Brighton & Hove City Council

Overview & Scrutiny

Title:	**Health Overview & Scrutiny Committee**
Date:	**2 December 2009**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Peltzer Dunn (Chairman), Allen (Deputy Chairman), Alford, Barnett, Harmer-Strange, Hawkes, Kitcat, Rufus, Hazelgrove (Non-Voting Co-Optee) and Brown (Non-Voting Co-Optee)
Contact:	**Giles Rossington** **Senior Scrutiny Officer** 29-1038 Giles.rossington@brighton-hove.gov.uk

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HEALTH OVERVIEW & SCRUTINY COMMITTEE

AGENDA

Part One **Page**

29. PROCEDURAL BUSINESS **1 - 2**

(copy attached)

30. MINUTES OF THE PREVIOUS MEETING **3 - 8**

Draft minutes of the meeting held on 30 September 2009 (copy attached)

31. CHAIRMAN'S COMMUNICATIONS

32. PUBLIC QUESTIONS

None have been received

33. NOTICES OF MOTION REFERRED FROM COUNCIL

No Notices of Motion have been received

34. WRITTEN QUESTIONS FROM COUNCILLORS

None have been received

35. MENTAL HEALTH COMMISSIONING AND PROVISION **9 - 32**

Report of the Director of Strategy and Governance on planned changes to Sussex-wide mental health commissioning (copy attached). Richard Ford, Executive Commercial Director, Sussex Partnership NHS Foundation Trust, will give a presentation on the Partnership Trust's "Better By Design" initiative.

36. NHS BRIGHTON & HOVE: STRATEGIC COMMISSIONING PLAN **33 - 44**

Report of the Director of Strategy and Governance on NHS Brighton & Hove's Strategic Commissioning Plan (copy attached)

37. DENTAL SERVICES FOR BRIGHTON & HOVE RESIDENTS **45 - 66**

Report of the Director of Strategy and Governance (copy attached)

38. ANNUAL HEALTH CHECK 2008-2009 **67 - 72**

Report of the Director of Strategy and Governance on the performance of local NHS Trusts in the annual audit of the NHS (copy attached)

39. HEALTH INEQUALITIES: REFERRAL FROM AUDIT COMMITTEE **73 - 110**

Report of the Director of Strategy and Governance on referral of the Audit Commission report on Health Inequalities by the Audit Committee (copy attached)

40. 2009/2010 HOSC WORK PROGRAMME **111 - 116**

(copy attached)

41. SWINE FLU PANDEMIC: UPDATE

(Papers to follow)

42. ITEMS TO GO FORWARD TO CABINET OR THE RELEVANT CABINET MEMBER MEETING

To consider items to be submitted to the next available Cabinet or Cabinet Member meeting

43. ITEMS TO GO FORWARD TO COUNCIL

To consider items to be submitted to the 10 December 2009 Council meeting for information

HEALTH OVERVIEW & SCRUTINY COMMITTEE

The City Council actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public. Provision is also made on the agendas for public questions to committees and details of how questions can be raised can be found on the website and/or on agendas for the meetings.

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For further details and general enquiries about this meeting contact Giles Rossington, 01273 29-1038, email giles.rossington@brighton-hove.gov.uk) or email scrutiny@brighton-hove.gov.uk

Date of Publication - Tuesday, 24 November 2009

Agenda Item 29

To consider the following Procedural Business:

A. Declaration of Substitutes

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

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

B. Declarations of Interest

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Declaration of Party Whip

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

D. Exclusion of Press and Public

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

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

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

Agenda Item 30

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00PM 30 SEPTEMBER 2009

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillors Peltzer Dunn (Chairman); Allen (Deputy Chairman), Alford, Barnett, Harmer-Strange, Kitcat and Rufus

Co-opted Members: Hazelgrove (Older People's Council) (Non-Voting Co-Optee)

PART ONE

15. PROCEDURAL BUSINESS

15A Declarations of Substitutes

15.1 There were none.

15B Declarations of Interest

15.2 There were none.

15C Declarations of Party Whip

15.3 There were none.

15D Exclusion of Press and Public

15.4 In accordance with section 100A(4) of the Local Government Act 1972, it was considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in section 100I (1) of the said Act.

15.5 **RESOLVED** – That the Press and Public be not excluded from the meeting.

16. MINUTES OF THE PREVIOUS MEETING

16.1 **RESOLVED** – That the minutes of the meeting held on 08 July 2009 be approved and signed by the Chairman.

17. CHAIRMAN'S COMMUNICATIONS

17.1 The Chairman announced that NHS Brighton & Hove had recently informed him of its intention to procure two city GP services: at Elm Grove and St James' Avenue. These services will replace the existing GP practices currently operating in these locations.

18. PUBLIC QUESTIONS

18.1 There were none.

19. NOTICES OF MOTION REFERRED FROM COUNCIL

19.1 There were none.

20. WRITTEN QUESTIONS FROM COUNCILLORS

20.1 There were two Written Questions from Councillors.

20.2 In response to a question from Councillor Brian Pidgeon, Darren Grayson, Chief Executive of NHS Brighton & Hove, apologised for publishing information on local healthcare services which could not be readily accessed by blind or visually impaired people. Mr Grayson told members that NHS Brighton & Hove had subsequently been in contact with the Federation of Disabled People to ensure that the information contained in the leaflet was available to local people with sight problems.

20.3 The Chairman noted that, aside from unfortunately being inaccessible to blind people, this was a truly excellent publication, presenting important healthcare information in a very readable format. The Chairman congratulated all those involved in preparing and publishing the leaflet.

20.4 Councillor Pidgeon noted that this was not the first time he had been obliged to raise similar matters with NHS Brighton & Hove and he trusted that he would not need to do so again.

20.5 In response to a question from Councillor Jason Kitcat, Dr Tom Scanlon, Director of Public Health for Brighton & Hove, told members that the decision to prescribe anti-viral drugs widely was taken at a national level after assessing all the available research evidence. The drugs were effective against the virus if taken early although the side effects, most of which were minor, had been greater than had been suggested by previous clinical trials. Regarding whether or not the use of paracetamol and ibuprofen prolonged the symptoms of flu, Dr. Scanlon cautioned against over-interpretation of one study, but also stated that even if their use slightly prolonged the presence of the virus in the body, their effectiveness in dealing with the symptoms of the flu was likely to outweigh this concern. The vast bulk of evidence was that they were both safe and effective.

20.6 Dr Scanlon also pointed out that although Tamiflu's side-effects had been rather more than had been anticipated, this did not mean that its use had been a mistake. There had been relatively few deaths in the UK in the first wave and it may have been that the widespread use of anti-virals had saved a number of lives.

20.7 Dr Scanlon told members that he had thus far been unable to ascertain the cost per unit of Tamiflu, but would pass that information on once he had it.

21. FLU PANDEMIC UPDATE

21.1 This Item was introduced by Dr Tom Scanlon, Director of Public Health Brighton & Hove. Dr Scanlon then answered members' questions.

21.2 Dr Scanlon told members that a (national) priority list for vaccination of members of the community had been prepared. This list included those between 5 and 65 years in seasonal flu 'at-risk' groups; pregnant women; people in regular contact with immuno-compromised persons; and over-65s in seasonal flu 'at risk' groups. Front-line medical staff (and some other groups of front-line workers) will also be vaccinated at an early stage, although the programme for these vaccinations is separate from the community vaccination programme. The timetable for these vaccination programmes would be shortly announced.

21.3 In answer to a question concerning the widespread prescription of anti-viral medication (e.g. tamiflu) during the first wave of the pandemic, Dr Scanlon informed members that this policy may well have slowed the spread of the virus (and therefore allowed for better emergency planning). In addition, the 'on-line prescribing' of Tamiflu meant that primary care services were not overwhelmed with pandemic-related queries to the detriment of their other work. However, this was not necessarily a zero-sum game, and there may also have been drawbacks to the wide-spread use of anti-virals at this stage in the pandemic (such as more severe than anticipated side-effects for some patients).

21.4 Dr Scanlon told the committee that planning for the swine flu pandemic was based upon national guidance. However, there was a good deal of decision making at a local level, as each locality had to take its own demography etc. into account.

21.5 Members were informed that it might, at some point during a second wave of swine flu, prove necessary to shut some or all local schools. This would be a local decision made between the Education Authority working in conjunction with the Health Protection Agency.

21.6 Dr Scanlon told members that Brighton & Sussex University Hospitals Trust (BSUH) had undertaken detailed planning for a surge in the pandemic. This preparation included planning to cancel/postpone elective surgery in order to free space for swine flu cases; planning for swifter and more effective patient discharge; and planning for the potential use of beds in private healthcare facilities (e.g. the Nuffield, the Sussex Orthopaedic Treatment Centre).

21.7 The committee was told that the swine flu vaccination was additional to the normal seasonal flu jab, although the first swine flu jab could be combined with the single

seasonal flu jab (currently, it was anticipated that two swine flu jabs would be required, although this could change). There did seem to be some evidence from around the globe that the swine flu virus effectively 'pushed aside' seasonal flu (i.e. that seasonal flu rates in some parts of the world have been considerably lower than anticipated during the first wave of the swine flu pandemic), although there was no guarantee that this would be repeated in a second wave of the pandemic.

21.8 RESOLVED – That the Director of Public Health's report be noted.

22. BRIGHTON & SUSSEX UNIVERSITY HOSPITALS TRUST (BSUHT) FOUNDATION TRUST APPLICATION

22.1 This item was introduced by Alex Sienkiewicz, Company Secretary of Brighton & Sussex University Hospitals Trust (BSUHT).

22.2 Mr Sienkiewicz told members that current plans for the Foundation Trust Board of Governors did not include emergency service representation (other than from the South East Coast Ambulance Trust), although final decisions on the trust governance structure had not yet been made.

22.3 In response to a question regarding whether current BSUHT Non-Executive Directors (NEDs) would be re-appointed as NEDs for the Foundation Trust, members were informed that, where possible, the trust did intend to retain its NEDs in order to ensure continuity during the transfer to Foundation Trust status. To this end, extensive training was being arranged for the current NEDs. In addition, recent appointments to the BSUHT board had taken account of the Foundation Trust application, with NEDs being sought who were able to cope with the demands of taking responsibility for a Foundation Trust.

22.4 In answer to a query about whether the proposed Foundation Trust would have both its Board of Governors and its Board of Directors chaired by the same person, Mr Sienkiewicz told members that this would indeed be the case, as this was a statutory requirement for Foundation Trusts. Although there was a potential clash of interests here, the trust was confident that problems could be avoided, particularly via the publication of clear procedures in the Standing Orders for both boards (which will form part of the planned Foundation Trust's constitution).

22.5 Mr Sienkiewicz told the committee that NEDs are currently appointed to NHS trusts by a nationally run Appointments Commission. However, when BSUHT becomes a Foundation Trust, then the trust Governors will appoint NEDs. Current NEDs with time left to serve will 'roll-over' to the initial FT Board of Directors for the duration of their terms.

22.6 RESOLVED – That BSUHT's approach to its Foundation Trust application be approved by the committee.

23. SOUTH EAST COAST AMBULANCE TRUST (SECAMB): FOUNDATION TRUST APPLICATION

23.1 Geraint Davies, SECamb Director of Corporate Affairs and Service Development, introduced this item.

23.2 In answer to questions as to how achieving Foundation Trust status would enable the trust to improve its services, members were told that Foundation Trusts are able to borrow commercially to improve their services. This would enable developments to be made (for instance in training more paramedics or renewing the trust's vehicle fleet) which would either not be possible under SECamb's current financial arrangements, or which would take much longer to enact.

23.3 In response to a query as to how a regional ambulance trust could hope to engage potential members, the committee was told that SECamb has already recruited 1300 people eager to become members. Given the trust's excellent history of public involvement, SECamb is confident that it can attract and maintain a broad and engaged membership.

23.4 Mr Davies told members about SECamb plans to develop its services in Brighton & Hove, moving away from the use of large ambulance stations in a few locations to having ambulances 'stationed' in parking places across the city. This will improve call-out times, as ambulances can be stationed near to the areas of greatest demand (e.g. the city centre).

23.5 Several members noted that there were potential problems with SECamb's governance structure, as the trust has to include representation from all parts of the area it covers (Sussex, Kent and Surrey), but must also ensure that it does not end up with an unmanageably large Board of Governors. SECamb's proposed governance structure involves a number of areas or interest groups being represented by single Governors, which begs a number of questions, including whether a single person can adequately represent the interests of a city such as Brighton & Hove, what to do when a Governor cannot make a scheduled meeting etc. Mr Davies assured members that the trust was doing all that it could to deal with these potential difficulties, including co-ordinating Board meetings around the availability of Governors.

23.6 RESOLVED – That SECamb's approach to its Foundation Trust application be approved by the committee.

24. AD HOC PANEL ON THE GP-LED HEALTH CENTRE: NHS BRIGHTON & HOVE RESPONSE TO HOSC RECOMMENDATIONS

24.1 This item was introduced by Councillor Trevor Alford, Chairman of the ad hoc panel.

24.2 RESOLVED – That the report be noted and NHS Brighton & Hove be thanked for its prompt and positive response.

25. HEALTH OVERVIEW & SCRUTINY COMMITTEE (HOSC) WORK PROGRAMME

25.1 Members discussed possible items for the HOSC work programme.

25.2 It was agreed that officers should seek to collate a number of suggested topics under themes, and that the resultant, concise, work programme should be presented to members at their next meeting.

26. CARERS' STRATEGY

26.1 This item was introduced by Denise D'Souza, Director of Community Care and by Tamsin Peart, Performance and Development Officer.

26.2 Members were told that the Carers' Strategy had been developed after conversations with a large number of representative organisations. The Carers' Survey, to which more than 400 people had responded, had also been used to inform the strategy.

26.3 Members were informed that money for carers is not 'ring-fenced'. However, NHS Brighton & Hove currently funds carers' services at a higher level than is suggested by Government guidance. Details about future NHS funding of these services will be included in the update of NHS Brighton & Hove's Strategic Commissioning Plan.

26.4 RESOLVED – That the report be noted.

27. ITEMS TO GO FORWARD TO CABINET OR THE RELEVANT CABINET MEMBER MEETING

27.1 It was agreed that Item 21 (flu pandemic update) and Item 25 (HOSC work programme) should be forwarded for information to Cabinet.

