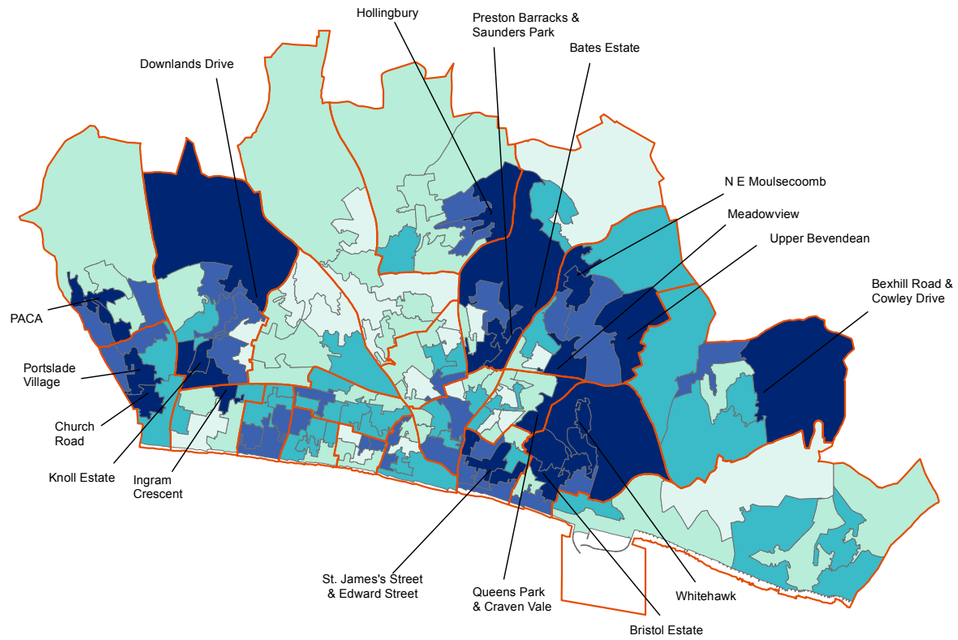
Unemployment

The city has a high unemployment rate, which is falling at a slower rate than has been seen regionally and nationally.[3]

There is a 7% unemployment rate in Brighton & Hove among 16-64 year-olds (10,800 people), which is higher than the South East (3%) and England (4%) (year ending March 2019)

Since 2010 Brighton & Hove's unemployment rate has fallen by 13% (1,600 people), far slower than the 45% seen in the South East and England

Indices of Deprivation 2019 Employment domain, ranked by score



28% (7,800 people) who are employment deprived live in East Brighton, Moulsecoomb & Bevendean or Queens Park wards

9% (around 27,500) of the working age population are involuntarily excluded from the labour market (Indices of Deprivation 2019)

Employment deprivation

Employment deprivation can be found across the city but is also concentrated in some neighbourhoods.[5]

Clusters can be found in East Brighton, Moulsecoomb and Bevendean, Queens Park, Hollingdean & Stanmer, Hangleton & Knoll, North Portslade and South Portslade.

Economic inactivity

Someone who isn't in work or actively seeking work is referred to as economically inactive.

In Brighton & Hove, there has been an 8% increase (3,400 people) in residents who are economically inactive since 2010,[3] whereas rates have decreased in both the South East (4%) and England (7%).

21% of 16-64 year-olds (44,100 people) are economically inactive,[3] similar to England (21%) but higher than the South East (19%)
(year ending March 2019)

43% of residents who are economically inactive are students,[3] which is a much higher rate than the South East (24%) and England (27%)

39% of those who are economically inactive would like a job,[3] which is also a higher rate than the South East (22%) and England (21%)

Students

- 38,340 students attend the two universities in the city,[2] an increase of 12% from 2014/15
- Students living in the city inflate the working age population – adding an estimated 63,200 19-28 year-olds
- This imbalances the city's economic profile

Unpaid care/volunteering

One in ten (13,400 people) of the employed population provide some degree of unpaid care to an individual they look after, compared to 11% in the South East and England (2011 Census).[12]

51% of the adult population of Brighton & Hove has volunteered at least once in 2018[13] (38% in the UK).

Reasons for economic inactivity in 16 to 64 year-olds (year ending March 2019)

	Brighton & Hove		South East	England
Student	19,100	43%	27%	27%
Looking after family/home	5,900	13%	24%	24%
Temporary sickness	1,000	2%	2%	2%
Long term sickness	8,400	19%	19%	22%
Retired	3,500	8%	16%	13%
Other	6,000	14%	13%	11%

Industry and employment

Brighton & Hove's largest employment sectors account for two thirds (65%) of all jobs:[6]

- Public admin, health and education - over 40,000 jobs (around a 1/3 of the economy)
- Professional and financial services - around 20,000 jobs
- Visitor economy activities - around 18,000 jobs
- Retail - around 16,000 jobs.

The city's business base is spread across a broader range of sectors, reflecting the large number of small businesses which characterise the city.

There are around 15,200 businesses in Brighton & Hove[7]
- **82% employ fewer than five people**
- **Around 40 (0.3%) employ more than 250 people**

Occupation

Brighton & Hove's resident population is notable for the comparatively high proportion of people working in 'higher level' managerial and professional occupations.[3] 60% of residents (94,200 people) are employed in these sectors, compared to only 51% in the South East and 47% in England.

Since 2010 the number of residents employed in higher level jobs has increased by 27% (25,900 jobs) while those working in lower level jobs has fallen by 11% (6,700 jobs) to 62,200 jobs.

Working patterns

- A quarter of workers work part time[8]
- Nearly 1 in 5 are estimated to work some sort of shift pattern[9]
- An estimated 1 in 20 is in non-permanent employment[9]

Commuting

More than one in ten workers work from home.[10]

There is a net daily outflow of workers from Brighton & Hove of around 5,000 people[11]
- **around 32,000 people commute into the city to work**
- **around 37,000 commute out of the city**

Average commuting time:

- women 16.5 minutes
- men 19.9 minutes.

Those aged under 30 have shorter average commutes than those aged 30 or over.

Salaries

Full time working residents of Brighton & Hove earn a median of £583 a week, which is £31 less than across the South East.[8]

The median full time weekly salary for someone employed in Brighton & Hove is £552. They may live in the city or live elsewhere and travel into the city for work. This is less than the median salary of Brighton & Hove residents, who may work in or out of the city.[8]

Salaries for both residents and those working in the city have increased by 12% since 2010.

SECTION 3 STARTING WELL - WORK, FAMILIES AND YOUNG PEOPLE

Access to education and learning throughout life, not just for children and young people in school, plays a vital role in being work ready.

Work is a key determinant of the health of children, young people and families. Starting well in life leads to better educational achievement, which in turn sets us up for a good working life and a better chance of good health as adults. However, inequality in household income and educational achievement can result in young people failing to reach their full potential in their working life.

Household income is important for good outcomes in children. There is strong evidence that household income is important for children's cognitive development, physical health and social and behavioural development. Evidence indicates that poorer children have worse outcomes in part only because they are poor, and not for other factors associated with low income.[6]

This section focuses on children and young people up to the age of 16, and explores the relationships between inequality and achievement, the actions in place locally to prepare our children and young people for work and casts an eye forward to the skills they will need to develop to thrive in the workplaces of the future.

> The early years are the first step to good educational achievement and access to good work

In general, children growing up in deprivation are at increased risk of poor health outcomes, for example low birthweight, obesity and tooth decay.[2,3,4]

Work, poverty, health and families

Good work helps lift families out of poverty. Living in a workless household is linked with an increased likelihood of living in poverty. However, being in work no longer guarantees to protect against poverty. An increasing proportion of people at the lower end of the UK's income distribution are living in a household where someone is in paid work.

Even in families where all adults work full time, one in six children are in poverty.[4] This highlights the importance of good work that pays a living wage.

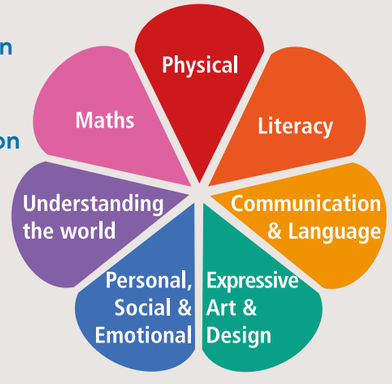
In 2000, 54% of children in poverty lived in a household where an adult worked. In 2017-18 this rose to 73% [3]

Starting well in life leads to better educational achievement, which in turn sets us up for a good working life and a better chance of good health as adults.

The early years are the first step to good educational achievement and access to good work. Early language development and communication skills are primary indicators of child wellbeing due to the link between language and other social, emotional and learning outcomes. Children from socially disadvantaged families are more than twice as likely to be identified with a Speech, Language and Communication Need (SLCN). More than half of children living in areas of high social deprivation may start school with SLCN.[15]

The Early Years Foundation Stage includes seven areas of learning that shape educational programmes in early years settings. Children are defined as achieving a good level of development (GLD) if they achieve at least the expected level of development for the Early Learning Goals in: personal, social and emotional development; physical development; communication and language; mathematics; and literacy. The last six years have seen considerable improvement in children's level of development: 72% in 2019 (72% in England) from 45% in 2013 (52% in England).

Areas of learning in the Early Years Foundation Stage



However, the percentage of children eligible for free school meals achieving a GLD has only increased to 52% (57% in England), and for children living in the 30% most disadvantaged areas has only increased to 60%. This challenge of narrowing the gap between the most and least advantaged children also persists nationally.

Good educational achievement is important to provide young people with good work prospects.

One of the reasons educational achievement is so important is that generally, salary prospects are related to educational achievement. In fact, the gap between pay for the more and less educated has widened.[11] However, in the UK educational achievement is more strongly linked to parental education and income than in other European countries.[11]

- **By age five,** children from the poorest 20% of homes are on average a year behind their expected development[11]
- **By age 11,** 75% of the poorest children reach the government Key Stage 2 level compared to 97% of children from the richest families[12]
- **At age 16** an achievement gap persists. In 2017/8, 44% of Brighton & Hove students in the most deprived areas achieved level 4/grade C in English and Maths GCSE equivalent compared to 86% in the least deprived areas.

Young people with specific health needs and disabilities are at risk of worse than average educational achievement and work prospects. Over half (54%) of young people with a long-term health condition reported having to delay their education or training, with 63% reporting that they were prevented from reaching their full educational potential.

Young people with disabilities account for 7% of those aged 16-24, but make up 16% of those not in education, employment or training.[16]

24% of 16-24 year-olds with work-limiting disabilities are unemployed compared to 14% of young people without such disabilities

Early years development and starting well at school: what we are doing in Brighton & Hove

The council's **Early Years Strategy** sets out how the outcomes for early years children will be improved, focusing on those who are most disadvantaged. The strategy will be updated in 2020 with a focus on speech, language and communication.

Brighton & Hove is one of 53 local authorities selected to take part in the national **Early Years Professional Development Programme** in 2020. Pre-reception Early Years practitioners from 15 settings will be supported to work with 2 to 4 year-olds to improve outcomes in language, literacy and numeracy for the most disadvantaged. At the end of the programme, participating settings will be accredited as communication friendly, and around 35 staff will be qualified at level 3 and 4 in language, literacy and mathematics for 2 to 4 year-olds.

The **National Children's Bureau Raising Early Achievement in Literacy (REAL) programme** has been adopted in children's centres and council nurseries. It aims to improve children's early literacy skills before they start school by working with parents to increase opportunities to learn in the home environment.

The **Providing Access to Childcare and Employment (PACE)** European funded project supports parents with two-year-olds to access childcare, training, volunteering and work. Each parent works with a keyworker in their local children's centre to create a personal development plan that focuses on small steps and achievable goals.

The **Universal Healthy Child Programme** (led by health visitors for families with children aged 0-5 and by school nurses for 5-19 year-olds) provides opportunities to identify and meet the needs of children at risk of poor outcomes and families in need of additional support.

EMAS and the REAL project

In the summer term, EMAS (Ethnic Minority Achievement Team) worked with a group of mothers from the Bangladeshi community and their nursery-aged children. The project was based on the Making it REAL principles which aimed to work with parents to improve the speaking, listening and literacy skills of pre-school children and give them a positive start.

The sessions were structured between events at the children's centre space at Fairlight School, home visits and an environmental print walk from the Level to Jubilee Library, where all the families were helped to join in. There was 100% attendance at every session and positive feedback from all the families. The project gave the EAL (English as an Additional Language) mums an opportunity to learn the important role they play in their children's learning by engaging with them through simple everyday activities.

www.brighton-hove.gov.uk/emas

School years and preparation for employment: what we are doing in Brighton & Hove

In December 2017, the Government launched a Careers Strategy which focused on ensuring that young people:

- understand the full range of opportunities available to them
- learn from employers about work and skills that are valued in the workplace
- have first-hand experience of the workplace
- receive a programme of advice and guidance delivered by individuals with the right skills and experience.

Secondary schools and colleges are required to develop their own strategies related to this.

In Brighton & Hove, a network helps schools connect with employers and industry professionals to ensure that young people learn about the world of work. During 2019/20 Brighton & Hove secondary schools are benefiting from **'Get Career Confident',** a funded programme delivering innovative resources and careers guidance.

The **Apprenticeship Support and Knowledge for Schools and Colleges programme (ASK)** supports secondary schools and colleges to transform how students think about apprenticeships. Support could include an inspiring apprenticeship awareness assembly, application workshops, careers fair attendance, free resources, a teacher CPD session or a range of other options.

Youth Employability Service - Steven's story

Steven contacted a Youth Employability Adviser directly as she had supported his sister four years ago. He had completed Levels 1 & 2 Motor Vehicle Mechanics, but the Level 3 course had been withdrawn leaving Steven without a course in September and feeling lost.

During Steven's first appointment he met with an adviser and they investigated all options including alternative colleges, apprenticeships and directly contacting employers. Steven was supported to write a CV and covering letter and the adviser concentrated on building Steven's confidence by discussing his skills. He was supported to apply to Kwik Fit and Renault and then worked with his adviser on interview practice. Steven felt confident in his skills and was able to talk about them passionately during his interview. The Youth Employability team was never in doubt of this!

Steven is really enjoying his apprenticeship: "It's going really well thank you. I have to go to Coventry for my training! But Kev is my mentor and I think he's probably one of the best people in there to work with. Thank you for all your help, you helped me a lot with everything."

www.brighton-hove.gov.uk/content/children-and-education/youth/youth-employability-service

Rebecca Butler –One of Steven's Employability Advisers

Widening participation programmes are provided by the Universities of Brighton and Sussex for local young people from primary school onwards, to equip them with an equal and fair chance to study in higher education.

The council's Youth Employability Service (YES) provides advice and guidance to young people up to the age of 19 (or 25 for those with an Education Health and Care Plan) who are not in employment, education or training (NEET), or at risk of becoming NEET. There is a wide range of re-engagement programmes available in the city which give young people the opportunity to develop their confidence and employability skills to support personal progression.

> Around 10% of the UK's workforce is in an occupation likely to grow by 2030 and 20% in an occupation likely to shrink

How will work look for future generations?

Rapid changes to the way we live, our housing, health and entertainment, influence the way we work, learn and travel. These changes can affect our environment, our economy and our satisfaction at work and are likely to impact on our young people.

Around 10% of the UK's workforce is in an occupation likely to grow by 2030 and 20% in an occupation likely to shrink.

Education, healthcare and wider public sector occupations are thought likely to grow, so an increase in people trained in those particular knowledge fields is expected. Emphasis has also been given to a greater need for interpersonal competencies, an increasing importance on social skills, judgement and decision-making.[18]

In 2018, the Brighton & Hove Chamber of Commerce organised a big debate on skills required for the workplaces of 2030.[19] Key themes identified included:

- **Change isn't something new**. Rather than worrying about this we need to empower people to embrace and enjoy change. Emotional intelligence, adaptability and resilience are key attributes for the future workforce
- **More connections between education and business are essential.** The more we bridge the gap between education at all levels and work, the better equipped our next generations will be. Specifically, lessons on careers choices, building an understanding of the types of roles available and paths to follow to make informed decisions and play to strengths are key.

STARTING WELL RECOMMENDATION

Continue to tackle the gaps in school readiness and educational outcomes, and support personal progression in order to reduce income, employment and health inequalities in later life.

For: Brighton & Hove City Council, nurseries, schools and colleges, health services, community and voluntary sector and families

SECTION 4.1 LIVING WELL - HEALTH AT WORK

Creating healthy workplaces and a healthy workforce makes sense for business, the city and for the working age population. Employers are in a unique position to be able to improve the health of their workforce and the health of their business.

How can employers create healthy workplaces?

The Local Healthy Workplace Accreditation Guidance has been developed by Public Health England, the Local Government Association and the Association of Directors of Public Health. It supports local authorities across England to set up local healthy workplace accreditation schemes that are tailored to local needs as a way to improve the health of those in work. We recommend developing a healthy workplace scheme for Brighton & Hove, based upon this guidance and we want to collaborate with local stakeholders to take this forward.

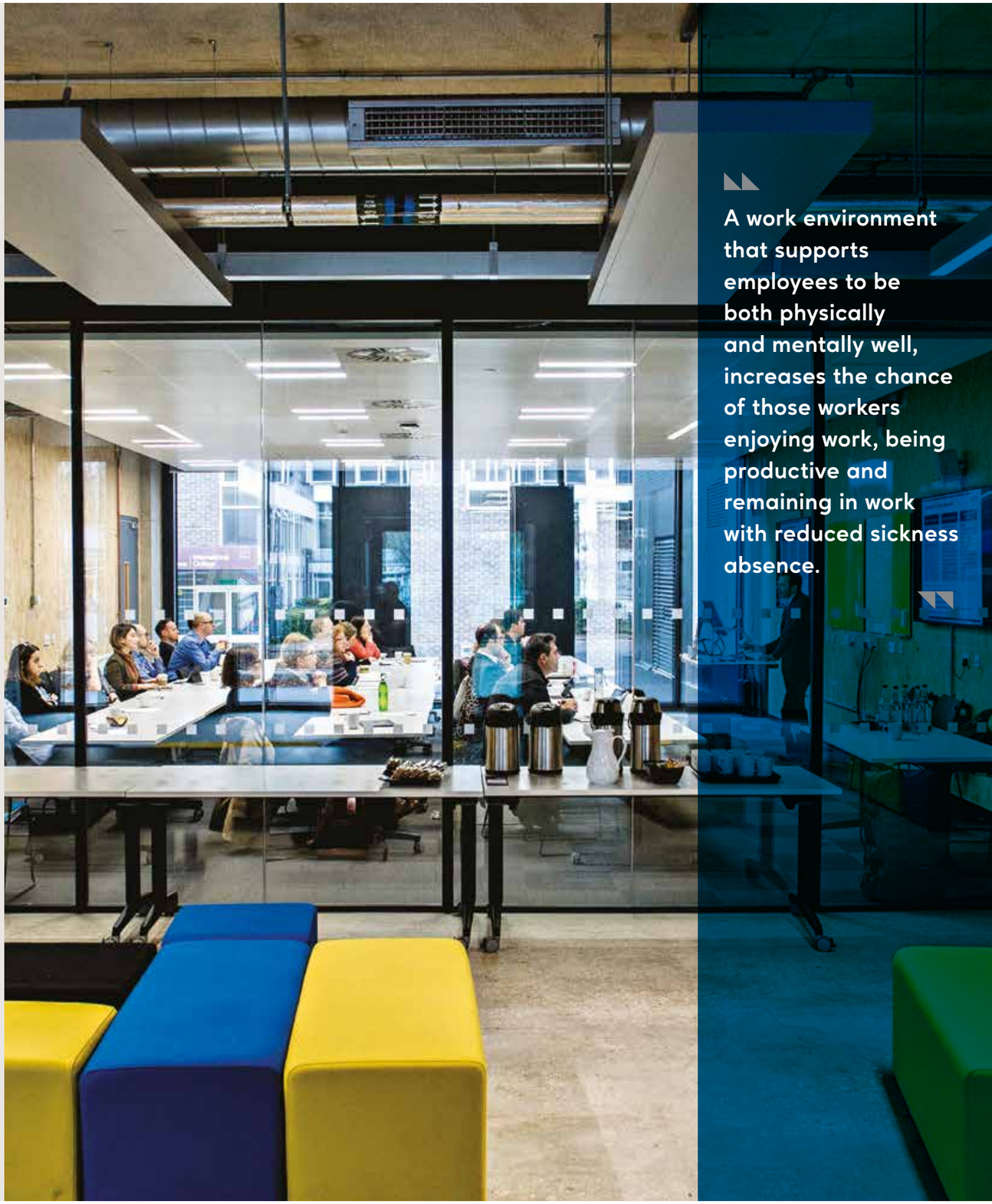
We recognise that employers are at different stages in creating healthy workplaces and supporting the wellbeing of their workforce. Some will find it simpler than others to put these tips into action. In particular, small businesses and home-workers will sometimes need different approaches to those that work for larger employers.

As a city characterised by a high proportion of small businesses, we could do more to understand what is helpful for health and wellbeing in those workplaces.

Mooncup Ltd

Mooncup Ltd, manufacturer of the Mooncup menstrual cup, employs 20 staff, nine of whom are aged over 40. In 2017, Mooncup Ltd was the winner at 'The Best Place to Work' by Brighton & Hove Business Awards. This was partly due to the good health and wellbeing practices they promote in their offices such as monthly massages, daily office-made vegan lunches, team days out, standing up desks and having dogs in the office. Additionally, a mindfulness session is available each week as well as occupational therapist visits when required.

SECTION 4.1 LIVING WELL - HEALTH AT WORK



A work environment that supports employees to be both physically and mentally well, increases the chance of those workers enjoying work, being productive and remaining in work with reduced sickness absence.

TIPS FOR EMPLOYERS FOR A HEALTHY WORKPLACE

1. Are you supporting 'good work'?

'Good work' includes stable and secure employment with fair and good pay, under the worker's control, manageable demands, and with opportunities for skills learning, training and career development. (Also see section 1).

2. Do you have a health promoting work environment?

Food

Why? Two out of three adults are overweight or obese. Being overweight or obese increases the chance of sickness absence.[1]

How? The Eatwell Guide provides an evidence based guide for a healthy balanced diet[2] and the Government Buying Standards Framework[3] ensures that food provided in public sector settings encourages healthier eating habits.

Think about: Are healthy fresh options available, affordable, attractive and accessible during working hours (including antisocial shifts)? Do vending machines contain healthy options? Are food heating and fridge storage options available? Are healthy refreshments available at events or meetings?

Physical activity

Why? One in four women and one in five men are inactive. Benefits of being active include reduced risk of death, cancer, heart disease, diabetes, bone and joint problems, stress and obesity. Benefits for businesses include greater productivity, reduced sickness absence, reduced travel congestion/ costs, and cleaner air (from active travel).

How? Encourage, facilitate and reward active travel (travel by bicycle, on foot or public transport) by providing cycle to work schemes, on-site showers and cycle storage, subsidising public transport costs and active travel challenges. Reduce inactivity or sedentary behaviour during the working day with active breaks, walking meetings and standing desks, and encourage physical activity in and around the working day through workplace initiatives eg lunchtime yoga, walks or 'Couch to 5k'.

Think about: How sedentary is your workforce? What proportion travel actively to work and during the working day? Do you encourage active breaks?

Tobacco

Why? Smoking tobacco is the leading cause of premature death. Stopping smoking at any time has considerable health benefits. Brighton & Hove has high smoking rates. Smoking costs businesses £3.3 billion in lost productivity and smoking breaks nationally. People who smoke take an average of 30 minutes in cigarette breaks within business hours each day.

How? Helping smokers with evidence-based smoking cessation support and medication increases their chance of quitting by 400%. NICE guidance recommends employers allow their employees to access support during working hours without loss of pay.[5]

Think about: Do you allow workers paid breaks for smoking cessation? Do you have an up to date smoking policy? Have you considered banning smoking in outdoor spaces outside your workplace (smoke free legislation covers workplaces,[4] but these spaces may attract smokers). Do you have clear signage? This discourages smoking breaks and presents a positive smoke-free image to visitors.

Alcohol

Why? Alcohol is estimated to cost the Brighton & Hove economy £107 million a year, including £25 million in economic impacts. Two in five adults in the city drink over the recommended amount (14 units per week) compared to one in five nationally. Drinking too much alcohol is a significant cause of absenteeism from the workplace, as well as presenteeism (being present at work whilst unwell from alcohol). Supporting employees to manage alcohol in the right way could have a positive impact on your business, as employees who drink within sensible levels will be more productive.

How? Promotion of alcohol focused campaigns like Dry January and other digital lifestyle support like One You www.nhs.uk/oneyou to all employees. Some professions, such as hospitality or construction industries, are at higher risk of harmful drinking levels - ask for more tailored support from local health promotion or alcohol services.

Think about: Do you have a work drinks fridge? Does your team socialising always involve drinking alcohol? Do you have a workplace drugs and alcohol policy? Is your workplace alcohol-free? If you have a work event are alcoholic drinks provided automatically - could non-alcoholic beers or mocktails be an option? Would you find it easy to talk to a colleague about alcohol? Do you know what to do if you think a colleague may have an alcohol problem?

3. Are you providing a healthy workplace throughout the life course?

Do your workers feel supported through the natural life-course including pregnancy, maternity and paternity, shared parental and adoption leave, breast-feeding, early parenting, returning to work after maternity leave, with young children, through the menopause, with long-term health conditions, ageing and bereavement? Supporting workers through the ageing process covered in Section 5 of this report and through bereavement at the end of this chapter.

A few small changes to your policies or ways of working will make a big difference to employees at significant times in their lives.

New parents

Why? The majority of businesses employ parents. Working parents have an incentive to be loyal and dedicated workers, as they have dependents to care for. Maternity, paternity leave and shared parental leave as well as adoption leave are a statutory right, including paid and unpaid leave.[7]

How? By having policies and practice that support family-friendly working hours and provide support to return to work following maternity, paternity, shared parental or adoption leave.

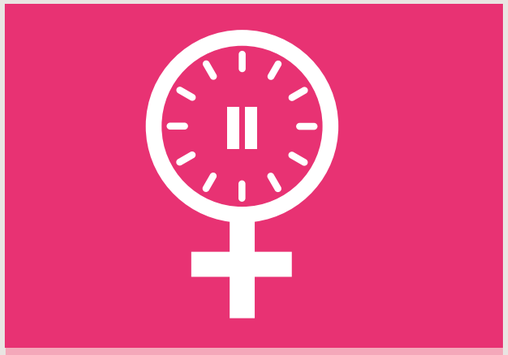
Think about: Do you offer Keep In Touch (KIT) days to facilitate a smooth return to work? Do you have a flexible working policy? Do you provide guidance on leave entitlement and maternity/ paternity pay, shared parental leave, adoption leave, premature baby leave, maternity support leave, still birth, and right to return to work for mothers?

Breastfeeding

Why? Breastfed babies are less likely to get ill with respiratory and diarrheal infections, which is good for babies and for parents' sickness absence rates. Supporting breastfeeding is simple, inexpensive and has been shown to result in greater productivity and loyalty.[6]

How? Ask mothers how you can best support them on returning from maternity leave. Tell them how you support breastfeeding in a practical way with a private suitable place to express milk or feed infants, breaks, and appropriate facilities for expressed milk storage. It is not acceptable for new mothers to have to express milk in a workplace toilet.

Think about: Do you have a breastfeeding policy? Do you carry out a new mother's risk assessment to consider hazards associated with the workplace or conditions that could affect her ability to breastfeed or express milk? Do you provide suitable rest facilities for pregnant/breastfeeding mothers? Do managers know how to talk to and support new and breastfeeding mothers?



Menopause

Why? The menopause usually occurs between 45-55 years, with many women affected by peri-menopausal physical or psychological symptoms including loss of confidence. As the gender and age profile of the workforce changes, the business importance of supporting women through the menopause in a confident and positive way increases. Having an effective policy in place can help raise awareness and understanding of the issue, improve retention and help create/maintain a diverse workforce, reducing the potential for sex, age and disability discrimination.

How? There is a fast developing range of guidance and information available for businesses, managers, and those affected by the menopause including a guide[8] and model policy.[9]

Think about: Do you have a menopause policy? Do you provide training for managers on how to support peri-menopausal workers? Do you have flexible working guidance? Do you support workers and managers to discuss the menopause and how best to manage it in an open manner?

Brighton & Hove Buses

Brighton & Hove Buses employ over 1,500 people and as a business they are developing their approach to supporting the health and wellbeing of their staff.

Over the past year they have offered free NHS Health Checks to their staff, hosted stalls from the council's Healthy Lifestyle Team to support staff who want to stop smoking or drinking, or to become more active, and introduced Mental Health First Aid, as well as upskilling their managers in mental health awareness.

Equality and diversity have also been a key focus. They are already a Disability Confident Employer and have offered new training, including sessions on the menopause. They offer free sanitary products in staff bathrooms and have also offered practical help to parents and carers, including financial contributions in emergencies. Brighton & Hove Buses have already seen benefits in better morale, engagement and commitment and are committed to continuing this wellbeing work.

www.buses.co.uk

4. Is your management culture and work environment supporting good work and good mental health and wellbeing?

NICE recommends developing policies to support workplace culture, such as respect for work life balance and the six Health and Safety Executive (HSE) management standards for work-related stress.[10]

- Demands (Impact of work patterns and work environment)
- Control (how much say the employee has in the way they do their work)
- Support (from the organisation, line manager and colleagues)
- Relationships (promoting positive working to avoid conflict and dealing with unacceptable behaviour)
- Role (if employees understand their role within the organisation and whether the organisation ensures that they do not have conflicting roles)
- Change (how change is managed and communicated in the organisation).

5. Are you protecting workers from exposure to potential physical risks at work?

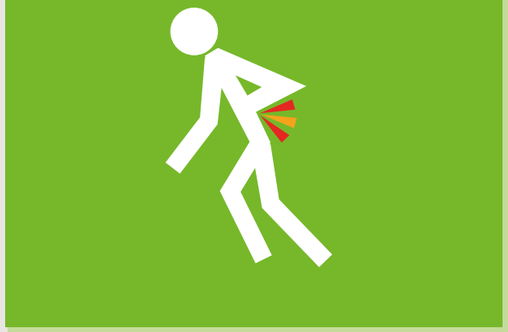
This includes accidents or exposure to harmful chemicals or infectious agents through measures such as health and safety procedures, safety equipment, vaccination, infection control and safer shift patterns. Occupational physical risks are diverse, and vary by profession. For example, prolonged sun exposure leading to an increased risk of skin cancers for outdoor workers and high physical injury risks for those in the construction industry.

Health and safety legislation and procedures form the basis of what an employer is required to do to protect the workforce from these risks, but to support a healthy workforce and workplace there is more that employers can do. An example would be physical activity or weight management programmes to help reduce the risk of musculoskeletal problems, or sun-safety procedures for outdoor workers such as those working in parks and green spaces, at the beach or in the construction industry. This is important for Brighton & Hove as a seaside city with higher than average rates of skin cancer.

6. Are you reducing the risk of workers developing the most common work-related health problems?

Musculoskeletal (MSK) problems and mental health problems are common and the causes of the highest number of working days lost.

However, workplaces can help prevent these conditions, and where they do occur can help employees recover, stay in work and reduce the risk of recurrence.



Musculoskeletal health

Why? Musculoskeletal conditions affect bones, joints, muscles and tendons, including back, neck, shoulder, knee and other joints. They are the cause of one in five working days lost, one third of long-term sickness absence, and a significant cause of work disability and poor productivity. One in eight of the working age population report suffering from a musculoskeletal problem. As our working population ages and works for longer, the challenge will increase.[11] Industries particularly affected include agriculture, construction, health and social care and transportation and storage.[11] Risks range from physical risks to the significant risks of a sedentary desk-based work environment. Work may cause new problems or exacerbate pre-existing ones. Employees with musculoskeletal problems are also at increased risk of stress, anxiety and depression which will affect their ability to cope with and recover from a musculoskeletal condition and their ability to work. Support from employers can lead to improved productivity, reduced sickness absence and a happier, healthier workforce.

How? Lots can be done to reduce the risk of musculoskeletal problems for your workforce and business:

- Prevent it: Provide a health promoting work environment. Ensure the physical environment and job reduces the risk of problems occurring or becoming worse because of work, in line with the Health and Safety Executive guidance.[12]
- Identify early and intervene: Look at your data, be aware as early as possible of workers with MSK problems and make adjustments to work or the work environment. Consider if early intervention with physiotherapy, self-management, occupational health or other healthcare interventions will make improvements.
- Support self-management: Avoid exacerbations and maintain a healthy active workforce. Consider targeted interventions like 'physical activity to look after your back'.
- Support rehabilitation and return to work: Consider changes to the work environment, hours, shifts and the type of work. Ensure employees have access to physiotherapy, self-management or other healthcare interventions as appropriate.

Think about: Business in the Community (BITC) have produced a toolkit highlighting the key issues for employers and employees and useful guidance on how to prevent and manage MSK conditions and reduce the costs and impact for your business www.bitc.org.uk/toolkit/musculoskeletal-health-toolkit-for-employers

Mental health

Why? One in six adults has a common mental disorder[13] and it's a leading cause of sickness absence and of long-term sickness absence. This has significant costs for the government, economy and employers, with half of the costs from presenteeism (less productive individuals due to poor mental health) and additional costs from sickness absence and more frequent staff turnover.[14] This amounts to £33-42 billion a year (or £1,205-£1,560 per year per employee).[15] Of those with a long-term physical health condition, one in three has a mental health problem, usually anxiety or depression.[16]

In the event of loss of life through suicide, the impact to all those affected in the workplace, family and social networks is very great. Brighton & Hove has one of the highest suicide rates nationally with risks varying between occupations.

How? The Stevenson/Farmer review of mental health and employers[14] recommends a set of mental health core standards, a framework of actions for organisations to implement:

- Produce, implement and communicate a mental health at work plan that promotes good mental health and outlines support available for those who need it
- Develop mental health awareness among employees by making information, tools and support accessible
- Encourage open conversations about mental health and the support available when employees are struggling, during the recruitment process and at regular intervals throughout employment and offer appropriate adjustments to employees who need them
- Provide employees with good working conditions and ensure they have a healthy work life balance and opportunities for development
- Promote effective people management to ensure all employees have a regular conversation about their health and wellbeing with their line manager, supervisor or organisational leader. Train and support line managers and supervisors in effective management practices
- Routinely monitor employee mental health and wellbeing by understanding available data, talking to employees, and understanding risk.

Think about: Using the guide 'How to implement the thriving at work mental health standards in your workplace

www.mind.org.uk/workplace/mental-health-at-work

DYING WELL - SUPPORTING BEREAVED AND TERMINALLY ILL WORKERS

At any time, one in ten employees is likely to be affected by bereavement.[1] Although this is an intensely challenging time for individuals, a compassionate and flexible approach from employers can ensure that the impact on both the individual and the organisation is minimised.[2] Employees are allowed time off to deal with bereavement involving a dependent such as spouse, partner, child or someone who depends on the employee for care.[3] Female employees who suffer a stillbirth after 24 weeks are entitled to statutory maternity leave and pay.

Grief impacts on almost every aspect of a bereaved person's life. It can interfere with their thought processes, concentration and sleep patterns at a time when they may need to make important decisions. Fatigue, anxiety and mood swings are common. Knowing that they are supported by their employer can help to minimise the employee's stress levels and reduce or avoid periods of sick leave.

Employers can prepare for managing bereavement in the workplace by having a clear bereavement policy, and by training managers, HR teams and selected staff to have compassionate and effective conversations with bereaved employees.

Supporting and recognising the needs of terminally ill staff is also important. As part of Our People Promise to support wellbeing at work, Brighton & Hove City Council has added its name to a charter aimed at helping employees with a terminal illness.

In December 2019, council leader Nancy Platts and chief executive Geoff Raw signed the 'Dying to Work' Charter alongside representatives from GMB, UNISON and the Trades Union Congress (TUC). The charter protects the rights of terminally ill staff and ensures they cannot be dismissed because of their condition.

LIVING WELL RECOMMENDATIONS

Promote the importance of good work across the city, for example through the Brighton & Hove Living Wage campaign.

For: Economic Partnership partners including Chamber of Commerce

Use evidence-based resources to improve health and wellbeing and prevent ill health at work.

For: The council and employers

Consider how health at work can be improved for those working in small businesses and at home.

For: The council and partners including the Chamber of Commerce

Establish a healthy workplace scheme for Brighton & Hove.

For: The council and employers

SECTION 4.2 THE ROLE OF THE NHS IN CREATING A HEALTHY WORKFORCE

The NHS as a healthy employer

The NHS is a large employer with responsibilities for staff health & wellbeing, and healthy workplaces.

The NHS People Plan[1] aims to make the NHS the best place to work and identifies the need for leadership for culture change as well as major recruitment and retention initiatives. The priorities are:

- Creating a healthy, inclusive and compassionate culture, promoting inclusive leadership
- Tackling bullying and harassment, violence and abuse
- Enabling fulfilling careers, with training and career development
- Ensuring everyone feels they have a voice, control and influence, including a focus on:
  - Physical and mental health and wellbeing, reducing sickness absence
  - Workload, work-life balance, flexible working, and caring responsibilities
  - Working environments.

Locally, priorities of the Sussex Health & Care Partnership, in response to the NHS Long Term Plan,[2] include developing healthy NHS workplaces and workforce health and wellbeing.

The NHS supporting people to stay in work

The NHS plays a crucial role in keeping people well, helping them to recover and be able to get back to work after injury or a period of illness and to support and educate people in self-care and self-management of their long-term health conditions.

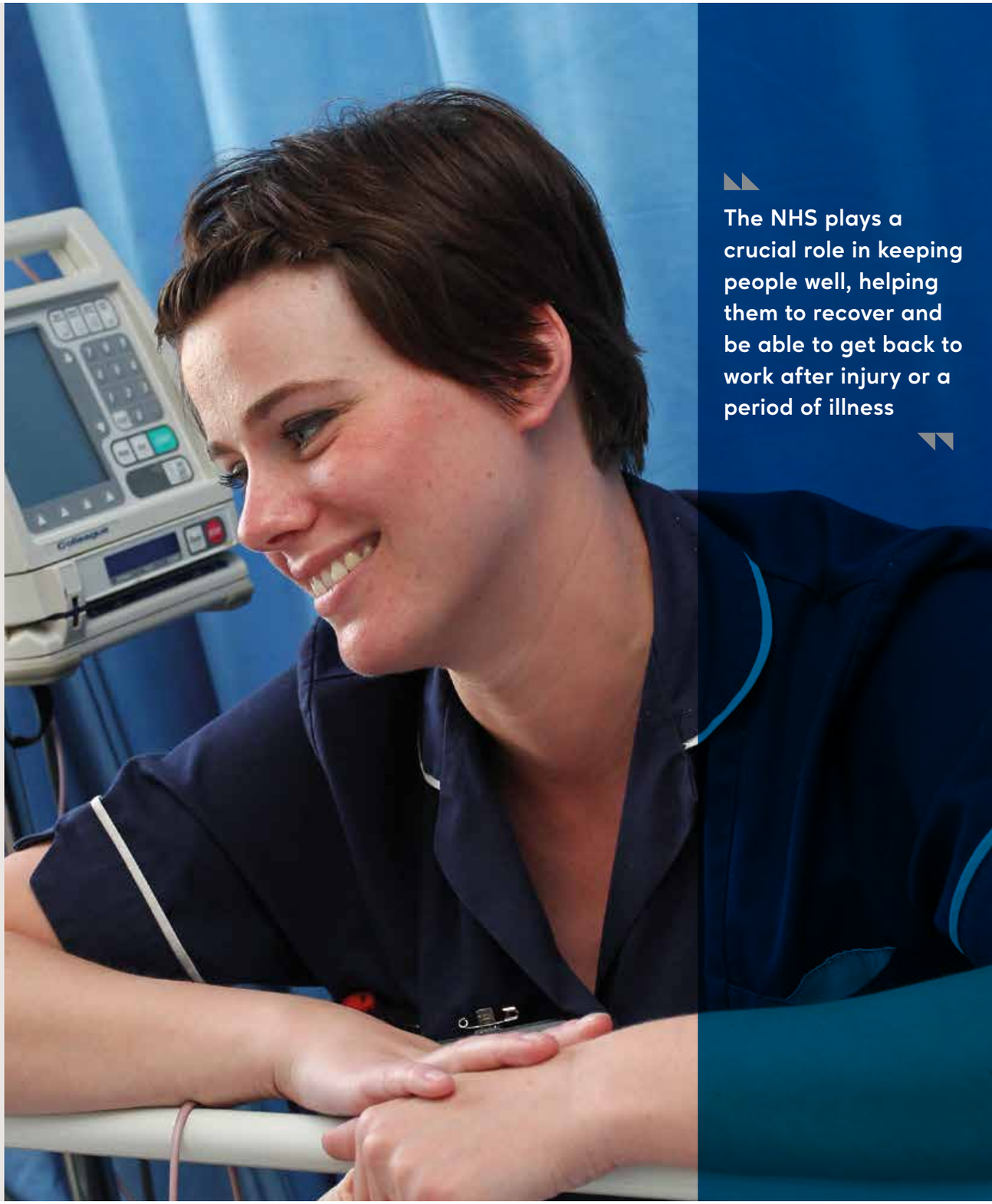
Nearly a quarter of the population of Brighton & Hove is living with two or more long-term physical or mental health conditions and the likelihood of having a mental health condition increases as the number of physical health conditions increase.

This highlights the importance of preventing and managing the health conditions of the workforce, their families and the economy.

There are more people with two or more long-term conditions under the age of 65 years than there are aged 65 years or over

28,000 < 65 years

23,500 65 +



The NHS plays a crucial role in keeping people well, helping them to recover and be able to get back to work after injury or a period of illness

SECTION 4.2 THE ROLE OF THE NHS IN CREATING A HEALTHY WORKFORCE

People with long-term conditions should have personalised care plans to help them manage their conditions at work and employers need to make reasonable adjustments to support their employees. The NHS Long Term Plan includes increasing access to physiotherapists in primary care, to support people back into work quickly by treating their musculoskeletal conditions.

We know that those who are off work for more than four weeks are more likely to stay out of work permanently.[1] Currently, 'fit notes' are the main tool for GPs to support people who have been off work for four weeks or more to return to work. They consider what people can do rather than what they cannot. People may not always be fully recovered, as getting back to work can help recovery.[4] Although there have been relatively few evaluations, the option 'maybe fit' [for work], used in 10% of cases, has been found to be helpful as it includes agreed work solutions to support recovery such as altered hours, amended duties or adaptations.[5]

> "I use fit notes to help support a patient to get back to work. Working with the patient and employer to plan a return to work programme with altered hours, such as working from home, or switching from the night shift to the day shift after sickness."
>
> Local GP Dr J. Simpkin

Free flu jabs for health & social care workers

As flu contributes significantly to winter pressures on health and care services, flu vaccinations are funded by the NHS for frontline health and social care workers

Vaccinations benefit staff, their families and friends, patients, visitors and helps reduce the levels of all-cause mortality and flu like illnesses.[3]

www.nhs.uk/flu

Sussex Community Foundation NHS Trust (SCFT)

disability confident EMPLOYER

SCFT employs 5,000 staff and provides community healthcare and children's services across Sussex. It has an ageing workforce, with 62% of over 50s describing themselves as feeling 'as fit as ever'. Recognising their experience, sound judgement and job knowledge, it is essential that these skilled staff are retained.

To support staff with long-term health conditions the occupational health & wellbeing service offers:

- 121 health & wellbeing assessments, healthcare advice and resources
- Health & wellbeing events to reduce risks of developing long-term health conditions and to support the maintenance of a healthy and happy workforce
- Support in self-management eg psychological talking therapies, physiotherapy, occupational psychologist, pain management
- A health action plan template to assist staff and managers to identify support they feel would help them at work, and if needed Access to Work and re-employment schemes
- Three levels of support for staff with mental health issues, including an employee assisted programme, a bespoke occupational health psychology service, and signposting to specialist mental health services.

www.sussexcommunity.nhs.uk

Sussex Partnership Foundation NHS Trust (SPFT)

The trust provides mental health services across Sussex. It supports its 4,000 staff with a range of wellbeing initiatives:

Mental Health First Aiders support colleagues during periods of stress, from 'a bad work day' to a family crisis.

Wellbeing Champions ensure correctly set up display screen equipment, reasonable adjustment assessments in place, mental health awareness, equality and diversity.

Menopause information - working with the Henpicked charity henpicked.net to produce a menopause leaflet, set up a menopause working group, arrange talks for staff, provide support for those experiencing difficulties and develop training for managers.

Health and Wellbeing Initiative Fund provides small grants for team and individual activities.