28. ITEMS TO GO FORWARD TO COUNCIL

28.1 There were none, although it was noted that the ad hoc panel report on the GP-Led Health Centre and NHS Brighton & Hove's response to the report recommendations would, as a matter of course, go to full Council for information.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Agenda Item 35
Brighton & Hove City Council

Subject:		**Mental Health Commissioning and Provision**		
Date of Meeting:		**02 December 2009**		
Report of:		**The Director of Strategy and Governance**		
Contact Officer:	Name:	Giles Rossington	Tel:	29-1038
	E-mail:	Giles.rossington@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 Sussex Primary Care Trusts (PCTs) recently announced their intention to change significant aspects of the way in which they commission mental health services. The attached report from NHS Brighton & Hove explains this new approach (see **Appendix 1** to this report).

1.2 Sussex Partnership NHS Foundation Trust (SPFT), the main supplier of statutory mental health, substance misuse and learning disability services across Sussex, also plans a major reconfiguration, seeking both to improve the quality and cost effectiveness of its activities and to align them more closely with the Sussex PCTs' revised commissioning intentions. This SPFT initiative is termed "Better By Design."

1.3 Better By Design will involve the reconfiguration of a range of mental health services provided by SPFT, including community care, day hospitals, in-patient care and specialist services. SPFT will give a presentation on Better By Design at the 02 December HOSC meeting (slides from this presentation are included as **Appendix 2** to this report).

1.4 Changes to Sussex PCT commissioning intentions and the Better By Design initiative are likely to result a significant re-drawing of the map of Sussex-wide mental health services, with a greater emphasis given to community care, to providing more specialist care within Sussex, and to being more responsive to service users' requirements in terms of service design. However, whilst these can all be viewed as desirable outcomes, there are also likely to be controversial elements to these changes, perhaps particularly in terms of the loss of an estimated 100 in-patient mental health beds across Sussex.

2. RECOMMENDATIONS:

2.1 That members note the contents of this report and the additional information provided by NHS Brighton & Hove and Sussex Partnership NHS Foundation Trust.

3. BACKGROUND INFORMATION

3.1 Sussex Partnership NHS Foundation Trust (SPFT) was established in 2006 to deliver statutory mental health, substance misuse and learning disability services across Sussex. These services had formally been provided by several separate NHS trusts working out of various localities around the county. SPFT is commissioned by four Sussex PCTs: NHS Brighton & Hove, NHS West Sussex (which is the lead commissioner for mental health services across Sussex), NHS Hastings & Rother and NHS Downs & Weald.

3.2 In Brighton & Hove, SPFT manages Mill View Hospital and the Nevill Hospital, as well as providing community mental health care and a range of other services. SPFT is an important partner of the city council via Section 75 arrangements.

3.3 Better By Design will propose a reconfiguration of SPFT services in line with changes in the commissioning intentions of Sussex PCTs. Should this reconfiguration entail 'substantial variations' in service provision across the county, the NHS bodies involved would be obliged (in accordance with the requirements of the Health and Social Care Act 2001) to consult with local HOSCs, with stakeholder organisations (including Local Authorities), and with the general public. Given the scale of some of the changes being considered it seems reasonable to assume that elements of Better By Design will be deemed to constitute a substantial variation of services.

3.4 HOSCs have two statutory roles in this type of major reconfiguration. Firstly, HOSCs can choose to take a position on the quality of the public consultation undertaken by NHS trusts. Members may wish to satisfy themselves that a consultation is appropriate in scale to the changes planned; that it is inclusive (particularly in terms of engaging with groups of people who may typically be 'hard to reach' via conventional means); and that the relationship between the consultation and the NHS decision-making process is clear (i.e. that it is apparent how and to what degree public opinion can influence the service re-design). Should a HOSC consider NHS consultation plans to be inadequate, then it can, as a last resort, make a formal referral to the Secretary of State for Health.

3.5 HOSCs also have a statutory power to consider whether plans to make substantial changes to healthcare services are in the best (health) interests of local residents. If a HOSC believes that plans with have a deleterious effect on the health of local people, then it can again make a formal referral to the Secretary of State for Health (although it must be prepared to evidence any claims that it makes).

3.6 There are three HOSCs operating within Sussex: Brighton & Hove City Council HOSC, East Sussex County Council HOSC and West Sussex County Council HOSC. There is a potential problem here in terms of a Sussex-wide reconfiguration, in that plans which might improve services across the whole of the patch could well impact negatively upon one particular area (perhaps especially in terms of initiatives to centralise specialist services in one locality). Therefore, if each HOSC examined Better By Design in isolation, it might object to plans which impacted upon its bailiwick, even if there was a compelling reason to make the change from a Sussex-wide perspective. Similarly, a HOSC might be tempted to approve plans which improved services in its area, even if they involved unacceptable cuts to services in neighbouring localities. In so doing, an HOSC might well be acting quite properly, as individual HOSCs are enjoined to protect the interests of their residents rather than any broader public interest.

3.7 In order to avoid this problem, major initiatives which cut across Local Authority boundaries are sometimes scrutinised by a joint HOSC (JHOSC). JHOSCs are time-limited joint committees which assume the statutory powers of their constituent HOSCs as they relate to a particular issue. Members of a JHOSC are required to consider the impact of healthcare initiatives across the entire JHOSC area when they make their decisions; thereby, at least in theory, eliminating the risk of parochial decision making. However, before establishing a JHOSC, members should be aware that joint committees typically require considerable additional resourcing, both in financial terms and, particularly, in terms of members' time. It is therefore generally assumed that a JHOSC should only be considered as a 'last resort' – when it is evident that an issue cannot be dealt with separately by the individual HOSCs concerned.

3.8 SPFT and/or the commissioning PCTs will presumably look to seek HOSC (or JHOSC) endorsement of their consultation and/or reconfiguration plans at a later date (depending on whether they consider their proposed reconfiguration of services to constitute a substantial variation in local healthcare provision). However, at this juncture members are only being asked to ***note*** information relating to Better By Design and to revised PCT commissioning intentions, not to make any decisions.

4. CONSULTATION

4.1 None has been undertaken in preparing this report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are no direct implications for the council in this report for information.

Legal Implications:

5.2 The Health Overview and Scrutiny Committee has powers to scrutinise the NHS and represent local views on the development of local health services (Sections 7-10 of the Health and Social Care Act 2001). The Local Government and Public Involvement in Health Act 2007 has further strengthened the requirements for NHS organisations to involve service users in the planning and development of services. The Health Overview and Scrutiny Committee can accordingly make recommendations on the process for review and the proposals themselves. HOSC also has powers to report to the Secretary of State where it feels the proposals would not be in the best interests of the Health Service in the area.

Lawyer Consulted: Elizabeth Culbert; Date: 01.11.09

Equalities Implications:

5.3 One of the biggest challenges in any public consultation is how to engage effectively with your target audience. SPFT runs services for people with mental health problems, substance misuse issues and learning difficulties, so these people, their families and carers, and others who may require these services at a future date, might be considered to be the core target audience for the Better By Design consultation and any consultation relating to the commissioning of these service areas. However, there are well-established difficulties in communicating with all these groups via conventional means. Members may therefore be interested to learn about the specific steps adopted by the NHS to ensure that current and potential services users are fully involved in the consultation process. Since these groups include some of the most disadvantaged and stigmatised people in the community, this is a core equalities issue.

Sustainability Implications:

5.4 None identified at this point, but changes to the configuration of SPFT services may mean that patients typically have to travel further for treatment (although changes might well have the opposite effect). If planned changes are likely to have a negative impact upon travel times etc. then members may be interested to learn how the sustainability

implications of these plans have been assessed, and what ameliorative measures have been put in place.

Crime & Disorder Implications:

5.5 None directly, but any reconfiguration of mental health services county-wide is likely to have crime & disorder implications (e.g. in terms of secure and forensic services, some substance misuse services etc).

Risk and Opportunity Management Implications:

5.6 None identified.

Corporate / Citywide Implications:

5.7 SPFT provides a range of key services for Brighton & Hove, either on its own or in partnership with the council. Effective mental health, learning disability and substance misuse services will enable the council to meet its commitments to provide "better use of public money" and to "reduce inequality by increasing opportunity"

SUPPORTING DOCUMENTATION

Appendices:

1. Information provided by NHS Brighton & Hove;

2. Information provided by Sussex Partnership NHS Foundation Trust

Documents in Members' Rooms:

None

Background Documents:

1. The Health and Social Care Act (2001)

2. The Local Government and Public Involvement in Health Act (2007)

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	Appendix 1

Subject:		**Development of the Working Age/Adults Mental Health Commissioning Strategy for 2010-2013 and the Transforming Mental Health Services Programme**
Date of Meeting:		**2nd December 2009**
Report of:		**Claire Quigley, Director of Delivery, NHS Brighton & Hove**
Contact Officer:	Name:	Margaret Cooney, Mental Health Commissioner, NHS Brighton & Hove
	E-mail:	Margaret.Cooney@bhcpct.nhs.uk;
Wards Affected:	All	

1 SUMMARY AND POLICY CONTEXT

1.1 We know that many people in Brighton and Hove experience mental health problems:

- at any one time 1 in 4 adults is mentally unwell to some degree
- around three quarters of them are anxious or depressed
- almost one third of GP consultations concern mental health issues
- stress is the commonest reason for being off work
- up to 1 in 7 people in the city are lesbian, gay, bisexual or trans-gender. Pe from these communities are more likely to contemplate suicide, misuse dru alcohol, or suffer anxiety and depression.
- our city has a number of people who are mentally ill and also misuse drugs alcohol. Their needs are very complex and can only be met if different publi services (e.g. health, social care, housing, police) work together closely
- Serious mental illness in the city is much higher than the England average. Reasons for this include:
- ***drug use*** – Brighton and Hove has the most problem drug users in the Sou East and the 17th highest in England. More than 2,000 working age people drug users who inject.
- ***alcohol misuse*** – more than 50,000 people over 16 regularly drink too muc and our city has a very high number of alcohol-related deaths among men.

The national policy context for mental health has seen a shift towards:

- a greater focus on health and wellbeing,
- recovery from mental illness and

- improving patients' experience of care.

1.2 Locally we know we spend a relatively high amount on mental health services and there are opportunities for getting greater efficiencies from our main provider, Sussex Partnership NHS Foundation Trust, but that this has to be done as part of a whole system approach to mental health.

1.3 Over the summer months, NHS Brighton and Hove and the City Council have been consulting on their refreshed Working Age Mental Health (WAMH) Strategy which addresses the key local and national strategic drivers.

1.4 The priorities for the next 3 years been set by consultation with a range of stakeholders including users, carers, staff and clinicians as well as members of the public. The overwhelming priority outcomes were quicker access into services when needed and improved case management.

1.5 Financial pressures on public sector funding means there is little investment expected in commissioning mental health services. There are however a range of efficiencies that can be made and reinvestment in services is possible. It is anticipated that the approach to Transforming Mental Health Services will improve access to and the quality of services whilst retaining financial control.

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2 RECOMMENDATIONS

2.1 That the HOSC :

- notes the process to set the key outcomes areas for the next 3 years
- notes the focus of the transformation programmes, specifically the intention to commission services for people over the age of 17 years based on need, not age (as in the current commissioning model).
- notes that services for children and young people will be scoped at a later stage.

3 BACKGROUND INFORMATION

3.1 Brighton and Hove has a high level of mental health needs together with a large number of people at increased risk of mental health problems.

3.2 The commissioning budget for mental health in 2009/10 is £46,649,515 for adults and older peoples mental health with a further £5,116,177 being spent on substance misuse services. This is slightly above the national

average for adults and older people (Office of National Statistics (ONS) cluster average per head of adults in the city). To align the commissioning budget for adults' services to the ONS average would equate to an overall reduction of between £4m- 6million.

3.3 Reviews of our main mental health service provider – Sussex Partnership NHS Foundation Trust (SPFT) – undertaken on behalf of commissioners across Sussex suggest that we should be aiming for greater efficiencies across many of the service areas including the access service, acute bed lengths of stay, occupancy rates and overall capacity.

3.4 Since 2000, the main strategic driver for change has been the Mental Health National Service Framework[1] and implementation which initially focused on the modernisation of specialist services. More recently the policy drive in the New Horizons[2] document for mental health has been for a greater focus on commissioning for health and wellbeing, primary care (including improving access to psychological therapies) and on recovery from mental illness, with a focus on optimising the quality of life after or with mental illness. Locally the transition of focus from specialist services to recovery has not progressed rapidly and the mental health system as a whole needs to be developed as a whole system for this to happen. 'Putting People First' (Department of Health 2007) also places an emphasis on choice and control and creating a different market place where people themselves will become commissioners of community based services as they use their individual or personal budget to purchase their own support services.

3.5 During 2009 an independent evaluation of SPFT services was undertaken by the Whole System Strategies (WSS)[3]. This is being used as the driver for local quality changes in SPFT services including options to change acute inpatient services and develop community services.

3.6 Within current services we know that we have poor performance against waiting times for assessment and for services to start, and that they are below the agreed standards. Brighton and Hove also has twice the average length of stay in acute beds than West and East Sussex.

3.7 We have feedback from service users and carers that there is often poor quality across a range of services including out of hours, crisis support teams and the inpatient service.

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[1] *Department of Health, National Service Framework for Mental Health 1999.*

[2] *Department of Health, New Horizon: towards a shared vision of mental health 2009.*

[3] *Whole Systems Strategies Consultants: Mental Health Services for Working Age Adults in Sussex: Review of Acute Bed Provision, 2009.*

3.8 The PCT in partnership with the City Council embarked on a re-fresh of the WAMH Strategy earlier in the year and we have been consulting on our vision for transforming mental health services over the next 5 years in line with national and local drivers for change. The consultation period closed on 21 October and responses were received from 180 individuals from a range of sources including service users, GPs, NHS and City Council staff, carers and residents of the city. The final strategy will go to the Joint Commissioning Board in January for formal discussion

3.9 In light of the feedback we have had from local people on the strategy, the context of high mental health needs, relatively high spend, the need to improve the efficiency and patient experience of local services, a commissioning plan to transform mental health services over the next 5 years is in development and will be attached to the strategy when submitted to the Joint Commissioning Board in January.