Mindfulness Based Cognitive Therapy

Wellbeing Wednesdays weekly bulletin with top tips. **Wellbeing resources** eg Managers' guide to Mental Health in the Workplace, and Partnership Perks - benefits guide.

www.sussexpartnership.nhs.uk

Brighton Sussex University Hospitals NHS Trust (BSUH)

BSUH is an acute teaching hospital trust employing 8,000 staff. It's Health & Wellbeing programme supports and provides opportunities for staff to lead healthy lives and make choices that support their wellbeing at work.

"I really do believe that our jobs in healthcare demand the best of us. In order for us to be able to give our best we need to pay attention to our own health and wellbeing and that of our colleagues."

Denise Farmer, Chief Workforce and Organisational Development Officer

Initiatives include:

- Sharing wellbeing information through webpages, newsletters, posters, twitter and a wellbeing toolkit
- Physical activities arranged for and by staff including swimming, football, pilates and tap dancing. Most instructors are staff who support colleagues while sharing their own hobby or interest.
- Ward-based sessions for staff who might not have much time e.g. yoga, mindfulness, health checks, shared tea breaks or breakfasts
- Beezee Bodies free 12-week weight loss group, supporting people to make small, realistic changes, to help lose weight.

www.bsuhwellbeing.nhs.uk

Ward breakfast

How the NHS can build community wealth and provide access to good work

The NHS is the UK's biggest employer, and locally the three largest NHS Trusts employ 17,000 people across Sussex. They can make a major impact by providing access to good work for local people.

The influence of the NHS in improving health and wellbeing extends far beyond providing health and care services. It is an 'anchor institution' – an organisation that is rooted in local communities, is a major employer and purchaser of goods and services, and operates on a not for profit basis.[6] As such, NHS Trusts can influence the wider determinants of health and build community wealth.

The NHS can make a major difference to the local community by[7]:

- purchasing more locally

- using its buildings and spaces to support communities

- reducing its environmental impact

The NHS Confederation has recommended that NHS organisations work more closely with their Local Economic Partnership, including training and education providers, to develop plans that provide an increased supply of local people into the health and care sector.[8]

> The NHS is the UK's biggest employer, and locally the three largest NHS Trusts employ 17,000 people across Sussex

THE ROLE OF THE NHS RECOMMENDATIONS

Ensure that helping people to stay in work is a key aim of managing physical and mental health long-term conditions.

For: NHS, employers, the council and the community & voluntary sector

Develop the role of health and care services as local 'anchor institutions' to build community wealth and provide access to good work for local people.

For: NHS, the council and other local organisations

SECTION 4.3
EQUALITY, INCLUSION AND WORK

Everyone should have equal access to employment regardless of gender, ethnicity, age, disability, sexual orientation, gender identity and religion. However, when considering employment and the workplace, many inequalities remain, for example gender and disability.

Since 2017, organisations with over 250 employees are required to publish information about their gender pay gap. In 2018 the gender pay gap by occupation for full-time employees favoured men for the main occupation groups. The gap ranged from 5% for people in sales and customer service type occupations to 24% for skilled trades. Although the gender pay gap fell between 2017 and 2018 to 9% among full-time employees, among all employees it was 18% because of more women working part-time. The gender pay gap for full-time employees is now close to zero for people aged 18-39 years and the greatest closure was for those aged 40-49 years.[1]

Employees of Chinese, Indian and Mixed ethnicity all had higher median hourly pay than White British employees in 2018 in Great Britain; while Pakistani and Bangladeshi employees had the lowest median hourly pay.[2] On average, Chinese employees earned 31% more than White British employees; while Bangladeshi employees, on average, earned 20% less than White British employees. The existing pay gap between White British and employees from other ethnic groups is generally smaller for younger employees than for older employees and narrows once other characteristics such as education and occupation are taken into account; however some significant gaps still remain, particularly for those born outside of the UK.

Although the gender pay gap fell between 2017 and 2018 to 9% among full-time employees, among all employees it was 18% because of more women working part-time

People with disabilities are more likely than people without disabilities to be economically inactive. The unemployment rate (the proportion of economically active people aged 16- 64 who are unemployed) for people with a disability was 8% in January-March 2019, meaning 3.3 million people with disabilities of working age were economically inactive (not in work and not looking for work). For people without disabilities the rate was 3%. The economic inactivity rate for those with disabilities was 44% compared with 16% for those without disabilities.[3] However, nationally over the five years to March 2019, the number of people with disabilities in employment increased by almost 950,000 (32%), compared with a 1.1 million increase (4%) in the number of people in employment without disabilities. Therefore, almost half of the growth in employment levels over the last five years was from people with disabilities. But the 'disability employment gap' (the difference in the employment rate of people with disabilities and people without disabilities) in January to March 2019 was still 30%. Over the five years up to January to March 2018, the disability employment gap reduced by 3.8 percentage points.

Good employment benefits the health and wellbeing of both the population and individuals.

SECTION 4.3 EQUALITY, INCLUSION AND WORK

Supporting people with disabilities into employment

In 2017, the government published a strategy **Improving lives: the future of work, health and disability** aiming to get a million more disabled people into employment by 2027.[4] The proposals included tailored employment support for disabled people and people with health conditions, delivered through Jobcentre Plus new Disability Employment Adviser Leader roles and new training for work coaches. Specialist Employability Support is to be provided for people with the greatest needs. Support for young people with disabilities, including apprenticeships and overcoming workplace access issues, were also included.

In 2016 an independent review[5] considered the difficulties faced by people using alcohol or drugs or who are obese in terms of gaining work.

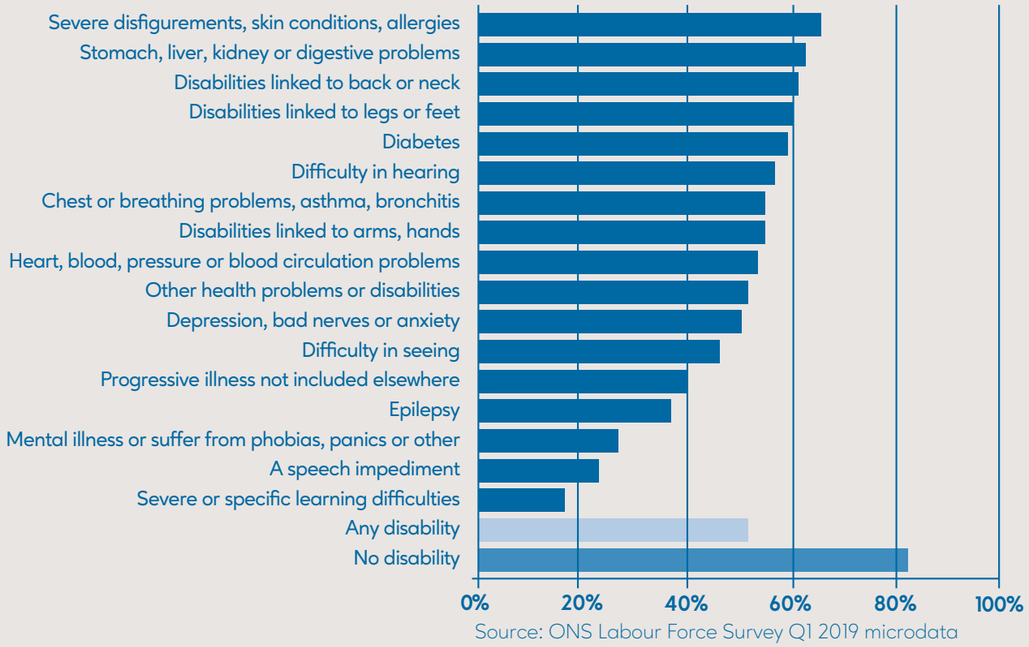
Most obese working-age people are in employment, but severe obesity is associated with lower rates of employment. Obesity is a significant risk factor for sickness absence, claiming disability benefits and retiring early. Some employers are reluctant to recruit obese people because of the perceived risks.

Mental health

Individual Placement and Support Services (IPS) that provide employment support to people with mental health problems have good evidence of their effectiveness. The fundamental approach of IPS is 'place then train'. Trained employment specialists work closely with clients to help them find competitive paid work and then continue to support the clients and their employer.

A review after 12 months[6] found that people who received supported employment were more likely to be in competitive employment (34%) than those who received pre-vocational training (12%). The number of people who needed to be supported for one person to obtain competitive employment was 4.5.

Employment of people with disabilities by health condition %, Age 16-64, January-March 2019



Source: ONS Labour Force Survey Q1 2019 microdata

Figure from: People with disabilities in employment. House of Commons Library.[3]

Routes

Led by local charity Community Works, the 'Routes' project supports people who are long-term unemployed or economically inactive into learning and employment. It adopts a community development approach to supporting participants in deprived areas of Sussex, including the wards of Hangleton & Knoll, East Brighton, Moulsecoomb and Bevendean.

Routes is a Building Better Opportunities Project funded by The European Social Fund and The National Lottery Community Fund in the Coast to Capital Local Economic Partnership area. The Brighton & Hove delivery partners are The Hangleton & Knoll Project and the Brighton Housing Trust (The Whitehawk Inn).

Dedicated advisers offer personalised funded packages of support to address complex barriers to work and learning, as many participants declare mental health issues, experience disabilities and are aged over 50. The offer includes tailored advice and guidance to design personal development plans, practical employment preparation, and access to volunteering, training and financial support for travel, clothing and childcare.

The project initially ran from September 2016 until February 2019 and additional Building Better Opportunities funding has enabled Routes to continue until 2021 to support at least 300 people.

To date the project has helped:

- 212 people with multiple barriers to enter the labour market
- 35 people move into employment
- 43 people move into education and training
- Nearly half of the participants report an improvement in their health and wellbeing and reduced isolation.

People report improvement in their motivation, confidence, mental health and work readiness during the programme. This positive impact extends to their families and communities.

www.routes.org.uk

Community Roots specialist employment support

In October 2019 the Community Roots service was launched in Brighton & Hove, bringing together 16 local services committed to supporting good mental health and wellbeing across the city. Specialist employment support is delivered as part of the new network and is provided by Southdown.

Southdown work in partnership with Sussex Partnership NHS Foundation Trust's mental health clinical teams, and local Job Centres and employers, to increase opportunities for people with mental health challenges to secure and retain employment through IPS.

In 2018/19, Southdown's IPS worked with 328 clients, 47 of whom had autism. In total, 88 people found paid employment in a competitive setting or worked as self-employed. An additional 30 volunteering and work experience placements and 84 education and training placements were found.

Community Roots employment specialist with a client

76% of these clients were still in work three months after they secured employment, 53% after six months and 35% after one year. Some of the clients identified as not being in sustained employment had moved on from their original employment to new employment elsewhere.

The service is continually working to challenge stigma, and to widen the range of services which refer clients.

www.southdown.org/how-we-help/employment-support

The success of such mental health based programmes has led to a national trial of 'place then train' employment support being carried out for people using alcohol and drugs.

Substance misuse

One of the **Improving lives: the future of work, health and disability** report's recommendations was to provide high-quality employment support within substance misuse treatment services. Brighton & Hove is one of seven sites taking part in a national study of the impact of IPS on adults receiving treatment from local community alcohol and drug treatment services (IPS-AD Trial). Participants have alcohol, opioid or other drug problems and have been unemployed or inactive for at least six months and want to work.

In Brighton & Hove, three employment support specialists are based within Pavilions Drugs & Alcohol Service, with an individual caseload of up to 25 clients, providing up to nine months support for each client.

Half of the individuals receive 'treatment as usual' and the other half receive intervention from the employment specialists. A wide range of outcomes are recorded but the primary outcome is at least one day of employment in the open competitive job market during 18 months of follow up. By June 2019 the service had supported 21% of the people in the IPS intervention group into paid employment.

The Supported Employment Team - Mark's story

The Brighton & Hove Supported Employment Team is a council service helping employers to have a diverse workforce, and working with local residents with disabilities to overcome their barriers to employment. The team focus on working with people with learning disabilities and autism, and young people with disabilities.

Mark came to the Supported Employment Team because he was struggling financially and wanted to make changes in his life. He had never found the right job, so hadn't been able to sustain long-term employment. As well as having a learning disability and other health issues he had struggled most of his life with mental health issues including depression and anxiety. Mark found it hard to leave his house or answer the door.

Mark was interested in working in a care home. As his confidence improved, the Supported Employment Team contacted Autumn Lodge, a local care home, and organised work experience for one morning per week over four weeks in a variety of roles. The manager offered Mark a position as a kitchen assistant working a few hours a week, as this is the role where Mark felt most confident and best suited his skills.

Mark is thrilled he has achieved his personal goal of gaining meaningful employment before his 50th birthday. His self-confidence and self-esteem have increased and he has been asked to work more hours. He has also been swimming regularly and volunteers in a charity shop. Although still facing many challenges, Mark is much happier and is excited about his future. Mark feels this is a direct result of gaining paid employment.

www.brighton-hove.gov.uk/supported-employment

Learning disability

People with learning disabilities want to work and want to work in the same types of jobs as the rest of society. Providing effective supported employment for people with learning disabilities can reduce health inequalities and benefit employers.[7]

The number of people with a learning disability who have a job is very low. In England in 2018-19, 6% of people known to social services were in paid employment,[8] compared to 53% of people with a disability and 82% of non-disabled people in the UK.[9] In Brighton & Hove in 2018-19, 9% of people with a learning disability known to social services were in paid employment.[8]

Employers with experience of employing people with learning disabilities have positive views of their employability and performance. They are generally reliable and dedicated workers who improve staff morale, increase diversity, reduce staff turnover, take less sick days and enhance the social corporate responsibility of their employers.[10]

The adjustments needed when employing a person with learning disabilities are easy to implement and low-cost. On average, adjustment costs are only £75. Access to Work is a discretionary government scheme that pays a grant to employers which can go towards extra employment costs.[10]

Employment resources:
www.mencap.org.uk/employerinfo

At Work Service

Possability People is a local charity which provides advice and support to help improve the health and wellbeing of disabled people and those living with long-term conditions.

Their At Work Service provides a range of tailored support services for employers and their staff teams. An equitable approach and involvement helps reassure and give employers confidence that they are doing the right thing. Small and Medium Enterprises (SME) and some of the city's largest employers now have greater confidence and skills in managing and supporting those with a musculoskeletal condition in the workplace; have been supported to have open dialogue with employees; have received guidance on developing Wellness Action Plans which have provided clarity as to what helps keep their staff well at work and what approaches and adjustments are helpful. Occupational health teams have also valued the contribution the service has made in providing early interventions to prevent sickness absence. For example, through alleviating difficulties experienced outside of work making employment more sustainable in the longer-term, and supporting returns to work through our ability to bring new ideas, approaches and perspectives in relation to reasonable adjustments. As an example, one SME could save £78,000 in employee replacement and agency costs, with further potential savings of £5,478 in presenteeism and sickness absence costs.

Possability People

Wherever possible, the At Work Service is supported by delivering Disability Confidence Training – opening up broader opportunities for employers to think differently about and take action to improve how they recruit, retain and develop disabled people.

www.possabilitypeople.org.uk/how-we-can-help/independent-living/communityemployment/possability-people-at-work

SECTION 4.3 EQUALITY, INCLUSION AND WORK

Team Domenica

Team Domenica is a social enterprise charity, created in 2016 by Rosa Monckton, whose daughter has Down's Syndrome. Team Domenica's mission is to help people with learning disabilities discover their career potential, create employment opportunities and remove barriers to work in local communities. Based in central Brighton, they operate a unique three-tier set-up of training centre, training café and employment centre.

The training centre has three core employment programmes to provide an extended transition between the education environment and world of work. They include structured study and training, extended work placements with partnered employers, and wrap-around support for candidates who transition into paid work.

The two training cafés are open to the public and enable candidates to practice professional and social skills through being centrally involved in the running of Café Domenica. The cafés bring local people together, educate them on the real value gained by interacting with people with learning disabilities and strengthen their relationships within the community.

Team Domenica's Employment Centre aims to establish relationships with local companies and provide guidance and advice on employing young people with learning disabilities. They work with employers across all industries including supermarkets, banks, hotels, businesses and small charities across Brighton & Hove.

www.teamdomenica.com

Supporting working carers

Supporting unpaid carers is a key priority for the city. Along with the NHS Clinical Commissioning Group, Brighton & Hove City Council have developed a Carers Strategy, aimed at creating a Carer Friendly City. Being an unpaid carer does not discriminate on the basis of age and the strategy spans the needs of young carers (under 18) to those over 80 years.

Locally we have developed a partnership approach to supporting all carers through the Carers Hub. This provides a range of services including: raising awareness, information and advice, assessment services, and specialist services (including dementia carers, young carers, young adult carers and peer support).

National research has identified the 'top three interventions' for supporting working unpaid carers: a supportive employer/line manager; flexible working; and additional care leave. We are developing and providing a range of services for both working carers, and local employers. The Carers Hub supported 443 working carers in 2018/19. Over the past 12 months they provided carer awareness training sessions to more than 50 local employers, and helped small to medium employers to join Employers for Carers, which allows them to access a comprehensive range of support and resources for free.

There are 23,967 unpaid carers in the city (2011 Census)

Carers UK estimate that their economic contribution is equivalent to £437 million per year

A Carers Employers Passport is also available for employers supporting unpaid carers. It records the care they provide, the impact this has, and the adjustments that have been agreed to support them to reduce the 'juggling' of work and caring.

12% of the carers supported in Brighton & Hove also work, compared to the national figure of 3% (2018/19 Carers Survey)

The Carers Centre's Working Carers Lead, Steve, providing information at our Carers Rights Day event, November 2019

Supporting migrants into work

Brighton & Hove's International Migrants Needs Assessment looked at the qualifications and skills brought to the city by migrants, what employment sectors they occupy, and the barriers experienced by migrants as they seek work.

The difficulties faced by refugees are particularly acute. Often highly skilled and qualified, refugees may have to leave their homes at very short notice and become traumatised and demoralised by long journeys in search of safety. Unless they arrive on a resettlement programme, refugees may also have had long periods of inactivity and uncertainty while they wait for their asylum applications to be decided upon, leading to a loss of confidence and skills.

These challenges are compounded by barriers including limited opportunities to develop skills and convert existing qualifications. Employers may also lack awareness of refugees' skills, potential and their entitlement to take up employment in the UK.

Migrant ESOL Support Hub

In Brighton & Hove, a local partnership project, the Migrant ESOL Support Hub, is guiding migrants who may be far from the labour market towards the most appropriate English language provision and the steps they need to take to find employment. The council is also seeking to learn from local refugees in the labour market and explore ways of supporting the recruitment of refugee communities.

www.trustdevcom.org.uk/what-we-do/equalities-and-inclusion/mesh-the-migrant-and-esol-support-hub

BRIGHTON & HOVE MESH MIGRANT ESOL SUPPORT HUB

EQUALITY, INCLUSION AND WORK RECOMMENDATION

Join up health and employment support for groups finding it hardest to access employment.

For: Department for Work & Pensions, the community & voluntary sector, the council, NHS and our communities

SECTION 5 AGEING WELL AND WORK

Health is the biggest determining factor as to whether older workers can remain in work, outweighing other factors such as job satisfaction and work quality.[1]

As people live longer, the population of older people will increase, and as changes to the state pension age come into effect, we need to ensure that people are supported to be in good quality work for as long as they need to be.

This enables individuals to plan and save for their retirement, helps employers to maintain a skilled workforce, and leads to increased tax revenue and reduced demand on public services.[2]

There is evidence that the social engagement many of us enjoy in our jobs can delay cognitive decline and the risk of dementia. Fulfilling work can also help us to define our place and purpose in society and promote self-esteem and confidence.[1,4]

Being able to remain in good-quality work for as long as you need to not only benefits the financial, health and social wellbeing of individuals, but, is also good for the economy and makes the state pension more affordable.[5]

Challenges faced by older workers

For some people early retirement is planned and well managed, but for many older workers, leaving employment prematurely or involuntarily because of health issues can be catastrophic for their financial future and that of their families. Poor health is also a barrier to participating in volunteering opportunities in later life.[6]

Brighton & Hove has a high rate of income deprivation affecting older people in the city (20%) compared to England (16%) and the South East (12%). There is also a higher than average proportion of older people living alone and locally, poverty in single pensioners is higher compared to pensioner couples. The majority of single pensioners are female.

Older workers typically face higher levels of long-term unemployment and low pay.[4]

Women face particular difficulties in accessing work in later life as they are more likely to be caring for family members, and are more likely to be in part-time work.[5]

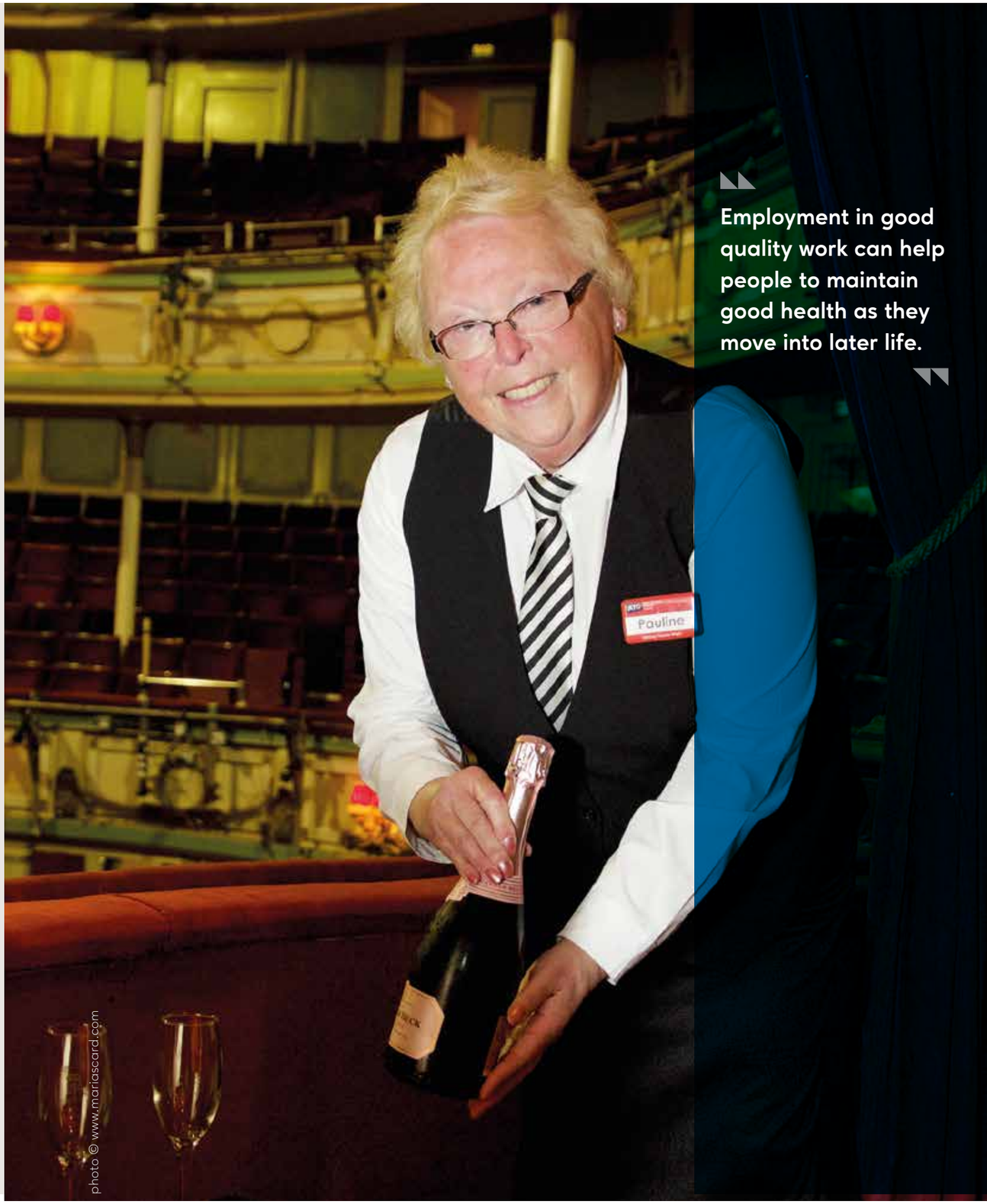
Brighton & Hove has a high rate of income deprivation affecting older people in the city (20%) compared to England (16%) and the South East (12%)

As we live longer many people are also faced with being carers for longer. There is evidence that this is having a negative impact on levels of volunteering, with today's retired people giving less time than previous generations.[6]

Health and wellbeing

Healthy life expectancy is a measure of the average number of years a male or female would expect to live in good health. This has fallen in recent years from 63.9 years to 61.6 years for males and from 64.1 years to 62.2 years for females. People are therefore living longer in ill health.

In Brighton & Hove the proportion of people in employment aged 50-64 years is significantly lower than the England average (72%), whereas, for those aged 25-49 years it is significantly higher (82%)



Employment in good quality work can help people to maintain good health as they move into later life.

This, alongside the rising retirement age, means that increasing numbers of people of working age are in ill-health.[7]

The most prevalent health conditions affecting people aged 50-64 are musculoskeletal conditions (21%), cardiovascular conditions (17%) and depression and anxiety (8%). Evidence suggests that mental health problems such as depression and anxiety have the greatest impact. Nationally, only 43% of those with a long term health condition in the 50-64 age group are in work, compared to 83% of people with no long-term health conditions.[4]

Older workers, including volunteers, look for employment that offers any adjustments needed for health conditions and disabilities - as poor health overrides all positive factors in shaping decisions about staying in work.[8] They value learning, training and opportunities for career progression, as they are seen to support work-life balance and strengthen connections. However, workers aged 50 and over are not only less likely to seek out or take part in work related training than younger colleagues, but they are also less likely to be offered it.[1]

Workers aged 50 and over are not only less likely to seek out or take part in work related training than younger colleagues, but they are also less likely to be offered it

Discrimination and inclusion

The House of Commons Women and Equalities Committee recommended that all jobs should be available on flexible terms unless an employer can demonstrate an immediate and continuing business case against doing so. This would allow older workers to participate in employment on an equal basis.[5]

Despite it being against the law to discriminate against anyone in the workplace because of their actual or assumed age, research with employers found that though they valued older workers, few were taking any actual steps to change their policies and practices regarding the recruitment, retention and training of older workers.[9]

There is an argument that even using the term 'older worker' to categorise an employee can give rise to prejudice and discrimination, and often age-stereotypes will surface where there is technological change or pressure to reduce jobs.[10]

Age friendly workplaces

Brighton & Hove is a member of the UK Network of Age Friendly Communities and in 2018 the Centre for Ageing Better produced a toolkit for employers to encourage and support an age friendly employment workplace.[11] This toolkit is also relevant to managing volunteers as a recent review found that separate 'older people's' volunteering programmes can exacerbate barriers relating to ageist attitudes, and that it is preferable to ensure all opportunities are inclusive and age friendly.[8]

UK Network of Age-friendly Communities

The age-friendly employer's toolkit recommends five broad actions:

1. Be flexible about flexible working - hire flexibly and widen the range of working options available, help people navigate the system, and help managers manage flexibility.
2. Hire age positively - conduct age positive recruitment, minimise age bias in recruitment, and develop returner or re-entry programmes.
3. Ensure everyone has the health support they need - create an open and supportive culture around managing health at work, ensure full, equal, and early access to support any reasonable adjustments, make sure support is sustained over time for workers with health conditions.
4. Encourage career development at all ages - ensure that development training and progression is available equally to all ages, provide guidance at mid-life and beyond, including retirement plans, and help people to manage transitions and plan for the future.
5. Create an age-positive culture - monitor and share workforce data by age, equip line managers with the skills to manage age-friendly practices, and encourage interaction and networking among staff of all ages.

Until 2010 the UK state pension age was

65 years
for men and
60 years
for women

equalising to
65 years
for both by 2018

By 2039 both men and women will have to wait until they are
68 years
before qualifying for a state pension

AGEING WELL RECOMMENDATIONS

Use the age friendly employer's toolkit to help local employers become more age-friendly, promote health at work, help staff in mid-life to plan for their future, and support more older workers to remain in good work for longer.

For: The council, Brighton & Hove CCG and employers

SUMMARY OF RECOMMENDATIONS

STARTING WELL

Continue to tackle the gaps in school readiness and educational outcomes, and support personal progression in order to reduce income, employment and health inequalities in later life.

For: Brighton & Hove City Council, nurseries, schools and colleges, health services, community and voluntary sector and families

LIVING WELL

Promote the importance of good work across the city, for example through the Brighton & Hove Living Wage campaign.

For: Economic Partnership partners including Chamber of Commerce

Use evidence-based resources to improve health and wellbeing and prevent ill health at work.

For: The council and employers

Consider how health at work can be improved for those working in small businesses and at home.

For: The council and partners including the Chamber of Commerce

Establish a healthy workplace scheme for Brighton & Hove.

For: The council and employers

Ensure that helping people to stay in work is a key aim of managing physical and mental health long-term conditions.

For: NHS, employers, the council and the community & voluntary sector

Develop the role of health and care services as local 'anchor institutions' to build community wealth and provide access to good work for local people.

For: NHS, the council and other local organisations

Join up health and employment support for groups finding it hardest to access employment.

For: Department for Work & Pensions, the community & voluntary sector, the council, NHS and our communities

AGEING WELL

Use the age friendly employer's toolkit to help local employers become more age-friendly, promote health at work, help staff in mid-life to plan for their future, and support more older workers to remain in good work for longer.

For: The council, Brighton & Hove CCG and employers

GET IN TOUCH - HOW WE CAN HELP YOU

Together we can make a plan to help your staff get healthier. We can help you make positive changes and stick to them, and make sure they become part of your organisation's everyday life.

We can help you:

- find out what your staff need to be more healthy
- access the accredited Level 2 Understanding Health Improvement in the Workplace training course
- plan and put into action a workplace wellbeing programme
- make sure your wellbeing programme is working

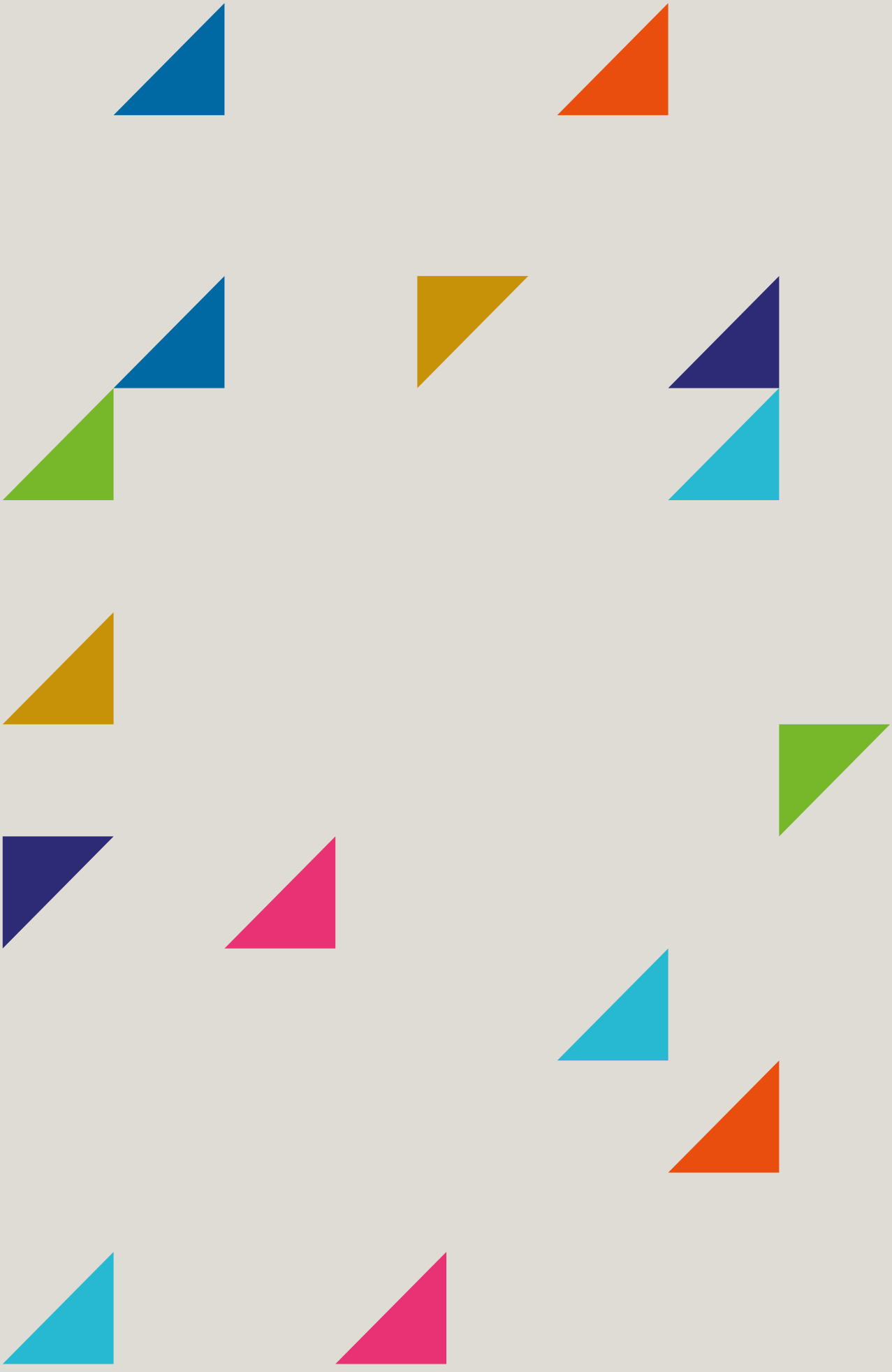
Depending on your organisation, we may also be able to offer your staff:

- support with healthy eating
- support to apply for the Healthy Choice Award for your staff canteen
- help to make your workplace sugar smart
- talks and workshops about how to increase physical activity, including active travel to and from work
- support to stop smoking
- support and advice about alcohol or drugs
- NHS Health Checks for people over 40 years old

The areas we focus on are:

- general advice about good health
- physical activity and active travel
- healthy eating
- emotional health and wellbeing
- smoking
- drugs and alcohol

To find out more about the support we can give you:
Email healthylifestyles@brighton-hove.gov.uk
Call 01273 294589
Visit our website at www.brighton-hove.gov.uk/healthylifestyles



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

Title:	Joint Health and Wellbeing Strategy - Outcome measures
Date of Meeting:	24 March 2020
Report of:	Alistair Hill, Director of Public Health, Health and Adult Social Care
Contact:	Kate Gilchrist, Head of Public Health Intelligence Tel: 01273 290457
Email:	Kate.gilchrist@brighton-hove.gov.uk
Wards Affected:	All

FOR GENERAL RELEASE

Executive Summary

Health and Wellbeing Boards have a duty to prepare a Joint Health and Wellbeing Strategy for meeting needs identified in the Joint Strategic Needs Assessment (JSNA).

The Brighton & Hove Health and Wellbeing Strategy 2019-30 was approved by the Board in March 2019. It sets out the vision that everyone in Brighton & Hove will have the best opportunity to live a healthy, happy and fulfilling life.

This paper presents proposed high level outcomes measures for the strategy.

Glossary of Terms

JNSA – Joint Strategic Needs Assessment
CCG – Clinical Commissioning Group
GPs – General Practitioners
NHS Long Term Plan – the new plan for the NHS to improve the quality of patient care and health outcomes.

1. Decisions, recommendations and any options

1.1 That the Board approves the outcome measures for the Joint Health and Wellbeing Strategy.

2. Relevant information

Background

2.1 Health and Wellbeing Boards have a duty to prepare a Joint Health and Wellbeing Strategy for meeting needs identified in the Joint Strategic Needs Assessment (JSNA).

2.2 The Brighton & Hove Health and Wellbeing Strategy was approved by the Health and Wellbeing Board in March 2019. It is a high-level strategy that sets out the vision of the Board for improving health and wellbeing and reducing health inequalities in Brighton & Hove. The vision for the Board and its partners is that Everyone in Brighton & Hove will have the best opportunity to live a healthy, happy and fulfilling life.

2.3 The strategy states our ambition that by 2030:

- People will live more years in good health (reversing the current falling trend in healthy life expectancy) and
- The gap in healthy life expectancy between people living in the most and least disadvantaged areas of the city will be reduced.

2.4 Four key outcomes for local people are identified: starting well, living well, ageing well and dying well.

2.5 In July 2019 the Board agreed that the Strategy, in addition to the ambitions set out under 2.3, would have a small number of high level outcome measures for each of the four wells.

Development of the outcome measures

2.6 Indicators are suggested based upon: the needs set out in the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy; where they are population level outcomes; where Brighton & Hove performs poorly against comparators (or England); or where there are significant inequalities within the city. Where appropriate, indicators have an additional inequalities element to reflect the overarching ambition of the Strategy.

2.7 In the main indicators are taken from: the Public Health Outcomes Framework; NHS Outcomes Framework and Adult Social Care Outcomes Framework.

2.8 The outcome measures have been informed by the engagement carried out on the Joint Health and Wellbeing Strategy. The outcome measures are

supported by a number of short-term system indicators, e.g. DTOCs, waiting times, monitored by the Partnership Board.

2.9 These indicators have so been informed by discussions at Families, Children and Learning, Public Health and Health and Adult Social Care Directorate Management Teams, the Health & Care the Partnership Board, the Clinical Commissioning Group Local Management Team meeting and the Councillor Performance and Information Group.

2.10 Once the set of outcome measures is agreed, the Public Health Intelligence team will provide trajectories for possible ambitions by 2030 for approval by the Health and Wellbeing Board in June 2020.

The proposed outcome measures

2.11 The list of proposed outcome measures is under each of the four wells are:

	Proposed Joint Health and Wellbeing Strategy outcome measures
Overarching	• People will live more years in good health (reversing the current falling trend in healthy life expectancy). • The gap in healthy life expectancy between people living in the most and least disadvantaged areas of the city will be reduced
Determinants of health	As related strategies are developed e.g. housing, transport, we will seek the inclusion of health and wellbeing related outcome measures in these strategies. At present it is therefore proposed that these are not included directly as Joint Health and Wellbeing Strategy outcomes indicators but are included in the Joint Strategic Needs Assessment summary approved by the Board each year.
Starting well	• The gap in having a good level of development at end of reception between pupils eligible for FSM and other pupils is reduced • The high rates of • smoking • alcohol and • drugs use in 15 year olds are reduced • Educational attainment at 16 is improved for all pupils and those from disadvantaged groups • The percentage of pupils who often/sometimes feel happy increases OR often/sometimes worry about the future decreases • Immunisations (MMR two doses by five years)

Living well	• The gap between the overall employment rate and the rates for those with long-term health conditions, learning disabilities and in contact with mental health services are reduced • The percentage of adults with high levels of happiness is increased and with high levels of anxiety is reduced • The percentage of physically active adults (i.e. who undertake a minimum of 150 minutes of moderate physical activity per week) is increased • The adults smoking prevalence, and the gap between routine and manual workers and other groups, are reduced • Alcohol related admissions to hospital are reduced • Drug related deaths are reduced • HIV 95|95|95 (95% of all people living with HIV know their HIV status; 95% of people with diagnosed HIV infection receive sustained antiretroviral therapy; 95% of people receiving antiretroviral therapy with have viral suppression) • The percentage of cancers detected at an early stage is increased • Deaths from suicide and undetermined injury are reduced
Ageing well	• Health related quality of life for older people is increased • Good quality of life for carers is increased • Repeated admission to hospital is reduced • Hospital admissions due to falls are reduced • Permanent admissions to residential and nursing homes are reduced
Dying well	• People dying in their usual place of residence Local indicators will be considered in the first year

Monitoring the outcome measures

2.12 The Board will receive an annual update on progress, which will enable Board members to maintain oversight of the strategy and identify where they need to take further action as systems leaders.

3. Important considerations and implications

Legal:

3.1 The Health and Wellbeing Board is required to publish a joint Health and Wellbeing Strategy pursuant to the Health and Social Care Act 2012 Section 193. In preparing the Strategy the Local Authority and the CCG must have regard to Guidance and involve local people and the local Healthwatch organisation.

Lawyer consulted: Nicole Mouton Date: 4/2/20

Finance:

3.2 The Health and Wellbeing Strategy informs priorities, budget development and the Medium Term Financial strategy of the Council, Health and other partners. This will require a joined up process for future budget setting in relation to all local public services where applicable. This will ensure that the Council and CCG have an open, transparent and integrated approach to planning and provision of services. Where applicable organisations will align their budget procedures whilst adhering to individual financial governance and regulations.

Finance Officer consulted: Sophie Warburton Date: 4/2/20

Equalities:

3.3 The strategy, and the outcomes measures set out within this paper, includes a strong focus on reducing heath inequalities. The strategy and its delivery is underpinned by the data within our Joint Strategic Needs Assessment which takes the life course approach identifying specific actions for children and young people; adults of working age and older people; and key areas for action that reflect specific equalities issues including inclusive growth and supporting disabled people and people with long-term conditions into work. An Equalities Impact Assessment is not required for the strategy itself but should be completed for specific projects, programmes and commissioning and investment decisions taking forward the strategy, as indicated within this delivery plan.

Sustainability:

3.4 Sustainability is at the heart of the health and wellbeing and this is reflected in the inclusion of active travel, improved air quality and use of green and open spaces in the key areas of action.

Supporting documents and information

Appendix1: Brighton & Hove Health and Wellbeing Strategy
https://new.brighton-hove.gov.uk/sites/default/files/health/brighton-hovehealth-wellbeing-strategy-2019-2030-26-july-19.pdf

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

Title:	Better Lives, Stronger Communities	
Date of Meeting:	24 March 2020	
Report of:	Rob Persey, Executive Director of Adult Social Care and Health, Health and Adult Social Care, BHCC	
Contact:	Grace Hanley, Assistant Director	Tel: 01273 292928
Email:	grace.hanley@ brighton-hove.gov.uk	
Wards Affected:	All	

FOR GENERAL RELEASE

Executive Summary

Our vision is for everyone in Brighton & Hove to have the best opportunity to live a healthy, happy and fulfilling life at every stage of someone's life. We will do this by working with our communities to promote and improve their health and wellbeing, and by supporting people to live independently.

A four year programme of work called *Better Lives, Stronger Communities* is being planned by Brighton and Hove City Council Health and Adult Social Care.

This programme will focus on how best we can work with individuals in the City with care and support needs, and their communities.

Glossary of Terms

BLSC - Better Lives, Stronger Communities

Strength based approach - Strengths-based approaches | SCIE

ASCOF- The Adult Social Care Outcomes Framework (ASCOF) measures how well care and support services achieve the outcomes that matter most to people. The ASCOF is used both locally and nationally to set priorities for care and support, measure progress and strengthen transparency and accountability

1. Decisions, recommendations and any options

1.1 The recommendation is that the Board agrees:

- To support the direction of travel of BLSC and this programme of work.
- To support HASC to adopt a strengths and asset based approach.
- A further detailed update (review of implementation plans) comes back to the Board in March 2021.

2. Relevant information

2.1 To achieve our vision, we need to find solutions to those issues facing the City with regard to Adult Social Care demand:

2.1.1 Our 65 plus population is projected to increase overall by 25% from 2020 to 2030, marginally higher than the national projected increase of 24.4%.

2.1.2 The number of cases of early onset dementia 30-64-year olds is expected to increase year on year for Brighton and Hove where the average for ASCOF comparators is reducing.

2.1.3 Further to this the number of people aged 65+ predicted to have dementia is expected to increase by 28.5%in the same period (lower than the national increase of 51.2%)

2.1.4 22% of the city over the age of 20 are living with two or more long term conditions.

2.2 Against this backdrop, Health and Adult Social Care in Brighton and Hove needs to address issues around how our citizens can:

- Find solutions to support their wellbeing and maintain a good life.
- Access help and advice when they need it to enable them to live well.

- Access person centred and specialist support to maximise their opportunities for independence.

- Access social workers and occupational therapists who understand the needs of our citizens and enable them to achieve their desired outcomes.

2.3 This we must do whilst meeting our legal obligations and maintaining our statutory requirements.

2.4 To do this and in line with best practice, we will focus our efforts on:

- How people access the help they need.
- How we support people to be as independent as possible.
- How we work with people who have more specialist needs
- How people access community assets.

2.5 Our programme will:

- Ensure that solutions are developed collaboratively with those with care and support needs, our staff, and partners.
- Develop our model of practice known as a "strengths based practice". This will support adult social care in Brighton and Hove to deliver in line with national developments and local requirements.
- Equip us to develop and sustain a service which is financially viable.
- Recognise the key role of commissioning- with a focus on quality
- Make sure that technology is integral to the changes we need to make.

2.6 We are currently drafting detailed implementation plans for the programme under the following work-streams:

- How people access the help they need and access (First Contact).
- How we support people to be as independent as possible (Short Term Enablement).
- How we work with people who have more specialist needs (Specialist Intervention).

2.7 These will evolve through engagement with other Directorates, the voluntary sector and City wide partners, importantly including our NHS stakeholders. Collaboration and co-production will be key to identifying common starting points. Immediate priorities for the programme include:

- The development of an early help model for the service.
- Looking at the development of a community reablement service.
- The development of a commissioning strategy.
- Piloting a "move on" project.

- Looking at how we can best align Mental Health social work to the programme.
- How people can access assets available in their communities

3. Important considerations and implications

3.1 **Legal:**

"Guidance on a strength based approach to care has been produced by Social Care in Excellence (SCIE). This independent improvement agency supports the use of the best available knowledge and evidence about what works in social care practice.

The guidance should be read alongside the Care and Support statutory guidance produced under the Care Act 2014. The guidance is complementary to the Act and regulations. It provides tools for local authorities meeting their statutory duties towards protecting the person's independence resilience and ability to make their own choices and wellbeing."

Lawyer consulted: Date:

4. **Finance:**

4.1 The Better Lives, Stronger communities programme will support the delivery of the Financial Recovery Plan required for the Health & Adult Social Care directorate as part of the medium-term financial strategy. This programme of work will help develop a sustainable social care service. The Financial Recovery Plan will be developed as part of the implementation plans outlined in paragraph 2.5.

Finance officer consulted: Sophie Warburton Date: 12/03/2020

5. **Equalities:**

5.1 The programme of work includes a strong focus on reducing inequalities and improving outcomes for the individuals we support. The strategy and its delivery is underpinned by the adoption of a strength based approach as described in this document and appendix. We will change the way we work to reduce the number of 'hand offs' (transfers between teams), enabling more people to get the information, advice and help that they need in a timely way. An Equalities Impact Assessment is not required for the programme itself but should be completed for any specific projects, implementation plans, and commissioning and investment decisions taking forward this work.

Appendix 1

Strengths-based approaches

Strengths-based (or asset-based) approaches focus on individuals' strengths (including personal strengths and social and community networks) and not on their deficits. Strengths-based practice is holistic and multidisciplinary and works with the individual to promote their wellbeing. It is outcomes led and not services led. These resources describe how SBAs work in a variety of interventions and settings and provides information on how to enable and implement SBAs.

Care Act guidance on Strengths-based approaches

Prevention services based on a strengths-based approach support an individual's independence, resilience, ability to make choices and wellbeing.

Key messages

- The Care Act 2014 requires local authorities to 'consider the person's own strengths and capabilities, and what support might be available from their wider support network or within the community to help' in considering 'what else other than the provision of care and support might assist the person in meeting the outcomes they want to achieve'. In order to do this the assessor 'should lead to an approach that looks at a person's life holistically, considering their needs in the context of their skills, ambitions, and priorities'.
- Local authorities should identify the individual's strengths – personal, community and social networks – and maximise those strengths to enable them to achieve their desired outcomes, thereby meeting their needs and improving or maintaining their wellbeing.
- Any suggestion that support could be available from family and friends should be considered in the light of their appropriateness, willingness and ability to provide any additional support and the impact on them of doing so. This is also subject to the agreement of the adult or carer in question (see 6.64 of the Care Act guidance).
- The implementation of a strengths-based approach within the care and support system requires cultural and organisational commitment beyond frontline practice. Practitioners will need time for research and familiarisation with community resources. Accountability has to be with the practitioner and time has to be allowed for the assessment to be undertaken appropriately and proportionately.
- The objective of the strengths-based approach is to protect the individual's independence, resilience, ability to make choices and wellbeing. Supporting the person's strengths can help address needs (whether or not they are eligible) for support in a way that allows the person to lead, and be in control of, an ordinary and independent day-to-day life as much as possible. It may also help delay the development of further needs.

What is a strengths-based approach to care?

Strengths-based practice is a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets.

As such, it concerns itself principally with the quality of the relationship that develops between those providing and those being supported, as well as the elements that the person seeking support brings to the process.

Working in a collaborative way promotes the opportunity for individuals to be co-producers of services and support rather than solely consumers of those services.

"A strengths-based approach to care, support and inclusion says let's look first at what people can do with their skills and their resources and what can the people around them do in their relationships and their communities. People need to be seen as more than just their care needs – they need to be experts and in charge of their own lives" ***Alex Fox, Chief Executive of the charity Shared Lives***

The phrases 'strengths-based approach' and 'asset-based approach' are often used interchangeably. The term 'strength' refers to different elements that help or enable the individual to deal with challenges in life in general and in meeting their needs and achieving their desired outcomes in particular. These elements include:

- their personal resources, abilities, skills, knowledge, potential, etc.
- their social network and its resources, abilities, skills, etc.
- community resources, also known as 'social capital' and/or 'universal resources'.

A strengths-based approach…

A simple phrase that has different meanings for different people but an approach that when done right, opens up many possibilities.

A strengths-based approach can be used in any intervention, in any setting, with any client group, including carers, and by any social or health care member of staff.

The Care Act puts a strengths-based approach at the centre of any intervention, placing the individual, and not only their problems at the centre of the process and highlighting "what is strong, rather than what is wrong", identifying the resources someone has within themselves as well as who and what support they have around them.

This ensures that all their strengths and talents are identified and considered in all interventions; not just their needs and personal outcomes such as what is important for them or what would they like to achieve.

At the end of the day the core duty of the Care Act is to promote individual wellbeing which is broader than 'meeting eligible needs'

Interventions become holistic, person-centred and outcomes focused, which are key elements for a strengths-based approach, and will result in better outcomes and lives for individuals.

As individuals we are all different, and the Care Act recognises this. As individuals we have multiple skills, knowledge, talents, character traits, relationships and abilities. Social care interventions should consider all of those rather than a ‘one size fits all’ based on the catch-all labels such as ‘disability’, ‘dementia’ or simply ‘old’.

When we look beyond these labels amazing potential is revealed.

For example: Anne is a 67 year old woman who speak two languages, has a wide knowledge of international affairs, politics and environmental concerns. She speaks confidently, is very organised, reliable and is witty. She loves interacting with people, learning and teaching.

Anne is NOT just an elderly, lonely person with hearing and sight loss who is finding it very difficult to manage around the house and unable to go out on her own.

Through a strengths -based approach we support the individual to identify their personal outcomes, their needs and their strengths, including social and family networks and other universal resources available to them.

We can then work together to identify how the strengths – individual and community resources, can support them to improve their lives. This may be, for example, the local council, their skills or knowledge, a friend, library, neighbour, health club or a social group.

When we talk with individuals we have to create relationships based on a collaborative process that will enable us to explore together what their strengths, needs and personal outcomes are.

We need to move away from asking questions on a form to having a conversation and building a relationship. Move from ‘what problems are you having preparing a meal or getting out of the house?’ to ‘what does a good day look like for you?’

It is generally not easy to identify one’s strengths, and adults and carers can find it difficult. There are useful tools, for example, asking the right questions, strengths mapping, motivational interviewing, recovery model, three houses and so on. These can support practitioners and individuals in identifying strengths. They are all different and there isn’t a ‘one size fits all’ as individuals are different.

Using these tools people can discover assets and strengths they have or could have access to and that may be through local facilities, professionals or their own talents or those of a friend or family member.

Strengths and assets come in many shapes, sizes and ages.

A strengths based approach - unfolding great lives and outcomes.

Leadership in strengths-based social care

Key messages

- Leadership should encourage a positive attitude to risk and empower the workforce to take control and ownership over the provision of social care support, in order to facilitate innovation and creativity.
- Building buy-in and commitment is key in embedding strengths-based approaches. Leaders need to be visibly involved, working alongside people and building relationships with practitioners.
- Leaders need to clearly communicate about why strengths-based approaches are being adopted, what they are hoping to achieve as well as the values and principles that underpin these approaches. Celebrating and disseminating success stories is also important to inspire staff and build their confidence.
- Leaders need to embrace a systems approach to leadership, which means fostering a culture of distributed leadership and influence at all levels of the organisation. This means sharing power with and devolving responsibilities to leaders at different levels of the organisation to drive change forward
- Co-production is embedded in the whole process so adults, children and young people, carers and families are involved in developing, commissioning, delivering and evaluating services.
- The responsibility for making change happen cannot be held centrally. Leaders across the organisation should be supported to take ownership over new models of care and act as champions who will build buy-in and commitment from their team.
- A strengths-based approach to supervision is one that empowers and supports staff in their development and in their practice. This includes a focus on staff skills, celebrating successes and protecting time for reflexive conversations.
- Strengths-based approaches require leaders to commit to building the confidence and skills that practitioners need to work effectively with people. Leaders should act as coaches and mentors, provide platforms for support and training opportunities relating to working in a strengths-based way.

"A strengths-based approach requires a new kind of leadership, which draws strength from many more sources: the whole team, voluntary sector and other partners, and most importantly, from citizens themselves. Leaders practising strengths-based approaches will not try to effect change by themselves. They will share rather than hoard power, which in turn will enable them to ask more of those around them. The key measure of success is not their own strength, but the combined strength and capacity of the whole system."

Alex Fox OBE, Chief Executive, Shared Lives Plus

Further reading

- The Asset-based area (Think Local Act Personal, 2017)
- Strengths-based social work practice with adults: Roundtable report (Department of Health, 2017)
- Strengths-based approach: Practice Framework and Practice Handbook (Department of Health and Social Care, 2019)
- Senior leader buy-in critical to success of strengths-based social work, says government guidance (Community Care, 2019)
- Developing systems leadership: Interventions, options and opportunities (NHS Leadership Academy, 2017)
- Leading strengths-based practice frameworks: Strategic briefing (Research in Practice, 2018)
- How can we use strengths-based approaches in social work? (Community Care, 2018)
- Growing innovative models of health, care and support for adults (SCIE, 2018)
- Asset-based places: A model for development (SCIE, 2017)
- Leadership in integrated care systems: Report prepared for the NHS Leadership Academy (SCIE, 2018)
- Strengths-based social care for children, young people and their families (SCIE, Leeds City Council and Shared Lives, 2018)
- Developing a wellbeing and strengths-based approach to social work practice: Changing culture (Think Local Act Personal, 2016)
- Reimagining social care: A study in three places – Thurrock, Somerset Wigan (Think Local Act Personal, 2019)
- Yorkshire and Humber ADASS: Strengths-based social care conference (Yorkshire and Humber ADASS, 2018)
- Evidence for strengths and asset-based outcomes (NICE/SCIE, 2019)

Ref: The Social Care Institute for Excellence (www.scie.org.uk/strengths)

Better Lives, Stronger Communities
Health and Adult Social Care

Health and Wellbeing Board

March 24th 2020

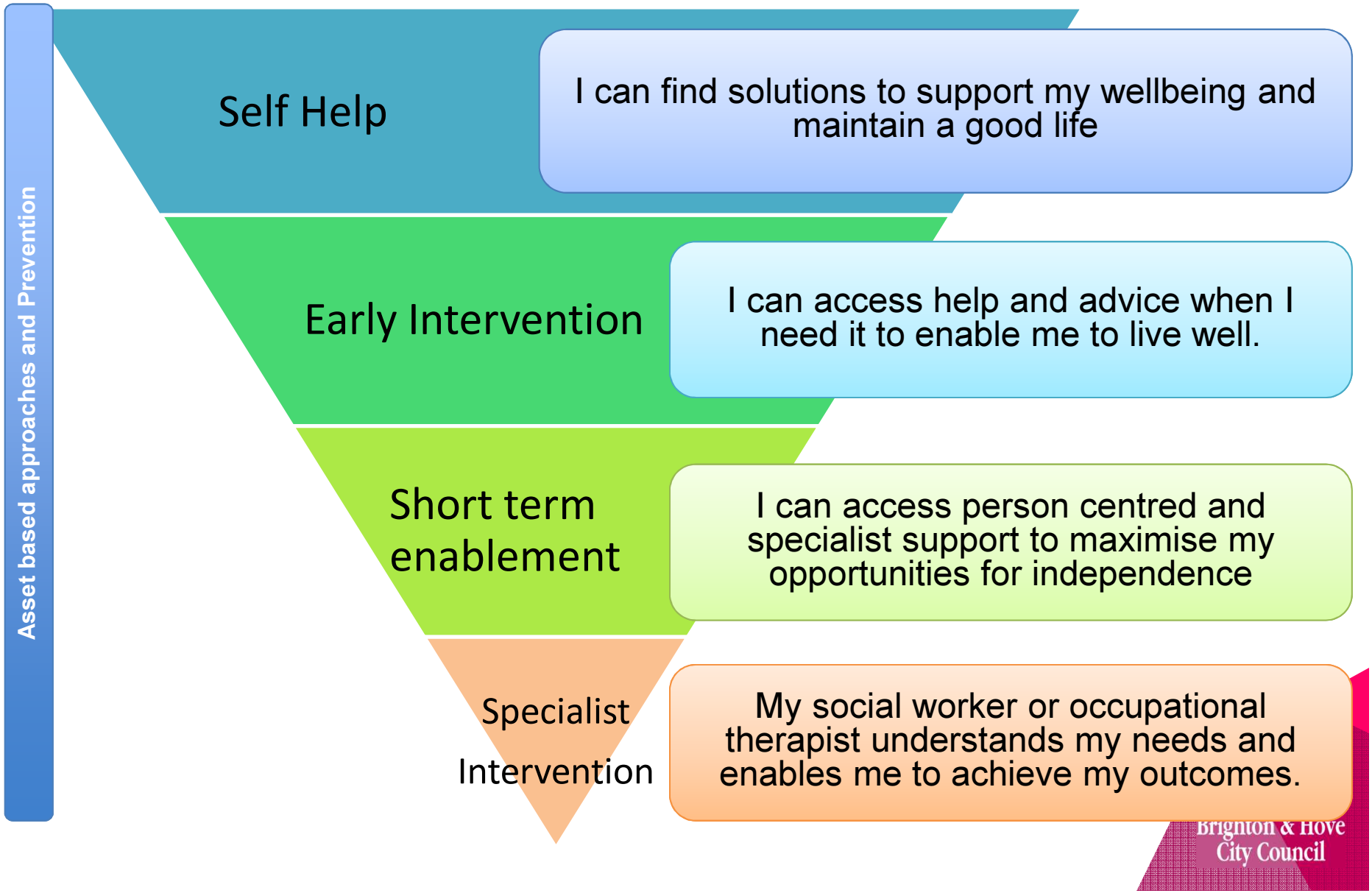
Issues facing our City

- Our 65 plus population projected to increase by 25% from 2020 to 2030 (national projection = 24.4%.)
- Aged 65+ predicted to have dementia is expected to increase by 28.5% in the same period
- The number of cases of early onset dementia 30-64-year olds is expected to increase year on year for Brighton and Hove where the average for ASCOF comparators is reducing.
- 22% of the city over the age of 20 is living with two or more long term conditions.

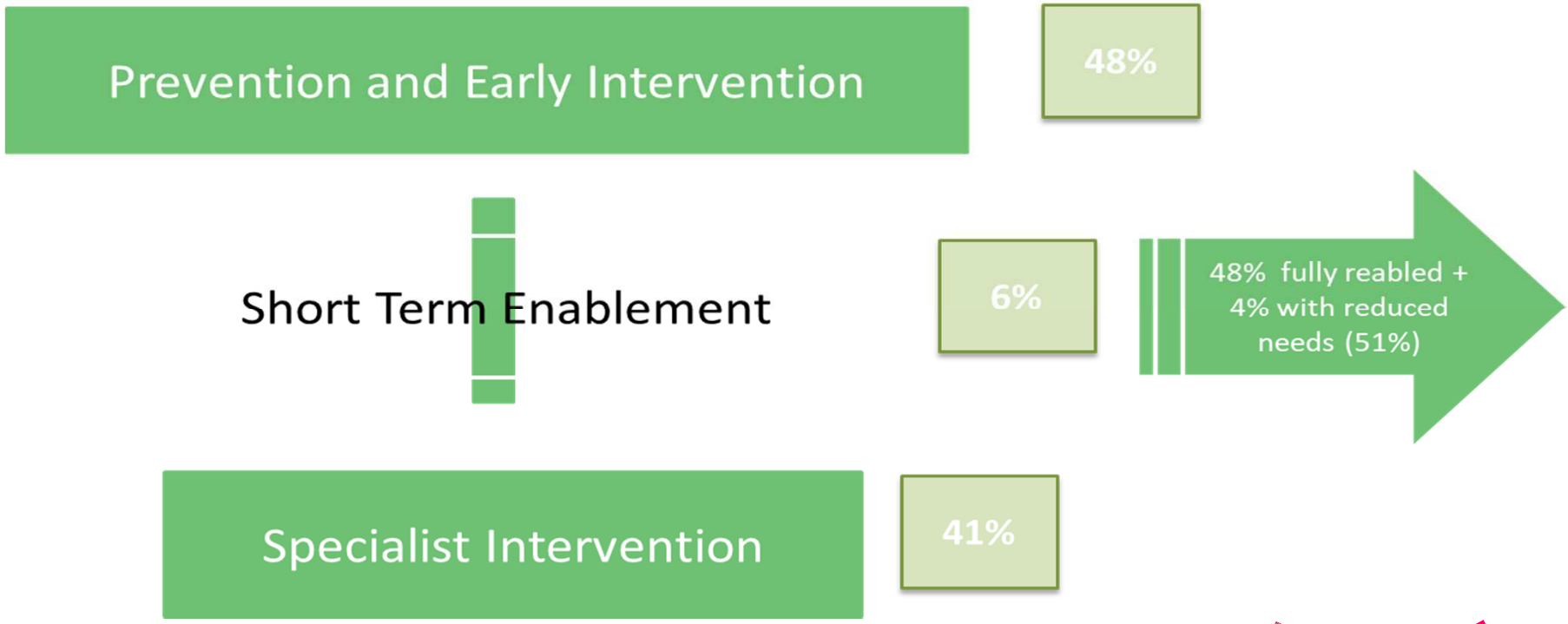
Brighton & Hove City Council

Our vision is for everyone in Brighton & Hove to have the best opportunity to live a healthy, happy and fulfilling life, by ensuring that they are starting well, living well, ageing well and dying well.

HASC Target operating model



Current Operating Model



- Levels of contacts resolved at First Point of Contact to be improved
- Levels of Short Term Intervention.
- High proportion of contacts passed on to the district teams.
- 'Drop out' between assessment and provision: Only 32% result in a service- suggests people are assessed unnecessarily.

Brighton & Hove City Council

Better Lives, Stronger Communities

We will focus our efforts on:

- **How people access the help they need** (First Contact)
- **How we support people to be as independent as possible**(Short term enablement)
- **How we work with people who have more specialist needs**(Specialist Intervention)

How we will work

- Working as one Council- shared priorities
- Working across the City – Partners and Stakeholders
- Embed person centred approaches in all that we do

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

Title:	Health & Adult Social Care Commissioning Strategy
Date of Meeting:	24 March 2020
Report of:	Rob Persey, Executive Director, Health & Adult Social Care
Contact:	Rob Persey Tel: 01273 295203
Email:	rob.persey@brighton-hove.gov.uk
Wards Affected:	All

FOR GENERAL RELEASE

Executive Summary

This strategy outlines our approach to the commissioning of adult social care, public health and supported accommodation and rough sleeping services in Brighton and Hove to improve outcomes; sustain quality; and improve resilience and sustainability of the wider health and social care system.

In both meeting our national and local policy drivers the role and importance of strategic commissioning of health and adult social care is clear. This strategy provides the overarching framework underneath which the Market Position Statement and specific care group commissioning plans will be prepared to shape the range of services available to eligible adults and carers and affected communities of interest.

The associated Market Position Statement and accompanying Commissioning Plans will be prepared and presented to the HWB later in the year.

1. Decisions, recommendations and any options

1.1 That the Board agrees this Commissioning Strategy and the principles the Council will apply in the commissioning, delivery and monitoring of future services.

1.2 That the Board notes that whilst presented as a BHCC strategy for HASC its application will involve considerable partnership working especially with the NHS.

1.3 That the Board requests the Market Position Statement to come to the next HWB in June 2020 with a timetable for the care group specific commissioning plans.

2. Relevant information

To improve the health and social care outcomes for our local population we must respond to changes in the population, our population's health and the health system. Several of the challenges we face are common across England, an ageing demographic with people living with increasingly complex health and care conditions thanks to advances in good public health and medical science. However, we have challenges also that are particular to Brighton and Hove, such as high levels of older people living alone at risk of social isolation and increasing levels of our working age population living with mental health conditions.

Strategic Commissioning is the process of ensuring that population level needs can best be met within available resources through the process of assessing local needs, understanding and shaping the market to best meet those needs, and developing and implementing a plan to meet them.

This strategy outlines our approach to the commissioning of adult social care, public health and supported accommodation and rough sleeping services in Brighton and Hove to improve outcomes; sustain quality; and improve resilience and sustainability of the wider health and social care system.

To support this we have an established policy framework, shared and supported by key partners especially Brighton and Hove Clinical Commissioning Group, which will support the decisions and approach we adopt and guiding principles against which we can be held to account for our commissioning activity over the next four years.

Commissioning of services for health and adult social care, irrespective of scale or value, statutory or discretionary will be guided by the following set of core principles:

Partnership and Collaboration - our approach to commissioning will encourage and support individuals, communities and organisations across the city to work together optimising our individual and combined strengths.

Prevention and Empowerment - we will actively commission services that empower people to take responsibility for their health and wellbeing where they can and enable communities to develop networks and local solutions.

Person Centred and Outcome Focused - Personalisation is enshrined in law which means that social care customers are entitled to choice and control over their support services. We will commission care based on the needs of the person rather than the needs of the service and move towards these being delivered against a set of agreed outcomes.

Co-Production - We recognise the transformational value of this approach built on the principle that those who use a service are best placed to help design it. We will develop relationships where we work more closely with service users, their families and carers to plan and deliver support together.

Value for Money - We will seek to optimise value for money through all the services we commission with respect to the most advantageous combination of cost, quality and sustainability to meet service user requirements including on a case by case basis giving consideration to bids to deliver services in-house.

Responsible for approximately one third of the Council's annual expenditure, whilst adult social care has had a degree of protection from the full impact of central government reductions to local authority funding, in real terms securing future financial sustainability remains the very real challenge. We continue to look forward to the much-needed long term funding arrangement for adult social care nationally that recognises the interface and co-dependency with supporting our NHS. In Brighton and Hove we are working ever closer with our NHS partners, be this through joint commissioning of services or operationally in the delivery of care to patients and services. Building upon strong foundations we look forward to further embedding our collaborative approaches with the local health economy and in the care specific commissioning plans we will provide further detail of what this will mean in practice.

The individual commission plans for the service groups will expand on the resource requirements in more detail for each specific area but the fundamental position this strategy acknowledges is that whilst demand and unit costs continue to increase, local government financing continues to require delivery of ongoing savings. In our ambition to further optimise the efficient allocation of our resources this strategy and the commissioning plans that sit beneath will need to be considered in the context of the Market Position Statement which will detail to the provider market what services the council will focus upon commissioning either on its own or in closer collaboration with health and other stakeholders.

3. Important considerations and implications

Legal:
The Council's proposed strategy for the commissioning of health and adult social care for the next 4 years must be considered by the Board for approval to enable the Board to provide City-wide strategic leadership to public health, health, adults and children's social care commissioning. This is a delegated function of the Board.

Lawyer consulted: Nicole Mouton Date: 12/3/20

Finance:

The Commissioning Strategy details the commissioning intentions for the Council and supports Council priorities. The costs associated with any further actions to implement the Strategy will need to be met from within current agreed capital and revenue resources. The Commissioning Strategy will inform future budget strategies.

Finance Officer consulted: Sophie Warburton Date: 12/03/2020

Equalities:

HASC commissioned services are focused on a number of protected groups, particularly older people, and people living with disabilities and long-term health conditions. Detailed equality impact assessments will be undertaken in relation to specific commissioning plans where appropriate.

Supporting documents and information

Appendix1: Health & Adult Social Care Commissioning Strategy

Brighton and Hove City Council

Health and Adult Social Care Commissioning Strategy

2020-24

CONTENTS

1) Executive Summary

This section to be drafted following March HWB

2) Purpose Policy and Principles

Purpose

This strategy outlines our approach to the commissioning of adult social care, public health and supported accommodation and rough sleeping services in Brighton and Hove to improve outcomes; sustain quality; and improve resilience and sustainability of the wider health and social care system. Commissioning is more than just a process to be followed. Good commissioning in the Health and Adult Social Care directorate will promote good health and wellbeing for all our residents, promote independence, provide high quality sustainable services and fundamentally improve the lives of people with eligible needs, their families, carers and the wider community. The commissioning strategy also makes clear the role that adult social care plays in the economy both locally and nationally and the need to reframe its economic significance in its own right. This element will be developed further in the city's Market Position Statement which will be available from the summer 2020.

Public health both sits in the directorate as a distinct function with statutory authority and equally as a principle that is and will continue to be woven into our future commissioning activity focusing as it does on improving health outcomes, reducing inequalities and setting the strategic direction for health improvement and wellbeing in Brighton & Hove.

Strategic Commissioning is the process of ensuring that population level needs can best be met within available resources through the process of assessing local needs, understanding and shaping the market to best meet those needs, and developing and implementing a plan to meet them.

As illustrated in the table below our approach to commissioning forms a continuous cycle of action and improvement, from identification of needs through to review of delivery and achievement of outcomes and includes commissioning, procurement and contract management activity.

Through our commissioning approach we will ensure that the right care is available, in the right place and at the right time. We will also ensure that this is financially sustainable and of good quality.

Policy

Prior to the Care Act 2014, people had different entitlements for different types of care and support. These were spread across various Acts of Parliament, some over 60 years old. The law was confusing and complex and the statutory policy framework within which local authorities were required to operate equally so. The Care Act updated and brought together all this previous legislation into one place, and with the adoption of a new duty on promoting Wellbeing charged local authorities to ensure adults and communities:

- receive services that prevent their care needs from becoming more serious, or delay the impact of their needs
- can get the information and advice they need to make good decisions about care and support
- have a range of provision of high quality, appropriate services to choose from.

Additionally, the Care Act placed carers on the same statutory footing as the people they care for and increased the local authority's responsibility to provide diverse services for carers. The overarching principle of well-being means that the services commissioned by local authorities must focus on maintaining physical and mental health as well as independence.

The Public Health budget is currently received as ring fenced grant and spend is monitored by Public Health England against mandated and non-mandated functions aligned to the national public health outcomes framework.

In 2019 Brighton and Hove City Council, together with local NHS partners and in consultation with the Voluntary and Community sector adopted the Joint Health and Wellbeing Strategy (HWBS) for the City. The ambition of this 10-year strategy running up to 2030 is such that it requires action and engagement from partners and stakeholders across the city. With a vision for the city stating:

EVERYONE IN BRIGHTON AND HOVE WILL HAVE THE BEST OPPORTUNITY TO LIVE A HEALTH, HAPPY AND FULFILLING LIFE

the HWBS provides an important policy framework for the Health and Adult Social Care directorate. Prepared under four wells; Starting Well, Living Well, Ageing Well and Dying Well, each area has implications for the directorates commissioning of services for public health and adult social care. The link to this strategy and the accompanying action plans is on the Council website and is recommended reading in providing additional policy context.

From a policy perspective it is important to reference the Council's corporate priorities for the next four years published in January 2020. One of these corporate priorities, a Healthy and Caring City states we will:

- increase healthy life expectancy and reduce health inequalities
- support people to live independently
- support people in ageing well
- support carers
- ensure that health and care services meet the needs of all

To help translate this policy framework into the operational working of the HASC directorate the Council has adopted the Better Lives Stronger Communities (BLSC) transformation programme which, explained later in this strategy, focuses mainly on adult social care but has relevance to all activity across the directorate and beyond.

In both meeting our national and local policy drivers the role and importance of strategic commissioning of health and adult social care is clear. This strategy provides the overarching framework underneath which the Market Position Statement and specific care group commissioning plans will be prepared to shape the range of services available to eligible adults and carers and affected communities of interest.

Principles

Commissioning of services for health and adult social care, irrespective of scale or value, statutory or discretionary will be guided by the following set of core principles:

Partnership and Collaboration - our approach to commissioning will encourage and support individuals, communities and organisations across the city to work together optimising our individual and combined strengths.

Prevention and Empowerment - we will actively commission services that empower people to take responsibility for their health and wellbeing where they can and enable communities to develop networks and local solutions.

Person Centred and Outcome Focused - Personalisation is enshrined in law which means that social care customers are entitled to choice and control over their support services. We will commission care based on the needs of the person rather than the needs of the service and move towards these being delivered against a set of agreed outcomes.

Co-Production - We recognise the transformational value of this approach built on the principle that those who use a service are best placed to help design it. We will develop relationships where we work more closely with service users, their families and carers to plan and deliver support together.

Value for Money - We will seek to optimise value for money through all the services we commission with respect to the most advantageous combination of cost, quality and sustainability to meet service user requirements including on a case by case basis giving consideration to bids to deliver services in-house.

SO WHAT!

Strategic Commissioning is the process of ensuring that population level needs can best be met within available resources through the process of assessing local needs, understanding and shaping the market to best meet those needs, and developing and implementing a plan to meet them. To support this we have an established policy framework, shared and supported by key partners especially Brighton and Hove Clinical Commissioning Group, which will support the decisions and approach we adopt and guiding principles against which we can be held to account for our commissioning activity over the next four years.

3) Context and Strategic Objectives

To improve the health and social care outcomes for our local population we must respond to changes in the population, our population's health and the health system. Several of the challenges we face are common across England, an ageing demographic with people living with increasingly complex health and care conditions thanks to advances in good public health and medical science. However, we have challenges also that are particular to Brighton and Hove, such as high levels of older people living alone at risk of social isolation and increasing levels of our working age population living with mental health conditions.

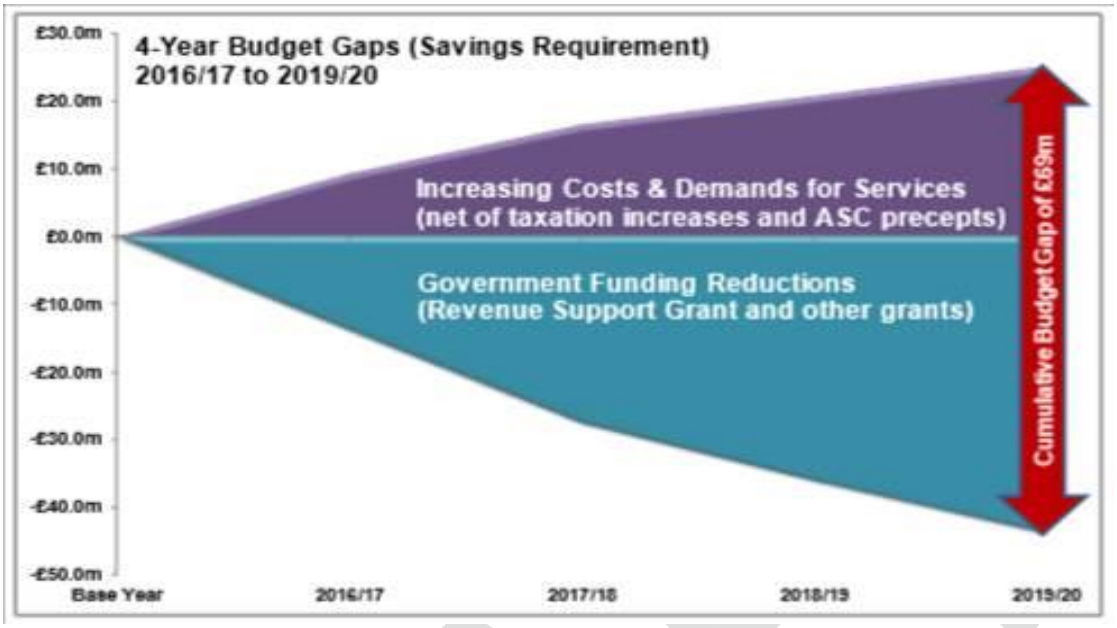
The Brighton and Hove Joint Strategic Needs Assessment illustrates that whilst life expectancy has plateaued in recent years, healthy life expectancy has fallen in the city meaning that on average a larger proportion of life is now spent in poor health. This has obvious consequences for our local health and social care systems and future commissioning will play a key role in trying to reverse this trend by helping to promote preventative approaches and deliver quality services closer to home, promoting wellbeing and independence.

There are currently around 290,000people living in the city and our population profile is comparatively younger than the rest of England. However, our population over the next 10 years is expected to increase at a faster rate than both the south east and England and by 2030 the age profile will be getting older also. In 10 years' time there will be over 5000 more people than currently aged 75 or older including 400 more people aged 90 plus. Related to this, the number of people aged 65+ predicted to have a dementia diagnosis is expected to increase by over a third from approximately 3000 to just over 4000 in the same period.

The number of people with a mental health disorder in Brighton and Hove is expected to increase by 1,537 (4.03%) in the 18-64 cohort by 2035. This is a significantly higher proportion than the expected increase across England. The city has significantly higher levels of homelessness per 1000 households compared to the national average. According to published evidence, the impact of this further increases the pressure on all adult social care services, and particularly mental health, with recent surveys indicating up to 80% of homeless people in England reporting that they had mental health issues, with 45% having been diagnosed with a mental health condition.

While we are experiencing both increased demand and higher levels of complexity in adult social care, Brighton and Hove City Council has had to continue providing services whilst its central government funding has been reduced by over £40 million since 2016 (as indicated in the table below).

Cumulative budget gap from reductions in revenue support grant and increased costs and demands

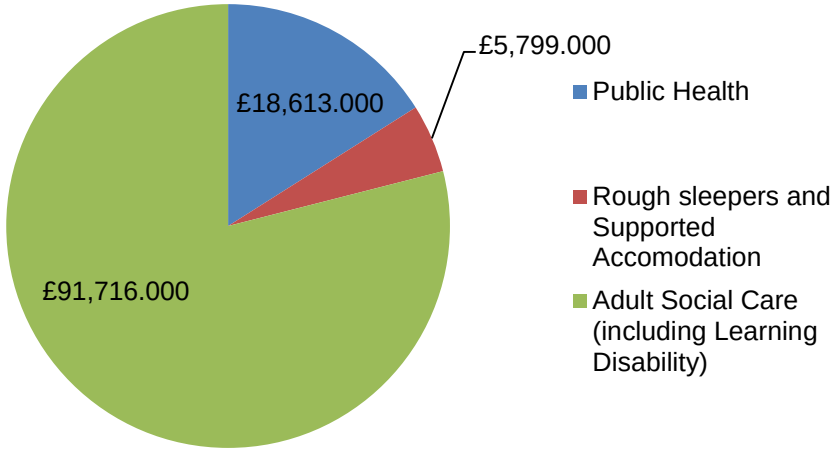


Responsible for approximately one third of the Council's annual expenditure, whilst adult social care has had a degree of protection from the full impact of central government reductions to local authority funding, in real terms securing future financial sustainability remains the very real challenge. We continue to look forward to the much-needed long term funding arrangement for adult social care nationally that recognises the interface and co-dependency with supporting our NHS. In Brighton and Hove we are working ever closer with our NHS partners, be this through joint commissioning of services or operationally in the delivery of care to patients and services. Building upon strong foundations we look forward to further embedding our collaborative approaches with the local health economy and in the care specific commissioning plans we will provide further detail of what this will mean in practice.

The individual commission plans for the service groups will expand on the resource requirements in more detail for each specific area but the fundamental position this strategy acknowledges is that whilst demand and unit costs continue to increase, local government financing continues to require delivery of ongoing savings. In our ambition to further optimise the efficient allocation of our resources this strategy and the commissioning plans that sit beneath will need to be considered in the context of the Market Position Statement which will detail to the provider market what services the council will focus upon commissioning either on its own or in closer collaboration with health and other stakeholders.

The chart below shows the totals current spend on commissioned services in 2019/2020.

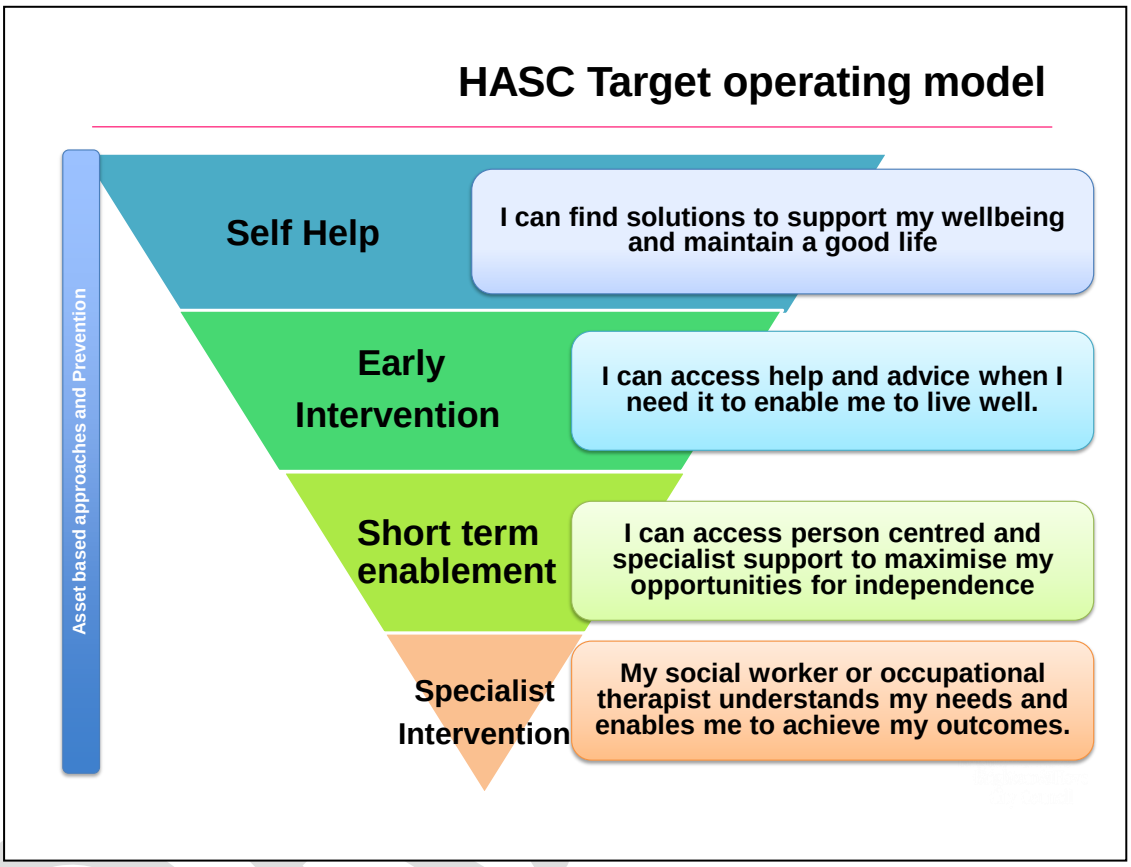
Spend (£) on Commissioned Services



In 2019 the HASC directorate embarked upon a major service transformation programme, Better Lives, Stronger Communities (BLSC). This programme which is being implemented now and for the next three years and should be seen as our 'business as usual' across the directorate but predominantly for adult social care adopts a strength and asset-based approach to delivery with a specific focus upon:

- redesigning the front door service to improve access to advice and information and signpost to preventative community interventions that maximise independence and wellbeing,
- improves the offer of short-term services such as community reablement to help positively turn peoples' lives from dependency where this is beneficial to the persons best interest, and
- reduce our current dependence upon long term placements into residential and nursing home centres except where this is the only safe and appropriate option for the person with eligible social care needs.

Better Lives Stronger Communities Operating Model



BLSC will underpin how we work differently now and looking forward and will require a significant cultural shift both in terms of our practice and that of our providers and partners. We will do this by focusing on what people can do, not what they can't do, building on their individual strengths, networks and utilising community assets before we look to put in place more traditional services.

We will focus upon commissioning the right services to support this new way of working. To enable us to do this we will continue to work collaboratively and effectively with other Council Directorates, the NHS, the Police, care providers, community, voluntary and social enterprises, and other partners. The strategic principles that underpin BLSC transformation programme are:

- Universal focus on supporting the wellbeing and independence of adults with care and support needs and their carers.
- Enabling our local community to help itself and support vulnerable residents.
- Developing 'First Contact' to resolve enquiries and meet need at the earliest possible point.
- Streamlining care and support journeys to improve outcomes and efficiency.

- Opportunities for automation, improved decision-making and new ways of working arising from the Council's investment in Eclipse.
- Efficient management of data to enable data driven decision making.
- Maximise opportunities for more joint working with other directorates and citywide community partners.

This will mean working closely with the Voluntary and Community Sector to ensure that services are in place to support people within their communities, focussing on prevention and ensuring that people are able to support themselves wherever possible.

To know where we want to go in the future we need to understand the position now. The HASC directorate provides a range of different services from preventative services to those where we are required to fulfil a statutory duty. Whilst recognising that the majority of commissioning activity sits within adult social care under our duties outlined in the Care Act, this does not account for the total sum of commissioning activity in the directorate which importantly commissions services across public health and also supported accommodation services for single homeless and rough sleeping. The groups of vulnerable adults for whom we commission services will generally fall into one or more of the following categories:

- Older people
- Adults with a Learning Disability and/or Autism
- Adults with a Mental Health condition
- Adults living with a Physical Disability or Sensory Impairment
- Adult Carers
- Single Homeless and Rough Sleeping

In providing services to these groups of vulnerable adults our main area of commissioned spend both in terms of volume and cost, is directed toward:

- Care home placements; both nursing and residential
- Homecare
- Alcohol and Substance Misuse
- Supported accommodation

The rising cost of services and the cost pressures experienced by many of our providers mean that ensuring we have the right services at a sustainable price is becoming increasingly challenging. As referenced earlier, the increasing demand and complexity of people's needs requiring social care support is adding to these pressures.

Despite the financial pressures in relation to higher levels of health needs, increasing demand and reducing resources we must continue to deliver our statutory responsibilities.

A snapshot of demand for adult social care in 2018/19 indicated the following activity:

- Over 4,500 new requests for social care support resulting in 1300 people being provided with long-term funded care services and a significant proportion of others receiving short term support
- Over 5,000 clients issued with equipment in their home to support their daily living and nearly 5,000 people registered to receive telecare primarily to support their safety and wellbeing;
- Over 1,000 Clients received a short-term service to maximise independence;
- Nearly 2,000 informal carers supported to maintain their caring role and lead a life outside of their caring responsibilities;
- Nearly 1,000 Safeguarding enquiries were carried out;
- Nearly 2,000 Mental Health Act assessments referrals.

During this period, we provided long term funded care services for 3,500 adults. This support was provided in the following ways:

- 1,700 Adults received domiciliary care in the community,
- 1,350 Adults received residential or nursing support (720 nursing care placements and 613 residential care placements);
- Approximately 450 adults receiving their care funded via a Direct Payment.

The objectives of the directorate's delivery of public health delivery are to:

- Improve health and wellbeing across the life course (Starting, living, ageing and dying well)
- Provide leadership and expert advice to improve population health, including publishing the Joint Strategic Needs Assessment, a comprehensive summary of the health and wellbeing needs of the population that underpins the commissioning and provision of health and care services,.
- Protect the health of the population by delivering the local public health role.
- Provide robust, quality assured intelligence and research about Brighton & Hove's their needs population

The Directorate provides and commissions a range of services to meet these objectives. The functions mandated by the conditions of the public health grant provided by central Government include;

- the national child measurement programme;
- NHS health check assessments
- sexual health services
- healthcare public health advice to NHS commissioners
- protecting the health of the local population.
- health visitor reviews for pregnant women and young children

Local authorities must also have regard to the need to improve the take up of, and outcomes from, drug and alcohol services.

Our largest contracts include 0-19 children's and young people's services, sexual health services and substance misuse services. Other services commissioned from the public health budget include weight management, Ageing Well, suicide prevention and stop smoking services. Our commissioned providers include NHS

primary care, NHS Trusts and the community and voluntary sector. The directorate is also a provider of services to improve the health of our residents, for example the Healthy Lifestyles service.

To ensure the successful delivery of the above services Public Health works in partnership with the NHS, other council directorates and a wide range of providers.

This section has outlined the societal challenges of demography and growing complexity of adult social care and public health set against the challenging background of increasing costs and rising demand. Additional to this landscape are further contextual factors which this commissioning strategy will factor for:

Workforce: The adult social care workforce is growing, although the sector continues to face considerable recruitment and retention challenges. If the workforce grows proportionally to the projected number of people aged 65 and over then the number of adult social care jobs in the South East region will increase by more than 40% over the next 10 years.