3.10 The priority areas from what people told us:

1. Simple assessments with less duplication and quicker access to services
2. Improved case management for people who have complex needs including better discharge processes
3. More community focus on mental well being
4. Increased range of services in the community
5. A wider range of services for anxiety and or depression
6. Greater support for carers
7. Improved integrated working with housing education, leisure and employment
8. More ways in which people can be involved in services improvements and quality
9. More people on direct payments or receiving SDS
10. A more diverse market with a greater choice of providers

3.11 Different stakeholder groups highlighted different priority areas:

- The priorities for **carers** were assessments, access to services and improved case management
- Priorities for **current service users/patients** were a request for simple assessments, improved access and community focus on mental well being
- Priorities for **past users** were simple assessments and improved case management
- Priorities for **GPs** were simple assessments, access and improved case management
- Priorities for **NHS mental health staff** were improved case management and integrated working
- For **non NHS mental health staff** it was simple assessments and access and improved case management and focus on prevention

- For those **who have never used services** it was more emphasis on well being and prevention and a wider range of services for anxiety and depression

3.12 From this work the ensuing priority outcomes for the next 3 years have been set as:

- Improved use of resources.
- Services based on need and not age (with the exception of dementia which will be commissioned as a separate strategy).
- Positive mental well-being to address social inclusion reduce stigma, ensure access to vocational support across all levels of need.
- Improved access through reducing waiting times for assessments and start of treatment.
- Improved treatment pathways including access to all levels of psychological therapy.
- Improved flow of care with improved care co-ordination.
- Greater range of primary care and community services.
- A skilled and diverse workforce.
- Improved self directed support opportunities for users and carers.
- Increasing interagency working between health, housing, vocational support, leisure and education services.

3.13 It is proposed that these outcomes will be delivered through the following 4 work programmes for commissioners:

1. **Improving outcomes through focusing on wellbeing and prevention services.**

   We envisage a greater role for the third sector and increased involvement of general practice so that we can offer greater choice, more personalised support with a focus on supporting people to stay in/return to work.

2. **Providing an efficient and effective gateway and triage**

   A working group will be established to improve access to current services and a pilot project will be initiated later in the year in order to improve the quality of primary care referral practice and triage referrals into the access service. It is anticipated that the access service will be re-commissioned for 2011/12 on the basis of this pilot.

3. **Care pathway design**

   By working closely with SPFT on their Better by Design programme ensuring their proposals for service redesign reflect our strategic priorities. Included in the programme of work will be:

   - Consideration of realigning the commissioning and provision of mental health services on the basis of need not age;
   - Improvements in the quality and access to community services enabling more people to remain at home;

- Review of day care provision;
- Reduction in the number of acute beds across Sussex;
- Increased access to psychological therapies

4. **Developing capacity in primary and community care**

   Enhanced role for primary care in the recovery stage through the introduction of the SMI LES:

   - Better meeting the needs of people with dual diagnosis;
   - Focus on areas with known gaps e.g. eating disorders, perinatal services;
   - Greater co-ordination of care across the whole pathway;
   - A focus on improved quality and workforce.

3.14 Within each of these work streams there will be a focus on:

- Effective pathways
- Waiting times for assessments and start of treatment
- The opportunities for peer support in service design
- The needs of carers
- Value for money
- Equalities

3.15 Currently two groups oversee this work for older people and people of working age. These groups will merge to become the overarching transforming Mental Health Strategy Implementation Group and will covers adults and older peoples commissioning.

3.16 A joint strategy between the PCT and city council and is being developed with input from SPFT and from the 3rd sector. It is recognised that there will be no additional funding available and that we are committing to more effective use of money and ensuring that we do this in partnership with local stakeholders. The consultation work to date has been seen as successful at engaging with key partners and with being open about the financial and quality issues that have influenced the strategy.

3.17 There has been a multi agency steering group involved in the development of this strategy which has included user and carer representatives. This group will continue and will be developed into the overarching implementation groups in the next 3 years.

3.18 Commissioning for Dementia is also a key area for development locally and although not covered in this strategy it is linked through the commissioning group. Brighton and Hove is in a unique position when compared to East and West Sussex. Due to differences in population demographics, Brighton and Hove should not expect to see a dramatic increase in the number of people expected to have dementia in the future. However, it is clear that there are nearly 2,000 people in Brighton and Hove, likely to have dementia,

but who have not yet been diagnosed or do not receive specialist support.

3.19 In line with the National Dementia Strategy, and given the feedback received on current services, the patient offers below set how dementia services will be improved locally. We will:

- Ensure that diagnosis and detection services improve, so that more people with dementia receive a diagnosis
- In line with increased diagnosis, improve early intervention and support services, to ensure people are able to maintain their independence for longer.
- Ensure appropriate community services are in place to meet the needs of people with dementia and their carers.
- Ensure mainstream services are able to meet the needs of people with dementia.
- Improve the quality of care experienced by people with dementia and their carers, across all aspects of the care pathway.

4 CONSULTATION

4.1 Consultation on the WAMH Strategy ended on 21 October 2009. The strategy priorities and the transforming action plans are being consulted on with key stakeholders on 10 December. A formal consultation period on the redevelopment on inpatient beds and other areas will commence in mid January 2010.

4.2 The PCT and city council will continue to use the current infrastructure to support the ongoing development of services. These include service user and carer meetings, meetings with clinicians, people working in mental health services and the third sector. Further online consultations will take place on the content of the 4 work streams.

5. FINANCIAL & OTHER IMPLICATIONS

5.1 Financial implications

Currently the adult mental health commissioning budget is 12% above our ONS comparator groups and for Older People with Mental Health problems is at least 20% more. Value for money and managing resources is a priority in this plan.

5.2 Legal implications

None identified at this stage

5.3 Equalities implications

Equalities are addressed though focus on the 6 equalities strands in the

transformational plans.

An initial Equalities Impact Assessment on the strategy and the 4 work streams will take place in December 2009 and will be reviewed annually or when significant changes are added to the plan.

5.4 **Sustainability Implications**

None identified at this stage

5.5 **Crime and Disorder Implications**

5.6 **Risk and Opportunity Management Implications**

Potential risks include:

- Failure to address value for money and quality in a strategy will result in continuing high costs, poor outcomes and poor user experience.
- Failure to realign resources to improving access to psychological therapies is a risk (covered in programme 3)
- Failure to implement the Local Enhanced Scheme (this is known as a LES, this scheme rewards GP for providing extra services) for people who have a serious mental illness (SMI). The SMI LES allows for the continued variability in relation to the treatment and management of SMI patients in primary care. (covered in programme 4)

5.7 **City wide Implications**

The programme of change will be based on local outcomes and on quality measures and this will be apart of the performance management of any contacts with provider and this information will be publically available.

SUPPORTING DOCUMENTATION

Appendix 1: Audit of engagement processes: WAMH strategy setting priorities and engagement processes

Appendix 2 : Invitation to a further consultation event being held on 10th December 2009.

Documents in Members' Room:

None

Appendix 1 Audit of engagement processes: WAMH strategy setting priorities and engagement processes

i.	User and Carer strategy group	29th April 10th June 27th July
ii.	CCVS mental health network meetings	26th March 2nd April 30th April 7th July 9th Sept 17th November
iii.	Carers specific groups	3rd September 5th November
iv.	3 User and carer workshops	7th September
v.	PBC meetings	18 - 30 July
vi.	Stakeholders	11th November
vii.	Online survey 186 respondents	September – October

Appendix 2: Future consultations on the content of the strategy - Public event 10th December 2009

Mental Health Commissioners for adults and older people would like to invite you to the following event

Transforming Mental Health Services for adults and Older People in Brighton and Hove

We will run the presentation and workshop 3 times during the day. Please come to the session that suits you best

Date: Thursday 10th December 2009

Morning session: Jury's Inn 10am – 12.15pm

Afternoon session: Jury's Inn 1pm - 3.15pm

Evening session: Brighthelm Centre 5.45pm - 8pm

Jury's Inn – 101 Stroudley Road, Brighton, BN1 4DJ
Brighthelm Centre – North Road, Brighton, BN1 1YD

This event will:

- Clarify where we are now in terms of whole system mental health services
- Discuss the next 3 years in terms of service improvements and efficiencies
- Debate the longer term issues for mental health commissioning

The event will consist of presentations from Commissioners on the context for change, priorities and the future.

A teaching trust of Brighton and Sussex Medical School

Sussex Partnership NHS
NHS Foundation Trust

Better by Design

Richard Ford
Executive Commercial Director

The case for change

- National politics and policy
- The economy, money and efficiencies
- Increased demand for services
- Commissioner expectations
- Competition and partnerships

Sussex Partnership NHS
NHS Foundation Trust

So we need to work differently….

- Faster developments, decisions and delivery
- Innovations and new ventures
- More efficient ways of working
- Leaner thinking
- Tighter controls
- Service changes
- Improved information

Sussex Partnership NHS
NHS Foundation Trust

Underpinned by a culture of ambition

- Becoming as good as the best
- Ruthless attention to performance and delivery
- Continuous cycle of growth, refinement and development
- Customer focus, choice, people we serve at the centre
- Underpinned by our R and D and people strategies
- Being psychologically minded
- Delivering this via our staff Compact

Sussex Partnership NHS
NHS Foundation Trust

Better by Design – core components

- **Improved services and better value**
- **Consistent with New Horizons**
- **Key components: all care groups**
  - Optimal service models standardised for Sussex
  - Based on best evidence
  - Skilled and empowered staff
  - Continued reduction in beds overall
  - Specialist services provided in Sussex where best to do so
  - Increased productivity
  - Realising the benefits of teaching and foundation status

Better by Design – Our Revised Product Range

1. **New direct access services such as Health in Mind**
   - Fast responses
   - Streamlined governance
   - New treatment modes
   - Working with other providers
   - Co-location with primary care
2. **Community teams as the foundation of everything else we do**
   - Clarity of purpose
   - Increased activity
   - Improved relationships, especially with primary care
   - Working from fewer better bases
3. **Specialist community services (upping the pace on delivery)**
   - Dementia services
   - Dual diagnosis
   - Eating and personality disorder services
   - Secure and forensic developments
   - Others where the business case can be made

Better by Design – Our Revised Product Range

4. Intermediate services

- Specialist therapy centres based on best evidence
- Out of hours responses for crisis
- Dementia developments including memory assessment, home and intermediate care, shared care with acute trusts

5. Residential services

- Self-directed care via individual placements
- Less specialist services in partnerships with third sector

6. Inpatient care for adults

- Improved response to crises means lower demand for beds
- Overall reduction from 459 to 359 acute adult (all ages) beds
  - Fewer wards and fewer sites will release fixed costs
  - Agreed Sussex-wide approach with commissioners

7. Increases in specialist inpatient care

- Secure and forensic
- Learning disability inpatient care
- Tier 4 substance misuse
- Other possible increases e.g. CAMHs

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	**Agenda Item 36** Brighton & Hove City Council

Subject:		**NHS Brighton & Hove: Strategic Commissioning Plan**		
Date of Meeting:		**02 December 2009**		
Report of:		**The Director of Strategy and Governance**		
Contact Officer:	Name:	Giles Rossington	Tel:	29-1038
	E-mail:	Giles.rossington@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report introduces NHS Brighton & Hove's (NHSBH) latest Strategic Commissioning Plan: SCP (2010-2011). The SCP itself is still in draft at this point and is not available for distribution. However, information on the SCP supplied by NHSBH is included as **Appendix 1** to this report.

2. RECOMMENDATIONS:

2.1 That members:

(1) note the information contained in this report and its appendix;

(2) request that NHS Brighton & Hove facilitates a workshop event at which HOSC members (and possibly other Councillors) could learn more about the Strategic Commissioning Plan.

3. BACKGROUND INFORMATION

3.1 NHS Brighton & Hove (NHSBH) commissions publicly-funded healthcare services for residents of Brighton & Hove.

3.2 NHSBH's high -level medium term commissioning strategy is encapsulated by the city Strategic Commissioning Plan (SCP). The SCP identifies the key healthcare challenges facing the city, and proposes commissioning strategies to tackle these issues.

3.3 The SCP is periodically revised, and the latest revision (2010-2011) will be published in the new year. Information on the contents of the revised SCP is reprinted as **Appendix 1** to this report.

3.4 Amongst the specific issues that HOSC members may wish to consider in relation to the latest SCP include: why NHSBH's priorities are as they are? How NHSBH intends to measure whether it has been successful in tackling an issue? Why, if NHSBH's 2010-11 priorities differ from its 2009-10 priorities, there has been a change of emphasis (i.e. have problems actually been solved before moving on to a new issue)? HOSC members may also wish to consider the committee's work programme in light of NHSBH's 2010-11 priorities.

3.5 The SCP can be a challenging read, as it is necessarily a complex document, encompassing the commissioning of all publicly-funded healthcare services for city residents. HOSC members may therefore wish to consider asking NHS Brighton & Hove to provide further information on the SCP, perhaps in the form of a workshop event for selected HOSC members.

4. CONSULTATION

4.1 Informal consultation with NHS Brighton & Hove has been undertaken in preparing this report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are no direct implications for the council in this report for information

Legal Implications:

5.2 Legal advice has not been sought on this report for information

Equalities Implications:

5.3 None identified, although NHSBH will have assessed equalities issues when revising its SCP

Sustainability Implications:

5.4 None identified, although NHSBH will have assessed equalities issues when revising its SCP

Crime & Disorder Implications:

5.5 None directly

Risk and Opportunity Management Implications:

5.6 None identified

Corporate / Citywide Implications:

5.7 The city council is an important partner of NHS Brighton & Hove, particularly in terms of social care provision. The city Strategic Commissioning Strategy has been developed in partnership with the city council and reflect the council's corporate priorities as well as those of the Primary Care Trust.

SUPPORTING DOCUMENTATION

Appendices:

1. Information supplied by NHS Brighton & Hove

Documents in Members' Rooms:

None

Background Documents:

1. None

NHS Brighton and Hove

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	Appendix 1

Subject:		**Progress report on the development of The NHS Brighton and Hove Strategic Commissioning Plan 2009-2014**		
Date of Meeting:				
Report of:		**Deputy Chief Executive / Director of Strategy NHS Brighton and Hove**		
Contact Officer:	Name:	Andrew Demetriades	Tel:	01273 54 5423
	E-mail:	andrew.demetriades@bhcpct.nhs.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The purpose of this report is to provide the Health Overview and Scrutiny Committee with an update on the review and redevelopment of the PCT's Strategic Commissioning Plan which will be submitted as part of year 2 World Class Commissioning (WCC) process in mid January 2010. This is a national requirement of all PCTs.