Staff turnover in Brighton and Hove is estimated at 26%, which although lower than the region average of 30% and lower than England at 31% is still significant. We estimate also that in Brighton and Hove at any one time approximately 8% of roles in adult social care were vacant, this equates to around 550 vacancies at any one time.

This challenge of recruiting and retaining a social care workforce is also impacted by the UK's departure from the European Union as the proportion of EU workers in both the NHS and the social care sector has grown over time, suggesting that both sectors have become increasingly reliant on EU migrants. This Commissioning Strategy will need to respond to workforce challenges across the sector as the situation continues to unfold with respect to future migrant worker arrangements.

Service Quality: Overall provision of regulated services in the city is of a high standard. At present just over 90% of Care Quality Commission regulated services in the city are rated 'good' or 'outstanding' which is significantly higher than the national average of 83**%.**

Brighton and Hove City Council, the Clinical Commissioning Group (**CCG**), and Care Quality Commission (**CQC**) work in partnership to gather intelligence to prioritise intervention following any significant concerns about services provided to vulnerable adults living in the City.

We will continue to support this quality of service through our ongoing approach to quality and contract management (part of the commissioning cycle) to ensure the delivery of services commissioned is in accordance with the specifications for services and the quality expected. This will be explored further in the care group specific commissioning plans and the Market Position Statement.

The council currently provide several in-house services, including hostels, discharge to assess and respite care beds and a reablement service delivered in people's homes. As stated in our principles earlier the Council will source the most effective way to provide future services of good, sustainable quality and will assess on a case

by case basis the potential for these delivered through an in-house option as well as exploring external commissioning.

4) Commissioning Priorities and Plans

This Commissioning Strategy for the next 4 years will be supported by commissioning plans detailing the specific priorities that need to be addressed within their individual area of focus. Whilst these plans will contain greater detail of the demand and supply for specific services there are some key priorities of a scale that merit mention here.

To deliver in practice the policy drivers referred to earlier in this strategy the following priorities will underpin our commissioning:

Promote Prevention and Empowerment

As stated in the health and Wellbeing Strategy we will continue to ensure that communities are supported to develop networks and local solutions that lessen social isolation and improve wellbeing which in turn will reduce the need for more specialist services. We will do this in collaboration with our vibrant voluntary and community sector who are well placed to support in this area.

Support Carers

An unpaid carer provides support to a partner, child, relative or friend who couldn't manage to live independently or whose health or well-being would deteriorate without this help. This could be due to frailty, disability or serious health conditions, mental ill health, or substance misuse. There are over 23,000 unpaid carers in Brighton and Hove and in 2016 their estimated economic value to the city was over £430 million per annum.

We will continue to invest and develop our support services for Carers to ensure that those providing informal care are supported in their roles. This includes the Carers Hub that was jointly commissioned by the Council and CCG and brings together local organisations with council staff to provide a single point of access for unpaid carers to get access to information and support in a timely way.

Reprofile the Residential and Nursing Care Home market

We currently place significantly more people into residential and nursing care than our comparators. Over 1,000 people in the city live in Council funded residential and nursing care, representing 67% of overall Community Care budget spend. Rates of admission to long-term care in Brighton & Hove are much higher than rates across England and these are increasing, whilst rates across England are decreasing, as shown in the table below

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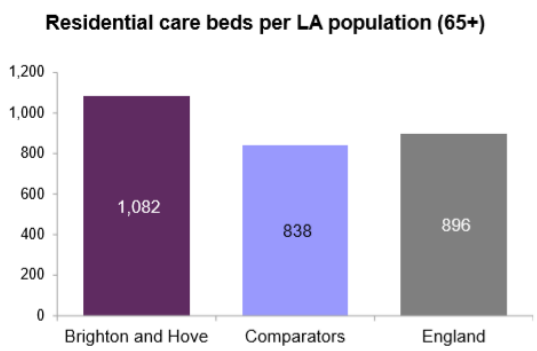

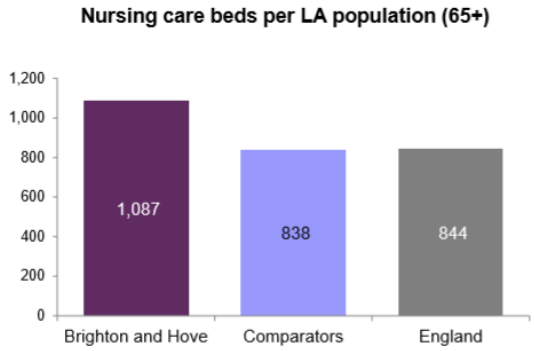

A priority for the council will be to ensure a local market is in place that optimises support for people living at home to optimise their outcome potential and reduce our current level of placement particularly in residential care.

Whilst the need to reprofile the number of residential and nursing beds in the city is recognised we also appreciate the importance and often difficulty in developing alterative accommodation options. We will work collaboratively with existing care home providers in managing this priority and explore opportunities for providers to diversify where appropriate. Population projections come with an associated rise in the number of people living with complex long-term conditions, including mental health conditions; whilst dementia rates are predicted to increase sharply in the next decade. So, whilst the overall number of beds will reduce, there is a need for increased specialist residential and nursing care provision that can meet this growing complexity of care needs.

<u>Development of Supported Living/Accommodation Provision</u>

We will work with providers to develop the market around supported living services to ensure that services are in place to meet the growing demand and reduce the reliance on residential and nursing provision.

This will involve collaboration with a broad range of providers and partners, including other directorates within the Council to ensure that accommodation and development opportunities are maximised. This provision will need to be developed to support vulnerable adults across all the commissioning plans.

<u>Increase access to Community Reablement</u>

We believe that everyone has reablement potential and to support this we will develop a community reablement service to ensure that people are provided with the opportunity to improve their independence before moving to a package of care or residential placement. This will ensure that peoples reablement opportunities are maximised and ongoing support reduced as much as possible.

Recommission Home Care services

Alongside reviewing and developing our community reablement offer we will prioritise recommissioning our current Home Care services framework arrangements. We recognise the increasing demand and changing nature of these services, for example in response to growing pressures on NHS services including the priority to discharge from hospital in a timely manner and understand the importance of homecare in enabling people to remain at home with the necessary support and reducing the need to enter residential care. To do this successfully we need to ensure that the homecare we commission can manage increasing complexity and has the appropriate workforce to deliver this. By addressing this we will be able to support people to live well in the community and prevent people with significant health or care needs from having to use emergency services or being admitted to hospital inappropriately. Home Care plays a significant role in supporting the overall health and care system in the city and ensuring that we have a sustainable homecare market and associated workforce in the city is a high priority.

Promote Direct Payments

A direct payment is when a personal budget is paid directly to an individual to buy their own care and support in line with their assessed needs and they manage their care also, with support available if required. It allows those in receipt of a direct payment to have more choice and control over their lives by enabling them to make decisions about how their care is delivered.

We will look to grow our direct payment offer to support personalisation, choice and independence across both adult and children's services.

We will look to develop our Personal Assistant (PA) market to ensure that those people wishing to employ a PA are able to access them and receive the relevant support in a timely way. We also see this as an important way to support the growing demands and pressures on the homecare market

Expand Shared Lives

Shared Lives is a CQC regulated service where individuals and families provide care and support to people who live with them in their family home. People using the service have the opportunity to be part of the carer's family and social network.

The provision of Shared Lives reflects the drive for more preventative, personalised, community-based care and support to reduce the reliance on more traditional services e.g. residential and nursing.

The Council currently operates an in-house shared lives service and also commissions an independent provider both of which are predominantly focussed on people with a learning disability. While we wish to continue to expand this area we will also conduct a review of the existing provision across both Children's and Adults with a view to an enhanced shared lives offer to support a greater range of people who are able to live more independently and move away from more traditional residential settings.

Increase use of assistive/personalised technology

Whilst there is consideration in how assistive technology (primarily care link) can support people when they make contact with the council there is far more that can be explored in this area. The range of assistive technology available is increasing every year. We will look to develop a greater understanding of this technology and how this be used to support people to increase their independence.

Explore Outcome focused commissioning

We will look to implement more outcome-based commissioning / contracting to promote the achievement of outcomes rather than outputs with a view to driving and promoting a focus on independence and reablement.

Contracting methods already mentioned above such as Individual Service Funds can support this approach but will require providers and the Council to think more creatively about contracting and the associated risks etc. when moving to these more flexible approaches.

Explore the potential to use Individual Service Funds

We will look for opportunities to pilot different approaches to the traditional models of contracting and evaluate the possible benefits of Individual Service Funds. This contracting for flexible support can improve outcomes for individuals while enabling service providers to provide flexible support and can help build greater partnerships and trust between councils and providers while realising efficiencies.
We have already identified services within learning disabilities and an acquired brain Injury service both of which provide support living service and where we feel this approach may be of benefit.

Adopt a Council and City-Wide Approach

To support our transformational programme BLSC within Health and Adult Social Care, commissioners will need to work closely with other directorates within the Council and stakeholders across the City.

We will work in collaboration with the voluntary and community sector to support our focus on prevention and enabling and empowering people to take responsibility for their health wellbeing. We will look to maximise community assets and support people to take early action to help people to live well for longer and to remain independent.

This will include ensuring we have clearly developed accommodation pathways focused on reducing admissions to residential care and supporting step down through a progressive and enabling approach.

Commissioning Plans

Commissioning plans for the areas highlighted in this strategy are being developed and will be published through 2020 with a timetable presented to Health and Wellbeing Board for agreement in June 2020. This will be alongside a refreshed Market Position Statement that will also be presented to the Health and Wellbeing Board in June 2020 and will support providers in understanding service provision

development opportunities and how the Council will support them to tackle the challenges that we face as a sector.

Item 67

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

Title: Brighton & Hove Healthwatch GP Report 2020 Date of Meeting: 24 March 2020 Report of: Michelle Kay, Project Coordinator, Healthwatch Contact: Penny Jennings Email: penny.jennings@brighton-hove.gov.uk Penny Jennings <Penny.Jennings@brighton-hove.gov.uk> Wards effected: ALL **FOR GENERAL RELEASE**
Executive Summary Healthwatch is the local independent consumer champion for health and care. Healthwatch is a co-opted member of both the Brighton & Hove Health Overview & Scrutiny Committee (HOSC) and the Health & Wellbeing Board (HWB), and is presenting its GP patient review 2020 to the Health & Wellbeing Board. (**Appendix 1**).
Glossary of Terms

1. Decisions, recommendations and any options

1.1 That the Board agrees to note the Healthwatch GP report and support its recommendations to General Practice, Practice Managers and their staff; recommendations for Pharmacists; for NHS England; Brighton and Hove

Clinical Commissioning Group (CCG); and Brighton and Sussex University Hospitals NHS Trust.

1.2 Many of our recommendations feature elements of personalised care including appointments being available outside of the working day; providing choice of GP and longer appointments to meet those with complex needs; and involving patients in decisions about treatment and referral options. Recommendations will be presented in full at the March Health and Wellbeing Board meeting.

2. Relevant information

2.1 Key findings are presented below. Full findings will be presented at the March Health and Wellbeing Board meeting.

Overall patient feedback

- 89% of patients rated the overall quality of care communication as good or very good, by either their GP or nurse combined, on seven criteria.
- Patient satisfaction with their GP Practice was also generally good. We assessed GP Practices using seven criteria of satisfaction and on average 70% of patients rated five from the seven criteria as good or very good.

GP Capacity

- Patient caseloads have increased from 2,394 patients per doctor in 2017/18 to 2,479 in 2018/2019. This is against an England average of 1,825 per doctor.
- The number of GP Practices has decreased from 48 to 35 from 2015 to 2019. There are also currently five branch surgeries that provide GP services. Two GP Practices have closed since our last report in 2018 and a further closure/merger is planned for early 2020. This undoubtedly affects ease of accessibility, especially for patients with mobility challenges.

Accessibility

- Booking by telephone is popular but not always easy to use: 92% of patients book an appointment by telephone but only 68% of patients find booking this way to be easy. This mostly affects those less able to visit the GP Practice in person and/or those less likely to use online booking systems.
- Urgent GP appointments are not guaranteed: 81% of GP Practices could not guarantee same day booking for urgent appointments.[1]

[1] Read this article from Pulse Today on increased waiting times and decreases in same-day appointment availability: http://www.pulsetoday.co.uk/news/gp-topics/access/15-increase-in-patients-waiting-a-month-for-a-gp-appointment/20038643.article

- Choice of GP is not guaranteed: 29% of patients who wanted a choice of GP, were unable to achieve this. This mostly affects patients with long-term health conditions including mental health issues, where consistency of care is important.

Personalised Care

- There is a low awareness of preventative services. Of patients who should be targeted for preventative services, 37% are unaware of health checks for 40-74 year olds; 44% are unaware of abdominal aortic aneurysm screening; 25% are unaware of bowel cancer screening; and 53% are unaware of annual health checks for people with long-term health conditions.
- 70% of people referred to an NHS service with a mental or emotional health problem, felt not all their needs had been met or their needs had only been partially met.[2]
- In addition, patients with long-term health conditions, including mental health, spoke to us about needing consistency of care. Patients wanted longer appointments, to allow complex conditions to be treated in full and to allow the diagnosis of more than one condition. Patients asked for medical staff that specialise in their condition.

3. Important considerations and implications

3.1 Legal:

There are no legal implications to this report

Lawyer consulted: Nicole Mouton Date: 9/3/2020

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

[2] This finding drawn from patient satisfaction for the referral services, is based on a small sample size and therefore should be interpreted with a degree of caution.

Finance Officer consulted: Sophie Wharburton Date: 9/3/2020

3.3 Equalities

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

Supporting documents and information

Appendix1:

Healthwatch Brighton & Hove GP Review: Patients' experiences of primary care in Brighton and Hove during 2019

Please note the GP Report is final but not yet launched. It's circulation outside of Health & Wellbeing Board members is therefore embargoed until the March Board meeting.

healthwatch Brighton and Hove

GP Review 2020:

Patients' experiences of primary care in Brighton and Hove

REPORT PUBLISHED MARCH 2020

Contents

About us

Healthwatch Brighton and Hove is the independent champion for people who use health and social care services in Brighton and Hove.

Our job is to make sure that those who run local health and care services understand and act on what really matters to people. We listen to what people like about services and what could be improved. We share what people tell us with those with the power to make change happen. We encourage services to involve people in decisions that affect them. We also help people find the information they need about services in their area.

Acknowledgements

Healthwatch Brighton and Hove would like to thank the following volunteers who have supported this project by carrying out surgery visits, inputting patient responses into the online software tool. We also thank them for their input into the question preparation, and feedback on carrying out the project and suggestions for future projects:

Nick Goslett
Chris Jennings
Fran McCabe
Sylvia New
Sue Seymour
Maureen Smalldridge
Angelika Wydra

In addition, we would like to thank Chris Jennings for the additional time he has provided in data preparation, analysis and support to the writing of this report.

Healthwatch Brighton and Hove would also like to thank all of the Practice Managers and Practice staff of the 34 GP surgeries who facilitated our visits. We are also grateful to the patients who participated in the surveys.

1. Executive Summary

Since our last report in 2018, the primary care landscape has changed. The NHS Long Term Plan (LTP) provides a framework for improving NHS services over the next 10 years, see https://www.kingsfund.org.uk/publications/nhs-long-term-plan-explained. Brighton and Hove Clinical Commissioning Group (CCG) have submitted to NHS England their response to the NHS LTP along with others to form a coordinated Sussex Plan overseen by the Sussex Health and Care Partnership (SHCP), previously known as the Sustainability and Transformation Partnerships (STPs).[1] The SHCP aims to create an Integrated (Health) care system (ICS)[2] and as part of this, GP practices are forming Primary Care Networks (PCNs) in partnership with other practices (read this British Medical Association article for more information: https://www.bma.org.uk/connecting-doctors/the_practice/b/weblog/posts/primary-care-networks-pcns). "The SHCP seeks to bring together 21 organisations all working together to meet the changing needs of all the people who live in our area. We want to offer better health, better care and to ensure we make the most efficient use of our resources."[3]

GP Practices within PCNs will be expected to offer additional services to their core GP function, including extended access (including virtual and roving GPs, extended hours, physiotherapy, minor surgery and social prescribing (wellbeing services such as support for long-term conditions, complex social needs and mental health support).[4]

At the same time, changes within the Emergency Department in hospitals (A&E), will affect GP capacity. GPs have been present in A&E for some time, working shifts alongside hospital doctors. In 2017, GP Streaming (Primary Care Front Door) was introduced at the Royal Sussex County Hospital A&E from 8.00am to 11.00pm each day. This was a dedicated GP service and an alternative to seeing a hospital doctor.[5]

In 2019, an Urgent Treatment Centre[6] was also introduced as a distinct service operating at the Royal Sussex County Hospital. This may create a further stretch on GPs (and other healthcare professionals who will be meeting patient demand in this model). Also, across the country, GPs are facing ever-increasing caseloads of patients[7] together with GP Practice closures and mergers.

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[1] See Brighton and Hove Clinical Commissioning Group's website for further details on the STP: https://www.brightonandhoveccg.nhs.uk/our-programmes/sustainability-and-transformation-partnership

[2] See NHS England's explanation of the ICS here: https://www.england.nhs.uk/integratedcare/integrated-care-systems/

[3] Read more on the SHCP here: https://www.seshealthandcare.org.uk/

[4] See NHS England's "Social prescribing" for further information: https://www.england.nhs.uk/personalisedcare/social-prescribing/

[5] Read Healthwatch's 2018 review on Adult A&E for further information on this: https://www.healthwatchbrightonandhove.co.uk/publications/healthwatch-reports/2018-reports/

[6] Read this article by Brighton and Hove Independent for further information: https://www.brightonandhoveindependent.co.uk/health/new-urgent-treatment-centre-to-open-at-royal-sussex-county-hospital-1-9003072

[7] See NHS Digital data from General Practice Workforce, 30 June 2019

In this context, Healthwatch wanted to find out how Brighton and Hove practices are set to deliver core functions before they prepare themselves to offer the additional services expected under the PCN arrangement. Having carried out a review in 2017 (forming our report published in 2018 and referred to as 'our 2018 report' from hereon) we wanted to see how things had changed since then. We also looked at 2019's findings in the context of the national picture, as demonstrated by the 2019 NHS National GP patient survey (referred to as the National Survey from this point forward and accessed here: https://www.gp-patient.co.uk/).

We spoke to 998 patients across all 40 GP locations in Brighton and Hove (35 practices and five branch surgeries). Responses were derived from online and face-to-face questionnaires. For the latter, we visited 34 GP Practices in person where it was also possible to observe aspects of the waiting area. We found:

Overall patient feedback

- 89% of patients rated the overall quality of care communication as good or very good, by either their GP or nurse combined, on seven criteria.
- Patient satisfaction with their GP Practice was also generally good. We assessed GP Practices using seven criteria of satisfaction and on average 70% of patients rated five from the seven criteria as good or very good.

GP Capacity

- Patient caseloads have increased from 2,394 patients per doctor in 2017/18 to 2,479 in 2018/2019. This is against an England average of 1,825 per doctor.
- The number of GP Practices has decreased from 48 to 35 from 2015 to 2019. There are also currently five branch surgeries that provide GP services. Two GP Practices have closed since our last report in 2018 and a further closure/merger is planned for early 2020. This undoubtedly affects ease of accessibility, especially for patients with mobility challenges.

Accessibility

- Booking by telephone is popular but not always easy to use: 92% of patients book an appointment by telephone but only 68% of patients find booking this way to be easy. This mostly affects those less able to visit the GP Practice in person and/or those less likely to use online booking systems.
- Urgent GP appointments are not guaranteed: 81% of GP Practices could not guarantee same day booking for urgent appointments.[8]

[8] Read this article from Pulse Today on increased waiting times and decreases in same-day appointment availability: http://www.pulsetoday.co.uk/news/gp-topics/access/15-increase-in-patients-waiting-a-month-for-a-gp-appointment/20038643.article

- Choice of GP is not guaranteed: 29% of patients who wanted a choice of GP, were unable to achieve this. This mostly affects patients with long-term health conditions including mental health issues, where consistency of care is important.

Personalised Care

- There is a low awareness of preventative services. Of patients who should be targeted for preventative services, 37% are unaware of health checks for 40-74 year olds; 44% are unaware of abdominal aortic aneurysm screening; 25% are unaware of bowel cancer screening; and 53% are unaware of annual health checks for people with long-term health conditions.
- 70% of people referred to an NHS service with a mental or emotional health problem, felt not all their needs had been met or their needs had only been partially met.[9]
- In addition, patients with long-term health conditions, including mental health, spoke to us about needing consistency of care. Patients wanted longer appointments, to allow complex conditions to be treated in full and to allow the diagnosis of more than one condition. Patients asked for medical staff that specialise in their condition.

Primary care services in Brighton and Hove are succeeding to meet patient expectations in many respects. However, Practices are faced with the challenge of ever-increasing caseloads, increased complex and long-term conditions, in the context of an ever-ageing population. Read the Office for National Statistics article on 'Living Longer: how our population is changing and why it matters' for further information: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/livinglongerhowourpopulationischangingandwhyitmatters/2018-08-13. In addition, there is a clear expectation in NHS future plans that GP practices and PCNs will deliver more healthcare and greater variety of healthcare.

Our recommendations include suggestions of how to meet these challenges. Many of our recommendations feature elements of personalised care including appointments being available outside of the working day; providing choice of GP and longer appointments to meet those with complex needs; and involving patients in decisions about treatment and referral options. Our full recommendations can be read in Section 2 on page 9 of this report.

[9] This finding drawn from patient satisfaction for the referral services, is based on a small sample size and therefore should be interpreted with a degree of caution.

1A: Response from Key Stakeholders

Prior to publication, this report was shared with a number of colleagues at the Brighton and Hove Clinical Commissioning Group, who collectively sent their comments which have been incorporated into the final report. We were pleased to receive this response to our report from Lola Banjoko, on behalf of the CCG:

> *"Thank you for providing us with the opportunity to comment both on the accuracy of the report and also on the recommendations contained within it, prior to its final publication. The CCG recognise the valuable contribution Healthwatch makes supporting, informing and improving service delivery for those people who use health and social care in Brighton and Hove."*

This report was also shared with the Care Quality Commission and we were pleased to receive this response from Emily Hempstead, on behalf of the South East Region CQC:

> *"We would like to thank you for sending us this report. I have shared it internally here at the CQC. We will use the details to inform our monitoring and inspection scheduling for Brighton and Hove.*
>
> *I meet with Healthwatch regularly and so I look forward to discussing the report in more detail."*

2. Recommendations

A: Recommendations for General Practice, Practice Managers and their staff

Bookings

A1. Ensure bookings by telephone are supported by enough staff capacity and good customer service.

A2. Ensure online bookings are supported by an efficient and customer friendly system.

A3. Better promote use of low-cost alternatives to booking appointments in person e.g. online bookings.

A4. All practices should offer additional opening times at weekends or one weekday evening and/or offering 'extended access' through a PCN hub or existing services (for example, IC24).

A5. Increase the number of urgent appointments. Patients have a strong expectation that GP urgent appointments should be available.

A6. Reduce waiting times to have a booked appointment with a nurse or a GP.

Consultation

A7. Increase promotion and availability of cost-effective alternatives to face-to-face consultations, such as telephone or online consultations. When promoting, focus on the benefits to patients of using these services.

A8. Provide opportunity to allow patients continuity of care, including seeing the same doctor.

A9. Allow time in appointments for GPs to understand the full issue, including different conditions that may link to one another and to listen fully to the patient (a holistic approach).

A10. Where possible, ensure patients have access to more GPs that specialise in their condition, particularly where it is long-term, for example mental health issues.

A11. Continue to keep appointments on the day, as timely as possible and keep patients informed of any delays while waiting.

Complaints

A12. Ensure the complaints procedure is open and transparent and that all patients are aware of how to provide comment about the surgery (positive and negative).

A13. Ensure all reception and medical staff are trained in basic customer service skills, with the ability to deal with complaints and challenging behaviour and/or refer to the Practice Manager where appropriate.

A14. Consider a separate area for patients to speak confidentially to reception staff.

Preventative Services

A15. Raise awareness of preventative services, particularly targeting patients who are most likely to need these services.

- Target patients aged 40-74 with information about Annual Health Checks;
- Target patients aged 65-75 with information about Abdominal Aortic Aneurysm Screening;
- Target patients aged 50-74 with information about Bowel Cancer Screening.
- Target patients with long-term health conditions with information about Annual Health Checks for these conditions.

Suggestions for environmental improvements

A16. Ensure patients with disabilities can access the surgery easily and comfortably. Where possible, make 'reasonable adjustments' (Equalities Act 2010) to facilities including providing a hearing loop in reception and ramps from the pavement to the front door.

A17. Ensure patient information in the waiting area and reception, is well organised, tidy and up to date.

A18. Ensure facility signs (e.g. for the washrooms) are clearly visible and facilities are well-stocked.

A19. Ensure waiting areas are comfortable including offering water, lighting that works and a range of seating.

B: Recommendation for Brighton and Hove Clinical Commissioning Group (CCG)

B1. Continue to promote the use of pharmacies as a first point of contact for minor complaints.

B2. Within the context of closing or the merger of GP surgeries, consider the population density in that area and the availability of nearby GP services.

B3. Healthwatch would welcome the opportunity to carry out further research regarding the experience of patients who raise emotional and mental health issues through primary care.

C: Recommendations for Brighton and Sussex University Hospitals NHS Trust

C1. Reduce waiting times from GP referral to appointment for specialist treatment.

C2. Where possible, work with other secondary care providers to keep patients informed any changes to waiting times for specialists.

D: Recommendations for Pharmacists

Feedback from our report indicates that pharmacists are generally providing a good service to patients. Small areas for improvement could be:

D1. Decrease delays in issuing medication.

D2. Ensure pharmacies have the most commonly prescribed medications in daily stock.

3. Introduction

3A: Project Objectives

Our objective for the project was to explore the patient experience of GP Practices, primarily:

- **Patient caseload and the impact of surgery mergers.**
- **Accessibility:** opening hours, access to appointments and waiting times.
- **Surgery environment:** our volunteers carried out environmental audits, exploring ways to enhance patient accessibility and comfort of the GP surgery.
- **Patient satisfaction:** including suggestions for improvements and patients' comments on the NHS primary care services.
- **Prevention, referrals and out of hours services:** we also explored patient experience of these services as an extension of the GP core contract, particularly in the context of emerging PCNs and their offer of additional services.
- **Comparison with the Healthwatch 2018 GP review:** throughout this report, we have compared 2019's findings with the 2018 report, asking whether there have been any changes and if so, have things improved or declined for the primary care patient?

We considered our findings in the context of the national picture, by comparing our results with those from the 2019 NHS National Survey.[10] While there were some similarities between our local survey and the 2019 National Survey, Healthwatch explored a number of areas in greater detail, as well as asking patients about new areas relevant to local insight.

Our survey explored the following additional areas to the 2019 National Survey.

- Convenience of surgery location.
- Alternative consultations to in person appointment.
- Satisfaction with waiting times between booking and attending appointments.
- Awareness of preventative GP services.[11]

[10] The 2019 National Survey can be found here: https://www.gp-patient.co.uk/
[11] Of particular importance, in the context of prevention being prioritized as part of the Primary Care Network (PCN) arrangements.

- Patient experience of transferring registration due to GP closure or merger.[12]
- Patient experience of the 'extended hours' service.
- Patient preference for additional opening hours.
- Patient experience of getting medication.[13]
- Patient experience of raising an emotional or psychological issue at a GP/nurse consultation.[14] This included:
    - the response of the GP/nurse to the patient's emotional or psychological concern;[15]
    - actions taken by the GP/nurse;
    - any referral made including waiting time associated with this referral;
    - patient satisfaction with the service received through the referral including whether the service helped to resolve the medical complaint and
    - patient suggestions for improvements with the referral and/or service referred to.
- Patient rating out of 10, of their GP surgery, and whether they would recommend their surgery to someone who has just moved into the area.
- Patient suggestions of what three things are most important for a GP practice to provide a good service.
- Patient experience of referrals to a specialist or for tests at a hospital or clinic, including waiting times and impact on health.

In addition, we distinguished between different medical practitioners (i.e. doctors and nurses). We asked patients to feedback separately on their experience of both. In contrast, the 2019 National Survey asked questions regarding the last appointment regardless of which 'healthcare professional' was seen.

[12] Healthwatch were made aware of two GP practices closing during the last twelve months and we wanted to find out if patients had been affected by these.
[13] Healthwatch ran a survey on online pharmacies earlier in the year, and we wanted to ask similar questions in this survey to capture up-to-date patient experience.
[14] Healthwatch have been made aware of the increasing patient demand for mental health services and this is also highlighted as an area for PCNs to prioritise.
[15] This was the only question the National Survey also asked about mental health issues and therefore we compared our findings on this question alone. The remaining questions that we asked, were not covered by the National Survey and therefore no comparison could be made.

Individual practice reports will be written separately, in addition to this main report. These will be shared with the relevant Practice Manager, Patient Participation Group and PCN Director. They will include comparisons found and observed between the individual surgery and found across all Brighton and Hove surgeries.

In line with NHS convention,[7] the term 'surgery', 'surgeries' and 'GP practice(s)' are used interchangeably throughout our report. Some of the reviewed sites are named 'surgeries' and others are 'practices'.[16]

[7] See this example on the NHS website: https://www.nhs.uk/using-the-nhs/nhs-services/gps/patient-choice-of-gp-practices/.

[16] Of the 40 locations which offer GP services across the city, five are branch surgeries. The difference for the patient, between main and branch surgeries is not significant and the service offered to patients is often the same. To read the NHS explanation of branch surgeries, visit: https://developer.nhs.uk/apis/gpconnect-1-3-0/development_branch_surgeries.html

3C: Methodology

The GP Review 2019 took place between April and September 2019. During this time, we gathered patient opinion from all 40 GP locations across Brighton and Hove, using an online survey. GP practices ranged from one practice with one doctor working three days a week to another practice with the equivalent of just over 11 full time doctors.[17]

In addition to the online survey, our volunteers visited 34 of these surgeries in person, offering paper copies of the survey to all patients waiting for appointments.[18] Each of the 34 surgeries was visited once, by one or two of our volunteers. Patients were advised by the volunteers that participation was voluntary, and that the information given would be confidential and anonymous and only for the use of Healthwatch Brighton and Hove. Most patients completed the survey by hand themselves. A few patients preferred to sit with the volunteer and answer questions verbally, with the volunteer recording answers on to the paper survey. Each survey took approximately 15-20 minutes to complete.

Both surveys covered the following areas about patient experience:

- accessibility;
- getting an appointment;
- quality of care and service availability;
- getting medication;
- overall assessment of GP practice; and
- medical help when GP services are unavailable.

In addition, the online survey included these sections:

- mental Health and
- referrals

The online survey contained all the same questions as the paper survey. It also included additional questions within the following areas:

- accessibility:
    - additional question on mode of transport to get to surgery.
- quality of care and service availability:
    - additional questions about care in a new location due to surgery closure and
    - use and satisfaction with 'extended hours' service.
- Demographic information:
    - Additional questions on long-term health conditions.

[17] One surgery has 11.3 GP full-time equivalent i.e. the full-time equivalent is based on a five-day week, therefore one GP working for four days would be represented as 0.8 GP full-time equivalent.
[18] A few patients declined to complete the survey but approximately 99% of those asked, agreed to do so.

During each surgery visit, our volunteer(s) were asked to record their observations about the environment, the staff and the comfort for patients of the waiting area and reception. They used a checklist of questions covering the following areas:

- Information displayed
- Hygiene/Toilets
- Communication
- Waiting area environment
- Feedback on Practice
- Other observations

Volunteers were asked to provide comments for each area, based on a number of suggested criteria such as 'Is display of information cluttered?', 'Are toilets accessible and well signposted?'

Our online survey was distributed to the Healthwatch Brighton and Hove mailing list, our key stakeholders and via our website. It was available from 9th April to 9th September 2019. Our first surgery visit took place on 9th May and our last on 9th September. In total, we received 998 responses to our survey (405 online responses and 593 responses in person).

Copies of the online and paper surveys can be viewed along with a copy of the environmental observation checklist, on our website here: https://www.healthwatchbrightonandhove.co.uk/publications/healthwatch-reports/. All questions are also shown in 5A: Survey Questions Asked, page 80 at the end of this report. Each table shows the number of patients who responded to the question as well as the number and percentage of patients per response option.

All surveys were recorded on to an online software tool called SNAP Surveys and then downloaded into Excel for analysis. Analysis matched the format of this report, looking at all 998 responses to each question, then looking at responses per GP practice for comparison between surgeries. Where possible, we compared 2019's responses to those we reported in our 2018 GP Report. Where available, we also made comparisons between Brighton and Hove findings and national findings using the 2019 NHS National Survey. It is worth mentioning that while some questions were the same between the National Survey and our own, the response options occasionally differed meaning we were unable to compare the surveys.

We wanted to explore if general satisfaction (or dissatisfaction) for a patient's surgery, was linked to the same patient's satisfaction (or dissatisfaction) for particular areas of experience. We chose three areas to look at, namely:

- overall satisfaction with practice vs satisfaction with waiting times to book a routine GP appointment;
- overall satisfaction with practice vs waiting times in surgery for GP appointment and

- overall satisfaction with practice vs quality of care ratings for GPs (see Section 4BIII: Communicating with patients, page 24).[19]

It is worth mentioning that practices are not weighted for the purpose of this report and while some practices returned over 100 surveys, others returned less than ten. However, where comparisons are made between surgeries, we only include those practices where we have received 15 or more responses to the survey or relevant question (the same approach to the 2018 report).

Findings (Section 4, from page 18) are presented in six chapters, namely:

- overall satisfaction across practices;
- care quality;
- accessibility of GP services;
- surgery environment;
- overall satisfaction and suggestions for improvements and
- prevention, referrals and out of hours services.

[19] See 4BIII: Communicating with patients, page 24, of this report for more information. Quality of care communication was derived from a combination of giving patient enough time; listening to patient; explaining tests and treatments; involving patient in decisions about their care; treating patient with care and concern; having access to relevant medical information about patient and having access to relevant medical information about patient.

4. Findings

4A: Overall satisfaction across practices

We chose seven key indicators to provide a snapshot of the overall patient satisfaction for each practice in the city.[20]

- Satisfaction with waiting times between booking and attending routine GP appointment.[21]
- Satisfaction with waiting times between booking and attending urgent GP appointment.[22]
- Overall satisfaction with quality of care – GP.
- Overall satisfaction with quality of care – nurse.
- Satisfaction with opening hours.
- Overall patient rating for each practice from 1 to 10, with 1 being the least satisfied and 10 being most satisfied.
- Patient recommendation of practice to friend/family member.

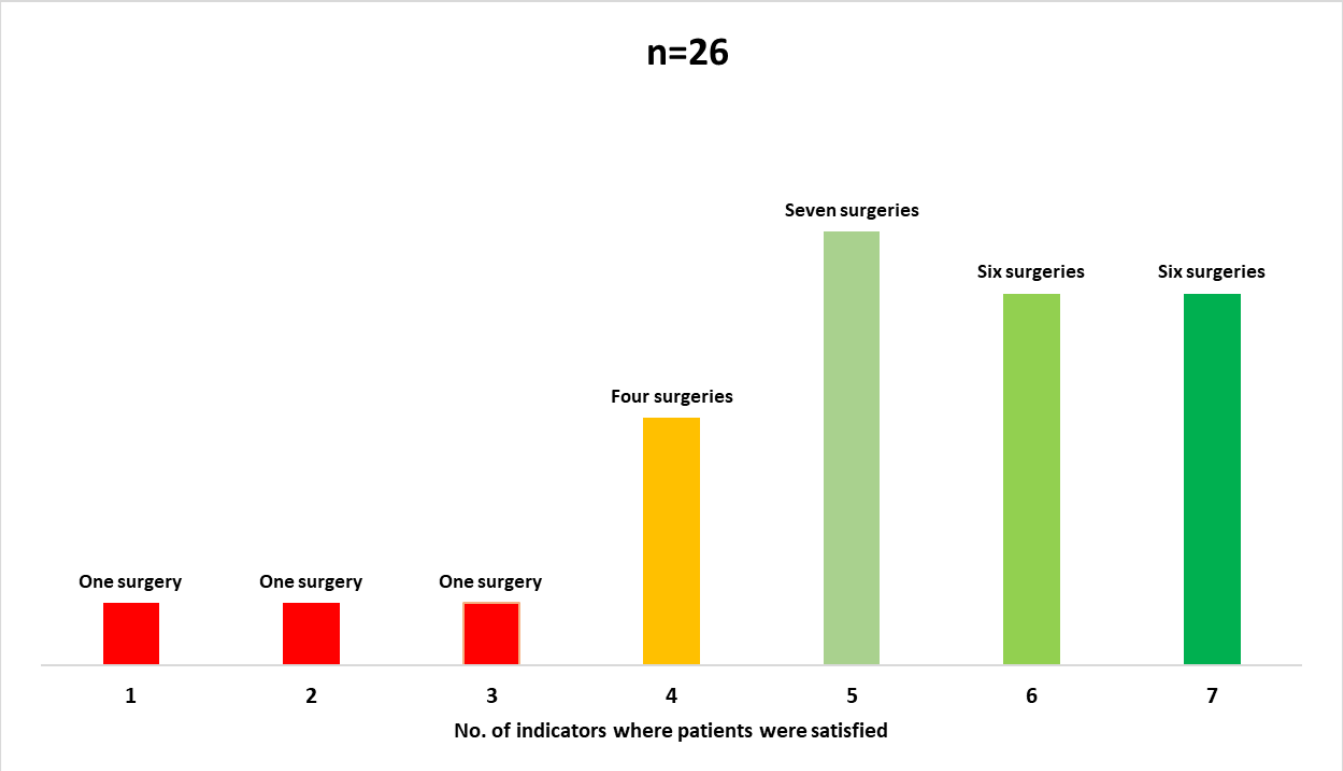
Using these seven measures shows that patient satisfaction of GP practices differs across the city (Figure 1).

- Patients at six practices (23%) were 'satisfied'[23] on all of the above indicators.
- At the other end of the scale, patients at three practices (12%) were 'satisfied' on less than four of the indicators.
- The average number of indicators where patients were 'satisfied'[24] was five indicators across all surgeries.

The degree of variation indicates that patients were generally happier with the service they received from some GP surgeries, compared to others (Figure 1).

[20] In this comparative analysis, we only included the 26 practices where we received 15 or more responses to the survey. In addition, where comparisons are made between surgeries elsewhere in this report, we also only include those practices where we received 15 or more responses to the survey or relevant question. This is the same approach as we took in our 2018 report.
[21] In our 2018 report, this indicator used the average waiting times between booking and attending a routine GP appointment. In 2019, we have chosen to use patient satisfaction with these waiting times to ensure consistency with the other satisfaction indicators.
[22] As above we have used patient satisfaction with waiting times. In 2018, this indicator was the average waiting time itself.
[23] 'Satisfied' or 'very satisfied' were combined and 'good' or 'very good' were combined to confirm patient satisfaction per surgery. When comparing satisfaction across surgeries, we considered that a rating of seven out of ten or 70% and above indicated satisfaction. Less than seven out of ten or less than 70% indicated less than satisfied.
[24] 'Satisfied' or 'very satisfied' were combined.

Figure 1 Seven key indicators of satisfaction: Number of GP Practices by number of indicators where patients are satisfied or very satisfied.[1]



[1]For example, patients at one GP Practice reported satisfaction for only one of the seven indicators, whereas patients at six Practices reported satisfaction for all seven indicators.

4B: Care Quality

4BI: Number of doctors serving patients at GP practices

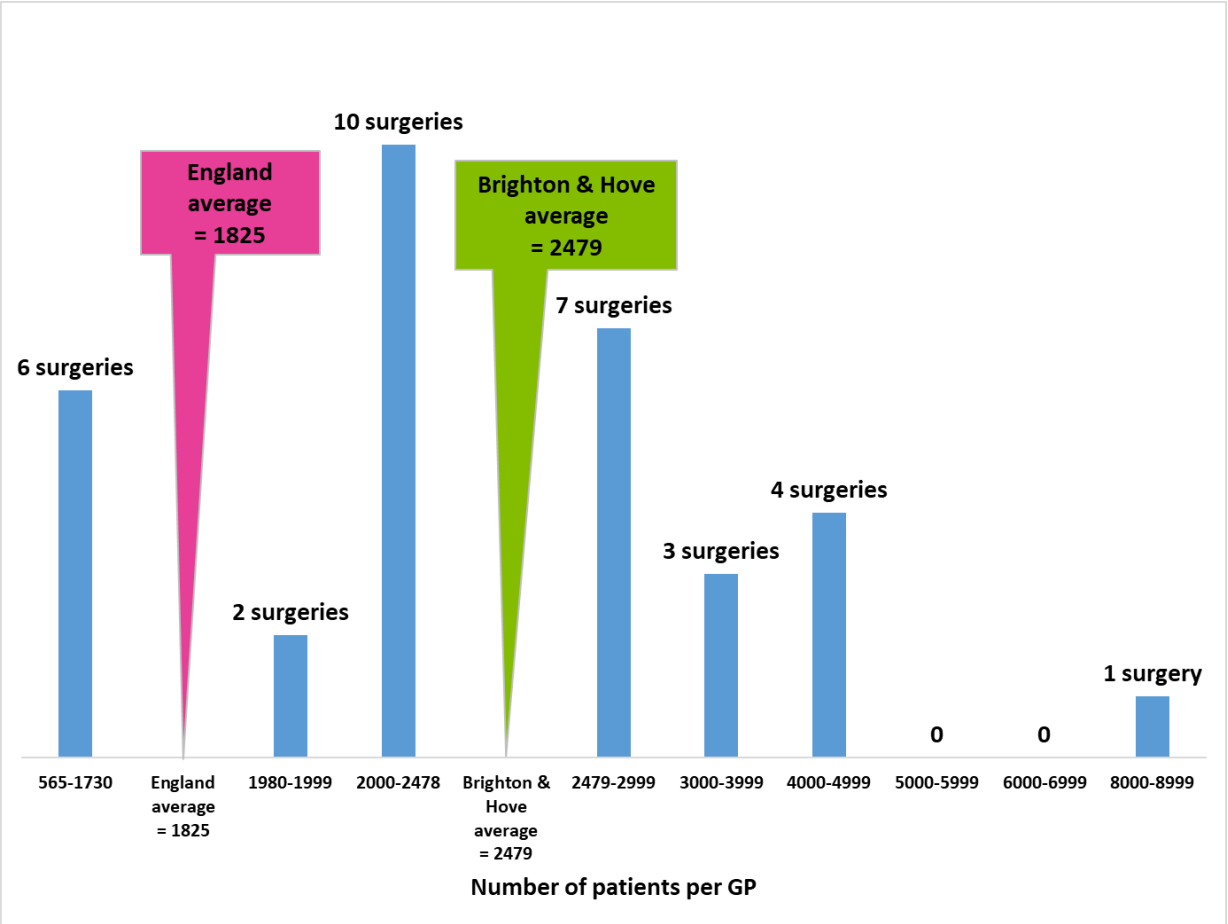
As we reported in our 2018 report, Healthwatch monitors and remains concerned by the falling number of GPs in Brighton and Hove in recent years.[25] We are also concerned by the number of GP Practices that have closed or merged in recent years, which has had the knock-on effect of increasing patient caseloads for other practices.[26]

Using NHS published data,[27] which provides the number of patients registered and the number of full time equivalent (FTE) GPs, we were able to work out the number of patients per GP at each practice.[28] The data showed significant variation in GP provision across practices (ranging from one practice with 565 patients per GP FTE and at the other extreme, one practice with 8,534 patients per GP FTE).

The average caseload for doctors in Brighton and Hove is 2,479 patients per GP. This is much higher than the England national average of 1,825 patients per GP. 82% of Brighton and Hove Practices (27 of 33)[29] were considerably above the England national average (Figure 2).

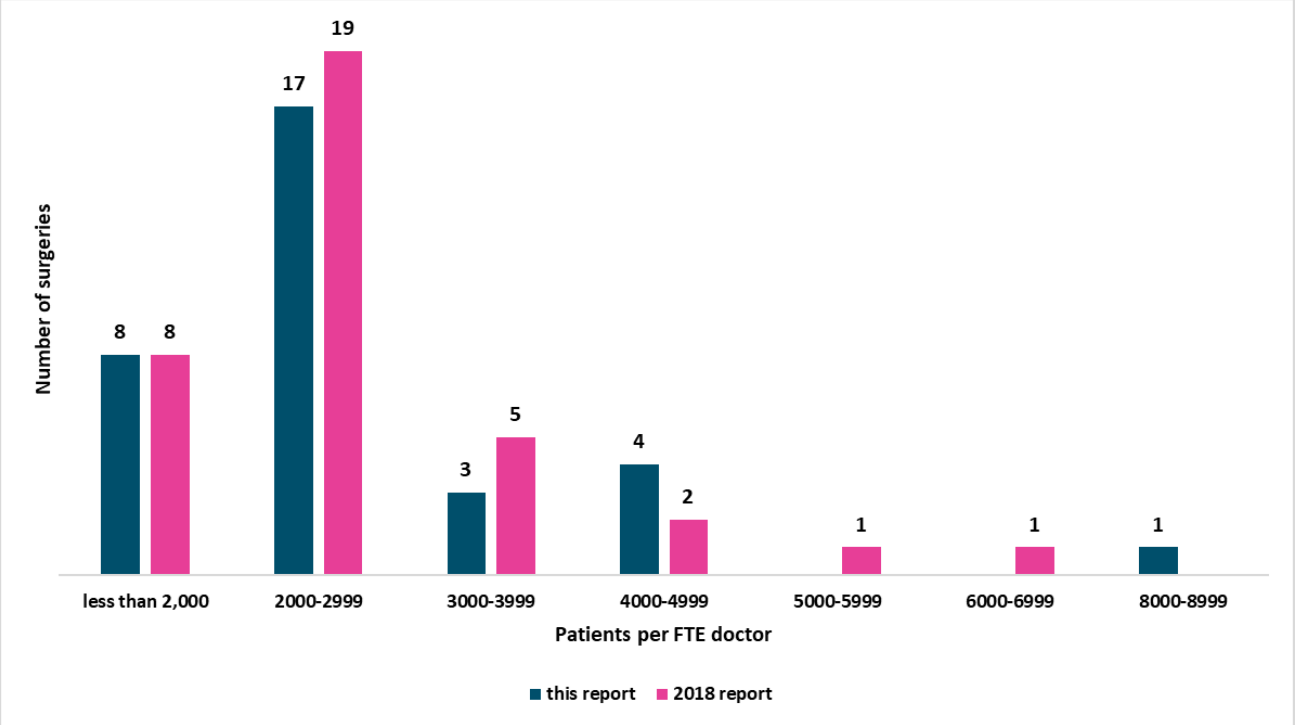
[25] See NHS Digital data from General Practice Workforce, 30 June 2019
[26] See 4BII: Impact of GP practice closures, page 23 for more detail.
[27] NHS Digital data from General Practice Workforce, 30 June 2019
[28] See data tables for detailed information on each surgery.
[29] Data provided by the CCG, was not available for four practices. Also, caseloads of branch surgeries were included in the caseload figure for the main surgery.

Figure 2 Number of Brighton and Hove GP Practices at each level of patients per doctor.



In comparison to 2018, where we reported there were four practices with more than 4,000 patients per caseload, this has now risen to five practices (15% of 33). At the other end of the scale, eight practices in the city (24% of 33) have less than 2,000 patients per doctor which is the same number of practices as reported in 2018 (Figure 3).

Figure 3 Number of Brighton and Hove Practices at each level of patients per doctor: this report compared to 2018 report.



The higher than average caseload across Brighton and Hove continues to be a concern. Non-GP staff such as practice nurses and paramedics provide invaluable primary care services, but GPs remain the main point of contact for initial diagnosis and prescription. The practice with the highest caseload, was also one of the lowest performing on the seven key performance indicators measuring patient satisfaction (see 4BIII: Communicating with patients, page 24) and had one of the lower ratings for overall patient satisfaction (see 4A: Overall satisfaction across practices, page 18).

GPs should be able to offer you longer slot times so you don't feel too rushed and get a chance to talk to the doctor about whatever you need to.

By the time I [build my confidence up to] get to an appointment I usually have a lot to talk about ... and not given enough time … health concerns are not always dealt with.

Patients' comments

Recommendation

- **The Brighton and Hove Clinical Commissioning Group should consider the impact of further GP surgeries closing or merging in Brighton and Hove.**

4BII: Impact of GP practice closures

As we reported in 2018, Healthwatch has continued to monitor the impact on patients of GP practice closures in the city.

As mentioned previously, during the last twelve months, two further practices have closed, and patients from these surgeries have been absorbed into two existing practices respectively,[30] potentially doubling the number of patients at these surgeries. Interestingly, these two surgeries had two of the lowest ratings of patient satisfaction.[31] We are also aware that another two surgeries will be merging in early 2020.[32]

I have severe osteoarthritis and am waiting for surgery. The extra walk to a new GP Practice is difficult and painful.

Since my GP Practice moved premises, I feel that everything has improved.

I have yet to find a new GP surgery in my catchment area that has not closed down or is full.

Patients' comments on moving to a new surgery

Patients who had experienced a practice change due to closure gave mixed reports on the new practice they moved to. While ten patients said the new practice was convenient, nine others said it was inconvenient. About the same number of patients (seven) said the service was better in the new place, as said it was worse (eight).

Patient comments reflected a mixed response to the experience of attending a new GP practice. Some patients felt there was little difference, or even reflected an improvement (in location or quality of service) as a result. Those patients who were unhappy with the move, reflected that either the surgery was further from them or not easily accessible by public transport. One person commented that poor waiting times at their current surgery, had resulted in them approaching another less convenient surgery for health care.

[30] One surgery closed in October 2018 and merged with an existing surgery. In November 2018, a further surgery closed and merged with another surgery.
[31] See section 4a 'Overall satisfaction across surgeries' for further information on this.
[32] One surgery is closing and merging into an existing surgery from 1st April 2020.

4BIII: Communicating with patients

GP practices should involve patients in consultations.[33] To assess the quality of care communication we asked patients how their doctor or nurse performed on seven patient-centred criteria:[34]

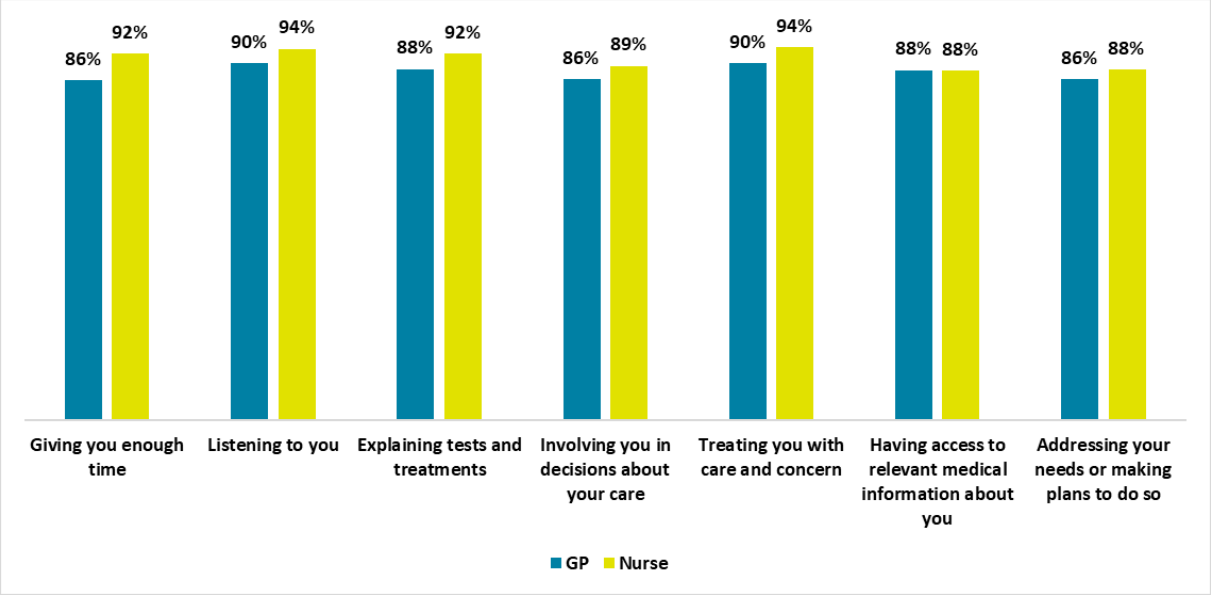
- giving patient enough time;
- listening to patient;
- explaining tests and treatments;
- involving patient in decisions about their care;[35]
- treating patient with care and concern;[36]
- having access to relevant medical information about patient[37] and
- addressing patient needs or making plans to do so.[38]

Response options were on a five-point scale ranging from 'very poor', 'poor', 'neither good nor poor', 'good' and 'very good' with an option of 'not applicable'. Responses that rated performance as 'good' or 'very good' were combined to produce a high-quality rating for each criterion. The ratings from these seven criteria were combined into an overall quality of care communication rating.

Overall, the quality of care communication was generally high with an average of 88% of patients rating GPs 'good' or 'very good' and an average of 91% of patients giving the same rating for nurses. This was similar to the results in the 2018 report, where 85% of patients rated GPs, and 90% of patients rated nurses, as 'good' or 'very good' (Figure 4).

[33] Read the Care Quality Commission's 'What can you expect from a good GP practice?' for further information: https://www.cqc.org.uk/help-advice/what-expect-good-care-services/what-can-you-expect-good-gp-practice.
[34] These were almost the same standards assessed against in the 2018 report, with the exception of one difference. In 2018, one of the standards used was 'Allowing patient to talk about more than one problem'. In 2019, we replaced this standard with 'Addressing patient needs or making plans to do so' as this standard was better aligned to a similar standard used in the 2019 National Survey (see https://www.gp-patient.co.uk/ for further information).
[35] Read the 'Caring' section in the Care Quality Commission's 'What can you expect from a good GP practice?' for further information: https://www.cqc.org.uk/help-advice/what-expect-good-care-services/what-can-you-expect-good-gp-practice#Caring
[36] Read the 'Caring' section in the Care Quality Commission's 'What can you expect from a good GP practice?' as above.
[37] Read the 'Effective' section in the Care Quality Commission's 'What can you expect from a good GP practice?' for further information: https://www.cqc.org.uk/help-advice/what-expect-good-care-services/what-can-you-expect-good-gp-practice#Effective
[38] Read the 'Responsive' section in the Care Quality Commission's 'What can you expect from a good GP practice?' for further information: https://www.cqc.org.uk/help-advice/what-expect-good-care-services/what-can-you-expect-good-gp-practice#Responsive

Figure 4 Percentage of Patients who said their GP or Nurse was Good or Very Good on aspects of Quality of Care Communication.



As Figure 5 shows, we compared individual surgeries to the average of 88% of patients rating 'good' or 'very good' for GPs and 91% of patients rating 'good' or 'very good' for nurses. Five surgeries received less than 79% of patients rating their GPs 'good' or 'very good'. This included 65% of patients at one surgery, and 73% of patients at two others. Two surgeries received less than 79% of patients rating their nurses as 'good' or 'very good', 72% at one surgery and 75% at another.

Important to patients is for health practitioners to:

Listen to what you say and do something about it.

Engage the patient in the diagnosis.

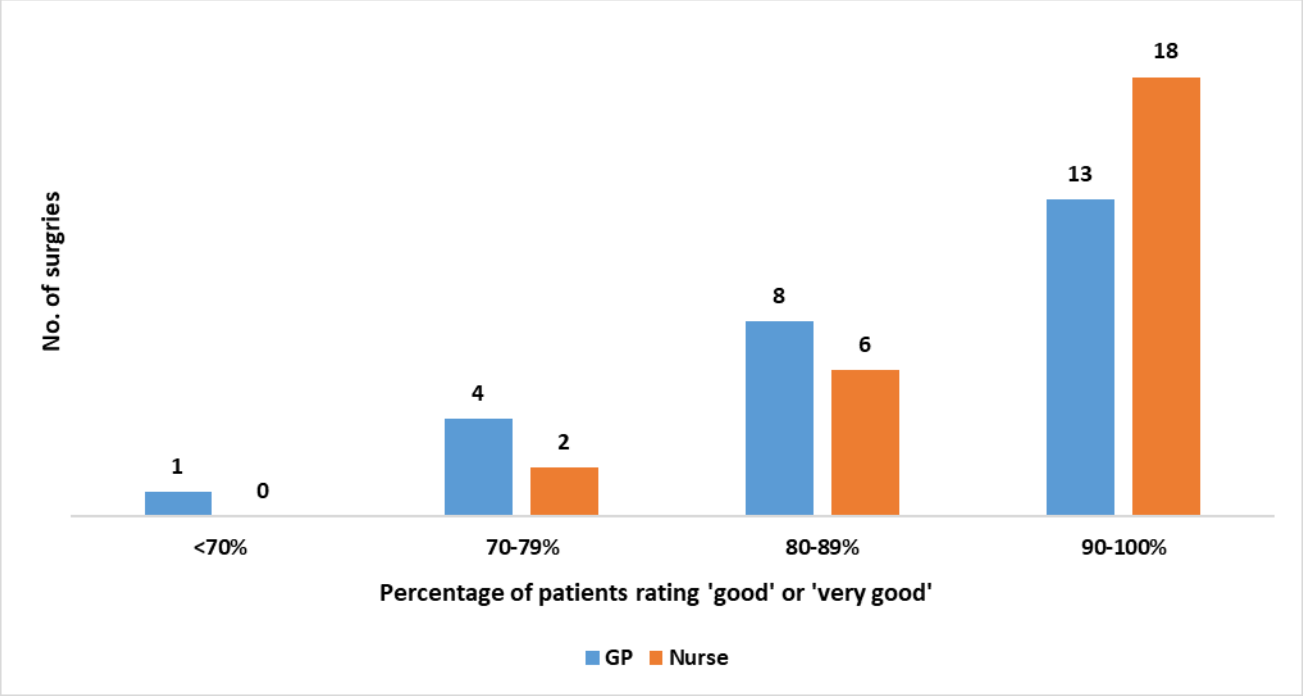
Treat you as an individual and with dignity and respect.

Patients' comments

Some surgeries received more than the average number of patients rating 'good' or 'very good'. Five surgeries received this rating from 95% of patients for their GPs quality of care communication and three surgeries received this rating from at least 97% of patients for their nurse quality of care communication, with 100% of patients giving this rating at one surgery, (Figure 5).

> *Important to patients is for health practitioners to:*
>
> *Allow time to discuss all issues.*
>
> *Have time to give personal attention.*
>
> *Remove the rule that states you can only discuss one issue.*
>
> *Patients' comments*

Figure 5 Distribution of GP and Nurse Quality of Care Communication Ratings per surgery.



Comparison with the 2019 National Survey

Some of the questions asked by Healthwatch about quality of care communication, were also asked in the 2019 National NHS survey:[39]

- Giving patient enough time;
- Listening to patient; and
- Treating patient with care and concern.

[39] The NHS ran a national GP survey in early 2019. Where possible, we have made comparisons between our local findings and national comparators. The NHS survey can be found here: https://gp-patient.co.uk/.

However, unlike our survey which asked separate questions about the quality of care communication of nurses and then the same about GPs, the National Survey did not distinguish between health professionals. The National Survey asked about the quality of care from any 'healthcare professional' that the patient saw at their GP surgery. This could include a GP, nurse, 'mental health professional' or 'another healthcare professional'.

Both our survey and the National Survey offered responses on a six-point scale, ranging from 'very good', 'good', 'neither good nor poor', to 'poor' and 'very poor', with 'doesn't apply/not applicable' as the sixth option.

We combined our 'good' and 'very good' responses for *both* GPs and nurses against the total combined responses to these questions. We compared these with the combined 'good' and 'very good' responses from the National Survey against their total responses, as below (Figure 6):

Figure 6 National Survey comparison: Quality of care for healthcare professionals

	Good' and 'Very good' responses			
	Giving you enough time	**Listening to you**	**Treating you with care and concern**	**Overall score for all three criteria**
HW	**89%**	**92%**	**92%**	**91%**
National	**87%**	**89%**	**87%**	**86%**

Healthwatch results on all three criteria separately were slightly higher in each case. Comparing overall scores, responses to the Healthwatch survey were 5% higher than for the National Survey.

4BIV: Consultations carried out by telephone, video, email or online

Telephone consultations

Patients across nearly all practices reported using telephone consultations to talk about a health problem.

The average use of telephone consultations at practices across the city was 29% (288 patients).[40] The majority of patients who had used this service, felt it had fully met their needs (74%, 211 respondents) with a further 23% (64 respondents) saying it had partially met their needs. Only 3% reported that it had 'not at all' met their needs. (Figure 7). This was slightly more than our 2018 report, in which 94% respondents who had used the service found it to be useful (either fully or partially).

A modern way of dealing with things which in my view saved both time and the doctors time in the particular circumstances.

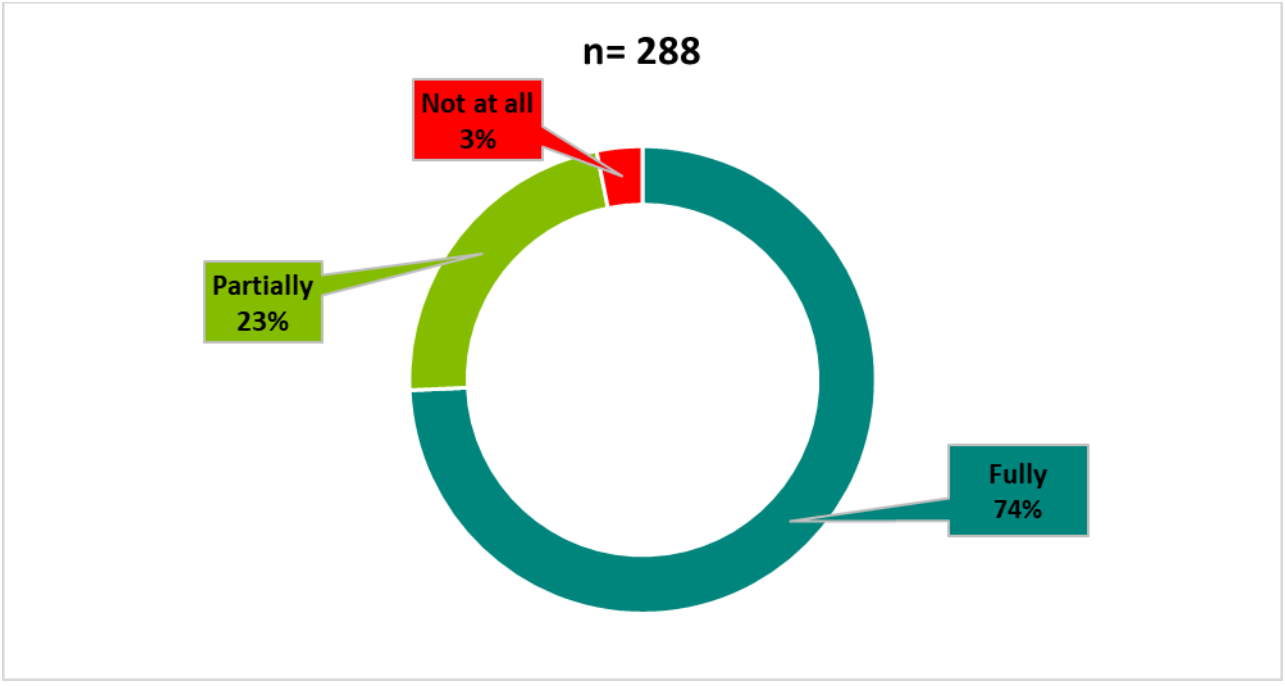
Because of my health conditions it is sometimes easier to have a telephone conversation with my regular Doctor

Had a telephone consultation whilst I was abroad and they gave a useful diagnosis.

Stayed in all day waiting and call came at 18:30.

Patients' comments on telephone consultations

Figure 7 Telephone consultation met needs?



The use of telephone consultations was extremely varied between practices. In 12 practices, less than 10% of respondents had used this type of consultation, whereas in six practices, more than 50% of respondents had used this method.

[40] We have shown percentages and numbers of responding patients for each finding throughout this report.

Email consultations
Very few respondents (11) had used email as a method of consultation. While the majority (seven) of these respondents said the consultation had fully met their needs (and three respondents said partially) these figures are not large enough to draw conclusions about the success of this method.

Other consultations
We also asked about video and online chat consultations, but these were not taken up by a substantial enough number of respondents, for us to draw any conclusions. Currently, only some surgeries are offering this method as an alternative to in-person consultations.

Recommendation

- **GP Practices should increase promotion and availability of cost-effective alternatives to face-to-face consultations, such as telephone or online consultations. When promoting, focus on the benefits to patients of using these services.**

4BV: Mental Health

Mental health services are prioritised in the NHS Long Term Plan,[41] Healthwatch asked patients about the service they had used when raising an emotional or psychological issue at a GP/nurse consultation. However, these questions were only asked in the online version of the survey, a total of 405 patients.[42] Of those we asked, 36% (144) respondents said they had raised this type of issue.

We asked patients who raised an emotional or psychological issue, to assess how their doctor or nurse responded to this. The survey asked for assessment based on four standard patient-centred criteria:

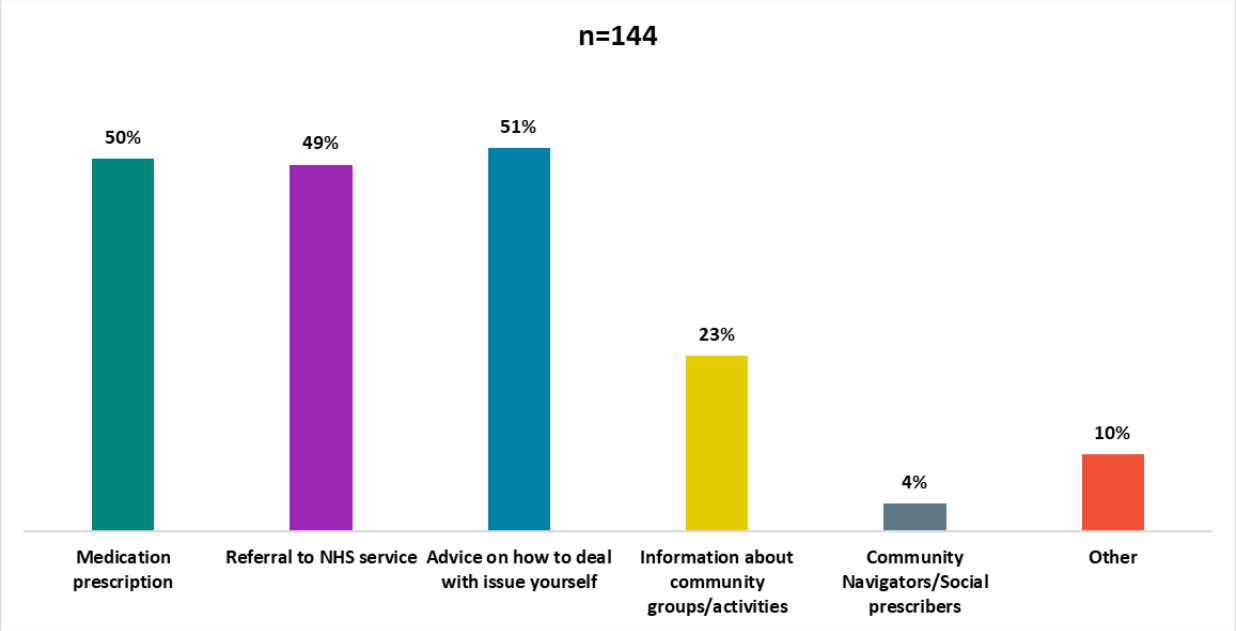
- giving patient enough time;
- listening to patient;
- showing empathy; and
- treating patient with care and concern.

Responses that rated the response as 'good' or 'very good' were combined and likewise the responses for 'poor' and 'very poor' were combined for each criterion. The combined ratings from these four criteria were combined again into an overall mental health care quality rating. Overall, the quality of care was high with an average of 80% of patients (113) rating either 'good' or 'very good'.

As a result of raising emotional or mental health issues, the 144 patients were offered a range of solutions by the GP/nurse and could be offered more than one solution (Figure 8). The most likely solutions offered were advice on how to deal with the issue themselves (51%, 70 patients), medication prescription (50%, 68 patients) and referral to an NHS service (49%, 67 patients).[43]

[41] See https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/ for more information, in particular sections on Aging Well, mental health commitments and Personalised Care.
[42] From the 405 patients who responded to the online survey, 400 responded to this particular question.
[43] Patients could be offered more than one solution. Therefore, total percentage of solutions add up to more than 100%.

Figure 8 Actions taken for patients who raised an emotional or psychological issue.



The survey asked patients how satisfied they were over, overall, with how the GP/nurse responded to their mental health issue. The majority of patients (77%, 110) were 'satisfied' or 'very satisfied' with the response from the GP/nurse, with almost one half of patients (48%) being 'very satisfied'. Of those who were 'satisfied' or 'very satisfied', the majority felt they were listened to, and were met with a caring and understanding response. But for those that were 'dissatisfied' or 'very dissatisfied' (12%, 16) patients often felt rushed, not listened to and sometimes the lack of understanding was felt to be linked to lack of expertise in the medical staff.

Caring and understanding[…]active listening and support.

Discussed all options and came up with a shared plan.

Felt rushed and not listened to.

No apparent understanding of the issues I need support with.

I got told to make a new appointment and I never went back.

I feel that not much can be done to help me. Deteriorating health is the cause of my unhappiness.

Not enough time nor the expertise in nursing staff.

Patients' comments about responses to mental health issues raised

Although this report focuses on primary care, the following findings outline patient satisfaction for the referral services (care and waiting times). The sample size for each means these should be interpreted with a degree of caution.

Referral to an NHS service
Of the 67 patients who were referred to an NHS service, waiting times for a referral seem to be long. Only 22 patients answered this question, but of those who did, the majority (15 respondents) had to wait at least three months for the appointment to come through, nine of these waiting up to six months or longer.

More than half of patients (57%, 33) were 'satisfied' with the service they received through the referral. However, a large minority (43%, 25) were not. In addition, while 30% of patients referred (16) felt the referral service had fully met their needs, the majority (70%, 37 patients) felt the service had only partially met their needs or not at all. Findings were similar when we asked patients whether the service had helped to manage or resolve the issue. While 37% (21 patients) felt the service had helped to improve the issue, over one half of patients (54%, 31) felt the service had not helped them. Only five patients (9%) felt the service had helped resolve the issue completely.

Brighton and Hove Wellbeing Service
Of the 67 patients referred to another service, the majority (62%, 40) were referred to Brighton and Hove Wellbeing Service. Again, the number of patients here is small and therefore the findings should be treated with a degree of caution. However, the overall findings suggest that while patients were generally 'satisfied' with the service, it did not guarantee a solution to the patient's mental health condition.

One half of these 40 patients received psychological therapy in-person. Others were referred to hospital, a psychiatrist or psychologist, or the Assessment and Treatment service.[44]

Looking at responses from these patients alone, more than half of patients (58%, 21) were 'satisfied' or 'very satisfied'. Four patients were 'dissatisfied' or 'very dissatisfied' while the remaining 11 were neither 'satisfied' or 'dissatisfied'. While ten patients felt the service fully met their needs, 20 patients had their needs only partially met and three not at all. Equally, while nine patients felt the service had helped improve their issue and five others felt it had resolved their issue, 21 patients felt the service had not helped at all.

Reasons for dissatisfaction and suggestions for improvement
Various reasons were given for being dissatisfied. These included waiting times being too long (five respondents), the service was not enough to solve the issue or

[44] The Assessment and Treatment service is the entry point into specialist mental health services. Patients are assessed to decide what care is best for them. This may be a specific therapy or longer-term care where a 'care coordinator' will support the patient through their recovery journey. Read the Sussex Partnership NHS Foundation Trust's web page on this centre for more information here: https://www.sussexpartnership.nhs.uk/service-brighton-hove-assessment-and-treatment

didn't provide the appropriate treatment (five respondents) or patients felt treatment needed to be longer (seven respondents).

Patients were also asked for suggestions or improvements to the service. The most likely suggestion related to shorter waiting times (25%, seven respondents) and an increased length of service when you receive it (25%, seven respondents also).

It gave me a kick start into the techniques I had learned previously.

Eight weeks is insufficient counselling to resolve matters or to manage ongoing issues. It is simply a temporary balm.

It helped a bit at the time but when the help stopped the issue returned.

My condition is not curable but treatable which is what has been done.

I have a better understanding of ME & try to self-manage it.

Patients' comments on whether the mental health service provided, helped to manage or resolve their issue

Recommendation

- **Healthwatch would welcome the opportunity to carry out further research regarding the experience of patients who raise emotional and mental health issues through primary care.**

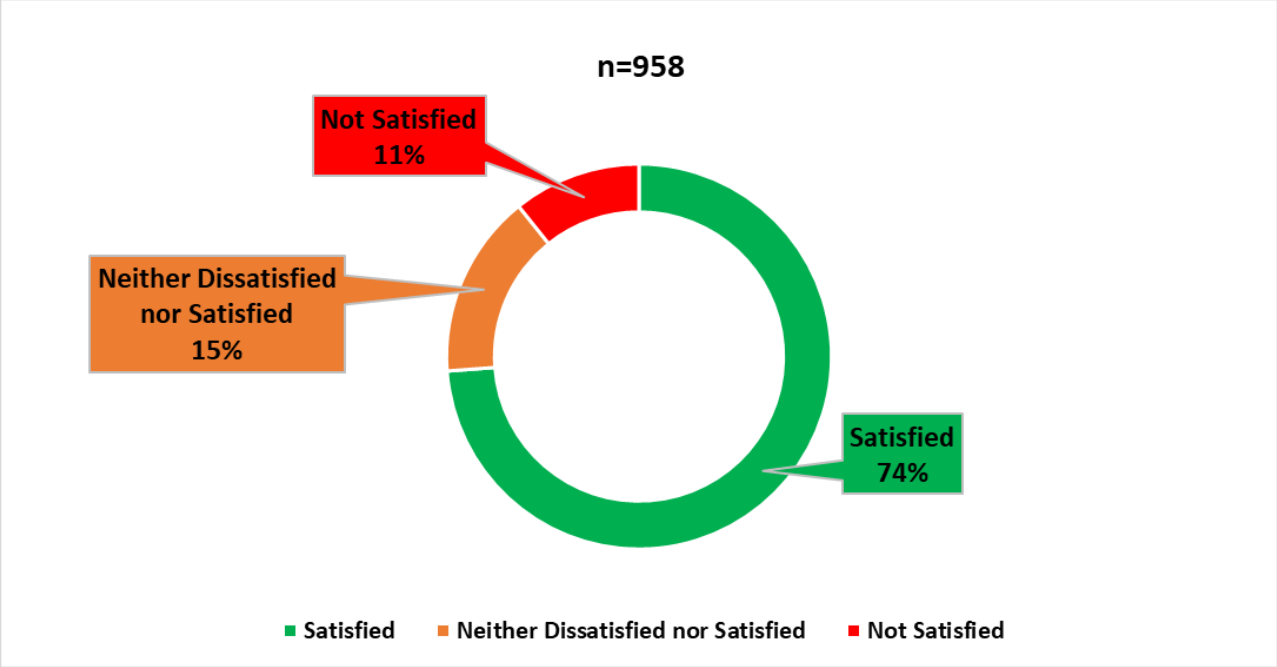
4C: Accessibility of GP services

4CI: Practice opening hours

Most practices opened for long business hours during the week (typically starting at 8.00am or 8.30am and finishing at 6pm or 6.30pm). Nine surgeries offered additional evening times (until 7.30pm or 8pm typically, with one surgery offering until 9pm on one night). Two surgeries offered a three-hour period on Saturday morning.

On a five-point scale ranging from 'very satisfied' to 'very dissatisfied', the majority of patients (74%, 707) were 'satisfied' or 'very satisfied' with opening times at their surgery (Figure 9). This is a similar finding to the 2018 report of 72%.

Figure 9 Patient satisfaction with surgery opening hours



Satisfaction with opening hours varied between practices. We compared patient responses at each surgery against the overall of 74% patient satisfaction. At six surgeries, less than 60% of patients were 'satisfied' or 'very satisfied' with opening times. At eleven other surgeries, over 80% of patients gave this rating for opening times.

If you work, it is impossible to see a doctor!

I can always get an appointment.

Patients' comments

In 2019, patients who were dissatisfied with current opening hours showed a preference for Saturdays and weekday evenings as additional hours. This remains unchanged since 2018. However, on the whole most patients are supportive of their GP opening hours.

Comparison with the 2019 National Survey
Our Healthwatch survey asked 'How satisfied are you with the hours that you can access a GP appointment?' The National Survey asked a slightly different question, by asking patients 'How satisfied are you with the general practice appointment times that are available to you?' We took the opinion that this was similar enough to make a comparison, while accepting that our responses would be only for GPs whereas the national responses would cover all appointments.

Our survey offered a five-point scale from 'very dissatisfied' to 'very satisfied'. The National Survey offered an almost identical scale with 'fairly satisfied' instead of our 'satisfied' option. The National Survey did offer a sixth option of 'I'm not sure when I can get an appointment' however, they received no responses to this option, which made it easy for us to compare responses like for like (Figure 10).

Figure 10 National Survey Comparison: Satisfaction with appointment times.

	Very Dissatisfied	Dissatisfied	Neither dissatisfied nor satisfied	Satisfied	Very Satisfied
Healthwatch	3%	8%	15%	46%	28%
National	7%	10%	18%	41%	23%

For both local and national patients, the majority were 'satisfied' or 'very satisfied' with appointment times. However, Brighton & Hove patients were on average more 'satisfied' than national patients; 74% of local patients compared to 65% of national patients. Equally, while 18% of national patients were dissatisfied (with rounding up), this accounted for only 11% of Brighton and Hove patients.

Recommendation

- All Practices should offer additional opening times at weekends or one weekday evening and/or offering 'extended access' through a PCN hub or existing services (for example, IC24).

4CII:Travel to practices

Over one half of the respondents (56%, 561) said their practice was within ten minutes journey time from their home. 80% (801) respondents were within 15 minutes journey time of their home.[45] From those who responded to the question online, the large majority (386, 96%) walked or came by car or bus. Almost one half of online respondents (196, 49%) walked to their surgery.

It is only a short walk from my house.

Close to home and close to where I work.

Have to get a bus and come twice a week for meds.

Have to travel by car and then try and find somewhere to park.

Patients' comments

Unsurprisingly, for the majority of all respondents (86%, 849), their surgery was convenient or very convenient. However, there were 45 respondents that felt their surgery was not convenient, with a common complaint being they had to take more than one bus, or drive and locate a parking space which was difficult to find. With surgeries merging or closing, these issues could become more evident.

Recommendation

- **For Brighton and Hove Clinical Commissioning Group: Within the context of closing or the merger of GP surgeries, consider the population density in that area and the availability of nearby GP services.**

[45] This figure includes the 56% of patients who said their surgery was within ten minutes journey time from their home.

4CIII: Booking appointments

The survey asked patients about their experience of using different methods of booking appointments. Most patients used either the telephone (95%, 914) or made an appointment in person at the surgery (78%, 722). Just over one third (37%, 343) reported using an online booking system (Figure 11).[46] These figures are very similar to those found in our 2018 report.

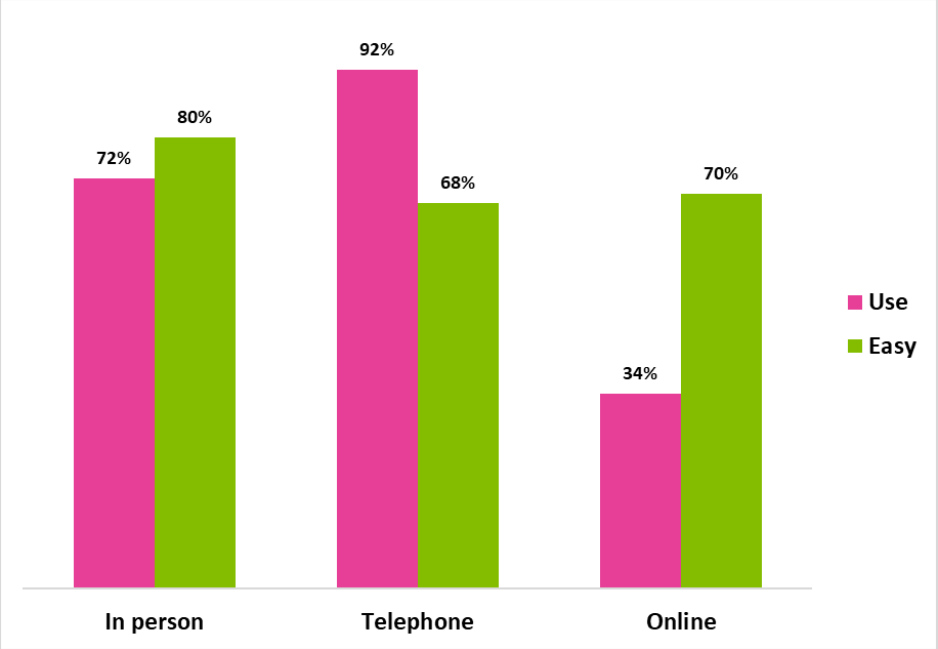
The majority of users found booking an appointment by any one of these methods, 'easy' or 'very easy' from a five-point scale ranging from 'very easy' to 'very difficult'. This is similar to our earlier report. Booking an appointment in person was considered 'easy' or 'very easy' by 80% of users, booking online was rated 'easy' of 'very easy' by 70% of users and 68% of users felt booking an appointment by telephone was 'easy' or 'very easy' (Figure 11). Compared with our earlier report in 2018, bookings in person and online have become slightly easier while bookings by telephone remain the same.[47]

Bookings by telephone and online could offer a low cost and convenient alternative to patients having to come into the surgery. They also help with demand on a busy practice. However, it is important that surgeries ensure the systems that are used for these services work efficiently. While the majority of patients (95%, 914) book by telephone, 32% of these patients found this method less than easy. This suggests that improvements could be made with either the telephone system and/or the customer service offered when patients get through to reception. Some of the comments we received indicate that some patients waited a long time to get through to the surgery. Surgeries could also approach this challenge by reviewing staff capacity to answer telephone calls.

All 40 locations across the city now offer online bookings[48] but only slightly more than one third of the patients we spoke to (37%, 343) have used this system. If our findings here are reflective of all Brighton and Hove patients, this could indicate that better publicity is needed to make the use of this service more widely spread.

[46] Patients were asked about all the methods they used. Therefore, total percentages of methods add up to more than 100%.
[47] In our 2018 report, we also reported that bookings by telephone were considered to be easy (or very easy) by 68% of users.
[48] All 40 locations offer online booking. One surgery had recently merged systems with another practice and the new system has been in place from the 17th September.

Figure 11 Use and ease of use of different booking methods



There was variation between surgeries on the ease of booking (via each method) suggesting that either customer service or systems differed across the City. For comparison analysis throughout this report, we only used those surgeries where we received 15 or more responses to the question being analysed. Therefore, comparisons between surgeries usually include findings from less than 40 surgeries. For example, in the case of urgent GP appointments, comparison analysis is made between the 21 surgeries who each returned 15 or more responses. Comparison analysis of urgent nurse appointments is made between eight surgeries who each returned 15 or more responses.

Appointment in person

There was some variation across surgeries, where more than one half of the patients at two practices found booking in person to be difficult. In contrast, there were ten practices, where at least 93% of users found the service to be easy to use.

Appointment by telephone

There was significant variation across practices. In four surgeries, over 50% of users found the telephone system difficult. In contrast, in three surgeries more than 90% of users found the system to be easy.

[Having an] easy to book appointments i.e. telephone answered by a person.

Being able to book to see a doctor without having to go through a phone consultation first.

Patients' suggestions for booking appointments

Appointments online (and other online services)
There was also significant variation across practices with the use of online bookings. In three practices, the majority of users (56%, 57% and 67% respectively) found it difficult to use. In contrast, over 90% of users at three surgeries found this service to be easy to use.

Variations could indicate that some practices are better organised than others, or that systems in use differ from surgery to surgery. This is an area where surgeries can look to improve, to ensure that patients are able to book an appointment as easily as possible. This is in the context that 62 of the suggestions made by respondents about ensuring a practice provides a good service, were about bookings (see Section 4EIII: Patient suggestions for what looks good in a GP surgery, page 66). Practice staff can also look to encourage the use of cost saving systems such as online bookings.

A large minority of patients had used an online method to order prescriptions (41%, 373) and a majority of patients had got test results (79%, 728). 87% of users in each case (236 for prescriptions and 630 for test results) had found the process easy.

Comparison with the 2019 National Survey[49]
Healthwatch asked patients 'generally, how easy/difficult has it been for you to do the following: book an appointment in person, by phone, online'. We offered the response 'Not used service' and were therefore able to derive the number of respondents who had used each service. The National Survey did not ask about ease of service, and therefore we cannot make a comparison on this criteria. However, they asked 'in the past 12 months, have you booked general practice appointments in any of the following ways?'. We were therefore able to compare local usage of these three booking methods against national usage, while accepting the National Survey specified the time period. In both surveys, the respondent may have used more than one booking service, hence the percentages represented in the table below add up to more than 100%.

The National Survey specified 'online including on an app' which we felt was comparable to the Healthwatch option of 'booked online'. The National Survey gave an additional option for booking 'by automated telephone booking'. We have therefore combined this with their 'by phone' responses, to compare against the Healthwatch 'by phone' responses (Figure 12).

Figure 12 National Survey comparison: Use of appointment booking methods.

	In person	By phone[1]	Online[2]
Healthwatch	78%	95%	37%
National	42%	80%	12%

[1] National figure is a combination of responses to 'by phone' and responses to 'by automated telephone booking'.

[2] National figures is for 'online including on an app'.

[49] The 2019 National Survey can be found here: https://www.gp-patient.co.uk/

In comparison to the National Survey, Brighton and Hove patients used each method more. Locally, 95% of patients booked appointments by telephone (in comparison to 80% nationally); 78% booked in person locally (compared to 42% nationally) and 34% booked online locally (compared to 12% locally).[50]

While the Healthwatch survey asked about the ease of use for each of these methods, the National Survey asked 'generally, how easy is it to get through to someone at your GP practice on the telephone?' While not the same question, comparing the national result against the local ease of booking by telephone they are interestingly the same (both 68%). The National Survey demonstrates a downward turn in ease of booking by telephone since 2012, while our results have remained the same from 2018 to 2019.

The National Survey also asked about ordering prescriptions online and a much lower percentage of respondents (16%) than our local survey (41%) said they had used this service.

Recommendations for General Practice

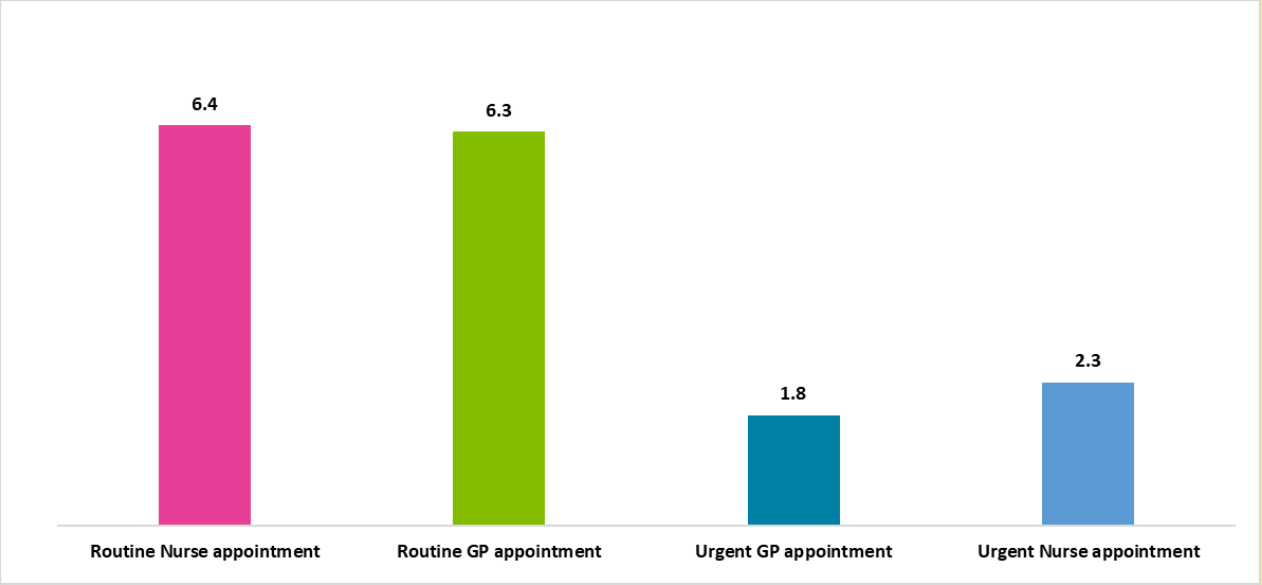
- **Ensure bookings by telephone are supported by enough staff capacity and good customer service.**
- **Ensure online bookings are supported by an efficient and customer friendly system.**
- **Better promote use of low-cost alternatives to booking appointments in person e.g. online bookings.**

[50] More than one booking method may have been used by a respondent. Hence, total percentages may add up to more than 100%.