1.2 NHS Brighton and Hove is required to submit a revised Strategic Commissioning Plan which reflects its priorities over a five-year timetable. The PCT has an existing 5 year strategic plan shared with the HOSC in 2008 which is being revised taking into account:

- The recommendations from the original WCC process.
- Major national and local operating environment changes
- The PCT's and partner learning's over the last year.

1.3 NHS Brighton and Hove consulted on its first strategic commissioning which was published in December 2008. The

proposed revised plan is consistent with the original direction of travel contained within the PCT's first SCP and re-emphasises plans to develop care closer to home and improve the health of the local population.

A key driver for the overall revision will be to address the financial challenges from 2011/2012 onwards. The overall aim of the PCT's strategy is to demonstrate the effective use of its resources whilst maximising health outcomes for the local population. The PCT's strategic plan will be underpinned by a five year financial plan and organisational development plan which are being developed in tandem to the SCP. The SCP will contain the outputs of the PCT's review of its visions, goals and major initiatives or "Priority Transformation Programmes" (PTPs) which have been developed and agreed through the Strategic Commissioning Board which involves City Council Officers.

2. RECOMMENDATIONS:

2.1 That members note and consider the progress report and process for the future development of the NHS Brighton and Hove revised Strategic Commissioning Plan prior to its submission in January 2010.

2.2 Members are asked to note that as part of the presentation that will be given to HOSC a number of key areas of future service transformation will be highlighted as areas of change for future discussion and review.

3. BACKGROUND INFORMATION

3.1 The PCT has reviewed its key commissioning activities which were contained within the existing strategic plan through a dual approach of the taking stock of existing initiatives and identifying and prioritising priority programmes for next five years.

3.2 The PCT has prioritised a number of key Priority Transformational Programmes (PTPs) for implementation over the 5 years of the plan. For each of the programmes work is ongoing define the investment and saving assumptions where key phases of implementation including outcomes and benefits for each programme.

3.3 As part of the next stage of development work the PCT has agreed a number of key cross cutting programmes of review which support the PCT's financial plan linked to achieving improved value for money across the PCT's commissioning portfolio.

A summary of the PTPs is shown in the table below:

Urgent Care A simpler, integrated urgent care system which ensures that people are seen quickly and by the right person in the right place
Primary Care Development of improved services with reduced variation in quality and performance. This will provide a strong foundation to enable the shift of services from secondary to primary care
Long term conditions and case management Providing systematic and integrated primary and community care for patients with a long term condition from self care to end of life, delivered through new models of care
Long term care and independence Develop Integrated rehabilitation and independence services which, together with case management, support people to live independently at home for as long as possible
Gateway and referral management Ensuring that patients are assessed and treated in the right place achieving greater value for money and improved clinical effectiveness
Acute hospital care Achieving reduced spend in secondary care will be achieved by reducing the cost base within the acute care and improving productivity and efficiency
Out of hospital care Transfer of services from the acute sector into community settings. Making services more accessible and promoting choice for local residents.
Cancer Improving prevention, access and treatment for cancer.
Specialised commissioning Increased management of specialised and tertiary services by better contract management, addressing service gaps and repatriation of out of

area activity
Transferring mental health services Ensuring effective mental health services along the whole pathway of care from improved wellbeing to effective assessment, treatment and recovery.
Transforming maternity services Offering choice to women, modernising maternity services and reducing inequalities for vulnerable groups
Transforming Children's Services Improving the lives and health of children and young people through the delivery of integrated, effective, evidence based and needs led services
Developing a healthy young city Facilitating a shift to healthier, lifelong behaviours in order to impact significantly on the population's health
Adding years to life Developing key interventions to reduce the gap in life expectancy between the least and most disadvantaged populations and to improve overall life expectancy

3.3.1. Improved value for money

The PCT will undertake reviews of key aspects of commissioned activity, targeting those areas where performance lies outside national and peer group PCT averages and/or where efficiency and productivity improvements can be potentially made.

This programme is being scoped as part of the SCP development process and will focus on potential areas including Mental Health, Infectious Diseases, adverse effects, elements of planned care as well as preventative health spend.

The final shape and phasing of these proposed programmes will be subject to further scoping and consideration. Where existing programmes of review are in place these will continue as per planned programmes of redesign or review.

3.3.2. Use of Commissioning system Levers

The PCT will review the application of commissioning levers such as tariffs and marginal rates linked to quality indicators available to drive further efficiency and productivity with local healthcare providers.

3.3.3 Corporate Efficiency

The PCT will be undertaking a review of all aspects of Corporate spend as part of its cross-cutting commissioning

Along with all South East Coast PCTs, the PCT is undertaking joint work to examine the potential establishment if a commercial support unit to migrate a number of key functions to a coordinating hub from the 1st April 2010.

4. HOSC INVOLVEMENT

4.1 It is proposed that HOSC will be kept apprised of the work being developed for each PTP area and in due course the potential areas of review once the details of the proposed approach to each areas and timing has been finalised and agreed by the Professional Executive Committee (PEC) and PCT Board.

4.2 The revised SCP will be finalised and submitted on January 22nd 2010 as part of the World Class Commissioning Assurance process, as the revised Strategy is still in development, it will be appropriate in early 2010 to consider any area that HOSC require the further scrutiny by members although it is not possible at this point to define whether there will be any likely “substantial variations” in local health care until the outputs of planned review work are completed.

5. CONSULTATION

5.1 The PCT is developing the revised strategic commissioning through a number of ongoing engagement activities. The PCT’s existing plan underwent extensive engagement through stakeholder events held in summer and autumn 2008.

5.2 A stakeholder event for key partners was held on November 11th 2009 which involved representatives from key healthcare providers including third sector organisations and City Council representatives.

5.3 Each planned priority transformation programme is developing more detailed change programmes as part of finalising delivery plans for each area. The PCT will publish more detailed delivery plans as part of the final SCP in due course.

5.4 The overall development of the Strategic Commissioning plan is overseen by the Strategic Commissioning Board which has Director

level representation form the PCT as well as representation from Director of Social Services and Director of Children Services for the Children and Young People's Trust (CYPT)

6. FINANCIAL & OTHER IMPLICATIONS:

6.1 The PCT retains a commitment to ensuring the revised plan delivers a sustainable financial position from 2010/11 – 2013/14 and that it is able to meet the pressures this will bring to the local health system.

6.2 The PCT is in the process of modelling a number of different financial scenarios as advised by the Department of Health through South East Coast SHA.

6.3 In overall terms from 2011/12 onwards, the PCT is planning to receive a zero increase in allocation which equates to approximately a 7% reduction in allocation for each year of the plan.

6.4 This will require the PCT to prioritise areas for investment across the whole of its commissioning portfolio with a particular focus on doing more for the same or less resource.

6.5 The focus of the Strategic Commissioning Plan refresh is therefore focusing on the alignment and prioritisation of Priority Transformation Programmes (PTPs) and cross-cutting programmes that are critical to achieving the PCT's commissioning goals as well as delivering improved quality and value for money over the planning period.

Legal Implications:

6.5 There are no anticipated legal implications.

Equalities Implications:

6.6 The PCT's official SCP submission was Equality Impact assessed in 2009. The revised document will be assessed for its impact in late December 2009/early January 2010.

Sustainability Implications:

None identified

Crime & Disorder Implications:

6.7 None identified

Risk and Opportunity Management Implications:

6.8 None identified.

Corporate / Citywide Implications:

6.9 None identified.

SUPPORTING DOCUMENTATION

Appendices: None

Background Documents:

1) NHS Brighton and Hove Strategic Commissioning Plan 2008 – 2013
2) World Class Commissioning Year 2 Assurance Handbook (Department of Health 2009.)

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

Subject:		**Dental Services for Brighton & Hove Residents**		
Date of Meeting:		**02 December 2009**		
Report of:		**The Director of Strategy and Governance**		
Contact Officer:	Name:	Giles Rossington	Tel:	29-1038
	E-mail:	Giles.rossington@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 Members are asked to note information presented by NHS Brighton & Hove concerning the local performance of dental services (contained in **Appendices 1, 2, 3 and 4** to this report).

1.1 (a) **Appendix 1** consists of a report from NHS Brighton & Hove on city dental services;

(b) **Appendix 2** consists of a map of dental activity/access across Brighton & Hove;

(c) **Appendix 3** consists of the report which went to HOSC the last time this issue was debated (February 2009);

(d) **Appendix 4** contains statistics on city dental performance.

2. RECOMMENDATIONS:

2.1 That members note the contents of this report and its appendices, and determine whether they require any further updates on this issue.

3. BACKGROUND INFORMATION

3.1 In March 2009, the HOSC received a report from NHS Brighton & Hove on the local performance of dental services (i.e. performance following the introduction of a new national dental contract in 2006).

3.2 The committee heard that many aspects of city dental care were performing well: often considerably better than national/regional averages. In particular, members were told that city NHS dental capacity was sufficient to cope with local demand. However, committee members did express concerns about some aspects of performance. These included:

- Attendance at dental practices – following the introduction of the new dental contract, the city experienced a significant fall in dental activity (mirroring the national trend). At the March 2009 HOSC meeting, members were told that local activity was now rising, although it was still some way below pre-2006 levels. It was not, however, clear at this point whether the long term trend was upward .

- 'Signposting' – at the March 2009 HOSC meeting members were informed of a range of activities undertaken by NHS Brighton & Hove to direct people to local dental practices with spare NHS capacity. It was not, at this time, clear how effective these initiatives had been.

4. CONSULTATION

4.1 This report has been prepared following informal consultation with officers of NHS Brighton & Hove.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are none for the council

Legal Implications:

5.2 Legal advice has not been sought on this report for information

Equalities Implications:

5.3 NHS Brighton & Hove is responsible for ensuring that NHS dental services are readily accessible to all city residents, including people from communities which may typically experience poor access to healthcare services - e.g. homeless people, people with mental health issues, people from BME communities, and people from localities in which relatively few dental services are sited (dental practices are

independent businesses and cannot be required to operate out of any specific locality, so the spread of dental practices across an area may not necessarily map with population density etc). Members may be interested in ascertaining what steps NHS Brighton & Hove has taken to ensure that city NHS dental services can be accessed by the entire local community.

Sustainability Implications:

5.4 None identified

Crime & Disorder Implications:

5.5 None

Risk and Opportunity Management Implications:

5.6 None identified

Corporate / Citywide Implications:

5.7 The NHS provides dental care for the entire population which is subsidised or free at the point of delivery. However, take up of these services is typically patchy (in both national and local terms), with many people who are entitled to NHS care not receiving any treatment at all. Since poor dental health can have a major impact upon the quality of people's lives, and since those least likely to access NHS dental care may tend, on average, to come from the most disadvantaged parts of the local community, encouraging more use of available NHS dental services will help achieve the council priority to "reduce inequality by increasing opportunity".

SUPPORTING DOCUMENTATION

Appendices:

1 - 4. Information provided by NHS Brighton & Hove

Documents in Members' Rooms:

None

Background Documents:

None

Appendix 1

Report to: Health Overview and Scrutiny Committee
Regarding: Update on the Dental Contract
Date: 20th November 2009
By Cherie Young, Primary Care Commissioner for Dental and Optometry Services

Purpose

The HOSC requested an update regarding how NHS Brighton and Hove commissions and monitors services provided under the General Dental Services Contract.

Background

The new General Dental Contract was introduced in April 2006, with the aim of improving access to NHS dental services for patients in England. To achieve this the reforms included a new system of contracting with NHS dentists, a new system of dental charges, and an end to registration for patients.

NHS Brighton and Hove is responsible for commissioning services that help prevent diseases of the mouth teeth and gums, and provide appropriate care and treatment where disease occurs to any patient that accesses a service in Brighton and Hove. This is regardless of the PCT in which that patient is resident or the GP practice with which they are registered. In other words, services are commissioned on a 'catchment' rather than 'residence' basis. The main diseases are caries (tooth decay), periodontal disease (gum disease) and oral cancer. The previous report presented to the HOSC which contains further information is attached to this document as appendix 1.

Financial Year 2008/2009 Year End Status

NHS Brighton and Hove dental contractors have shown a year on year improvement in attaining their contracted activity:

2006/2007	84.17%
2007/2008	87.5%
2008/2009	98.5%

Whilst this indicates that activity against the contract is being delivered the PCT is now directing its attention to monitoring its contractors to ensure not only that activity is being delivered but also that is directed to patient needs as well as new

patients.

Vital Signs

When the new dental contract came into effect in April 2006, the number of patients attending the dentist reduced and in March the HOSC asked for information to demonstrate whether the trend of local activity was going up or down. The following table illustrates the quarterly trend of an overall increase in the number of patient accessing NHS dentistry. The lastest vital sign for September 2009 is attached as appendix 2

	Unique patients seen (within preceding 24 months)
01 September 2008	144,432
01 December 2008	145,986
01 March 2009	147,656
01 June 2009	147,401
01 September 2009	148,159
	3,727
Increase over 12 month period	2.60%

NHS Brighton and Hove are, through vigorous contract monitoring, maximising the capacity for practices to take on new patients by reviewing rates of recall where it appears that dentally fit patients may be being recalled more frequently than clinically necessary.

NHS Brighton and Hove are participating in a Department of Health Communications pilot that aims to improve access to NHS dentistry. Part of the work will include producing a patient information leaflet containing details of the services available in the city and highlighting that patients should not anticipate routine 6 monthly recalls. Under the NICE recall guidelines a dentist needs to recall each patient according to the patient's clinical needs. Patients with good current and historical oral health can therefore anticipate the recall as infrequently as 24 months whilst patients with identified oral health needs can be recalled within 3 months. The implementation of these guidelines creates capacity within existing practices to see new patients on the NHS. We have set ourselves a target of reducing the percentage of patients re-attending under 9 months from 64% to 59%. The PCT current position in this respect against the Strategic Health Authority can be seen in the Quality Section of the September Vital Sign Report attached at Appendix 2.