4CIV: Waiting times from booking to appointment

Healthwatch asked patients how long they usually waited between booking and attending routine and urgent appointments. The following findings are based on patients' recollection of their waiting times. The average routine waiting times were similar for GP and nurse appointments (6.3 days and 6.4 days respectively). Urgent appointments had a considerably shorter wait, as would be expected: 1.8 days to see a GP and 2.3 days to see a nurse (Figure 13).

Figure 13 Average waits for each type of appointment (in days).



Waiting time performance varied considerably across practices as with our 2018 report. The widest variation was for routine nurse appointments, with a difference of 9.5 days between the shortest and longest wait.

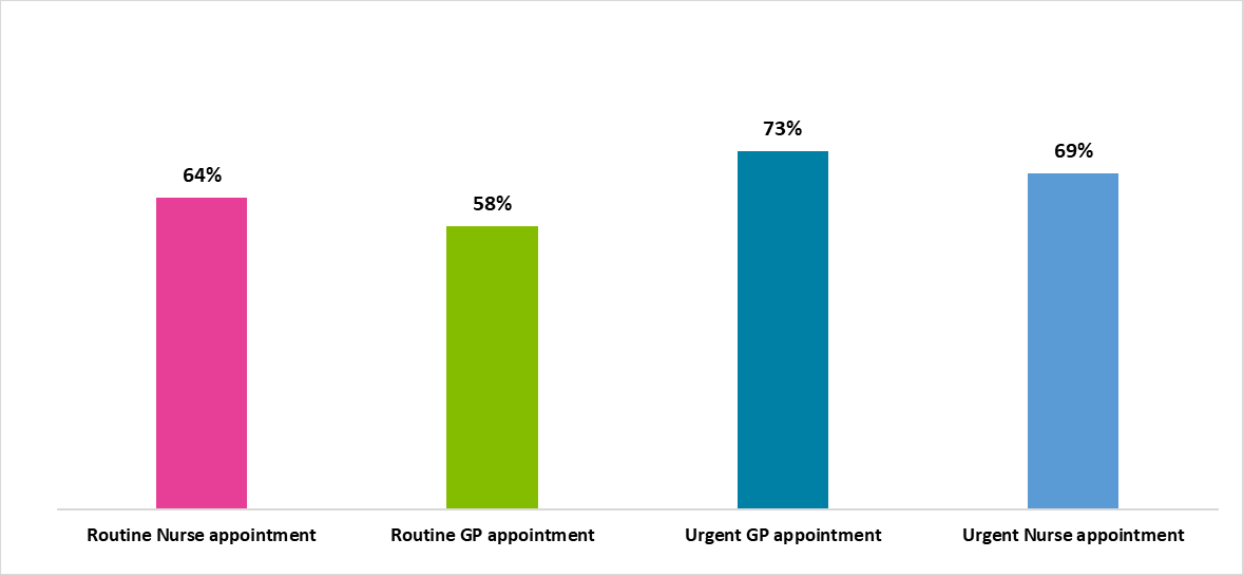
The majority of practices could not guarantee an urgent appointment within the day (81%, 17 surgeries in the case of urgent GP appointments and 100%, eight surgeries in the case of urgent nurse appointments).[51] This is similar to our 2018 report, in which 17 surgeries (75%) were able to offer an urgent appointment on the same day (either GP or nurse).

Satisfaction with waiting times varied, with the highest satisfaction levels for urgent appointments (Figure 14). Despite longer wait times for nurse appointments, patient satisfaction was higher for nurse appointments than GPs. This indicates that practices should be aware that patients expect to see a GP quicker than they expect to see a nurse, as the nature of the medical complaint is likely to be more serious and the need to see the GP therefore more urgent. All satisfaction levels have increased on our 2018 findings. This is interesting when we consider that waiting times have become longer. This may be linked to patient

[51] For comparison, we only included those practices where 15 or more responses had been received. 21 practices in the case of urgent GP appointments and eight practices in the case of urgent nurse appointments.

expectations and could be a result of better public awareness of capacity pressures on GPs and nurses.

Figure 14 Satisfaction with waiting times for each type of appointment.



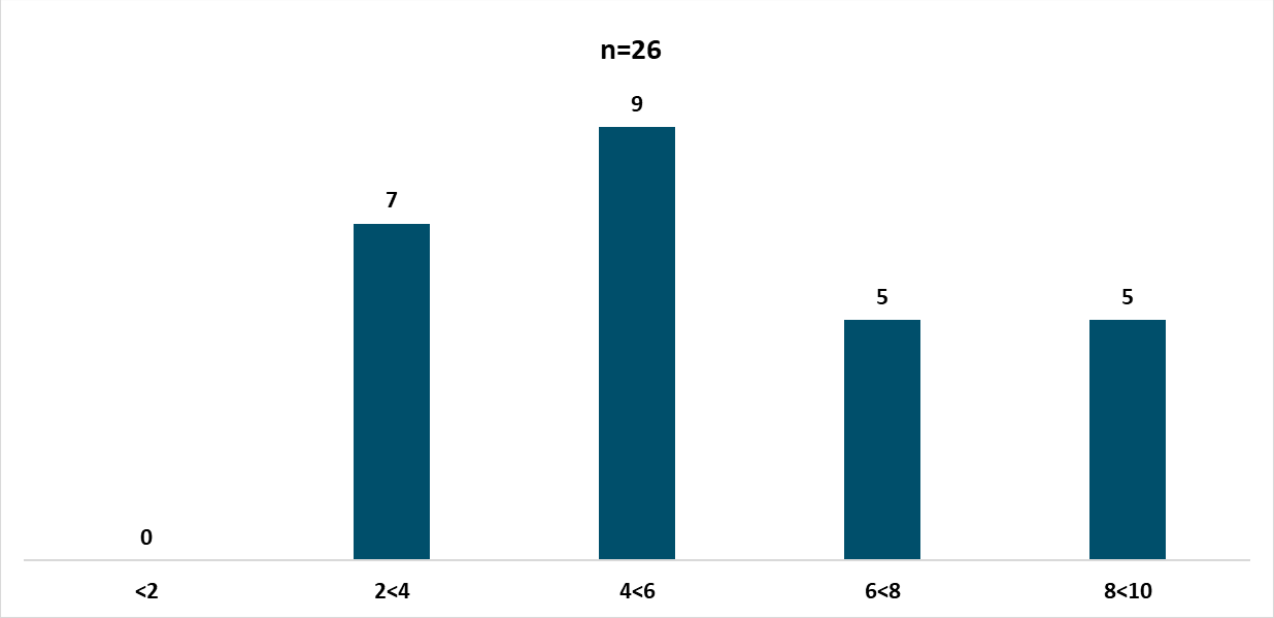
Routine GP appointments

The average wait for a routine appointment for patients in Brighton and Hove has gone up since our 2018 report to 6.3 days (in 2018 this was 5.4 days). One half of patients (49%, 436) received an appointment within three days but more than a quarter (26%, 237) had to wait a week. These are marginally worse figures than our 2018 report in which more than one half of patients (51%) were seen within three days and only 23% had to wait over a week.

Waiting times for routine GP appointments varied widely between practices, with the quickest waiting time being 2.3 days at one surgery and the longest 9.5 at another surgery. Seven surgeries averaged less than four days, with five of these, less than three days. However, five other surgeries averaged more than eight days wait. Patients at two surgeries waited an average of more than nine days for a routine GP appointment (Figure 15).

This large difference indicates the range of experiences of patients at different practices. Some were able to get a consultation within a couple of days while others had to wait nearly ten days.

Figure 15 Average wait times for routine GP appointments: no of surgeries at each stage of waiting time.

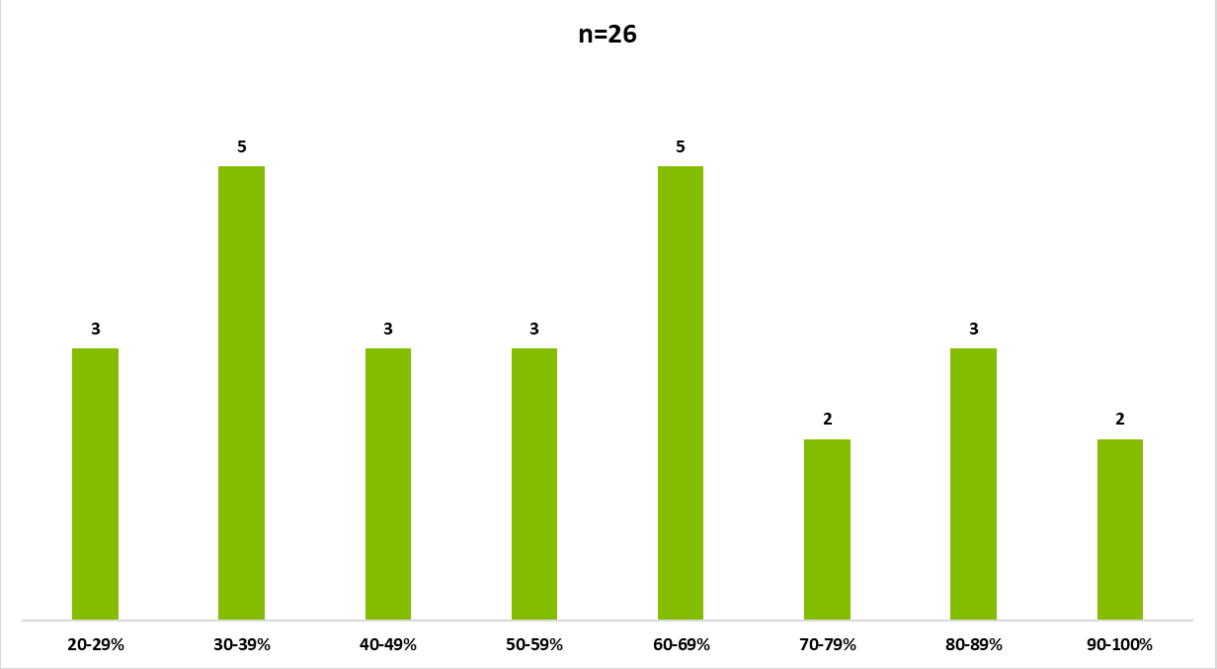


Interestingly, although wait times have gone up since we reported in 2018, satisfaction with waiting times has also increased from 51% (in 2018) to 2019 at 58% (534 patients). GPs are fewer in number and patient loads have increased and perhaps this has affected patient expectations around waiting times.[52]

Variation of patient satisfaction on waiting times between surgeries was significant, with one surgery receiving an average satisfaction of 26% and another surgery with an average of 96% satisfaction. Eight surgeries returned an average of less than 40% satisfaction while seven surgeries were rated about 70% on average (Figure 16).

[52] The Telegraph, Guardian and Times newspapers and ITV news all reported in early 2019 about waiting times breaching the two-week mark.

Figure 16 Overall satisfaction with waiting times for routine GP appointments: no of surgeries at each level of satisfaction rating.



The difference in waiting times between booking and attending appointments between practices is reflected in patient satisfaction with waiting times. This also applied to our findings in our earlier report. For 12 practices (71%) there was a relationship between quicker than average waiting times and higher than average patient satisfaction with waiting times. and vice versa (i.e. slower waiting times were related to lower patient satisfaction).

Waiting list and times are an issue but that isn't necessarily a GP issue.

The waiting time and limited booking are problematic.

Difficulty of getting an appointment is a problem. Usually have to wait a week.

Patients' comments on waiting times for appointments

While patient satisfaction has increased since we reported in 2018, waiting times for GP appointments are still an important determinant of this.

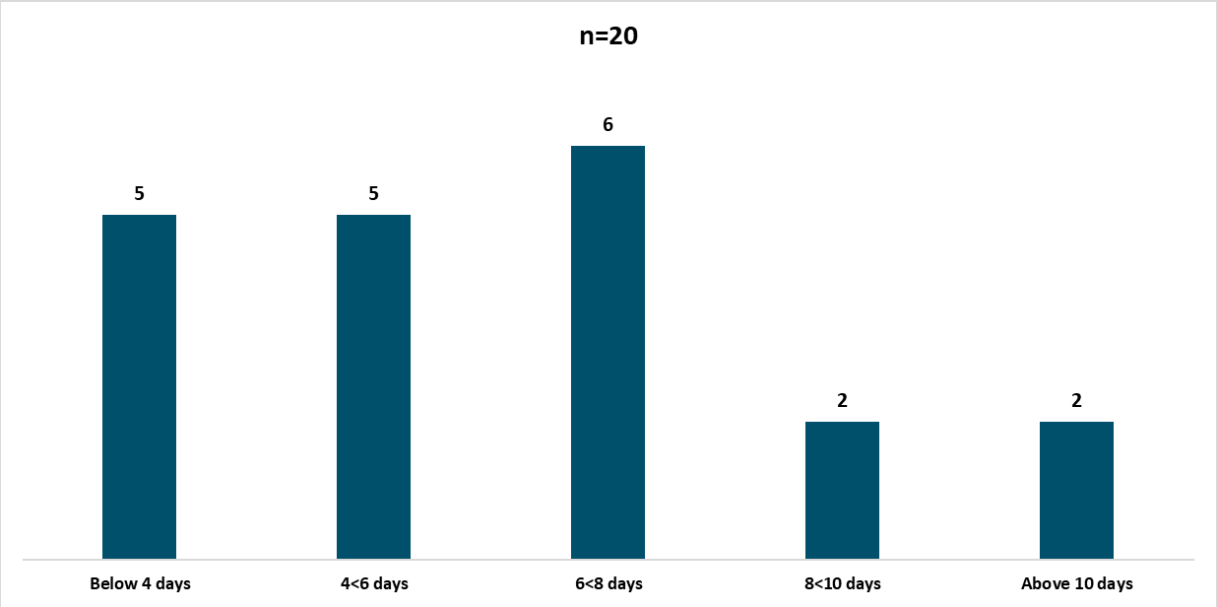
Routine nurse appointments

The average wait for a routine nurse appointment for patients in Brighton and Hove has increased slightly since our 2018 report to 6.4 days (in 2018 this was 6.2 days). Similar to waiting times around routine GP appointments in 2018, one quarter of patients (24%, 180) have to wait over a week for a routine nurse appointment. 40% (280 patients) are seen within three days.

There was some variation between surgeries on average waiting times. The quickest average waiting time of any one surgery was 2.9 days, while some patients at another surgery waited up to 12.4 days on average. A quarter of surgeries (five) averaged less than four days while two surgeries (10%) averaged

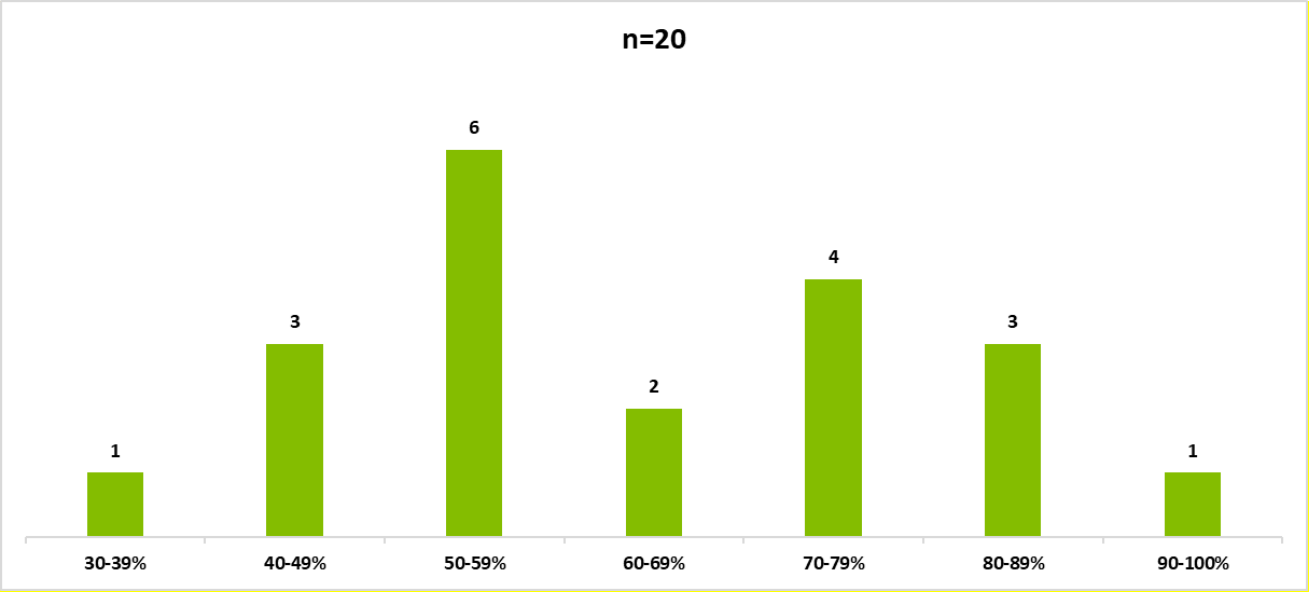
more than ten days for a routine nurse appointment. The variation indicates the different service that patients can expect to receive across the city (Figure 17).

Figure 17 Average wait times for routine nurse appointments: no of surgeries at each stage of waiting time.



Patient satisfaction ('satisfied' or 'very satisfied') with the wait times for routine nurse appointments was 64% (493 patients) and was higher than for GP appointments (58%). It was also better than satisfaction levels we reported in 2018 (58%). There was a wide variation between the lowest satisfaction rating at one surgery of 36% and the highest in another surgery of 93%. Four practices received satisfaction levels of less than 50% while another four surgeries achieved higher than 80% (Figure 18).

Figure 18 Average satisfaction for routine nurse appointments: no of surgeries at each level of satisfaction rating.



Urgent appointments

In 2019, we asked for a response for urgent GP appointments and a separate response for urgent nurse appointments. In comparison, our 2018 survey asked patients to feedback about all urgent appointments (i.e. GP and nurse combined).

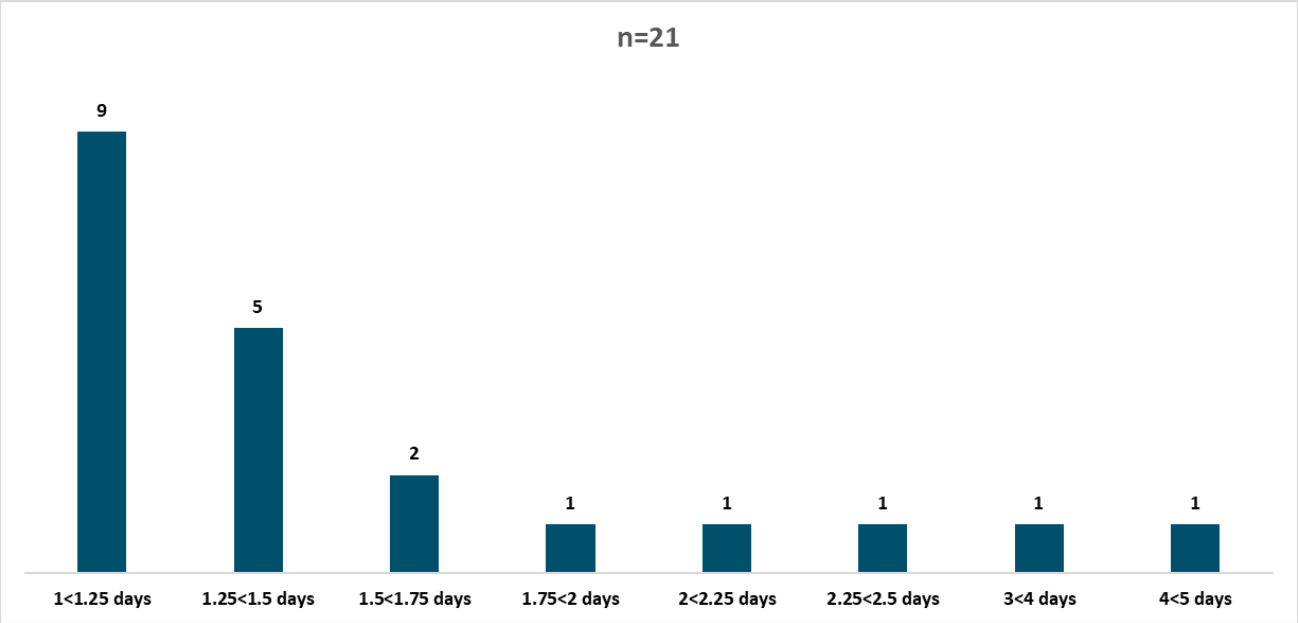
In our 2018 report, the large majority of patients, 86%, were seen the same day for urgent appointments with an average wait of 0.9 days. In 2019, we found a similar percentage of 85% (625 patients) saw their GP on the same day. Around two-thirds of patients (67%, 244 patients) were able to book an urgent nurse appointment on the same day.

However, 5% (38 patients) waited four days or more to see a GP for an urgent appointment and 9% (34 patients) waited the same time to see a nurse urgently. These figures are higher than when we reported in 2018 when we found that 3% waited four days or more.

There was some variation between practices.[53] The quickest waiting time for an urgent GP appointment was one day and the longest 4.8 days. Four surgeries (19%) averaged one day or less and two surgeries averaged more than three days (Figure 19).

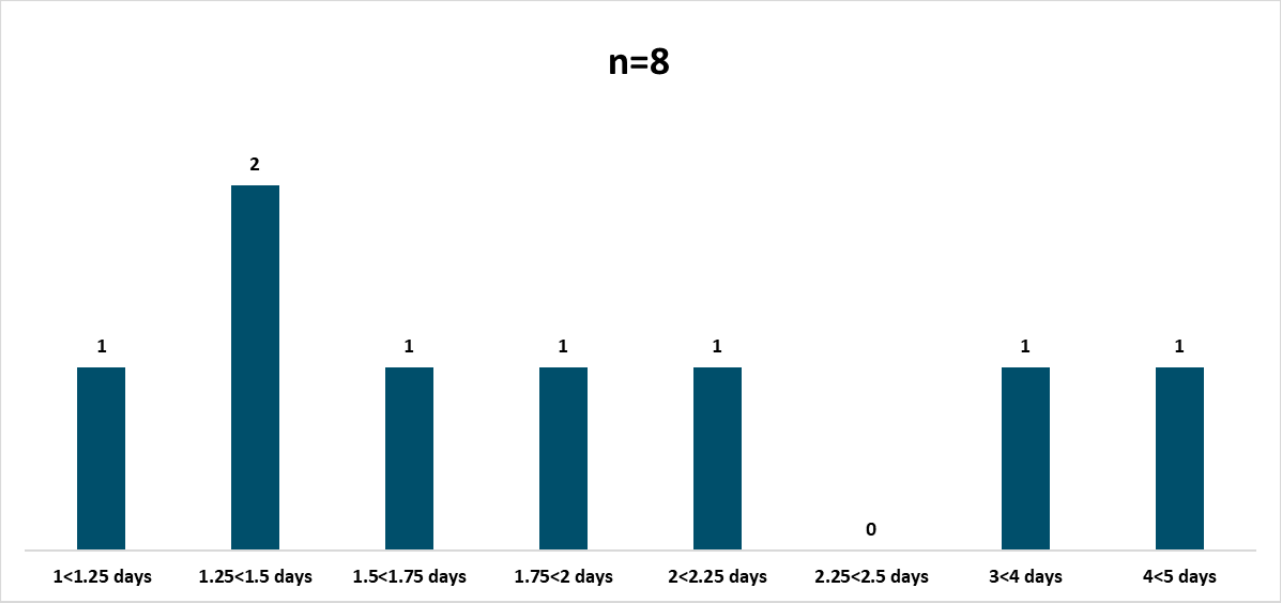
[53] For comparison analysis, we only used practices where we received 15 or more responses to the question: 21 practices in the case of urgent GP appointments and eight practices in the case of urgent nurse appointments.

Figure 19 Average wait times for urgent GP appointments: no of surgeries at each stage of waiting time.



For urgent nurse appointments, the quickest waiting time was 1.2 days and the longest four days, with three surgeries (38%) averaging less than 1.5 days and two surgeries more than three days (Figure 20).

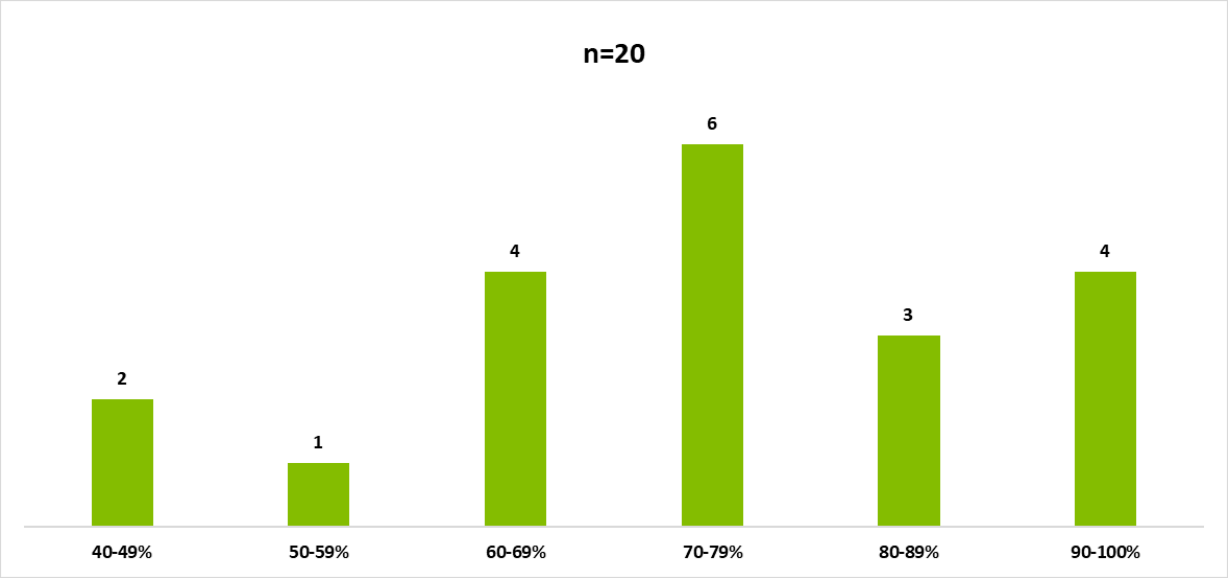
Figure 20 Average wait times for urgent nurse appointments: no of surgeries at each stage of waiting time.



Patient satisfaction with the wait times for urgent appointments was higher than for routine appointments. 73% of patients (535) were 'satisfied' with urgent GP appointments and 69% (318 patients) were 'satisfied' with urgent nurse appointments. This compares with our 2018 report where satisfaction with urgent appointments (GP and nurse combined) was 69%.

Variation was apparent between surgeries, with a greater difference on satisfaction with waiting times, for urgent GP appointments.[54] Patient satisfaction rating for urgent GP waiting times ranged across surgeries from 47% to 94%. Two surgeries received lower than 50% satisfaction with waiting times, while seven achieved higher than 80% (Figure 21).

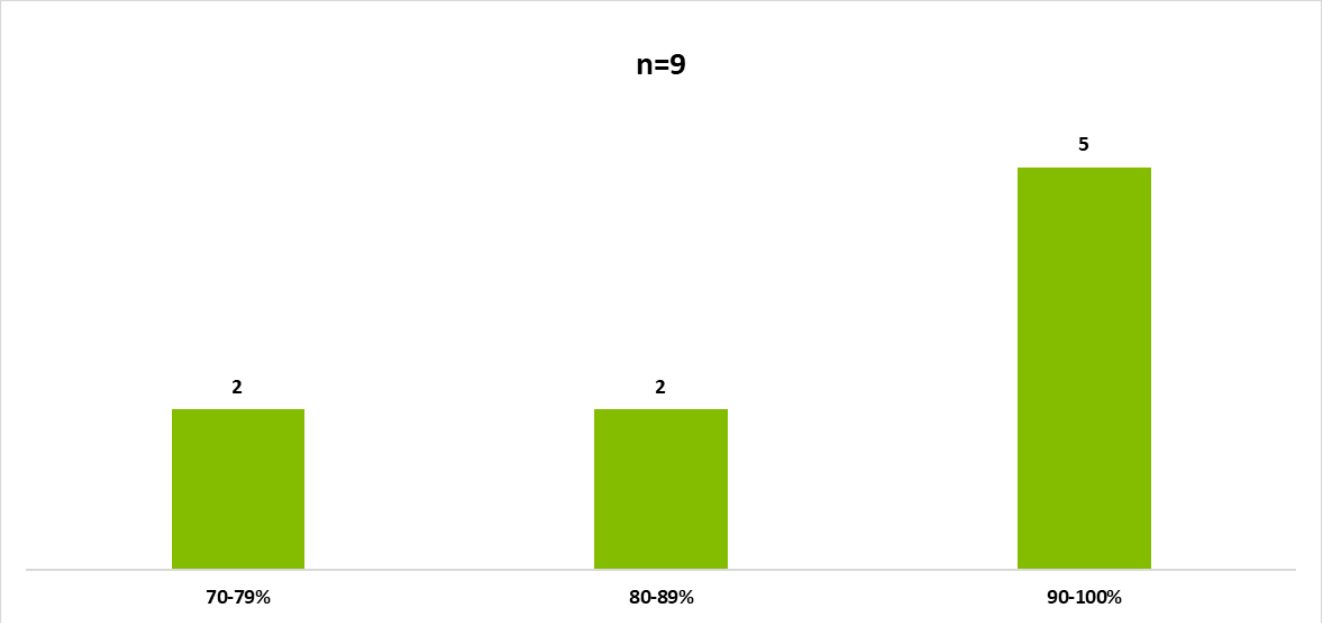
Figure 21 Average satisfaction with wait times for urgent GP appointments: no of surgeries at each level of satisfaction rating.



Satisfaction levels with urgent nurse appointments varied between 74% and 100%, with three surgeries scoring the top level. As with previous comparative data, Figure 22 compares those surgeries where we have received 15 or more responses to this question, in this case only nine surgeries met this criteria.

[54] For comparison analysis, we only used the practices where we received 15 or more responses to both questions: 20 practices for urgent GP appointments and nine practices for urgent nurse appointments.

Figure 22 Average satisfaction with wait times for urgent nurse appointments: no of surgeries at each level of satisfaction rating.



Comparison with the 2019 National Survey

The NHS National survey did not ask the same detailed questions as Healthwatch. The National survey made no distinction between routine and urgent appointments and no distinction between GP and nurse appointments. Combining scores for comparison in both surveys, the large majority of patients were not seen on the same day as they booked their appointment (60% locally compared to 67% nationally).

Recommendations for General Practice

- Increase the number of urgent appointments. Patients have a strong expectation that GP urgent appointments should be available.
- Reduce waiting times to have a booked appointment with a nurse or a GP.

4CV: Appointment waiting times on the day

The survey asked respondents how close to the scheduled appointment time they were usually seen, with a range of responses between 'on time' and 'more than 45 minutes' after the scheduled time. We asked patients to answer this question separately for GP appointments and again for nurse appointments. This differs from our 2018 report, in which we only asked patients to provide one response for waiting times overall.

Practices were better at ensuring appointments were exactly on time than when we reported in 2018 where the average waiting time was 13.6 minutes. In comparison, waiting times in 2019, averaged 8.9 minutes[55]. Separately, patients waited on average longer for a GP appointment (11.5 minutes, 955 responses) than they did for a nurse appointment (5.7 minutes, 769 responses).

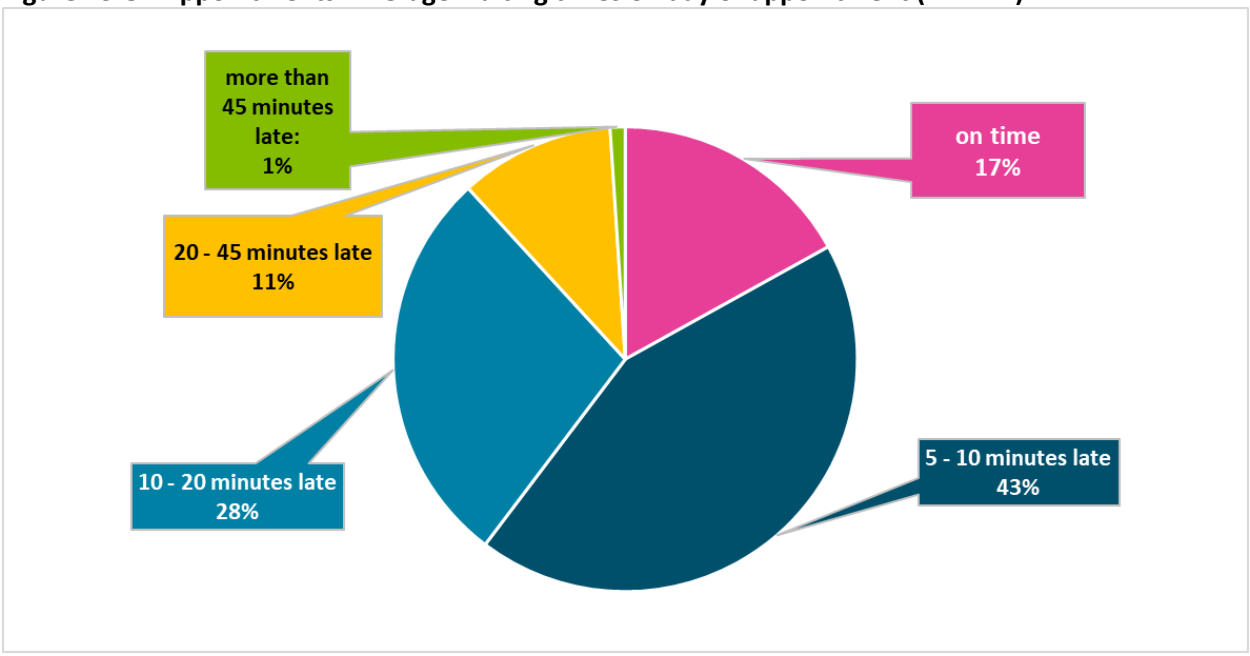
Staff are friendly and efficient. Wait times are not their fault.

Waiting times are the worst problem. 25 mins late at present!

Patients' comments on waiting times in surgery

Using the *combined* figures for GPs and nurses, 29% (503 patients)[56] reported that they were seen on time in 2019. This compares favourably to only 14% of patients being seen on time in 2018. Separately, in 2019, 17% (162 patients) saw a GP on time (Figure 23).

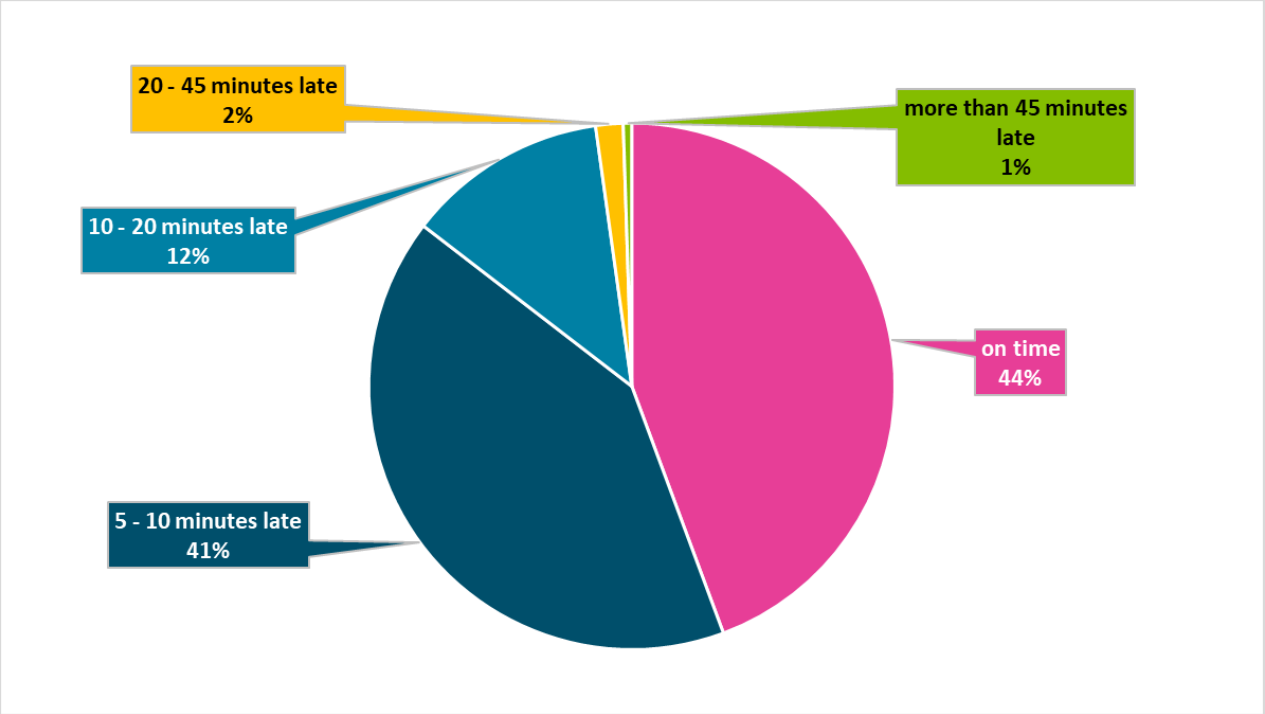
Figure 23 GP Appointments: Average waiting times on day of appointment (n=1724)



[55] Combination of 1724 responses across both questions on nurse and GP appointments.
[56] As figures are combined, the sample is of 1724 responses across both questions on nurse and GP appointments.

In addition, 44% (341 patients) saw a nurse on time (Figure 24).

Figure 24 Nurse Appointments: Average waiting times on day of appointment (n=1724).



There was considerable variation across practices,[57] as with our 2018 report. In thirteen practices, the average waiting time to see a GP on the day of an appointment, was less than ten minutes. In two surgeries, the average waiting time for a GP was above 17 minutes.

There was also variation across practices, in waiting times to see a nurse. Six practices had an average waiting time of less than four minutes, with three surgeries offering an average of less than three minutes. At the higher end, patients at three surgeries waited more than nine minutes on average to see a nurse.

Again, these variations demonstrate different experiences for patients across the City.

Comparison with the 2019 National Survey

The National Survey also asked how long patients waited for their appointment, on the day itself. Healthwatch distinguished between GP and nurse appointments. As there was no such distinction made in the National Survey, we combined waiting times for the two categories in our survey and worked out the averages for the combination. As the National Survey had slightly different time scales to the Healthwatch survey, we compared our 'one time' with the national '5 minutes late or less' and grouped all the other times under a general heading of 'not on time' (locally) and 'more than five minutes' (nationally) (Figure 25).

[57] For comparison analysis, we only used the practices where we received 15 or more responses to both questions: 27 practices for GP appointments and 20 practices for nurse appointments.

Figure 25 Comparison with National Survey: Waiting time on day of appointment.

B & H (Combination of routine GP and routine nurse appointments)		National ('your last appointment')	
on time	29%	5 minutes late or less	23%
Not on time	71%	More than five minutes	77%
	100%		100%

A higher percentage of Brighton and Hove patients (29%) were seen on time compared to national patients (23% were seen five minutes late or less).

Recommendation

- **For General Practice: continue to keep appointments on the day, as timely as possible and keep patients informed of any delays while waiting.**

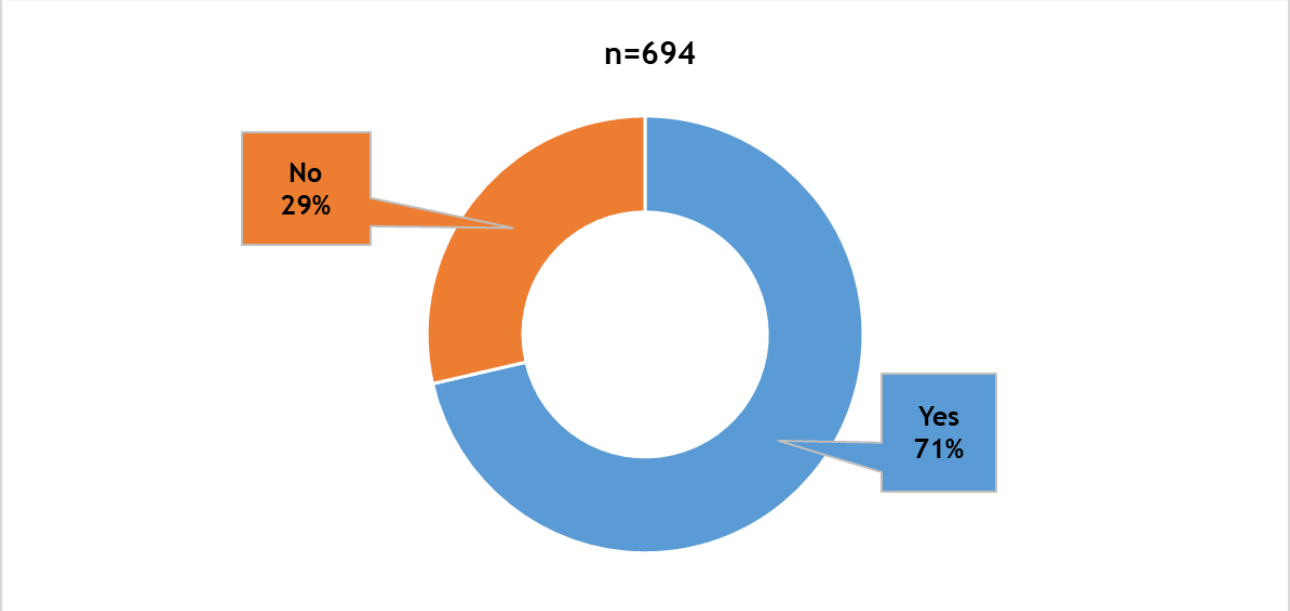
4CVI: Patient's use of own doctor

The majority of patients in Brighton and Hove (65%, 620) said they could see a doctor of their choice. This is a distinct increase in comparison to the findings in our 2018 report, in which only 48% of respondents could choose a doctor.

In addition, a majority of respondents in 2019 (72%, 694) said it was quite important or very important to be able to choose a doctor. This was also an increase on our earlier report, where 64% of respondents said they thought this was important. In 2019, patients cited a variety of reasons for wanting to see their own doctor. Some patients felt it was necessary to have consistency rather than taking additional time to explain their long-term or complicated conditions to a new doctor. Other patients (some with mental health conditions, such as anxiety or dementia) felt more comfortable with the same doctor.

Of those that *thought it was important*, almost one third (29%, 196) were unable to make this choice (Figure 26).

Figure 26 Patients who said it was important to choose which doctor they saw: how many could choose?



The NHS has prioritised mental health issues in their Long Term Plan.[58] Also the number of people with multiple and long-term health conditions is growing.[59] These may be important considerations in patients having consistency in their care, including seeing the same doctor or nurse.

[58] See https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/ for more information, in particular sections on Aging Well, mental health commitments and Personalised Care.
[59] See https://www.health.org.uk/publications/understanding-the-health-care-needs-of-people-with-multiple-health-conditions for further information. For Brighton and Hove specific, please read the Joint Strategic Needs Assessment 2020: https://present.brighton-hove.gov.uk/Published/C00000147/M00002166/AI00013008/$Item25JSNAsummaryforJCBAppendix1.doc.pdf

Each doctor I have seen here has been helpful. I'm happy to see whoever has time.

As long as a GP is qualified they should be able to help me.

It is easier to obtain an appointment if you see any doctor

All my health details are on the shared computer system, so it shouldn't matter who I see.

It is better to see the doctor who understands my [long-term] condition.

I suffer from anxiety and prefer to see the same doctor.

Some doctors are more helpful and friendly than others.