Promoting Access to Dentistry

Until September 2008 the Emergency Dental Service (EDS) based in Lewes was the only service provider for Brighton patients without a dentist. This is open from 18:30 – 22:00 Monday to Friday and 9;30 – 13:30 Saturday to Sunday. On average the service sees 88 Brighton and Hove residents each month.

Since September 2008 NHS Brighton and Hove have embarked on a pilot with local practices to supplement the existing EDS provision and promote access to dentistry. The PCT established a dental helpline and have agreed "Access slots" with dentists across the City during normal and extended surgery hours including Saturdays for patients in pain. On average these access slots see 60 Brighton and Hove residents each month. If possible the same practice then takes the patient on as a routine patient. Alternatively the patient would be referred back to the helpline to be informed of accepting dentists.

The helpline covers 4 PCT areas and the following table shows the levels of calls being dealt with in its first year of operation. On average there are over 100 calls a week to the helpline and almost half the volume of call are from patients in Brighton & Hove. On average one third of the calls from the city are for urgent care.

	Number of Calls - September 2008 to August 2009	**Percentage of Calls**
Hastings and Rother	618	10%
East Sussex Downs and Weald	660	11%
West Sussex	1916	31%
Brighton and Hove	2924	48%
	6118	

Information for Patients and the Public

NHS Brighton and Hove are communicating with local people about NHS dental services not only through their PALS and complaints procedures but also through direct contact at workshops in supermarkets and other public places. The following messages are being conveyed:

- Informing patients what they are entitled to expect and how they can get it

- Tackling misinformation
- Countering inaccurate media messages regarding service availability (in particular that it is difficult to get an NHS dentist) through signposting services and practices accepting patients

We continue to invest time and effort in presenting information in an accessible way using a range of techniques and we are now also working with the Department of Health in a communications pilot to determine effective methods of conveying these matters nationally to the public.

Feedback from Patients and the Public

During the current financial year to date the following issues have been raised by patients to NHS Brighton and Hove using the PALS and Complaints department

PATIENT COMPLAINTS		e.g.
Access and waiting	3	
Building relationships	1	practice attitudes
Information, Communication and co-ordinated care	5	patients charges, NHS v private treatment
Safe, high quality, co-ordinated care	15	clinical issues
No subject listed	7	

Total **31**

PALS ENQUIRIES		Eg
Access and waiting	5	service denied, service not available,
Building relationships	2	behaviour/attitude of practice
Information, Communication and co-ordinated care	83	information provided/ information requested, patients charges, treatment not available on NHS
Safe, high quality, co-ordinated care	18	emergency treatment, treatment available/options, patients charges, request for dentist
No subject listed	11	
Total	**119**	

Citizens Panel

A series of questions relating to dental services was included in a citizen's panel questionnaire that was distributed in September 2009. A total of 829 responses were received. In terms of awareness about how to access dentistry 64% of respondents said they would use word of mouth from family or friends. Only 21.5% of patients were aware of the dental help line and only 50% of patients were aware that there were dentists in Brighton and Hove taking on new patients.

The information from the Citizens Panel as well as from PALS and complaints indicate that the PCT needs to direct attention towards generating awareness of the availability of dentists as well as information on patients rights and treatment availability. It is anticipated that this will be included in the work being undertaken with the Department of Health in the Communications pilot.

Strategic Direction – Additional Local Investment in NHS Dentistry

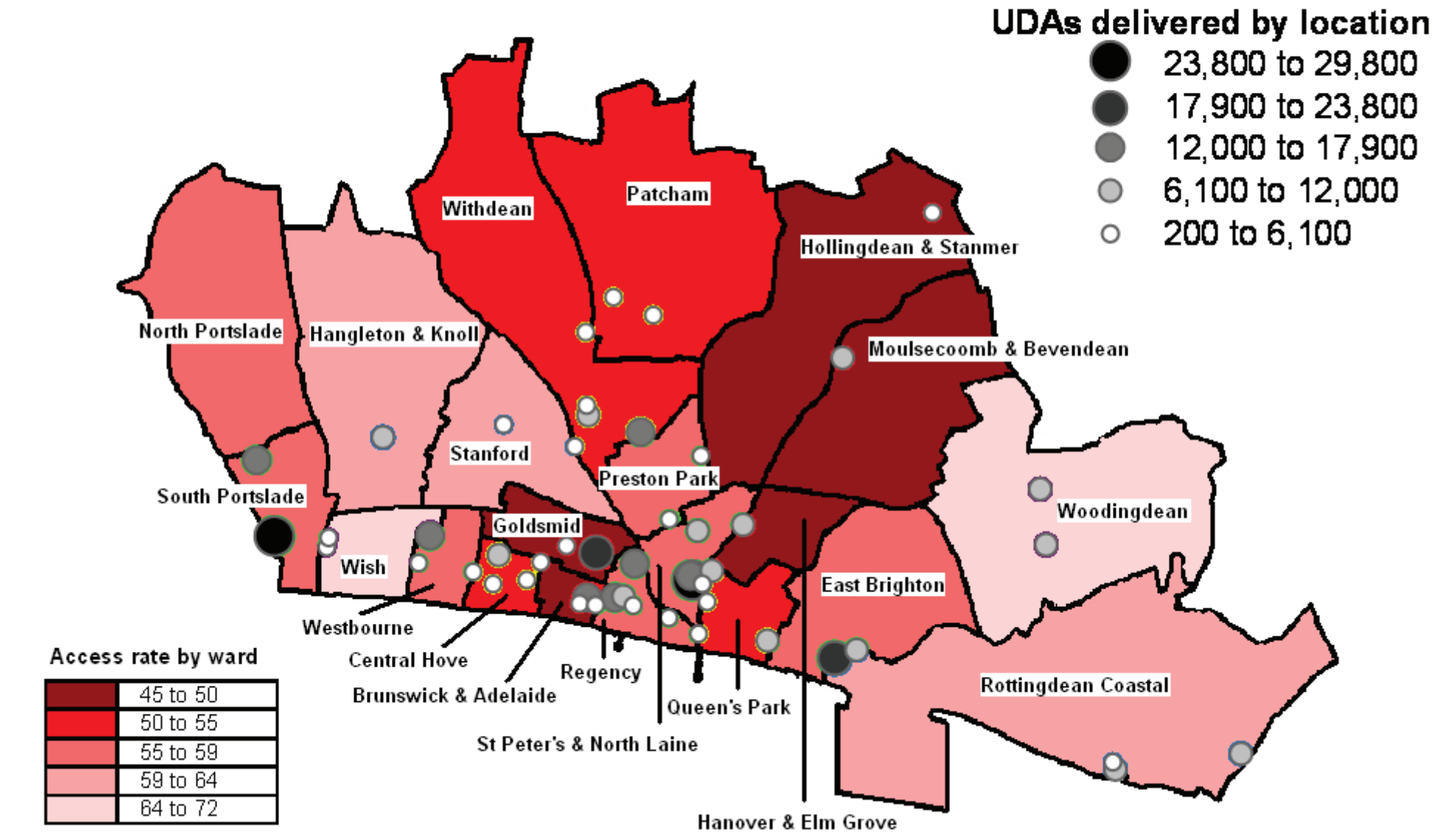
Data indicates that in 2008/09 58% of the local patients accessed NHS dentistry in the last 24 months. However there is variation in access rates geographically (as demonstrated by the map in appendix 3). It should be noted that of the 42% of patients not accessing NHS dentistry, a proportion will be accessing private dental care. An IPSOS MORI public satisfaction survey conducted in 2009 showed that of the Brighton and Hove residents not accessing NHS dentistry 58% of these were accessing a private dentist.

The PCT has made additional investment in NHS dentistry in 09/10 on a non-recurrent basis as part of a plan to increase access rates to reach the PCT's Vital Sign target of 62% of the population being able to access NHS dentistry by March 2011. In order to inform its ongoing commissioning arrangements for 2010/11 and beyond the PCT has commissioned a "social marketing" scoping exercise to determine the barriers to accessing NHS dental care and to identify why some residents continue not to access the available services. This exercise will be completed by February 2010 and will inform the PCT's detailed commissioning plans. Additional investment will be targeted to areas of highest need and the PCT is intending to undertake an open and transparent procurement exercise to secure new contracts seeking value for money and quality services for example, greater flexibility in opening hours, greater emphasis on oral health promotion and prevention regimes. The contracting mechanisms for these new contracts will include Key Performance Indicators to ensure that the patient's needs identified in the scoping exercise are fully met.

Summary

The PCT's overall contract performance is improving in terms of dental activity being delivered and the PCT has a high proportion of dentists accepting patients. The new Dental Helpline is proving successful in terms of responding to patient's requests to access dental services, although other feedback from patients and the public demonstrates that there is a need for further work in terms of communication and awareness to ensure all residents that want to are able to access NHS dentistry. Access rates to NHS dentistry differ by geographical area and the PCT's intention to increase investment in NHS dentistry is underpinned by plans to both improve communication and awareness as well as addressing some of the barriers to accessing NHS dental care in Brighton and Hove.

Access Rates by Ward and UDAs by location as at March 2009



Appendix 3

Report to: Health Overview and Scrutiny Committee
Regarding: Update on the Dental Contract
Date: 23rd February 2009
By Stephen Ingram, Strategic Commissioner Primary Care and Cherie Young, Primary Care Commissioner for Dental and Optometry Services

Purpose

The HOSC requested an update regarding how NHS Brighton and Hove commissions and monitors services provided under the General Dental Services Contract.

Background

The new General Dental Contract was introduced in April 2006, with the aim of improving access to NHS dental services for patients in England. To achieve this the reforms included a new system of contracting with NHS dentists, a new system of dental charges, and an end to registration for patients.

NHS Brighton and Hove is responsible for commissioning services that help prevent diseases of the mouth teeth and gums, and provide appropriate care and treatment where disease occurs to any patient that accesses them, regardless of the PCT in which that patient is resident or the GP practice with which they are registered. In other words, services are commissioned on a 'catchment' rather than 'residence' basis. The main diseases are caries (tooth decay), periodontal disease (gum disease) and oral cancer.

Contracts

Prior to the new contract it was possible for a dentist to set up a NHS practice wherever they wished, and to provide an unlimited amount of treatment. Under the new General Dental Contract those dentists who held a contract at 31st March 2006 were entitled to a new General Dental Service contract from 1st April 2006, initially based on the amount of care provided during the 'reference period' between 2004 and 2005. This reference period data formed the Unit of Dental Activity requirement for each contract together with the contract value and was guaranteed until 31st March 2009 with the PCTs dental budget ring fenced until 31st March 2011.

Dental Contractors are paid their contract value in advance and are required to hit the UDA target identified in the reference period within a tolerance of + or – 4%.

At the end of the financial year 2006/2007 NHS Brighton and Hove had achieved 90% of its target and successive improvements are being made to service delivery with projected delivery in the financial year 2008/2009 being 96%

Once the contract value protection goes on 31st March 2009, contract value becomes just like any other term within a GDS contract: it can be altered by agreement. If the PCT wants to change the contract value, then it may re-negotiate it with the practices concerned. For many contractors, their contract will continue unchanged in 09-10.

There is some concern among dentists with GDS contracts that they may be in danger of termination or required to amend their contract from April 2009. The position is that GDS contracts continue indefinitely, unless the contractor has not complied with the terms to such an extent that they warrant contract termination.

PCTs might wish to renegotiate contract values to tackle particular dental practices within their areas who are struggling to deliver the activity values specified.

Who Provides primary dental services

Primary dental care can be provided by

- Independent contractors with their associates (high street dentists)
- Dentists with Special Interests
- PCT Provider arms and other NHS organisations

The majority of NHS primary dental care is provided by independent contractors, working as single-handed practitioners or in partnerships.

What sort of services are provided

Independent contractors - are required to provide mandatory services under the standard GDS contract. Although the remuneration system no longer includes patient registration, providers tend to have a list of regular patients who have a continuing relationship with that practice. However if a practice has space in its appointment book, it should accept any patient who is seeking treatment. These Contractors must provide all proper and necessary dental care and treatment which a practitioner usually undertakes for a patient and which the patient is willing to undergo, this includes all treatment, including urgent treatment and where appropriate, the referral of the patient for advanced/additional services.

Mandatory services include

	General terms	**Unit of Dental Activity (UDA) counted against contract**	**Patients Charge Applicable**
Examination, diagnosis, (which includes the taking of radiographs) advice and planning of treatment –	diagnostics	1	£16.80

Preventative care and treatment, endodontic, periodontal, conservative, surgical treatment	Conservation	3	£44.60
Supply and repair of dental appliances, crowns and bridges	treatment involving Laboratory work	12	£198.00

Out of hours dental services - these are arranged separately from main provision to deal with urgent care needs which cannot be met in house during normal surgery hours (Monday to Friday 9 – 5) Patients who attend a dentist should contact their practice if in urgent need of care within surgery hours.

Specialist Primary Care Services - such as orthodontics and sedation services.

Salaried primary dental care services for groups with Special Needs

Dental Access Centres - designed for urgent and immediate care.

General Dental Service Contracts in Brighton and Hove

NHS Brighton and Hove currently holds 62 contracts with 55 practices across the city. The size of the contracts varies from 270 Units of Dental Activity (UDA) to 30,000 UDAs with contract values between £5,000 to £900,000.

The total net dental budget allocated by the Department of Health for Brighton and Hove for 2008/2009 was £12,300,000 and assumes that an amount of £3,354,000 will be collected in patient charges. The total monies available for spend is therefore £15,654,000. The dental spend on contracts totalled £12,812,000 with further funding being required to cover on-costs (eg superannuation/maternity and sick pay). NHS Brighton and Hove has commissioned further activity with contractors who have historically evidenced their ability to perform, on a short term contract basis for this and the next financial year to ensure the full budget is spent. This will create a window enabling a full procurement exercise in the open market against the Oral Health Needs Assessment (OHNA) to be undertaken.

In the week commencing 23rd February 2009, of the 50 practices within the city who provide mandatory services, 27 are taking on new patients.

Annual reviews of all the city's dental contracts have been undertaken for the financial year 2007/2008 and in year adjustments made where required.

Strategic Direction

Before NHS Brighton and Hove could begin to make improvements to primary care services, a map of the baseline was required to establish the present position. However, the PCT has a responsibility to commission any new contracts, enabling the provision of services to be directed to areas of need. In Brighton and Hove, OHNA has been carried out which will indicate areas where

additional provision should be targeted, and will provide the framework for commissioning future dental services, which will include both general and specialist services.

The OHNA covered the following areas:

1. Assess needs
2. Map existing services
3. Identify what needs to change

This enables NHS Brighton and Hove to rationalise commissioning dental services through assessing need and demand.

The OHNA has identified the need for a Consultant in Restorative Dentistry and NHS Brighton and Hove, following consideration, seek to procure this service to address the unmet need**Independent contractors** – Work has started in the development of not only a smoking cessation package that can be used in dental practices but also in an Oral Health Promotion package and it is anticipated that this will be ready to roll out to the practices this year.

Specialist Primary Care Services - the City has two orthodontic providers one of which is a single handed practitioner and the other is a large national company. These contractors only provide services to patients under the age of 18, who fit the new Index of Orthodontic Treatment Need criteria of 3.6 and above and do not require treatment by multi disciplinary teams (orthodontic treatment and constructive surgery) Patients who fall outside of the IOTN criteria and who do not have multi disciplinary needs will generally be offered the treatment on a private basis. Patients over 18 may apply to secondary care for their treatment or be offered treatment on a private basis.

There are two contractors who provide the majority of our sedation services although a further contractor has a small provision.

Salaried primary dental care services for groups with Special Needs – NHS Brighton and Hove currently hold a Service Level Agreement with South Downs Health who provide care for children and adults with special needs. This service also undertakes Oral Health Promotion in schools and the community.

Dental Access Centres – the Dental Access Centre in St James Street has historically provided urgent and routine care for routine patients within the city. However this service has recently been redesigned to provide urgent and routine care to hard to reach groups including substance misuse clients, travellers, clients with mental health issues, mother and children groups. The centre also provides a full upper and/or full lower denture service.

NHS Brighton and Hove are working closely with this service provider to promote these services with local people.

Emergency Dental service - This service is currently being provided for the city at the Emergency Dental Service based at Victoria Hospital in Lewes by East

Sussex Downs and Weald Provider arm. It is open from 18;30 – 22:00 Monday to Friday and 9;30 – 13:30 Saturday to Sunday.

The service is not unique to Brighton and Hove residents and, due to its location can be difficult for patients to access. The service has only limited capacity and at the present time turns away as many patients as it sees.

An EDS review is currently being led by East Sussex Downs and Weald PCT, however due to the length of time the review is taking and the fact that the contract and patients needs have moved on, NHS Brighton and Hove are embarking on a pilot with a local practice to supplement the existing EDS provision.

Promoting Access to Dentistry

Until September 2008 the EDS service in Lewes was the only service provider for Brighton patients without a dentist. With the implementation of the county wide dental helpline in September 2008 it became possible to implement patient care pathways. Access slots around the city were commissioned in normal surgery hours for patients in pain. If possible the same practice would then take the patient on as a routine patient. Alternatively the patient would be referred back to the helpline to be informed of accepting dentists.

The helpline covers 4 PCT areas and since September 2008 has received a total of 3,059 calls for both urgent and routine calls for the following areas

- East Sussex Downs and Weald 330
- Hastings and Rother 309
- West Sussex 958
- Brighton and Hove 1462

The higher number of calls from the city residents is due to the promotional activities that are being undertaken by NHS Brighton and Hove in directing patients to dental services.

On average one third of the calls from the city are for urgent care. (487)

Information for Patients and the Public

NHS Brighton and Hove are communicating with local people about NHS dental services not only through their PALS and complaints procedures but also through direct contact at workshops in supermarkets and other public places. The following messages are being conveyed:

- Informing patients what they are entitled to expect and how they can get it
- Tackling misinformation (potentially including from dentists)
- Countering inaccurate media messages regarding service availability through signposting services and practices accepting patients

We are investing time and effort in presenting information in an accessible way using a range of techniques including the following:

- The commissioning of a patient dental helpline 0300 1000 899
- The design and distribution around the city of dental posters and business cards advertising the dental helpline
- Internet – PCT and NHS Choices web sites
- Press releases
- Local advertising in papers and magazines
- On the week beginning 16th February 2009 NHS Brighton and Hove embarked upon a week long pilot SMILE radio campaign on southern FM. This campaign produced a further 20 helpline hits each day
- One aim is to hold workshops with the citys employers, promoting service availability and include an e mail advert for distribution within their organisation

Feedback from Patients and the Public

During the current financial year to date the following issues have been raised by patients to NHS Brighton and Hove using the PALS and Complaints department

PATIENT COMPLAINTS		eg
Access and waiting	3	
Building relationships	4	practice attitudes
Information, Communication and co-ordinated care	6	patients charges, Nhs v private treatment
Safe, high quality, co-ordinated care	24	clinical issues

PALS ENQUIRIES		eg
Access and waiting	10	service denied, service not available,
Building relationships	3	behaviour/attitude of practice
Information, Communication and co-ordinated care	169	information provided/ information requested, patients charges, treatment not available on NHS
Safe, high quality, co-ordinated care	16	emergency treatment, treatment available/options, patients charges, request for dentist

Performance Monitoring Arrangements

This following report is collated and provided to NHS Brighton and Hove by the central dental services division on a quarterly basis. It is also available at

contract level and this is used as the basis for discussion with practices on performance, value for money and improvement in access for patients.

a) Access

The report highlights the % change in the number of unique patients being seen in each successive quarter which indicates the ability of patients in each age range to access services across the city. The figures evidence the progressive impact the dental helpline/workshops and advertising campaign are having in identifying available services to patients

NHS Brighton and Hove monitor trends in the access report and link these with the quality report section to identify those factors which impact on access eg

- Recall intervals - reviewing rates of recall where it appears that dentally fit patients are being recalled over frequently and as a result new patients are unable to access services
- Courses of treatment - identifying and reviewing courses of treatment that are being inappropriately split and as a result patients could be inappropriately charged and contractors are receiving incorrect UDAs

b) Activity

The report graphically highlights the PCT performance in the current versus previous financial years and month on month

c) Quality

The report highlights quality being provided in numbers and percentages and gives a comparison against the StHA percentage. This allows NHS Brighton and Hove to take action to continually improve these quality issues

- recall intervals and courses of treatment see a)
- Urgent courses – at practice level this figure will be higher if urgent access slots are being provided. A high proportion of Band 1 urgent courses may indicate an issue with the quality of diagnosis or treatment planning. A very low level may indicate that patients are not able to access urgent treatment
- Continuations – a high level may indicate an issue with the quality of treatment being provided. A low level may indicate that patients are not able to access urgent treatment

Patient satisfaction survey – these measures are derived from results of routine monthly random patient questionnaires sent to 25,000 patients nationally by the NHS BSA DPD (the response rate is 50%). This information is looked at alongside feedback from PALS and feedback from the local dental helpline

NHS
Dental Services

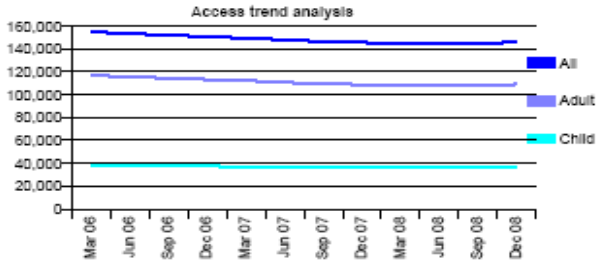
Vital Signs At a Glance Report for 5LQ Brighton and Hove City Teaching PCT - December 200

Number of General Contracts	62
Number of Orthodontic Contracts	2
Number of Mixed Contracts	0
Number of Providers	64
Number of Performers	225

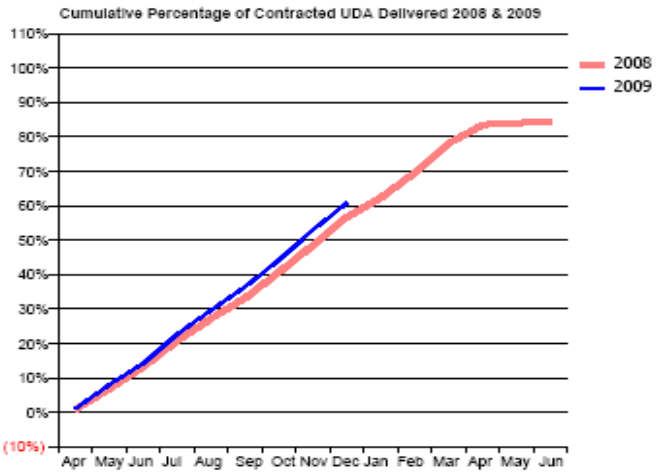
08/09 Contracted general activity (UDA)	464,736
Carry forward general activity (UDA)	2,453
08/09 Contracted orthodontic activity (UOA)	21,633
Carry forward orthodontic activity (UOA)	537
Baseline contract value	£12,937,272.60

ACCESS

Patients seen in 24 months	Total	Change since previous quarter
Quarter ending March 2008	145,006	
Quarter ending June 2008	144,649	→
Quarter ending September 2008	144,432	→
Quarter ending December 2008	145,986	→
Quarter ending March 2009		
Variance since March 2008	0.7%	→



ACTIVITY



	Adjusted Scheduled Activity (UDA)	
Month	2008	2009
April	4,540	5,406
May	33,820	37,836
June	65,732	66,481
July	102,428	105,958
August	134,459	138,261
September	163,665	169,802
October	200,794	205,847
November	239,258	245,615
December	279,486	282,882
January	307,038	
February	342,556	
March	364,797	
April	411,042	
May	413,552	
June	415,267	

QUALITY

	Quantity	PCT	SHA
% of FP17s for the same patient ID Re-attending within 3 months	21,683	17.1%	19.1%
% of FP17s for the same patient ID Re-attending between 3 months and 9 months	60,016	47.2%	52.0%
% of FP17s for Band 1 Urgent Courses	9,491	7.7%	7.6%
% of FP17s Relating to Free Repair or Replacements	807	0.7%	0.8%
% of FP17s Relating to Continuations	2,136	1.7%	2.1%
% of Patients satisfied with the dentistry they have received	908	90.9%	90.9%
% of Patients satisfied with the time they had to wait for an appointment	825	82.6%	85.6%

Please see PDF documents - Quarterly Vital Signs Report Guidance PCT.pdf and Vital Signs Reports Technical Explanations.pdf for report descriptions and definitions

NHS
Dental Services

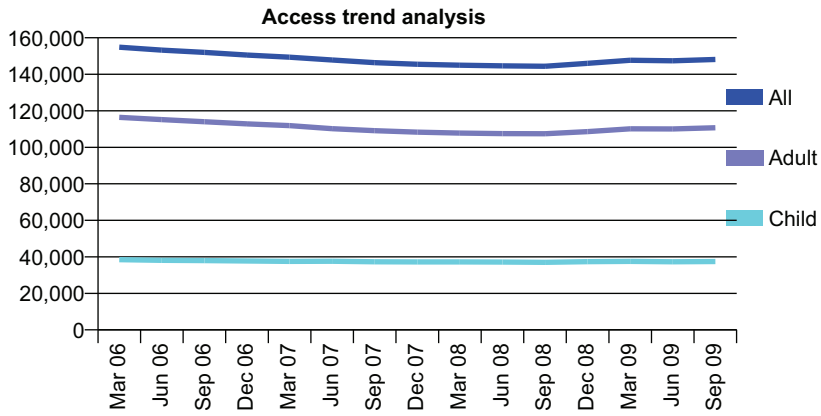
Vital Signs At a Glance Report for 5LQ Brighton and Hove City Teaching PCT - September 200

Number of General Contracts	61
Number of Orthodontic Contracts	1
Number of Mixed Contracts	0
Number of Providers	62
Number of Performers	257

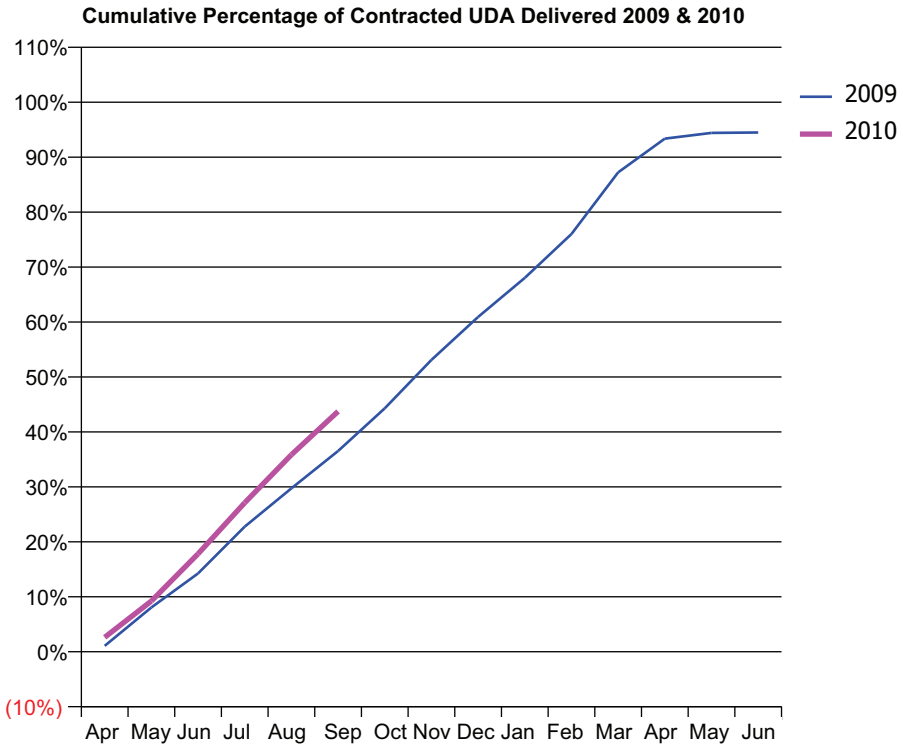
09/10 Contracted general activity (UDA)	426,802
Carry forward general activity (UDA)	-1,147
09/10 Contracted orthodontic activity (UOA)	18,457
Carry forward orthodontic activity (UOA)	-484
Baseline contract value	£12,185,834.90

ACCESS

Patients seen in 24 months	Total	Change since previous quarter
Quarter ending September 2008	144,432	
Quarter ending December 2008	145,986	→
Quarter ending March 2009	147,656	→
Quarter ending June 2009	147,401	→
Quarter ending September 2009	148,159	→
Variance since September 2008	2.6%	↑



ACTIVITY



	Adjusted Scheduled Activity (UDA)	
Month	**2009**	**2010**
April	4,978	11,201
May	37,408	39,392
June	66,053	76,074
July	105,530	115,781
August	137,833	153,046
September	169,374	186,732
October	205,419	
November	246,187	
December	282,454	
January	315,339	
February	352,411	
March	404,332	
April	432,835	
May	437,674	
June	438,036	

QUALITY

	Quantity	PCT	SHA
% of FP17s for the same patient ID Re-attending within 3 months	17,430	18.4%	19.8%
% of FP17s for the same patient ID Re-attending between 3 months and 9 months	43,322	45.7%	50.3%
% of FP17s for Band 1 Urgent Courses	7,233	9.3%	7.8%
% of FP17s Relating to Free Repair or Replacements	554	0.7%	0.8%
% of FP17s Relating to Continuations	1,493	1.9%	2.2%
% of Patients satisfied with the dentistry they have received	1,014	90.8%	91.7%
% of Patients satisfied with the time they had to wait for an appointment	959	85.9%	87.1%

Please see PDF documents - Quarterly Vital Signs Report Guidance PCT.pdf and Vital Signs Reports Technical Explanations.pdf for report descriptions and definitions

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

Subject:		**Annual Health Check 2008-2009**		
Date of Meeting:		**02 December 2009**		
Report of:		**The Director of Strategy and Governance**		
Contact Officer:	Name:	Giles Rossington	Tel:	29-1038
	E-mail:	Giles.rossington@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The "Annual Health Check" is a yearly assessment of NHS trust performance and financial management, formerly conducted by the Healthcare Commission (and latterly by the Care Quality Commission).