Patients' comments

Recommendation

- **For General Practice: Provide opportunity to allow patients continuity of care, including seeing the same doctor.**

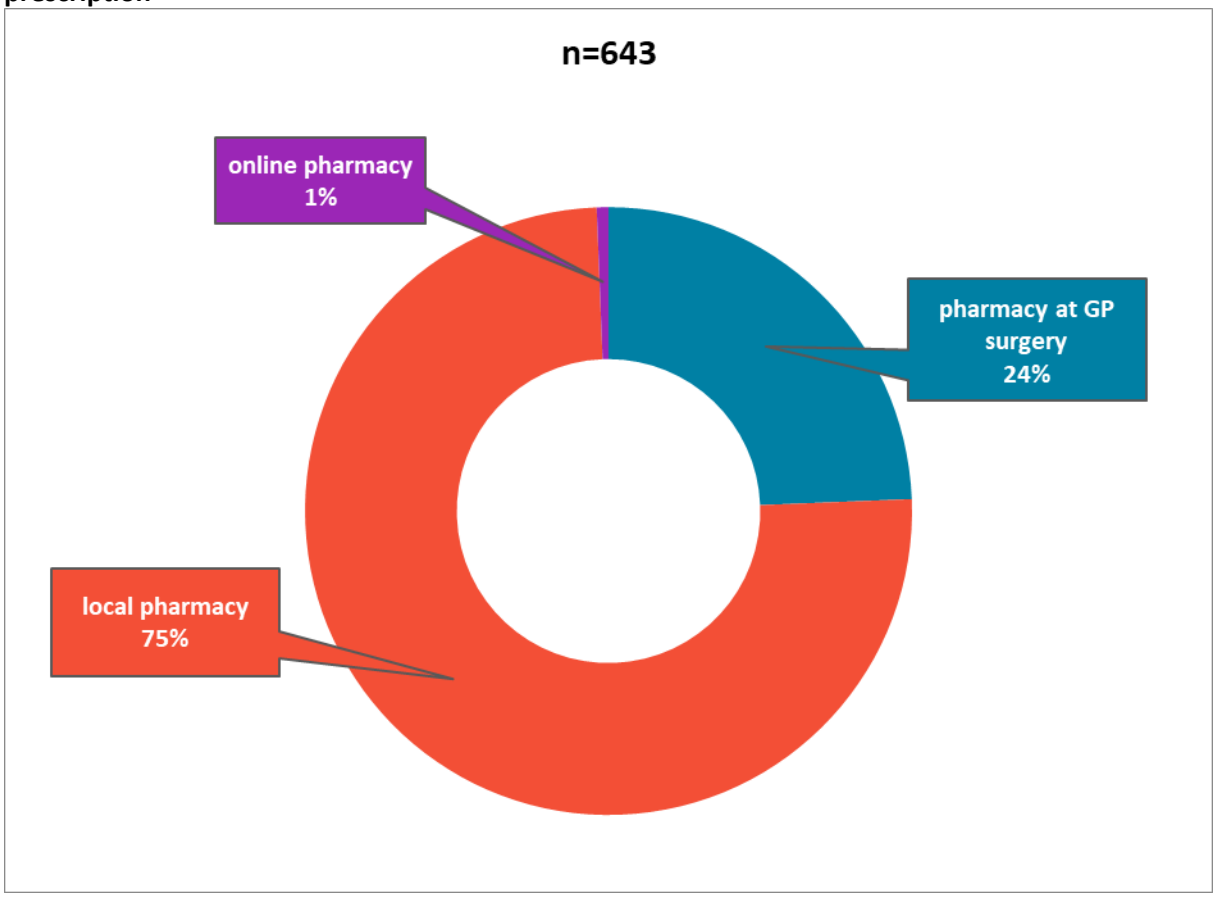
4CVII: Getting medication

In response to concerns about marketing from online pharmacy services, Healthwatch ran an online pharmacy survey (in 2019) for people who had received marketing from one of these companies. In the online pharmacy survey, we surveyed 91 people in Brighton and Hove and found widespread confusion about marketing received and the credentials of these companies. Therefore, we took the opportunity in the GP survey, to ask GP patients (if they were given a prescription by their GP) similar questions about where they got their medication from.

Prescription provided

The majority of patients we spoke to in the GP survey (67%, 643), had received a prescription from their GP and almost all of those who had (99%, 636), went to either a pharmacy located at the surgery or a local pharmacy to get the medication (Figure 27).

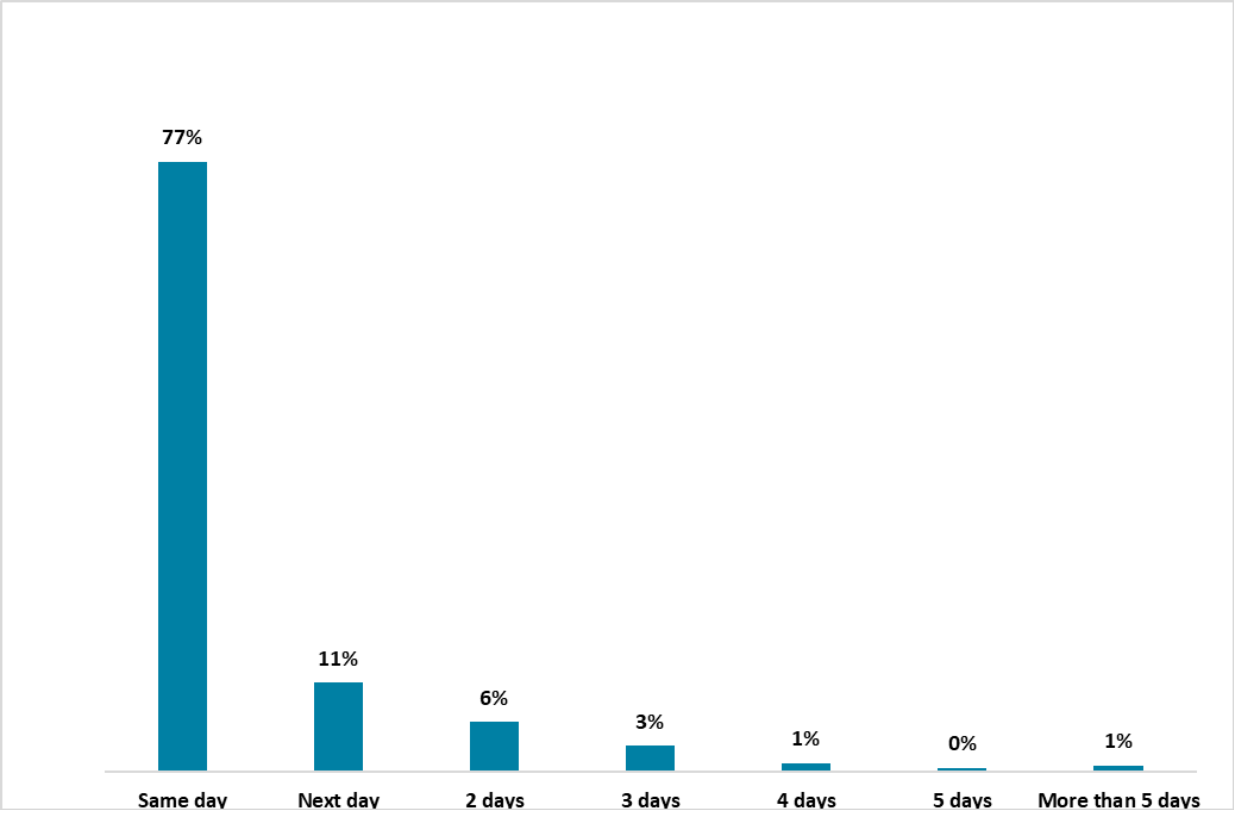
Figure 27 Patients given a prescription at last GP consultation: Type of pharmacy providing the prescription



Health problems due to delays

Healthwatch also asked patients how long they waited for the prescription and if any delay caused the patient health problems. While the majority (88%, 563) received their medication either on the day or the next day, 76 patients (11%) had to wait longer (Figure 28). A very small number of patients (25, 4%) felt delay had caused some health problems, with ten of these patients having to wait two days or longer.

Figure 28 How soon after seeing a GP did you get your medication? (n=639).



Recommendation for Pharmacists

Feedback from our report indicates that pharmacists are generally providing a good service to patients. Small areas for improvement could be:

- **Decrease delays in issuing medication.**
- **Ensure pharmacies have the most commonly prescribed medications in daily stock.**

4D: Surgery Environment

Healthwatch visited 34 GP surgeries in the city as part of the GP review.[60] At each practice, the Healthwatch team observed the environment from the patient's point of view. This included patient information, staff communication with patients, comfort of the waiting area and hygiene including toilet facilities. Observations were used to provide helpful suggestions of areas for improvement rather than awarding any quantifiable rating to each surgery.

Information Displayed

All of the surgeries that we visited had display boards with a variety of information for patients. The surgeries that stood out positively, were those that had taken the time to group information by subject, including sub-headings, and to ensure that information was up to date. Also, where information was provided in an eye-catching way (e.g. with the use of colour or background for different subjects). The inclusion of safeguarding material was considered important and some volunteers had specific suggestions to make about this. One surgery had a particularly useful display board that advised patients which service they should seek depending on the illness, health complaint or injury.

> *There was only a poster stating the name of the safeguarding lead and to ask for the person at the reception. Therefore, if someone wanted to remain anonymous there was no alternative way.*
>
> *Healthwatch volunteer observation*

In contrast, information was sometimes difficult to navigate, if there was no clearly defined subject groups, where leaflets were displayed loosely rather than in holders, and where posters were clearly out of date.

Hygiene/Toilets

Volunteer comments about most surgeries were that they were clean and tidy, and most had hygienic hand gel for patient use in the waiting area or reception.

The surgeries that were considered above average, included those where toilets were clearly signposted, with the facilities themselves being clean, tidy and well-stocked with paper and soap. Also, positive assessments were where surgeries provided facilities for wheelchair users, and baby-change facilities and where the emergency cord could be easily accessed.

> *The length of the emergency cord in the toilet was not reaching the floor, and therefore would be difficult to reach if someone fell.*
>
> *Healthwatch volunteer observation*

[60] This was from a total of 40 locations, including smaller branch surgeries.

In contrast, hygiene was considered to be below average, where signs to the facilities were not clearly visible, where facilities themselves were not accessible for disabled patients, or where paper or soap had run out.

Communication
In many of the surgeries we visited, volunteers commented that staff (receptionists and medical staff) communicated clearly and in a friendly manner with patients. Surgeries were rated above average, where staff were seen to create a calm, relaxed environment, where conversation was at a suitably quiet but audible tone, and where patients were met with a friendly welcome.

In particular, some staff were seen to deal with challenging enquiries from patients, responding calmly, taking time to listen to the patient and doing their best to respond appropriately.

> ***Staff have been trained in relation to confidentiality and can take patients to a side area if there is a need for a chat in private.***
>
> ***Healthwatch volunteer observation***

In contrast, communication could be improved, where staff responded in a hurried manner, or where conversations could be easily overheard by other patients. When patients raised a complaint, staff responded in an abrupt manner and seemed to act defensively or did not approach the patient to speak to them quietly but instead talked across the surgery.

Waiting area environment
Volunteers fed back that many of the surgeries provided a suitable waiting area with reasonably comfortable chairs. Those surgeries felt to offer more than the average, were those that offered a range of chairs suitable for patients with physical challenges (chairs with armrests, larger chairs and those with head rests). Having freely available drinking water was also important. Additional comfort was provided by surgeries that offered magazines to read or children's toys. Natural light and decoration such as pictures or colourful furniture were also a benefit.

> ***None of the seats have arms and I watched two older patients struggle to stand up.***
>
> ***There is a lowered desk at reception for wheelchair users.***
>
> ***Considering the small space, the reception staff have done well to make it feel open, relaxed and comfortable.***
>
> ***Healthwatch volunteers' observations***

In contrast, some waiting rooms could be improved by offering a range of chairs, including cushions on hard seating areas, offering books or toys and ensuring

lighting is maintained and water is freely available (or patients are clearly advised to ask reception for water).

Patient feedback encouraged
Most of the surgeries we visited, had a complaints procedure in place. However, volunteers felt that not all made this clear to patients. The best examples we saw displayed a comments/complaints box on the reception counter or clearly displayed in the waiting area. One surgery had a dedicated writing desk and chair available for patients to complete a comments form. Another surgery had produced a complaints leaflet clearly setting out the procedure including the contact details for the Practice Manager, the Patient Advice Liaison Service and the Health Services Ombudsman should patients need to escalate a problem. Reception staff were also aware of the complaints procedure and could advise patients accordingly.

In contrast, the team felt that in general, a surgery could improve its complaint procedure by ensuring comment forms were displayed clearly with an obvious box to post them into. Also, it is important for staff to be aware of the procedure and that information on the NHS friends and family test is available.

> ***No Friends and Family forms were visible and on asking the reception, none could be found. No complaint information was available. The receptionist said that if they wanted to, patients could ask them for details.***
>
> ***Healthwatch volunteer observation***

Other observations
Our volunteers also recorded additional comments to the areas above.

- Waiting areas could be enhanced by music or radio, as long as the volume was audible but not loud.
- Where surgeries offered car parking, some patients commented that there were not enough spaces available.
- Poetry and suitably relaxing pictures on the wall can help create a calm waiting room environment.
- Additional space for patients to speak confidentially to a member of the reception staff would benefit those surgeries that are open plan.
- Surgeries should be accessible to patients with physical disabilities. Where possible, surgeries should offer ramps up to the main door, lifts to consultation rooms or consultation rooms available on the same floor where patients enter the surgery. Suitable chairs, a portable hearing loop in the waiting area and disabled toilet facilities also help make a surgery accessible to all patients.
- Some areas of the surgery are suitable to display certain information. Information on sexual health and contraception is probably best displayed in or near the toilets. Whereas safeguarding information should be in an area that all can see it, while also providing duplicate information on this in the toilet area so that patients can take the details down in private.

Recommendations for General Practice

- Ensure the complaints procedure is open and transparent and that all patients are aware of how to provide comment about the surgery (positive and negative).
- Ensure all reception and medical staff are trained in basic customer service skills, with the ability to deal with complaints and challenging behaviour and/or refer to the Practice Manager where appropriate.
- Consider a separate area for patients to speak confidentially to reception staff.

Suggestions for environmental improvements to General Practice

- Ensure patients with disabilities can access the surgery easily and comfortably. Where possible, make 'reasonable adjustments' (Equalities Act 2010) to facilities including providing a hearing loop in reception and ramps from the pavement to the front door.
- Ensure patient information in the waiting area and reception, is well organised, tidy and up to date.
- Ensure facility signs (e.g. for the washrooms) are clearly visible and facilities are well-stocked.
- Ensure waiting areas are comfortable including offering water, lighting that works and a range of seating.

4E: Overall satisfaction and suggestions for improvements

In addition to feedback on individual issues, Healthwatch wanted to get a sense of how patients felt overall about their current surgery. We also wanted patients to give suggestions on how to improve their surgery. We therefore asked two sets of questions: one around overall satisfaction and another around what makes a good surgery. We also asked patients for additional comments about the NHS primary care service which we have also included here.

4EI: Overall satisfaction

We asked patients three questions about their overall experience of their GP practice:

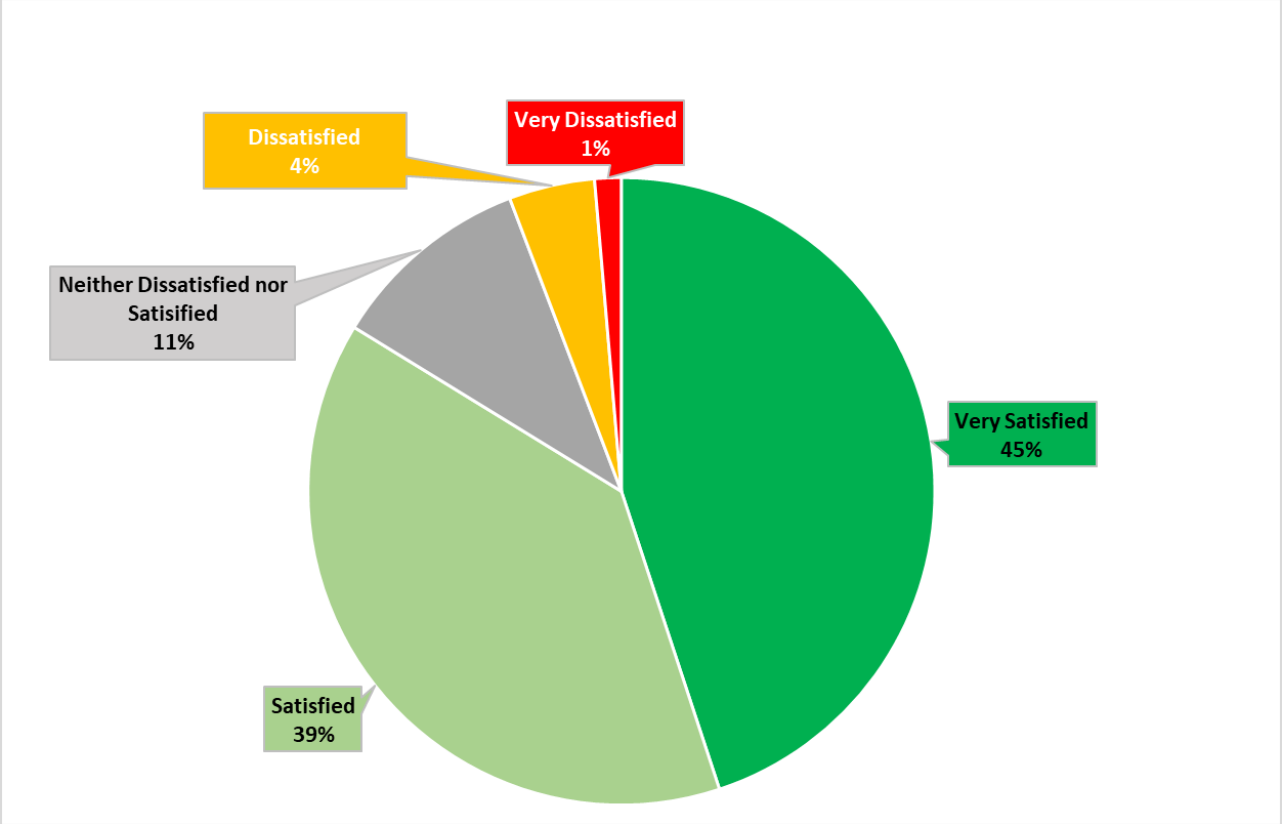
- overall satisfaction on a five-point scale;
- a similar question to the NHS Family and Friends Test, asking if they would recommend the practice to someone moving into the area, which uses a five-point scale, and
- an overall rating of their GP surgery on a 1-10 scale.

Patients were generally very positive about their GP practice and overall satisfaction compared favourably to findings in our 2018 report.

The majority of patients (84%, 794) were 'satisfied' or 'very satisfied' with their surgery (Figure 29). This compares to 82% in our earlier report.

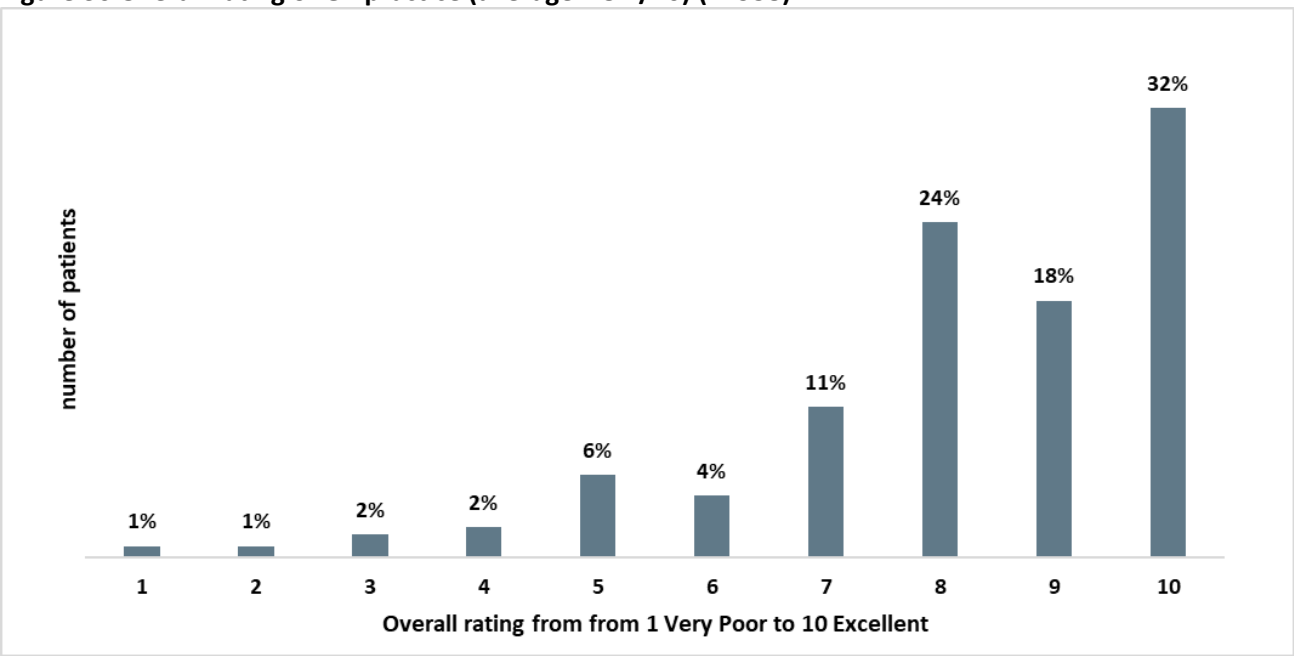
> The reception staff are the best: Effective and well organized.
>
> Doctors care and take time. I always feel listened to.
>
> The system for same day appointments seems to really work.
>
> I can always get an emergency appointment.
>
> ***Patients' positive comments***

Figure 29 Overall, how satisfied are you with your GP practice? (n=948).



Most (89%, 817 patients) said they would recommend their surgery to someone who has just moved to their local area (compared to 86% in 2018). Patients rated their surgery with an average score of 8.2 out of 10 (combination of ratings from 958 patients) and this compared favourably to an average rating of 7.9 in 2018 (Figure 30).

Figure 30 Overall rating of GP practice (average = 8.2/10) (n=958).



There was some variation between surgeries on all three criteria and for some surgeries, satisfaction levels were significantly below or above the average.[61]

Satisfaction levels varied from one surgery where only 50% of patients were 'satisfied', to another surgery which received satisfaction from 97% of patients. Less than 75% of patients were 'satisfied' or 'very satisfied' at five surgeries (with less than 60% of patients at two of these).

Too many patients, not enough doctors.

The receptionists are awful - make you feel you are a nuisance and do not provide any confidentiality.

I never see the same GP twice.

It's so difficult to get an appointment so preventative care just doesn't happen.

There is very little mental health support.

Patients' negative comments

More than 95% of patients were 'satisfied' or 'very satisfied' at four surgeries.

At five surgeries, less than 75% of patients were 'satisfied' or 'very satisfied' (with two surgeries achieving less than 60% patient satisfaction). Four surgeries, achieved satisfaction from 95% of their patients.

The number of patients recommending their surgery differed greatly between 58% of patients at one surgery to 100% at five other surgeries. For six surgeries, less than 80% of patients recommended their practice.

Ratings also varied between surgeries, with three surgeries receiving an average of less than 7 out of 10, and at the higher end, three other surgeries scoring an average of 9 or above.

[61] As with previous comparative analysis, we only used the practices where we received 15 or more responses to all questions. For these three questions, analysis involved 26 practices for overall satisfaction rating; 25 practices for recommendation and 26 practices for ratings out of 10.

4EII: Relationship between overall satisfaction and specific measures

We decided to find out if there was any relationship between overall patient satisfaction (or dissatisfaction) with their surgery, and satisfaction (or dissatisfaction) with some specific measures.

We chose three issues to look at:

- overall satisfaction with practice vs satisfaction with waiting times to book a routine GP appointment;
- overall satisfaction with practice vs waiting times in surgery for GP appointment, and
- overall satisfaction with practice vs quality of care communication ratings for GPs (see 4BIII: page 24).[62]

There was a strong relationship between each issue and the overall patient opinion (Figure 31). For those patients who were 'satisfied' or 'very satisfied' with their surgery, 86% of these (501 patients) were also 'satisfied' with waiting times to book a routine GP appointment. Likewise, from those patients who were 'dissatisfied' or 'very dissatisfied' with their surgery, 89% of these (41 patients) were also dissatisfied with waiting times to book a routine GP appointment.[63]

Similarly, for those patients 'satisfied' or 'very satisfied' with their surgery, the majority of these patients (65%, 501) were also satisfied with waiting times in surgery for a routine GP appointment. Likewise, from those patients dissatisfied or 'very dissatisfied' with their surgery, the majority (70%, 37) were also 'dissatisfied' or 'very dissatisfied' with the wait in surgery for the GP appointment.[64]

For the third criteria, there was also a strong relationship. For those patients 'satisfied' or 'very satisfied' overall, we found that 70% of these patients (554) had also rated their GP 'good' or 'very good' for all seven aspects of quality of care communication. Likewise, of those patients who were 'dissatisfied' or 'very dissatisfied', 84% of these (46 patients) did not rate their GP 'good' or 'very good', on at least one aspect of quality of care communication.[65]

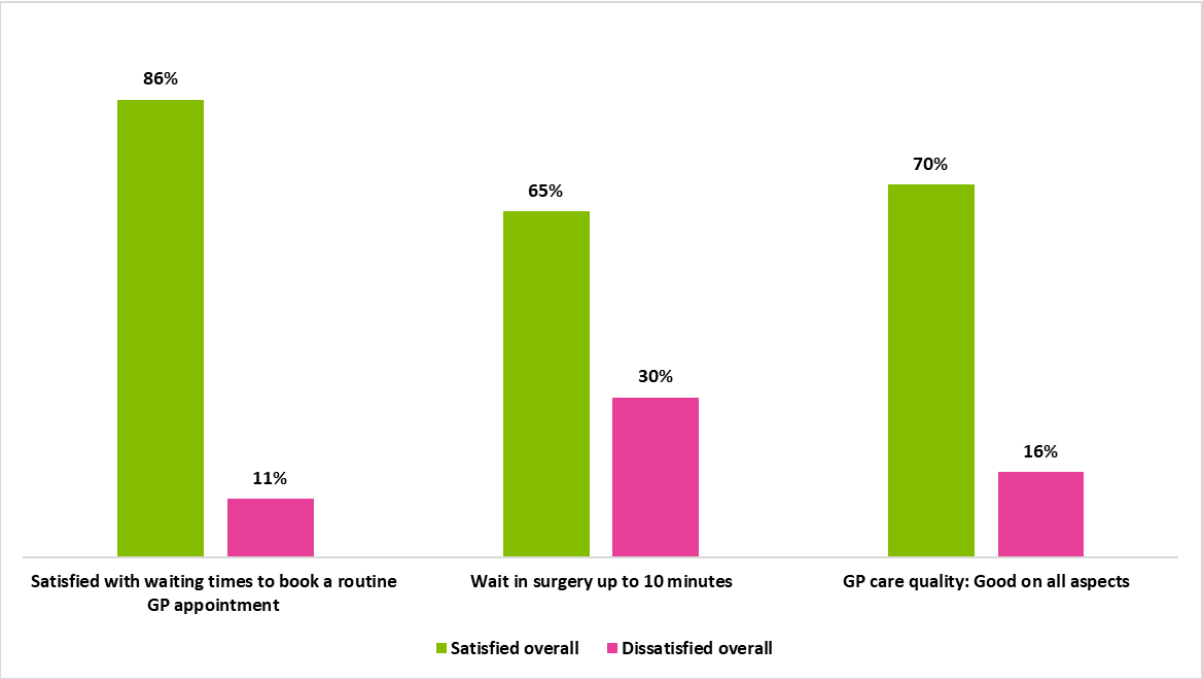
[62] See 4BIII: Communicating with patients, page 24, of this report for more information. Quality of care was derived from a combination of giving patient enough time; listening to patient; explaining tests and treatments; involving patient in decisions about their care; treating patient with care and concern; having access to relevant medical information about patient and having access to relevant medical information about patient.

[63] From a total of 627 patients who responded to the question on waiting times between booking and appointment. The remainder were neither satisfied nor dissatisfied or did not answer the question.

[64] From a total of 821 patients who responded to the question on waiting times in surgery. The remainder were neither satisfied nor dissatisfied or did not answer the question.

[65] From a total of 849 patients who responded to the question on quality of care. The remainder were neither satisfied nor dissatisfied or did not answer the question.

Figure 31 Relationship between overall satisfaction with GP surgery and specific measures.



Comparison with the 2019 National Survey

The National Survey asked about patients' overall experience with their GP practice, which was a close enough match to the Healthwatch question about overall satisfaction. In addition, the response options were very similar with 'very good' and 'fairly good' (nationally) being compared to 'very satisfied' and 'satisfied' (locally); 'very' and 'fairly poor' (nationally) being compared to 'very dissatisfied' and 'dissatisfied' (locally), (Figure 32).

Figure 32 National Survey comparison: overall opinion of surgery.

B & H		National	
Overall, how satisfied are you with your GP practice?		**Overall, how would you describe your experience of your GP practice?**	
Very Satisfied	45%	Very good	45%
Satisfied	39%	Fairly good	38%
Neither Dissatisfied nor Satisified[1]	11%	Neither good nor poor[1]	11%
Dissatisfied	5%	Fairly poor	4%
Very Dissatisfied	1%	Very poor	2%
	100%		100%

[1] Numbers shown add up to more than 100% for B&H and National respectively, as these figures have been rounded up from 10.5% in B&H and 10.6% nationally.

4EIII: Patient suggestions for what looks good in a GP surgery

Personalised care, putting the patient at the centre of healthcare and responding to individual needs, is widely recognised as important to all healthcare settings. GP surgeries need to be accessible, friendly, caring and flexible.

We wanted to help practices and commissioners deliver on these aims, by providing insight into what patients felt was most important in the provision of a good GP service. We therefore asked patients to list up to three things which they felt made a good GP practice.

The question was open ended and allowed patients to write their own answer. We received 2,338 suggestions from the total number of patients who responded to this question. We grouped responses into common themes and identified that 12 of the most popular categories were the same as we found in 2018, with one new popular category for 2019: time keeping (both for booking appointments and on the day of an appointment). In some of the cases one comment related to more than one theme. Therefore, the total percentage of comments add up to more than 100% in the chart below.

Five of the most popular categories were related to care (quality, listening, staff continuity, time and caring) and accounted for 36% of comments received. Five categories related to appointments (availability, ease of booking, same day appointments, opening times and new for 2019, time keeping) and included 34% of all comments. Three categories related to staff (receptionists, friendliness and quality) and accounted for 24% of all comments (Figure 33).

The three most common categories in 2019, were the same as we reported in 2018. These were appointment availability (19%, 446), good/caring doctors and nurses (12%, 283) and staff who listen (10%, 226), showing these considerations are still very important to patients.

Figure 33 Patients' views on what makes a good practice

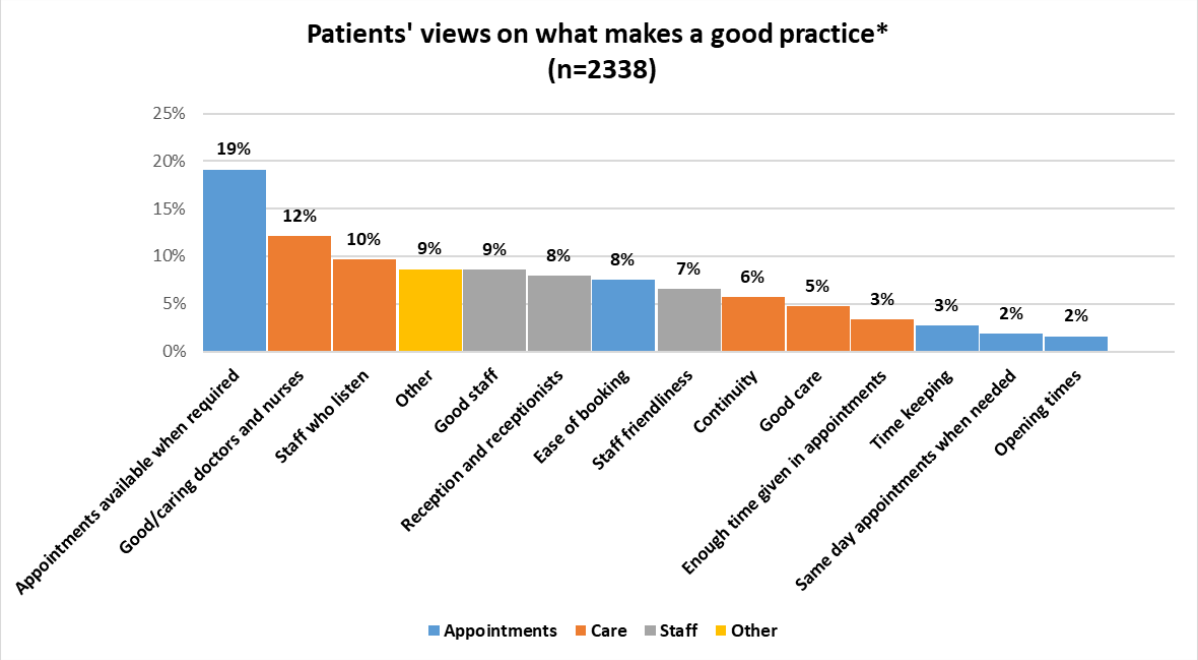


*Chart shows the 13 most popular categories, totalling 94% of all comments plus 'Other' which represents an additional 9%. Some comments related to more than one theme. Therefore, the total percentage of comments add up to more than 100% in the chart above.

Appointment availability (19%, 446 patients)
Patients suggested alternatives such as telephone consultations should be offered to avoid patients waiting too long for an appointment. GP practices should take into consideration patients that work in order to ensure suitable availability of appointments outside of the main working day. Patients also requested that they should be able to make an appointment within a few days, rather than waiting 'up to a week'.

Good/caring doctors and nurses (12%, 283 patients)
Caring doctors with 'empathetic skills' that treat a patient 'holistically' considering all symptoms rather than treating each symptom individually was felt important. Patients asked for medical staff to treat them seriously, with consideration and provide clear information.

Getting an appointment without the long phone waits, constantly engaged.

Good communication with you and with external services.

Proactivity and knowledge of all the options for care.

Building rapport with patients.

Understanding your medical history and taking the time to read your records before the appointment.

Patients' suggestions for a good GP practice

Staff who listen (10%, 226 patients)
Linked to caring and empathy, this was another common category about listening to the patient. Patients asked for staff to take them seriously, listen to the whole situation and give time to understand the patient's point of view.

Good staff (9%, 200 patients)
Within this category, 60 patients (21%) suggested that medical staff needed more experience and/or knowledge. Several patients mentioned knowledge of a particular need (e.g. mental health, diversity awareness, bereavement) was necessary to understand the patient's condition and therefore provide proper treatment.

Reception and receptionists (8%, 185 patients)
Patients asked for a clean and welcoming environment in the reception, and with helpful information on the walls such as 'photos of all the medical staff'. A number of patients talked about having reception staff who listened and were empathetic, and the availability of a separate area for patients to talk to reception staff privately.

Ease of booking (8%, 176 patients)
It was important for patients to be able to get through on the telephone quickly and easily. Patients also suggested better online services. However, patients were divided about the times of when an appointment could be booked. Some patients said that booking same day appointments made sense, while others requested 'no silly times to book for an appointment'.

Other themes
It was important to patients (7%, 153 patients) to receive a welcoming smile from both reception staff and medical staff, with politeness and a willingness to help. Many patients (6%, 134 patients) wanted consistency in the service, even if they were not seeing the same doctor. Patients who asked for good care (5%, 110 patients) wanted (better) feedback on results, following through after treatment, suggestions for non-medical treatments rather than an over-reliance on medication, as well as the more obvious suggestions for correct diagnosis and appropriate medicine.

Understanding your medical history and taking the time to read your records before the appointment.

Doctors who engage the patient in the diagnosis.

Medical staff who speak to my carer.

Offering home visits would be helpful as I am fully disabled.

Prompt referrals when necessary [and] chasing delays with referrals.

Offering self-care strategies and counselling.

Patients' suggestions for a good GP practice

Time-related themes

Many of the patients comments related to time in one way or another. More flexible and varied opening times were mentioned by 37 patients (2%) while another 3% (64 patients) requested better time keeping once appointments had been booked. Forty-three patients (2%) requested more availability of same day appointments particularly when the need was urgent. Patients also asked for more or enough time in the appointment. This is related to several of the previous themes, including 'staff who listen' and 'caring staff'. Seventy-eight patients (3%) spoke about more time to allow doctors and nurses to listen to all of the complaint, not just treat one symptom, having time to be empathetic and not make the patient feel rushed. Time was also linked to the ability for medical staff to make a correct diagnosis.

Recommendations for General Practice

- **Increase promotion and availability of cost-effective alternatives to face-to-face consultations, such as telephone or online consultations. When promoting, focus on the benefits to patients of using these services.**
- **All practices should offer additional opening times at weekends or one weekday evening and/or offering 'extended access' through a PCN hub or existing services (for example, IC24).**
- **Allow time in appointments for GPs to understand the full issue, including different conditions that may link to one another and to listen fully to the patient (a holistic approach).**
- **Where possible, ensure patients have access to more GPs that specialise in their condition, particularly where it is long-term for example mental health issues.**
- **Consider a separate area for patients to speak confidentially to reception staff.**
- **Ensure online bookings are supported by an efficient and customer friendly system.**

4EIV: Patient comments about the NHS primary care service

Healthwatch wanted to gauge patient opinion about NHS primary care services as an extension of the service they receive from the GP surgery. The question was open-ended, allowing patients to respond freely. A small number of patients (68, 7% of all respondents) offered comments on the NHS primary care service. Therefore, the findings here should be treated with some caution.

We grouped the comments into themes and identified the three most popular categories.

Funding
Almost one half of the comments (32, 47%) were concerned about funding. Patients commented that staff capacity and quality of care was at risk due to lack of funds. Many patients commented on the NHS being an excellent service that was deteriorating due to lack of funds. Some patients even commented that this risked the health of healthcare professionals themselves.

They are very overstretched and need more resources invested from Government to be able to care for people adequately.

More funds should flow from secondary to primary care.

If you want quality staff you need to pay for them

Unrealistic cuts are taking their toll on patients, quality of care, …the healthcare professionals themselves.

Patients' comments on the NHS Primary Care Service

Referrals
Eleven of the comments were about slow waiting times for referrals. This was often linked to comments about lack of funding for the service. In addition, three other patients mentioned the lack of communication between GPs and other services. Two other patients mentioned that routine tests were not as available as they should be.

Bad Service
Three patients were unhappy with the lack of availability for mental health support. One patient had a bad experience with the ambulance service and another felt the information on the NHS website was misleading. One patient found the outpatient service 'impossible' to navigate.

Commissioners to note the concerns of patients in respect of funding Primary Care.

4F: Prevention, referrals and out of hours services

4FI: Preventive GP services

Patients were asked if they were aware of a range of special services provided by GP practices, including screening, health checks and services to help quit smoking.[66] Where possible, the survey looked at awareness within the most appropriate target group for this preventive service.[67]

There was strong awareness for the following preventative services.

- Cervical cancer screening (96%, 360) for the target group of women aged between 25-64 years old.
- Breast cancer screening (90%, 277) for the target group of women aged 45-74 years old.
- Diabetic eye screening (100%, 17) for patients with diabetes.[68]

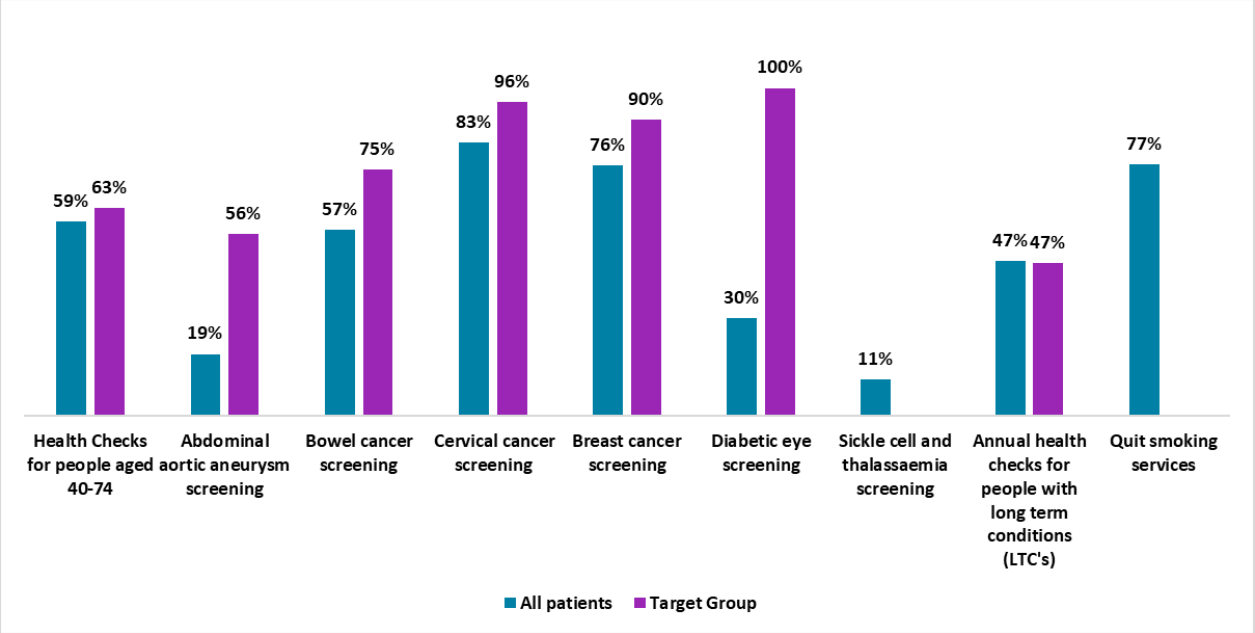
However, there was lack of awareness for the following preventative services.

- Health Checks for people aged 40-74: **over one third** of the target group of patients aged 45-74 years old were unaware of this.
- Abdominal aortic aneurysm screening: **almost a one half of** the target group of patients aged 65-74 years old were unaware of this screening.
- Bowel cancer screening: **one quarter of the** target group of patients aged 55+ years old were unaware of this screening.
- Annual health checks for people with long-term health conditions: over one half of patients who defined themselves as having a long-term health condition, were unaware of this check.[69]

Where we were unable to define a specific target group, we looked at awareness for all respondents (who had not self-selected the option 'not applicable).[70] The majority of respondents (77%, 371) were aware of the service to help quit smoking. There was a lack of awareness of sickle cell and thalassaemia screening, where the majority of respondents (89%, 480) were unaware of this service (Figure 34).

[66] Patients were given the option to select 'not applicable' where they felt the service did not apply to them.
[67] Target groups were defined by the demographic data collected as part of the survey and therefore may not have been an exact match.
[68] This target group was defined by patients who responded to the online survey only in which we asked about long-term health conditions. This question was not asked in the visit survey.
[69] This target group was defined by patients who responded to the online survey only in which we asked about long-term health conditions. This question was not asked in the visit survey.
[70] Patients were given the option to select 'not applicable' where they felt the service did not apply to them.

Figure 34 Percentage of patients who were aware of special preventative services.



Recommendation

- For General Practice: Raise awareness of preventative services, particularly targeting patients who are most likely to need these services.
  - Target patients aged 40-74 with information about annual health checks;
  - Target patients aged 65-75 with information about abdominal aortic aneurysm screening;
  - Target patients aged 50-74 with information about bowel cancer screening.
  - Target patients with long-term health conditions with information about annual health checks for these conditions.

4FII: Referrals to specialist treatment

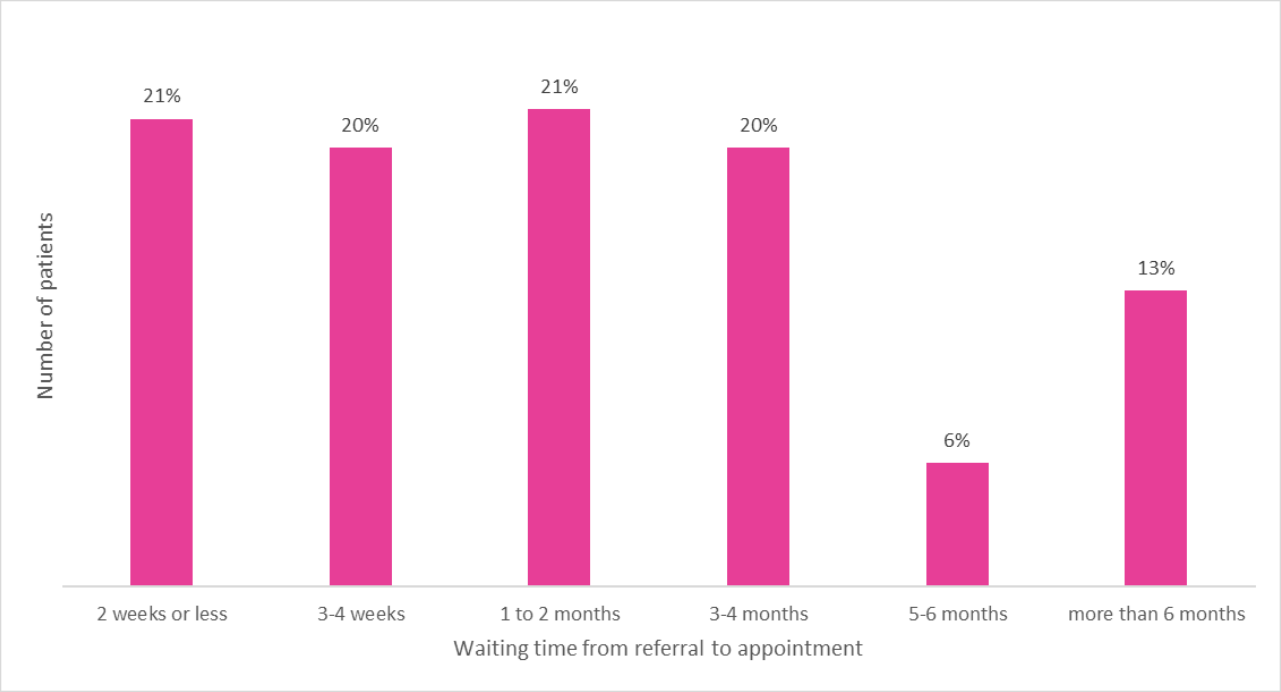
Patients can be referred by their GP for a specialist opinion or for diagnostic tests in the hospital or in a clinic. Although not part of GP care, the waiting experience of patients who need a referral or diagnostic test is an important component of their overall care. The NHS Constitution specifies that patients have a right to a maximum 18 week (126 days) waiting time from referral to consultant-led treatment[71]. Patients who have been referred for suspected cancer should be seen within a maximum waiting time of two weeks.[72]

More than one half the patients surveyed (61%, 243)[73] had been referred by their GP in the last year. Wait times between referral and the specialist or diagnostic appointment varied widely with a fifth being seen in two weeks or less while 13% waited more than six months. Patients were split on satisfaction with the waiting times between referral and appointment and satisfaction declined the longer patients had to wait.

Waiting time from referral to appointment date

The average waiting time for all those referred, was ten weeks, within the 18-week NHS maximum. This is the same finding as in our 2018 report. Individual waiting times varied, with 21% (49 patients) being seen within two weeks, while at another 13% (31 patients) waited more than six months (Figure 35).

Figure 35 Waiting time from referral to a specialist or for tests (n=235).



Please note chart shows more than 100% due to rounding up figures.

Waiting times were significantly different depending on which speciality the patient was referred to. This is the same finding as in our earlier report in 2018.

[71] NHS Constitution
[72] Read the Guide to NHS waiting times in England for more details.
[73] This question was only asked in the online survey, a total of 405 patients.

Patients waited on average, longer for Gynaecology (12 weeks), Orthopaedics (13 weeks) and ENT at the longest with 16 weeks. For those patients referred to dermatology (five weeks) or Ophthalmology (eight weeks) waiting times were considerably less. Interestingly, patients waiting for five specialities have experienced decreased waiting times on average since we reported in 2018, while patients waiting for another four specialities are waiting longer times than patients in our earlier report. This mixture of waiting times, demonstrates that patients receive a different service depending on the speciality they are being referred to.

The nine specialties in the table below accounted for 92% of the referrals reported by patients in our survey (Figure 36). Green highlight indicates that waiting times have decreased since our last report; red highlight indicates that waiting times have increased.

Figure 36 Referral waiting times per speciality and comparison with our 2018 report

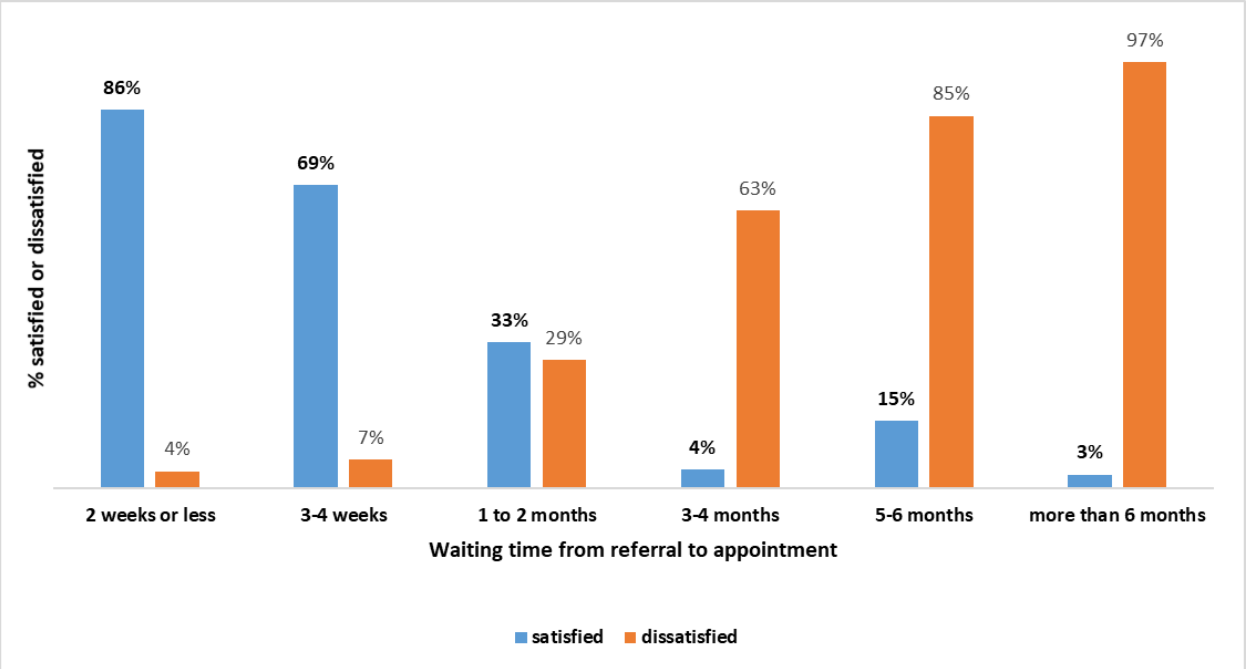
	2019		2018	
Speciality	Number of referrals reported	Mean waiting time (days)	Number of referrals reported	Mean waiting time (days)
Dermatology	5	32	15	67
Ophthalmology	8	56	18	74
Physiotherapy	23	67	24	92
Diagnostics*	45	69	28	33
Cardiac	17	71	19	102
Gastronintestinal	31	81	27	90
Gynaecology	12	86	17	40
Orthopaedics	19	91	36	62
ENT	17	111	24	67

**Diagnostics is not a specialty but includes referrals where the patient was referred for a diagnostic test (e.g. X-ray, Ultrasound, blood test or CT scan).*

Satisfaction with waiting time for specialist treatment

Patients were almost completely divided over satisfaction with waiting times. 40% (95 patients) were 'satisfied' and 38% (90 patients) were 'unsatisfied'. The remainder were 'OK' with waiting times. Unsurprisingly satisfaction levels were clearly related to the wait time experienced: 63% (90 patients) of those who had waited less than three months were 'satisfied' with the wait while 78% (70 patients) of those who had waited three months or more were 'unsatisfied' (Figure 37).

Figure 37 Satisfaction and dissatisfaction rates by waiting time for referral appointment.



Reported impact on health

Almost 40% (90) patients who had been referred felt the waiting time had a negative impact on their health. This rose to 69% in patients who were waiting three months or more. Both of these figures are higher than when we reported in 2018, where one third of patients felt their health had been impacted.

Patients' comments about impact on health

My health was not impacted because…

… [I] paid to go privately as it was over the Christmas period.

…cataracts are annoying but not life threatening.

My health was impacted negatively because…

…[I'm] in a lot of chronic pain and in need of surgery.

…it was mentally stressful, having lost my mother from a similar condition.

Keeping patients informed

Patients were asked if they were kept up to date with any changes to the hospital appointment. Almost one half (48%, 93) said they were kept fully up to date and a further one third (29%, 57) said they were communicated with 'to some extent'. However, a quarter of patients (23%, 45) were not communicated with at all. Two-thirds (76%, 34) of the patients who were not communicated with, had a wait of three months or more for their appointment.

Recommendations for Brighton and Sussex University Hospitals NHS Trust

- **Reduce waiting times from GP referral to appointment for specialist treatment.**
- **Where possible, work with other secondary care providers to keep patients informed of any changes to waiting times for specialists.**

4FIII: Out of hours primary care services

When patients are unable to get help through their doctor's surgery, they may turn to other services, such as A&E, NHS 111 or a local pharmacy. Healthwatch asked patients whether they had sought other services in the last year and if so, whether they were satisfied that these other services had met their needs as a patient. A quarter of patients (27%, 258) had sought medical help through an alternative service. Due to this small number of respondents, the following findings should be treated with a degree of caution.

We asked these patients to list all of the services they had used (i.e. some patients listed more than one service). The most likely service to be sought remains the NHS 111 service (51%, 132 patients), followed by a pharmacy (42%, 107 patients) and A&E (40%, 104 patients). (Figure 38). These are similar findings to those we reported in our 2018 report.

It's too difficult when you are in so much pain.

[I] didn't feel able to.

Anxiety, mental health issues and existing stress.

Patients' reasons for not seeking an alternative to the GP

Of those that chose not to seek a service, anxiety, pain, and inability to do so were some of the reasons given.

Where patients had sought help, satisfaction with each service varied (Figure 38). From the lowest at 44% (14) for using the NHS Choices website, to the highest at 72% (74 patients) for seeking medical help through a pharmacy.

The Alex is amazing, and we are lucky to have it!

I use the pharmacy instead of doctor frequently. Don't want to waste NHS time unnecessarily.

Out of hours access is easier to use than going to the GP surgery.

NHS choices and 111 basically lead you to being sent back to GP or onto A+E, so effectively pointless stalling services.

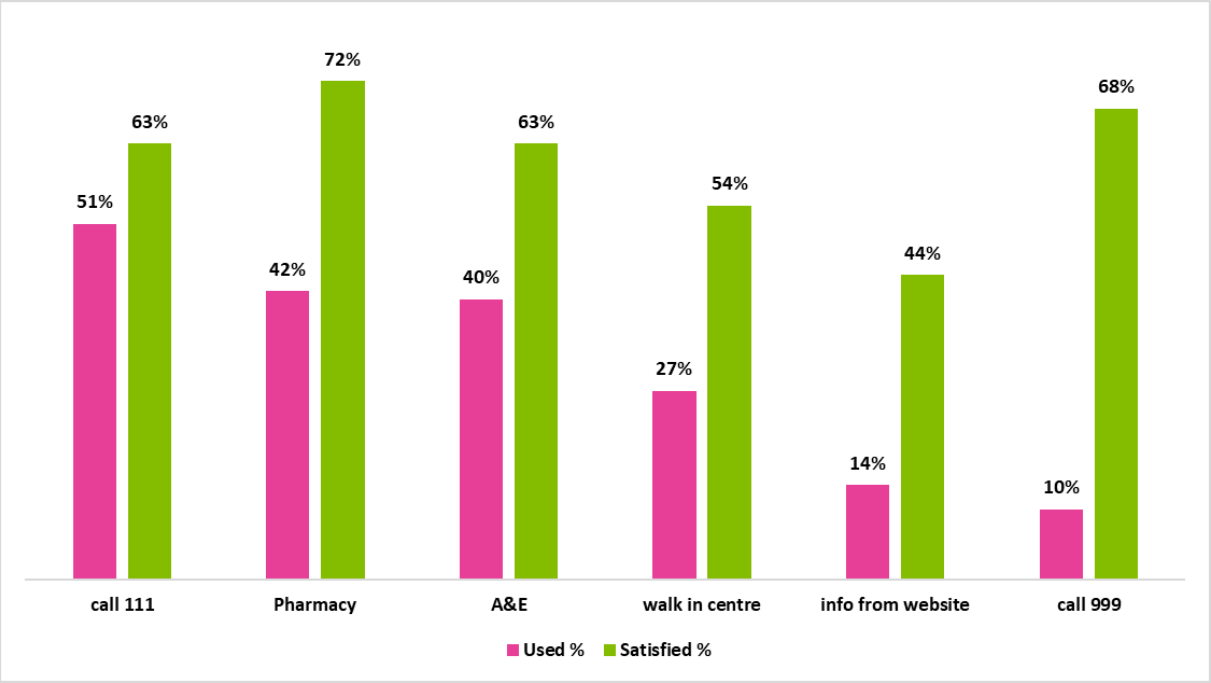
[I was told by] Brighton walk-in centre 'sorry, not enough staff today'.

Patients' comments on the out of hours service

Patient satisfaction with the help they received from a pharmacy has increased greatly since we reported in 2018, when it was 54%. In our earlier report, we noted the importance of the pharmacy service. The NHS has made efforts to publicise the use of pharmacies in this way and it is good to see that the service is increasingly satisfactory to patients. Information from NHS Choices website continues to be the least satisfactory service (in 2018, it was also one of the lowest at 17%), and although satisfaction has

improved since our earlier report, this indicates that there are still improvements that could be made.

Figure 38 Services used when unable to get a GP appointment and patient satisfaction



Comparison with the 2019 National Survey

The National Survey also asked patients if they had contacted another NHS service to see a GP when their surgery was closed. The national and local surveys were similar, with about a quarter of each set of patients, taking this option (Figure 39).

Figure 39 National Survey comparison: Seeking alternative services when GP is unavailable.

B & H		National	
Have you wanted or needed to get medical help after being unable to get a doctor's appointment in the last year?[a]		In the past 12 months, have you contacted an NHS service when you wanted to see a GP but your GP practice was closed?	
		Yes, for myself (13.4%)	
Yes	27%	Yes, for someone else (9.3%)	23%
No	73%	No	78%
	100%		101%

*Multiple responses were allowed in the national survey which is why the total adds up to more than 100%

[a] 'wanted or needed' in B&H is comparable to 'contacted' in National.

Both nationally and locally, patients were asked about where they went to seek further help and both surveys gave options to choose from. While some of these options differed between the two surveys, both asked patients if they sought help from either a pharmacy or A&E and therefore, we can compare results on these two criterion. However, the national survey asked about one occasion while Healthwatch asked about any occasion over the same twelve-month period. While around 40% of Brighton and Hove patients sought help from these two services, only a small minority did so nationally (Figure 40).

Figure 40 National Survey comparison: Which alternative service did you use?

	B&H	National
	Sought help from service	
Pharmacy	42%	3%
A&E	40%	8%

Recommendation for the Brighton and Hove Clinical Commissioning Group

- **Continue to promote the use of pharmacies as a first point of contact for minor complaints.**

5. Appendices

5A: Survey Questions Asked

Two forms of survey were used for the GP review, online and a paper copy handed to patients in GP waiting rooms. In total, we received 998 responses to our survey (405 online responses and 593 responses in person).

The tables below show each question asked in the online survey. Approximately two-thirds of these questions were also asked in the paper copy. Where they were only asked in the online survey, the total answered will indicate a smaller sample size.

How long does it take to get to the surgery from your home?	N	%
5 minutes or less	228	23%
5-10 minutes	333	33%
10-15 minutes	240	24%
15-30 minutes	141	14%
30-45 minutes	47	5%
45-60 minutes	5	1%
more than 60 minutes	2	0%
Total answered	996	100%
Not Answered	2	

How do you normally get to the surgery?	N	%
Walk	196	49%
Car	143	35%
Cycle	8	2%
Bus	47	12%
Taxi	6	1%
Mobility scooter/wheelchair	2	0%
Other	1	0%
Total answered	403	100%
Not Answered	2	

How convenient is this surgery for you?	N	%
Very Convenient	523	53%
Convenient	326	33%
Neither Inconvenient Nor Convenient	92	9%
Inconvenient	33	3%
Very Inconvenient	12	1%
Total answered	986	100%
Surgery is convenient for the respondent		**86%**
Not answered	12	

Book an appointment in person	N	%	Of those who used the service	N	%
Very Easy	270	29%	**Very Easy**	270	37%
Easy	305	33%	**Easy**	305	42%
Difficult	93	10%	**Difficult**	93	13%
Very Difficult	54	6%	**Very Difficult**	54	7%
Not Used Service	208	22%			
Total answered	930	100%	**Total service users**	722	
Not answered	68		***% who use service and found it easy or v easy***		***80%***

Book an appointment by phone	N	%	Of those who used the service	N	%
Very Easy	274	29%	**Very Easy**	274	30%
Easy	347	36%	**Easy**	347	38%
Difficult	205	21%	**Difficult**	205	22%
Very Difficult	88	9%	**Very Difficult**	88	10%
Not Used Service	46	5%			
Total answered	960	100%	**Total service users**	914	
Not answered	38		***% who use service and found it easy or v easy***		***68%***

Book an appointment online	N	%	Of those who used the service	N	%
Very Easy	146	16%	**Very Easy**	146	43%
Easy	93	10%	**Easy**	93	27%
Difficult	57	6%	**Difficult**	57	17%
Very Difficult	47	5%	**Very Difficult**	47	14%
Not Used Service	573	63%			
Total answered	916	100%	**Total service users**	343	
Not answered	82		***% who use service and found it easy or v easy***		***70%***

Order repeat prescriptions online	N	%	Of those who used the service	N	%
Very Easy	229	25%	**Very Easy**	229	61%
Easy	97	11%	**Easy**	97	26%
Difficult	27	3%	**Difficult**	27	7%
Very Difficult	20	2%	**Very Difficult**	20	5%
Not Used Service	547	59%			
Total answered	920	100%	**Total service users**	373	
Not answered	78		***% who use service and found it easy or v easy***		***87%***

Get test results	N	%	Of those who used the service	N	%
Very Easy	265	29%	**Very Easy**	265	36%
Easy	365	39%	**Easy**	365	50%
Difficult	71	8%	**Difficult**	71	10%
Very Difficult	27	3%	**Very Difficult**	27	4%
Not Used Service	199	21%			
Total answered	927	100%	**Total service users**	728	
Not answered	71		***% who use service and found it easy or v easy***		***87%***

			ONLINE ONLY: If yes, did the consultation meet your needs?						
Have you received any of these types of consultation?	Yes	Used	Fully	Partially	Not at all	Totals	Fully	Partially	Not at all
Telephone consultation	288	29%	211	64	9	284	74%	23%	3%
Email consultation	11	1%	7	3	1	11	64%	27%	9%
Video consultation	0						-	-	-
Online chat	1		0	0	0	0	-	-	-
None of the above	112								

Days wait from book to attend: Routine GP appointment	N	%
Same day	169	19%
2-3 days	267	30%
4-7 days	225	25%
8-14 days	156	17%
15-21 days	38	4%
22-28 days	25	3%
More than 28 days	18	2%
Total answered	898	100%
Mean wait time: Routine GP appointment	**6.3**	**days**
Not Used	62	
Not answered	38	
Overall % satisfied or very satisfied with wait for routine GP appointment		**58%**

Days wait from book to attend: Urgent GP appointment	N	%
Same day	625	85%
2-3 days	68	9%
4-7 days	16	2%
8-14 days	11	2%
15-21 days	3	0%
22-28 days	2	0%
More than 28 days	6	1%
Total answered	731	100%
Mean wait time : Urgent GP appointment	**1.8**	**days**
Not used	194	
Not answered	73	
Overall % satisfied or very satisfied with wait for urgent GP appointment		**73%**

Days wait from book to attend: Routine Nurse appointment	N	%
Same day	58	8%
2-3 days	222	30%
4-7 days	279	38%
8-14 days	127	17%
15-21 days	30	4%
22-28 days	13	2%
More than 28 days	10	1%
Total answered	739	100%
Mean wait time: Routine Nurse appointment	**6.4**	**days**
Not Used	187	
Not answered	72	
Overall % satisfied or very satisfied with wait for routine nurse appointment		**64%**

Days wait from book to attend: Urgent Nurse appointment	N	%
Same day	244	67%
2-3 days	86	24%
4-7 days	20	5%
8-14 days	7	2%
15-21 days	2	1%
22-28 days	0	0%
More than 28 days	5	1%
Total answered	364	100%
Mean wait time: Urgent Nurse appointment	**2.3**	**days**
Not used	514	
Not answered	120	
Overall % satisfied or very satisfied with wait for urgent Nurse appointment		**69%**

Timeliness of Doctor appointment	N	%
on time	162	17%
5 - 10 minutes late	414	43%
10 - 20 minutes late	266	28%
20 - 45 minutes late	103	11%
more than 45 minutes late	10	1%
Total Answered	955	100%
Not answered	43	

Timeliness of Nurse appointment	N	%
on time	341	44%
5 - 10 minutes late	316	41%
10 - 20 minutes late	95	12%
20 - 45 minutes late	13	2%
more than 45 minutes late	4	1%
Total Answered	769	100%
Not answered	229	

Can you choose to see a specific doctor?	N	%
Yes	620	65%
No	329	35%
Total answered	949	100%
Not answered	49	

How important is choosing a doctor?	N	%
Very Important	340	35%
Quite Important	354	37%
Not Important	188	19%
Not at all Important	86	9%
Total answered	968	100%
% who say choosing a doctor is quite or very important		**72%**
Not Answered	30	

Of those who said it was Quite Important or Very Important to be able to choose which doctor they saw, how many said they were in fact able to choose:		
Can you choose to see a specific doctor?	N	%
Yes	489	71%
No	196	29%
Total answered	685	100%
Not answered	9	

	Good or Very Good	**% Good or very good**	Total answers (excl Not Applicable)	Not Applicable	Not answered
Quality of GP Care: Giving you enough time	818	**86%**	954	7	37
Quality of GP Care: Listening to you	865	**90%**	961	5	32
Quality of GP Care: Explaining tests and treatments	798	**88%**	902	54	42
Quality of GP Care: Involving you in decisions about your care	763	**86%**	889	67	42
Quality of GP Care: Treating you with care and concern	851	**90%**	947	13	38
Quality of GP Care: Having access to relevant medical information about you	809	**88%**	917	39	42
Quality of GP Care: Addressing your needs or making plans to do so	788	**86%**	917	31	50
Overall Score	5692	**88%**	6487		

	Good or Very Good	% Good or very good	Total answers (excl Not Applicable)	Not Applicable	Not answered
Quality of NURSE Care: Giving you enough time	753	92%	815	102	81
Quality of NURSE Care: Listening to you	758	94%	810	109	79
Quality of NURSE Care: Explaining tests and treatments	714	92%	773	137	88
Quality of NURSE Care: Involving you in decisions about your care	640	89%	717	190	91
Quality of NURSE Care: Treating you with care and concern	763	94%	811	103	84
Quality of NURSE Care: Having access to relevant medical information about you	680	88%	773	136	89
Quality of NURSE Care: Addressing your needs or making plans to do so	639	88%	724	175	99
	4947	91%	5423		

Quality of GP Care: Giving you enough time	N	%
Very Good	495	52%
Good	323	34%
Neither Good nor Poor	86	9%
Poor	35	4%
Very Poor	15	2%
Total Answered	954	100%
% Good or Very Good		**86%**
Not applicable	7	
Not answered	37	

Awareness of: Health Checks for people aged 40-74			Target group	
	All		45-74	
	N	%	N	%
Aware	434	59%	318	63%
Unaware	297	41%	184	37%
Total (excluding not applicable responses)	731	100%	502	100%
Response: Not Applicable	207		14	
Not answered	60		14	
NB: Demographic data categories collected did not correspond exactly to target age group				

Awareness of: Abdominal aortic aneurysm screening			Target group	
	All		Men 65-74	
	N	%	N	%
Aware	136	19%	35	56%
Unaware	585	81%	28	44%
Total (excluding not applicable responses)	721	99%	63	100%
Response: Not Applicable	208		0	
Not answered	69		3	
NB: Demographic data categories collected did not correspond exactly to target age group				

Awareness of: Bowel cancer screening			Target group	
	All		55&+	
	N	%	N	%
Aware	453	57%	321	75%
Unaware	344	43%	107	25%
Total (excluding not applicable responses)	797	100%	428	100%
Response: Not Applicable	131		22	
Not answered	70		26	
NB: Demographic data categories collected did not correspond exactly to target age group				

			Target group	
Awareness of: Cervical cancer screening	All		Women 25-64	
	N	%	N	%
Aware	542	83%	360	96%
Unaware	108	17%	16	4%
Total (excluding not applicable responses)	650	100%	376	100%
Response: Not Applicable	270		17	
Not answered	78		8	
NB: Demographic data categories collected did not correspond exactly to target age group				

			Target group	
Awareness of: Breast cancer screening	All		Women 45-74	
	N	%	N	%
Aware	495	76%	277	90%
Unaware	153	24%	30	10%
Total (excluding not applicable responses)	648	100%	307	100%
Response: Not Applicable	275		12	
Not answered	75		7	
NB: Demographic data categories collected did not correspond exactly to target age group				

			Target group	
Awareness of: Diabetic eye screening			Patients with Diabetes*	
	N	%	N	%
Aware	191	30%	17	100%
Unaware	449	70%	0	0%
Total (excluding not applicable responses)	640	100%	17	100%
Response: Not Applicable	276		0	
Not answered	82		1	
			* online questionnaire only	

			Target group	
Awareness of: Diabetic eye screening			Patients with Diabetes*	
	N	%	N	%
Aware	191	30%	17	100%
Unaware	449	70%	0	0%
Total (excluding not applicable responses)	640	100%	17	100%
Response: Not Applicable	276		0	
Not answered	82		1	
			* online questionnaire only	

Awareness of: Sickle cell and thalassaemia screening		
	N	%
Aware	60	11%
Unaware	480	89%
Total (excluding not applicable responses)	540	100%
Response: Not Applicable	373	
Not answered	85	

Awareness of: Annual health checks for people with long term conditions (LTC's)				
			Target group	
			Patients with LTC's*	
	N	%	N	%
Aware	324	47%	81	47%
Unaware	364	53%	93	53%
Total (excluding not applicable responses)	688	100%	174	100%
Response: Not Applicable	237		13	
Not answered	73		13	
			* online questionnaire only	

Awareness of: Quit smoking services		
	N	%
Aware	371	77%
Unaware	112	23%
Total (excluding not applicable responses)	483	100%
Response: Not Applicable	425	
Not answered	90	

Have you had to receive care in a new location due to GP practice changes e.g. closure	
	N
Yes	26

For those who had had to go to a new location how convenient was it?	N	%
Very Convenient	5	19%
Convenient	5	19%
OK	7	27%
Inconvenient	3	12%
Very Inconvenient	6	23%
Total	26	100%

And how was the service at the new location?	N	%
Much Better	3	13%
Better	4	17%
Neither Worse Nor Better	9	38%
Worse	4	17%
Much Worse	4	17%
Total	24	100%
Not answered	2	

Satisfaction with GP opening hours	N	%
Very Satisfied	268	28%
Satisfied	439	46%
Neither Dissatisfied nor Satisfied	148	15%
Dissatisfied	79	8%
Very Dissatisfied	24	3%
Total answered	958	100%
% Satisfied or Very Satisfied with GP opening hours		**74%**
Not answered	40	

Have you used the 'extended hours' service getting you an appointment at a local surgery when your surgery is normally closed?		N	%
	Yes	77	20%
	No	306	80%
	Total answered	383	100%
	Not answered or Answered "Don't Know"	22	

Satisfaction with extended hours service of those who used it		N	%
	Very Satisfied	27	36%
	Satisfied	26	35%
	Neither Dissatisfied nor Satisified	10	14%
	Dissatisfied	7	9%
	Very Dissatisfied	4	5%
	Total Answered	74	100%
	Not Answered	3	

Additional opening times:	N	%
Number who expressed a preference for additional opening times	711	71%
No preference expressed	287	29%

Preferred additional opening times:	N	%
Saturday am	448	63%
After 6.30pm weekdays	341	48%
Saturday pm	269	38%
Sunday	187	26%
before 8am weekdays	169	24%
Lunchtime weekdays	153	22%
Other	74	10%
Total number who expressed a preference for addtitional opening times	711	

Were you given a prescription at your last GP consultation?		
	N	%
Yes	643	67%
No	311	33%
Total answered	954	100%
Not answered	44	

Of those given a prescription..		
What type of pharmacy provided the prescribed medication?		
	N	%
pharmacy at GP surgery	156	24%
local pharmacy	480	75%
online pharmacy	4	1%
Total answered	640	100%
Not answered	3	

Of those given a prescription..		
How soon after seeing a GP did you get y	N	%
Same day	491	77%
Next day	72	11%
2 days	40	6%
3 days	21	3%
4 days	7	1%
5 days	3	0%
More than 5 days	5	1%
Total answered	639	100%
Not answered	4	

Of those given a prescription..		
Did time taken to get medication cause health problems?		
	N	%
Yes	25	4%
No	603	96%
Total answered	628	100%
Not answered	15	

Of those who said the wait to get medication caused them health problems how long had they waited?	N	%
Same day	12	48%
Next day	3	12%
2 days	2	8%
3 days	2	8%
4 days	1	4%
5 days	2	8%
More than 5 days	3	12%
Total	25	100%

Have you raised an emotional or psychological issue at a GP/nurse	N	%
Yes	144	36%
No	256	64%
Total answered	400	100%
Not answered	5	

Of those who said they had raised an emotional or psychological issue:			
Please assess how the GP/nurse responded to the issue by giving you enough time:			
		N	%
	Very Good	79	55%
	Good	32	22%
	Neither Good nor Poor	16	11%
	Poor	8	6%
	Very Poor	8	6%
	Total answered	143	100%
% who felt GP/nurse was good or very good at giving them enough time			**78%**
	Not answered	1	

Please assess how the GP/nurse responded to the issue by listening to you:			
		N	%
	Very Good	80	56%
	Good	38	27%
	Neither Good nor Poor	9	6%
	Poor	9	6%
	Very Poor	6	4%
	Total answered	142	100%
% who felt GP/nurse was good or very good at listening to them			**83%**
	Not answered	2	

Please assess how the GP/nurse responded to the issue by showing empathy:			
		N	%
	Very Good	79	56%
	Good	35	25%
	Neither Good nor Poor	11	8%
	Poor	9	6%
	Very Poor	8	6%
	Total answered	142	100%
% who felt GP/nurse was good or very good at showing them empathy			**80%**
	Not answered	0	

Please assess how the GP/nurse responded to the issue by treating you with care and concern:			
		N	%
	Very Good	79	57%
	Good	31	22%
	Neither Good nor Poor	11	8%
	Poor	13	9%
	Very Poor	5	4%
	Total answered	139	100%
% who felt GP/nurse was good or very good at treating them with care and concern			**79%**
	Not answered	0	

Which of the following actions did the GP/nurse take? (select all that apply)		
	N	%
Medication prescription	68	**50%**
Referral to NHS service	67	49%
Advice on how to deal with issue yourself	70	**51%**
Information about community groups/activities	32	23%
Community Navigators/Social prescribers	5	4%
Other	14	10%
Total answered	137	
Not answered	7	

Which of the following actions did the GP/nurse take? (select all that apply)		
	N	%
Medication prescription	68	**50%**
Referral to NHS service	67	49%
Advice on how to deal with issue yourself	70	**51%**
Information about community groups/activities	32	23%
Community Navigators/Social prescribers	5	4%
Other	14	10%
Total answered	137	
Not answered	7	

Overall, how satisfied were you with how the GP/nurse responded to your mental health issue?		
	N	%
Very Satisfied	69	48%
Satisfied	41	29%
Neither Dissatisfied nor Satisified	17	12%
Dissatisfied	8	6%
Very Dissatisfied	8	6%
Total answered	143	100%
% who were satisfied with the overall response to their mental health issue		**77%**
Not answered	1	

What NHS service did you get a referral to?		
	N	%
Brighton and Hove Wellbeing Service	40	62%
Assessment and Treatment service (ATS)	6	9%
Crisis Support - Mental Health Rapid Response Service (MHRRS)	2	3%
Other	17	26%
Total answered	65	100%
Not answered	2	

How long did it take to receive treatment from the service (you were referred to			
		N	%
	one month or less	5	23%
	up to two months	2	9%
	three months	6	27%
	up to six months	8	36%
	longer	1	5%
		22	100%

What was the main service you received at the Brighton and Hove Wellbeing Service?			
		N	%
	Psychological Therapy (in-person)	20	59%
	Online therapy	2	6%
	Wellbeing group	2	6%
	Workshop	1	3%
	Other	8	24%
	None	1	3%
	Total Answered	34	100%
	Not answered	6	

How satisfied were you with the service you received?			
From those 40 who used the B&H Wellbeing Service		N	%
	Very Satisfied	11	31%
	Satisfied	10	28%
	Neither Dissatisfied nor Satisified	11	31%
	Dissatisfied	2	6%
	Very Dissatisfied	2	6%
	Total answered	36	100%
% who were satisfied with the Brighton and Hove Wellbeing Service			**58%**
	Not answered	4	

How well did the service you were referred to, meet your needs?			
		N	%
	Fully	16	30%
	Partially	31	58%
	Not at all	6	11%
	Total answered	53	100%
	Not answered	14	

Did the service you received help you manage or resolve the issue?			
		N	%
	Yes, helped resolve issue	5	9%
	Yes, helped improve issue	21	37%
	No, but issue now improved/resolved	14	25%
	No, issue remains same	16	28%
	No, issue now worse	1	2%
		57	100%
	Not answered	10	

Overall, how would you rate your GP practice on a 1-10 scale?		
Rating	N	%
1	8	1%
2	8	1%
3	16	2%
4	21	2%
5	56	6%
6	42	4%
7	102	11%
8	227	24%
9	174	18%
10	304	32%
Total Answered	**958**	100%
Mean rating	**8.2**	
Not answered	40	

Overall, how satisfied are you with your GP practice?		
	N	%
Very Satisfied	426	45%
Satisfied	368	39%
Neither Dissatisfied nor Satisified	99	10%
Dissatisfied	42	4%
Very Dissatisfied	13	1%
Total answered	948	100%
% who were satisfied with their GP service		**84%**
Not answered	50	

Would you recommend your GP practice?	N	%
Definitely	544	59%
Probably	273	30%
Probably NOT	76	8%
Definitely NOT	30	3%
Total Answered	**923**	100%
% probably or definitely recommend		**89%**
Not answered	75	

Have you wanted/needed medical help after being unable to get a GP appointment in the last year?	N	%
Yes	258	27%
No	684	73%
Total Answered	942	100%
Not answered	56	

Which of these services did you use when you were unable to get a GP appointment?	N	%
Pharmacy	107	42%
walk in centre e.g. Brighton station	70	27%
get information from NHS Choices website	35	14%
call 111	132	51%
call 999	26	10%
A&E	104	40%
Other	30	12%
None	8	3%
All who answered	257	
Not answered	1	

Please indicate how satisfied you were with the pharmacy service you used for urgent medical help.	N	%
Very Satisfied	34	33%
Satisfied	40	39%
OK	21	20%
Unsatisfied	7	7%
Very Unsatisfied	1	1%
Total answered	103	100%
% who were satisfied with the pharmacy service		**72%**
Not answered	4	

Please indicate how satisfied you were with the walk-in centre service you used for urgent medical help.	N	%
Very Satisfied	11	16%
Satisfied	26	38%
OK	15	22%
Unsatisfied	7	10%
Very Unsatisfied	10	14%
Total answered	69	100%
% who were satisfied with the walk-in centre service		**54%**
Not answered	1	

Please indicate how satisfied you were with the NHS choices website service you used for urgent medical help.	N	%
Very Satisfied	5	16%
Satisfied	9	28%
OK	11	34%
Unsatisfied	6	19%
Very Unsatisfied	1	3%
Total answered	32	100%
% who were satisfied with the NHS Choices website		**44%**
Not answered	3	

Please indicate how satisfied you were with the 111 service you used for urgent medical help.	N	%
Very Satisfied	42	34%
Satisfied	35	28%
OK	26	21%
Unsatisfied	16	13%
Very Unsatisfied	4	3%
Total answered	123	100%
% who were satisfied with the 111 service		**63%**
Not answered	9	

Please indicate how satisfied you were with the 999 service you used for urgent medical help.	N	%
Very Satisfied	11	44%
Satisfied	6	24%
OK	2	8%
Unsatisfied	4	16%
Very Unsatisfied	2	8%
Total answered	25	100%
% who were satisfied with the 999 service		**68%**
Not answered	1	

Please indicate how satisfied you were with the A&E service you used for urgent medical help.	N	%
Very Satisfied	32	32%
Satisfied	31	31%
OK	20	20%
Unsatisfied	15	15%
Very Unsatisfied	2	2%
Total answered	100	100%
% who were satisfied with the A&E service		**63%**
Not answered	4	

Have you been referred to a specialist or for tests at a hospital or clinic in the last year?	N	%
Yes	243	61%
No	157	39%
Total answered	400	100%
Not answered	5	

What was the time between date of referral and date of appointment at the hospital/clinic?	N	%
2 weeks or less	49	21%
3-4 weeks	46	20%
1 to 2 months	50	21%
3-4 months	46	20%
5-6 months	13	6%
more than 6 months	31	13%
Total answered	235	100%
% seen within two months		**62%**
Not answered	8	

How satisfied were you with this wait?		
	N	%
Very Satisfied	51	22%
Satisfied	44	19%
OK	52	22%
Unsatisfied	54	23%
Very Unsatisfied	36	15%
Total answered	237	100%
% who were satisfied with the wait for an appointment		**40%**
Not answered	6	

Did this wait have an impact on your health?		
	N	%
Yes	90	38%
No	146	62%
Total answered	236	100%
Not answered	7	

Were you kept up to date if you experienced any changes to the hospital appointment?		
	N	%
Yes, fully	93	48%
Yes, to some extent	57	29%
No, not at all	45	23%
Total answered	195	100%
Not fully informed of changes		52%
Not answered	48	

5B: Demographic questions

The following questions were asked of each patient who completed the GP Survey, either online or in paper form, unless stated otherwise.

Age Group	N	%
18-24	56	6%
25-34	105	11%
35-44	122	13%
45-54	185	20%
55-64	185	20%
65-74	160	17%
75-84	95	10%
85 or over	36	4%
Total answered	944	100%
Not answered	54	

Gender	N	%
Male	315	33%
Female	609	64%
Other	5	1%
Prefer not to say	17	2%
Total answered	946	100%
Not answered	52	

The following questions were only asked of those patients who completed the GP Survey online.

Do you identify as the sex you were assigned at birth?		
	N	%
Yes	373	96%
No	6	2%
Prefer not to say	10	3%
Total answered	389	100%
Not answered	16	

Ethnic origin	N	%
English/Welsh/Scottish/Northern Irish/British	841	90%
Bangladeshi	36	4%
African	7	1%
Asian & White	17	2%
Any other ethnic group	9	1%
Prefer not to say	27	3%
Total answered	937	100%

Sexual orientation		
	N	%
Heterosexual/Straight	302	80%
Lesbian/Gay woman	10	3%
Gay man	15	4%
Bisexual	9	2%
Other	8	2%
Prefer not to say	32	9%
Total answered	376	100%
Not answered	29	

Disability		
	N	%
Yes a lot	68	18%
Yes a little	85	22%
No	225	58%
Prefer not to say	9	2%
Total answered	387	100%
Not answered	18	

Day-to-day activities limited due to a health problem*	(Select all that apply)	
	N	%
Physical Impairment	97	64%
Sensory Impairment	12	8%
Learning Disability/Difficulty	3	2%
Long-standing illness	48	32%
Mental Health condition	43	28%
Autistic Spectrum	2	1%
Other	14	9%
People who answered this question and declared a health problem*	151	
**defined as having lasted or expected to last, at least 12 months*		

Do you have a long term health condition?		
	N	%
Yes	205	53%
No	183	47%
Total answered	388	100%
Not answered	17	

Please specify which long term condition you have		
	N	%
Atrial fibrillation	9	2%
Coronary heart disease	5	1%
Cardiovascular disease	9	2%
Hypertension	45	12%
Peripheral arterial disease	5	1%
Stroke and transient ischaemic attack	5	1%
Asthma	36	10%
Chronic obstructive pulmonary disease	9	2%
Obesity	17	4%
Cancer	8	2%
Chronic kidney disease	2	1%
Diabetes mellitus	18	5%
Palliative care	1	0%
Dementia	1	0%
Depression	37	10%
Epilepsy	4	1%
Learning disabilities	3	1%
Mental health	33	9%
Osteoporosis	15	4%
Rheumatoid arthritis	8	2%
Other	108	29%
Total answered	378	100%

5C: Table of Figures

5D: Glossary

- **The 2019 NHS Long Term Plan (LTP)** - provides a framework for improving NHS services over the next 10 years. Further reading: https://www.kingsfund.org.uk/publications/nhs-long-term-plan-explained).
- **Accident and Emergency (A&E) or the emergency department** – usually based in hospitals, provides emergency care 24 hours a day, seven days a week. A&Es treat conditions that need urgent assessment and treatment, for example choking, severe bleeding, chest pain and blacking out. Further reading: https://www.bsuh.nhs.uk/services/ae/.
- **Brighton and Hove Clinical Commissioning Group (CCG)** - is led by a group of local doctors and nurses and brings together all GP practices in the city. The CCG's role is to decide which health services are needed so that everyone has access to the services, professionals and treatment they need to stay well and live healthily. The CCG has a responsibility to consult with the people about what they need and want from health services in the city. Further reading: https://www.brightonandhoveccg.nhs.uk/publications/about-us.
- **General practices /GP surgeries** – An organisation of one or more GPs (general practitioners) who provide general medical services to a particular group ("list") of patients. In line with NHS convention, the term 'surgery', 'surgeries' and 'GP practice(s)' are used interchangeably throughout our report. Some of the reviewed sites are named 'surgeries' and others are 'practices'. There are 40 GP locations across Brighton and Hove. See this example on the NHS website: https://www.nhs.uk/using-the-nhs/nhs-services/gps/patient-choice-of-gp-practices/.
- **GP patient survey (NHS)** – the annual GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The survey is sent out to over two million people across the UK. The results show how people feel about their GP practice. Further reading: https://www.gp-patient.co.uk/.

- **GP Streaming (Primary Care Front Door)** - introduced in 2017, at the Royal Sussex County Hospital A&E from 8.00am to 11.00pm each day. This was a dedicated GP service and an alternative to seeing a hospital doctor. Further reading: https://www.healthwatchbrightonandhove.co.uk/publications/healthwatch-reports/2018-reports/
- **Integrated (Health) care system (ICS)** – NHS organisations, in partnership with local councils and others, taking collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. Further reading: https://www.england.nhs.uk/integratedcare/integrated-care-systems/
- **NHS England** – oversees the commissioning of health services in England. It sets direction for the health and care system as a whole. It's funding and objectives are set by the government and it is accountable to Parliament and the public. From 1 April 2019, NHS England and NHS Improvement have merged to become one new single organisation. Further reading: https://www.gov.uk/government/publications/nhs-mandate-2018-to-2019)
- **NHS Improvement** – now working with NHS England as one new single organisation. NHS Improvement supports foundation trusts and NHS trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. Further reading: https://improvement.nhs.uk/home/)
- **Patient caseloads** – the number of people registered at a GP Practice.
- **Preventative care/preventative services -** routine health care (or services) that includes screenings, services and counseling to help prevent illness, disease or other health problems. Examples include services to help quit smoking, cervical cancer screening and annual health checks for people with long-term health conditions. Further reading: https://www.england.nhs.uk/blog/thinking-differently-about-health-and-care/.

- **Primary Care Networks (PCNs)** – groups of GP practices working closely together with other primary and community care staff and health and care organisations, providing integrated services to their local populations. There are seven PCNs in Brighton and Hove. Further reading: https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-england/gp-contract-agreement-england/primary-care-networks-pcns.
- **Primary care services** - Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services. Further reading: https://www.england.nhs.uk/participation/get-involved/how/primarycare/.
- **Sussex Health and Care Partnership (SHCP)** – brings together 21 organisations all working together to meet the changing needs of all the people who live in Sussex. The SHCP aim is to offer better health, better care and to ensure they make the most efficient use of their resources. This is in response to the 2019 NHS LTP and part of the collective responsibility of an ICS (explained above). Further reading: https://www.seshealthandcare.org.uk/)
- **Sustainability and Transformation Partnerships (STPs)**. Previous term for the SHCP. In its previous form, the partnership included East Surrey, which has now merged with Surrey Heartlands STP. Further reading: https://www.brightonandhoveccg.nhs.uk/our-programmes/sustainability-and-transformation-partnership)
- **Urgent Treatment Centres (UTCs) – introduced in 2019 as an extension to** GP Streaming. Often within the A&E department of a hospital. They are GP-led, open at least 12 hours a day, every day, offer appointments that can be booked through 111 or through a GP referral, and are equipped to diagnose and deal with many of the most common ailments people attend A&E for. Further reading about the one introduced at the Royal Sussex County Hospital: https://www.brightonandhoveindependent.co.uk/health/new-urgent-treatment-centre-to-open-at-royal-sussex-county-hospital-1-9003072)