1.2 This report and its appendix detail the results of the assessment for 2008-2009 as it affects local NHS trusts, and provide some context for these results, comparing them with performance in 2007/2008 and 2006/2007.

2. RECOMMENDATIONS:

2.1 That members note this report.

3. BACKGROUND INFORMATION

3.1 The NHS Annual Health Check is a wide-reaching assessment of the performance and financial management of all NHS trusts.

3.2 Trusts are awarded both a headline score for performance and a headline score for financial management. Underpinning these ratings are a range of scores for performance against particular core standards. These standards are themselves often divided into dozens of sub-categories, meaning in practical terms that trusts have to report against several hundred performance standards every year.

3.3 The Annual Health Check is essentially a self-assessment exercise, with trusts declaring whether they believe they have passed or failed against particular standards, and evidencing their claims with background documents etc. Every year some trusts are chosen for inspection, either due to historical issues with aspects of their performance, concerns expressed by third parties, or because they have been randomly selected for a visit.

3.4 This is the last year in which this assessment system will operate. The Care Quality Commission will introduce its own assessment procedure for coming years, although the details of this are not yet entirely clear.

4. CONSULTATION

4.1 None has been undertaken in preparing this report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are no direct implications for the council in this report for information

Legal Implications:

5.2 No legal advice has been sought for this report for information

Equalities Implications:

5.3 None identified

Sustainability Implications:

5.4 None identified

Crime & Disorder Implications:

5.5 None directly

Risk and Opportunity Management Implications:

5.6 None identified

Corporate / Citywide Implications:

5.7 None identified

SUPPORTING DOCUMENTATION

Appendices:

1. The 2008/2009 Annual Health Check scores for local NHS trusts

Documents in Members' Rooms:

None

Background Documents:

1. None

Appendix 1

Annual Health Check: NHS Trust Performance 2008-2009

- **NHS Brighton & Hove**

  Quality of Commissioning: **GOOD**

  Quality of Financial Management: **GOOD**

  (07/08: FAIR/GOOD; 06/07: WEAK/FAIR)

- **Brighton & Sussex University Hospitals Trust**

  Quality of Services: **GOOD**

  Quality of Financial Management: **GOOD**

  (07/08: EXCELLENT/FAIR; 06/07: FAIR/WEAK)

- **Sussex Partnership NHS Foundation Trust**

  Quality of Services: **GOOD**

  Quality of Financial Management: **EXCELLENT**

  (07/08: EXCELLENT/GOOD; 06/07: GOOD/GOOD)

- **South Downs Health NHS Trust**

  Quality of Services: **FAIR**

  Quality of Financial Management: **GOOD**

  (07/08: WEAK/GOOD; 06/07: GOOD/FAIR)

- **South East Coast Ambulance Trust**

  Quality of Services: **FAIR**

  Quality of Financial Management: **GOOD**

  (07/08: GOOD/GOOD; 06/07: FAIR/FAIR)

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

Subject:		**Referral from Audit Committee: Health Inequalities**		
Date of Meeting:		**02 December 2009**		
Report of:		**The Director of Strategy and Governance**		
Contact Officer:	Name:	Giles Rossington	Tel:	29-1038
	E-mail:	Giles.rossington@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 At its 29 September 2009 meeting, the Audit Committee considered an Audit Commission report on Health Inequalities in Brighton & Hove (the Audit Commission report is reprinted as **Appendix 1** to this report; an extract from the relevant Audit Committee minutes is reprinted as **Appendix 2**).

1.2 The Audit Committee decided to refer the Audit Commission report to HOSC in order for HOSC to monitor the implementation of the report recommendations. Although not explicitly stated in the Audit Committee minutes, it seems reasonable to assume that the matter was referred to HOSC because Audit Committee members felt that 'health inequalities' were a HOSC issue.

1.3 However, whilst 'health inequalities' undoubtedly fall within HOSC's remit, it is clear from the Audit Commission report Action Plan that most of the report recommendations are not for implementation by health bodies. In fact, the bulk (seven out of nine) of the report's recommendations require implementation by officers of Housing Strategy (albeit sometimes working in conjunction with Public Health officers).

1.4 The scrutiny of Housing Strategy normally falls under the remit of the Adult Social Care & Housing Overview & Scrutiny Committee (ASCHOSC). As this is ostensibly an ASCHOSC matter and as ASCHOSC has well-established links with Housing Strategy, it might be thought more appropriate for ASCHOSC to monitor this issue.

1.5 The Overview & Scrutiny Commission (OSC) is charged with "determining arrangements for dealing with a particular issue" where "matters fall within the remit of more than one Overview & Scrutiny committee" (Constitution Point 6: Paragraph 3.1b)). Therefore, if HOSC members do not themselves wish to take responsibility for monitoring the implementation of the Audit Commission recommendations on Health Inequalities, they should consider referring the matter to the OSC rather than directly to ASCHOSC or any other O&S committee.

2. RECOMMENDATIONS:

2.1 That members:

(I) note the contents of the Audit Commission Health Inequalities report (**Appendix 1**);

(II) agree to refer the report to OSC for further consideration.

3. BACKGROUND INFORMATION

3.1 'Health Inequality' refers to the variable health outcomes across the population, with some groups of people typically suffering much worse health and earlier mortality than others.

3.2 Given the existence of a national framework of standardised NHS healthcare provision available to all UK citizens free at the point of contact, it is not generally considered that health inequalities significantly correlate with unequal access to healthcare or with major differences in the quality of NHS provision from place to place (although poorer communities may typically experience some access problems, particularly in terms of primary care services such as GP surgeries and dental practices).

3.3 Rather, health inequality is thought to correlate most strongly with social factors, such as worklessness, poor housing etc. Therefore, tackling health inequality requires effective partnership working between health bodies, local authorities and other agencies.

4. CONSULTATION

4.1 No formal consultation has been undertaken in preparing this paper.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are none for Overview & Scrutiny, as any monitoring work can be managed by the Overview & Scrutiny (O&S) team in the course of its day to day work.

Legal Implications:

5.2 No legal advice has been sought in relation to this report.

Equalities Implications:

5.3 Health Inequalities are clearly a core equalities issue. However, in the context of determining which O&S committee is best placed to monitor the implementation of the Audit Commission report, there are no particular equalities implications to consider.

Sustainability Implications:

5.4 None identified.

Crime & Disorder Implications:

5.5 None identified.

Risk and Opportunity Management Implications:

5.6 For Overview & Scrutiny to work efficiently, it is important that issues should be dealt with by the most appropriate O&S committee.

Corporate / Citywide Implications:

5.7 Tackling health inequalities is a core priority of the Council ("Reduce Inequality by increasing opportunity"). It is also a significant driver for the Local Area Agreement and one of the key determinants of NHS Brighton & Hove's commissioning strategy.

SUPPORTING DOCUMENTATION

Appendices:

1. The Audit Commission Health Inequalities report;

2. Extract of relevant minutes from the 29.09.09 Audit Committee meeting.

Documents in Members' Rooms:

None

Background Documents:
None

BRIGHTON & HOVE CITY COUNCIL

AUDIT COMMITTEE

4.00pm 29 SEPTEMBER 2009

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillors Hamilton (Chairman), Watkins (Deputy Chairman), Alford, Fallon-Khan, Kitcat, Simpson, Smith, Taylor and G Theobald

PART ONE

30. AUDIT COMMISSION: HEALTH INEQUALITIES ASSESSMENT REPORT

30.1 The Committee considered a report from the Audit Commission regarding the Health Inequalities Assessment Report (for copy see minute book).

30.2 The District Auditor began by summarising the report and stating that the Health Inequalities Assessment Report had been included in the 2008/09 audit plan for the Primary Care Trust and Brighton & Hove City Council. The report examined partnership working in Brighton & Hove on health inequalities and acknowledged the work already being done in this area. A focus on housing issues had been chosen and the conclusion had been good, but it was noted that more work needed to be done on sharing priorities and identifying and addressing need.

30.3 Councillor Watkins asked why the report had been submitted to the Audit Committee as an item for discussion. The Director of Finance & Resources stated that it was part of the Committee's remit to take this item and the District Auditor added it was for information only but demonstrated part of the work the Commission was doing for the audit fee they charged.

30.4 The Chairman asked if this item would be taken forward to the Health Overview & Scrutiny Committee (HOSC) and the District Auditor stated that this would be a matter for Officers to decide.

30.5 Councillor Kitcat asked why more joined up working in terms of the Primary Care Trust making representations at Licensing Panels was not considered. The District Auditor stated that only one theme had been chosen for the basis of the report and this related to housing issues. She recognised there was still much progress to be made on further joint working between partners however.

30.6 Councillor Watkins was concerned about how the recommendations from the report would be followed up and actions monitored, and the Chairman agreed, asking who would implement the recommendations of the report. The District Auditor stated that the

implementation of recommendations would form part of the action plan and it was the responsibility of Officers to monitor this.

30.7 The Chairman proposed that this item be referred to HOSC, and this was seconded by Councillor Watkins.

30.8 **RESOLVED** – That:

1. The Health Inequalities Assessment report is noted.
2. The Health Inequalities Assessment report is referred to the Health Overview and Scrutiny Committee for noting and monitoring of the recommendations.

The meeting concluded at 6.30pm

Signed Chair

Dated this day of

Managing Health Inequalities

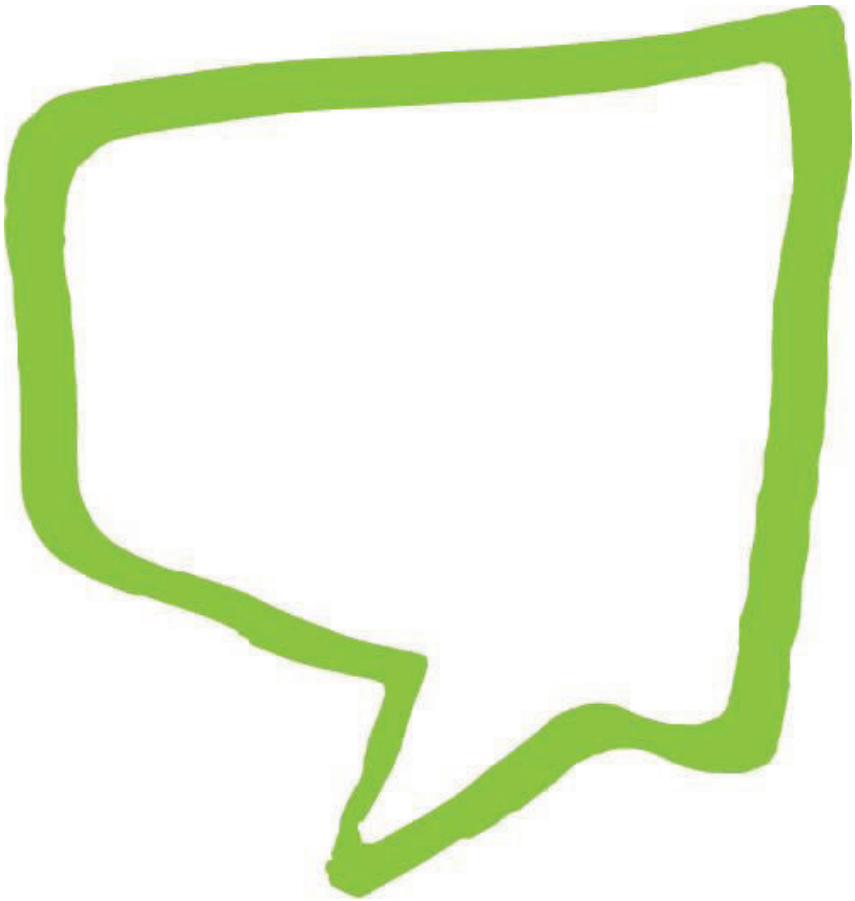
Phase 2

Brighton and Hove City Primary Care Trust

Brighton and Hove City Council

Audit 2008/09

September 2009



audit commission

Contents

Status of our reports

The Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission explains the respective responsibilities of auditors and of the audited body. Reports prepared by appointed auditors are addressed to non-executive directors/members or officers. They are prepared for the sole use of the audited body. Auditors accept no responsibility to:

- any director/member or officer in their individual capacity; or
- any third party.

Introduction

1 Health inequalities exist when some groups of the population suffer from significantly greater ill-health (morbidity) and earlier death (mortality) than the average and other groups of the population. There are significant levels of inequality globally, in some parts of the UK, and varying levels in all areas of the UK.

2 There is national and international recognition for the need to tackle health inequalities collaboratively. The 'Health is Global' (2008) five year national strategy demonstrates the links between economy, prosperity and health. It sets out actions to:

- 'improve the health of the UK and the world's population'; by
- 'combating global poverty and health inequalities'.

3 Tackling health inequalities is a formal requirement both of local authorities and Primary Care Trusts (PCTs). The reform agenda, as set out in the 'Commissioning framework for health and well being', emphasises the need for:

- 'joint strategic needs assessment by councils, PCTs and other relevant partners'; and
- 'sharing and using information more effectively'.

4 Tackling health inequalities absorbs huge amounts of public money in both local government and health sectors. Securing optimum value for money from these combined resources requires effective joint working among the public sector bodies in order to achieve public service agreement (PSA) targets.

5 Comprehensive Area Assessment (CAA) is a new assessment framework for councils and their partners to be implemented in 2009. Proposals describe an area-wide assessment by the inspectorates considering outcomes for people in an area and a forward look at prospects for sustainable improvement. This assessment will look at how well local public services are delivering better outcomes for local people in local priorities such as health. In managing partnership relationships, public bodies need to have regard to the risks to delivery. This includes identifying local needs and addressing them. The way in which health inequalities may be experienced by vulnerable groups will be a key part of this assessment in 2009.

Background

6 South East England is one of the healthiest regions in England with a comparatively well qualified workforce, low levels of unemployment and higher incomes. However, Brighton and Hove (B&H) presents a mixed picture when compared to England and the South East. For example:

- full-time workers in B&H gross weekly pay at £524.30 is greater than that of Great Britain (GB) at £479.20;
- more people are receiving job seekers allowance in B&H at 4.3 per cent compared to 3 per cent in the SE and 4.1 per cent in GB;[1]
- life expectancy in the SE was the second highest in England in 2007 at 77.7 years for men and 81.8 years for women;[2] and life expectancy in B&H is only slightly lower with only 17.5 per cent of local people reporting limiting long term illness.[3] However, this masks comparative inequalities in health outcomes between social groups and geographic areas.

Deprivation

7 To address inequalities the government has established a number of national regeneration programmes (NRP) that prioritise action in the most deprived areas where health inequalities are greatest. One of these is based in Brighton. B&H has some of the most deprived areas in England as measured by super output areas (SOAs) using the Index of Multiple Deprivation (IMD) and these are mostly in the East of Brighton.

Population

8 National Census information shows the people of B&H describe themselves as mostly white British (91.5 per cent), Christian (72.9 per cent) and with some of the lowest level of gypsy/travellers in England. Although we know there is a significant gay, lesbian and transgender (GLTG) population, there are no local statistics available for sexual orientation.

9 There are clear differences in the make up of the population of B&H that impact on health compared to other areas in the South East of England. For example B&H has:[4]

- the lowest proportion of 0 to 14 year olds (15.3 per cent); and
- the highest proportion of 15 to 49 year olds (54.9 per cent) who represent the bulk of the economically active population (workforce) and the large student population associated with local universities.

[1] Source: the Office of National Statistics (ONS) 2008 estimates
[2] Source: *South East Coast SHA Health Inequalities Strategy, 2007*
[3] Source: *Department of Health SHA Health Inequalities Baseline Audit, 2007*
[4] Source: the Office of National Statistics (ONS) most recent population data - 2004 mid year.

Key issues

10 Key issues currently affecting health outcomes in B&H include:

- high levels of non-decent housing in some parts of the city; as housing is the primary determinant impacting on health outcomes, we would expect housing to be the key focus of planning across B&H organisations;
- some of the highest suicide rates in England, which are persistently high despite intervention and linked to substance misuse; a cross-organisational planning initiative during 2008/09 worked to establish a Suicide Prevention Strategy;
- comparatively high levels of substance abuse – injectors; the Drug and Alcohol Action Team (DAAT) reported in 2005 that there were approximately 2,300 injecting users in the city, a higher rate than parts of inner London and the incidence of drug related deaths is amongst the highest in the country;[1]
- the high level of injecting drug users also means HIV infection is a key health issue in B&H;
- persistently higher rates of teenage pregnancy than the national average; and
- an increase in sexually transmitted disease.

11 Brighton and Hove's Director of Public Health who is appointed jointly by Brighton and Hove City Council ('the Council'), Brighton and Hove City Teaching PCT ('the PCT'), provides strong leadership on the public health agenda.

12 In 2004, Brighton and Hove was designated a 'Healthy City' by the World Health Organisation acknowledging strong commitment by the Council, PCT and partners to reduce health inequalities (HI). The Healthy City phase four programme currently focuses on urban planning and Health Impact Assessment (HIA).

13 The Local Strategic Partnership (LSP) has identified 'improving health and well-being' as one of its strategic priorities in its Sustainable Community Strategy 'Creating the City of Opportunities'. It has adopted a Health Inequalities Strategy and City Health Development and Action Plans to target cross sector action on the wider determinants of health.

14 Consultants commissioned by the Council and its partners to assist the Public Services Board (PSB) and LSP have reported on policy options for the future to reduce inequality and undertaken a detailed analysis mapping where inequality is most acute.

15 The Local Area Agreement 2008 to 2011 (LAA) for Brighton and Hove includes a number of relevant national and local indicators. Lead partners include the Council, the PCT, the Children and Young People's Trust, the Sussex Partnership Trust, Police and Fire authorities. These reflect the recognition that partnership working across the sectors is essential in tackling the wider determinants of health and inequality.

[1] Source: *Brighton and Hove City Council Corporate Assessment*, October 2006

16 The first phase of our review of Health Inequalities (HI) in Brighton and Hove was completed in May 2008. It found that the Council and the PCT have made good progress in establishing joint strategic arrangements to reduce HI. However, there is a high level of poor housing in Brighton and Hove and some health outcomes are persistently not improving and amongst the highest in England ie teenage pregnancy, drug and alcohol misuse, including smoking and suicide rates. People suffering poorer health outcomes are often also in housing need.

Audit approach

17 We agreed with the Council and the PCT that Phase 2 of our health inequalities work would evaluate the effectiveness of cross-organisational working on health inequalities. In order to probe this effectively, we focused on housing, the primary determinant of health.

18 The local Strategic Housing Partnership, led by the Council, is in the process of drafting and agreeing a new housing strategy for 2009 to 2013. Subsidiary strategies, including those for homelessness and Supporting People, are already in place. Further partnership working takes place at a sub-regional level in the Brighton and Hove East Sussex Together Partnership (BEST), set up to tackle housing conditions particularly for vulnerable people.

19 Our review focus has assessed the effectiveness of partnership working in:

- identifying and addressing need;
- consulting and engaging with local people;
- working together to allocate resources and secure good outcomes;
- sharing data for planning and monitoring;
- establishing means to measure outcomes and impact; and
- delivering on ambition.

20 We have carried out this work by:

- reviewing key strategies and supporting documents;
- interviewing officers from the Council and the PCT; and
- using a workshop at the Healthy Urban Planning Group (HUPG) to discuss our early findings with partner officers.

21 The presentation of findings and challenge questions which we used at HUPG in March 2009 is attached at Appendix 1.

Main conclusions

22 The partners in Brighton and Hove are working well together, demonstrating a strong commitment to tackling inequalities. However, against a backdrop of a multitude of different needs and a diverse range of targets, some of which have poorly defined success criteria, there is considerable work still to be done. For example, the partners led by the Council and the PCT need to prioritise objectives, agree areas of joint action and the use of health and housing resources so as to have the maximum impact in reducing health inequalities in the City.

Identifying and addressing need

23 The local strategic partnership has effectively gathered a good analysis of local needs to inform planning. The Local Area Agreement (LAA) for 2009 to 2011 effectively identifies local need. It makes clear links to other key documents that show inequalities between the most and least deprived people living in Brighton and Hove. In particular, it draws on the Reducing Inequalities Review, a thorough analysis of local issues which gives local partners a clear understanding of priority needs for disadvantaged people and places.

24 The draft housing strategy is clearly driven by the needs analysis. It is based on needs identified through the reducing inequalities review. Data was drawn together and presented on each of the themes in the strategy to identify local issues and to consult with stakeholders on headline goals and objectives. This means that the strategy aims to tackle important local issues.

25 Supporting strategies effectively identify needs and propose ways in which they should be addressed. They focus positively on local health inequalities. The homelessness strategy refers to the Reducing Inequalities Review and highlights key target groups. The first objective is to 'provide housing and support solutions that tackle homelessness and promote health and wellbeing of vulnerable adults'. This references other work driven by the single homeless strategy and the supporting people strategy. The priority actions in support of this objective identify actions which are clearly focused on the housing and support needs of vulnerable groups. For instance, they include actions to support people with mental health needs, to tackle delayed transfers of care and for people with learning disabilities.

26 However, some weaknesses were identified. Housing strategies do not define clear success criteria. The homelessness strategy, for instance, does not give a clear indication of the likely impact for vulnerable groups. The success of action for people with mental health needs is a reduction in homelessness due to mental ill health, without being specific and without linking to related impacts, such as reducing risk of suicide. It is therefore not clear how health inequalities will be reduced as a consequence.

Recommendation	
R1	Define success criteria in housing strategies more clearly and with a sharper focus on outcomes for vulnerable people. This is a high priority that should be completed in six months. This is a high priority that should be completed within six months.

Consultation and engagement

27 The housing strategy has been informed by consultation with local people. Each planning group had representatives from stakeholders and the local community champions. In addition, there was some action to reach target groups. Service users in hostels were trained to carry out consultation sessions with other users. This enables real life issues to be brought into the setting of strategy.

Working together

28 The awareness of the health inequalities agenda is well established in the City's partnerships. The LSP has emphasised the importance of Healthy City and this means a good impact in discussions at many levels. For instance, planning policy in the local development framework supports the way housing provision will address health inequalities, such as in setting minimum standards for development. All new homes in the City are required to be built to lifetime home standards so that they are adaptable to lifestyle changes such as the need for wheelchair access. This broad agenda creates the potential for impact across many services.

29 There is a range of fora which offer good opportunities for discussion of housing issues and health inequalities. At a high level, the Strategic Housing Partnership oversees this work and is chaired by the Leader of the Council. The partnership has not yet reviewed its objectives in light of the Health Impact Assessment findings and aims of the new Housing Strategy. The Healthy Urban Planning Group provides a good forum for discussion of detailed health issues that may emerge from proposed significant planning developments and a useful vehicle for highlighting the beneficial impacts that developments may have on reducing health inequalities. This has also been used to discuss housing strategy in its broader context. These fora are building awareness and understanding between partners of inequalities agenda.

30 Partnership working in developing housing strategy is good. For each element of the housing strategy, partnership development groups have been established with good representation from the PCT and the voluntary and community sectors. The Council is taking steps to maintain its involvement in implementation, for instance by allocating a monitoring and scrutiny role into the future. The involvement of many partners in its development offers the prospect of a good level of ownership in implementation.

31 However, the extent of the impact of this awareness and discussion on policy and practice is not yet fully developed. From our review, it is not clear how specific needs will be addressed in a shared way by partner organisations, nor how resources of separate organisations will be prioritised to address shared outcomes. Where we can judge some strengths in the housing strategy and its supporting plans, separation of function continues to drive action. For instance, there is little reference in the PCT's Strategic Commissioning Plan to the way in which action on housing needs can achieve health priorities. Although needs data has created an understanding that inequalities need to be addressed through a focus on people and place, there is no explicit response to this in the strategies we have reviewed. These indicators suggest that there is more to do to transfer a broad commitment into a robust method of sharing and prioritising resources and actions between partner organisations.

32 The sub-regional partnership, Brighton and East Sussex Together (BEST), is developing a broader focus to include health inequalities issues. The group has developed an approach to bidding for and sharing housing renewal resources. It is a positive example of partnership working in allocating the funding jointly. In addition, the partnership intends to use its new understanding around health inequalities to refocus its years 2 and 3 programme to achieve better health outcomes.

Recommendations	
R2	Ensure that the roles and responsibilities of key partnership groups with input to housing strategy are clearly set out and understood; in particular, review and revise the objectives of the Strategic Housing Partnership and BEST to reflect the broader focus on health inequalities issues. This is a high priority that should be completed within six months.
R3	Use partnership fora as a means to challenge further the way in which resources are allocated to address need, and challenge particularly how resources in health and local government can be focused to tackle needs. This is a high priority that should be completed within six months.

Sharing data

33 The LSP has high quality shared data. The reducing inequalities review, in two phases, established a clear analysis of deprivation and inequalities experienced in the City. It has been used since to inform planning. The public health annual report also presents strong analysis of data. The LSP has a partnership data group which agrees approaches to the use of data by partners. And the LSP has created a local intelligence service called Brighton and Hove Local Information Service (BHLIS) which presents a range of data in one place, accessible to partners and available for analysis. Data is therefore a key shared resource for partners locally.

34 Data is not yet being used well to focus on outcomes. It is not clear from our review how strategies respond directly to specific data analysis, for instance by commissioning services to address specific needs identified and targeting services on deprived wards. Nor is it clear how well the shared data enables partners to agree targets and focus the use of separate resources. This might lead to the type of challenge where the partnership focuses extra investment in reducing teenage conceptions because of its potential to reduce demand for housing or other services. It is notable that BHLIS does not contain any of the LAA or other partnership targets. Therefore, though it offers a rich data source, it does not enable a focus on the desired or expected outcomes. Data is therefore confirming the current position rather than challenging future impact.

Recommendation

R4 Make shared data work harder by:

- making clear links to LAA targets and LSP planned outcomes; and
- using it to analyse the way in which resources are allocated for maximum impact.

This is a high priority that should be completed within six months.

Measuring outcomes

35 The proposed measures of success in housing strategies are inadequate. The proposed success measures tend to be:

- general rather than specific, eg reduction in homelessness;
- not clear about the health benefits of actions; and
- not clear about the impact on people.

The supporting people strategy, for instance, does not set specific and measurable indicators of success. The success criteria tend to focus on general reductions in homelessness, street drinking, delayed discharge, and many more - without being specific about what will be achieved. The integrated pathways of care are referenced - but the involvement of health services is not clear and beneficial health outcomes are not identified. For instance, in providing a range of actions to promote independent living for people with mental health needs and physical disabilities, the measures focus on reductions in homelessness and delayed discharge, without being clear of the health benefits to individual service users. In this respect, it is difficult to have a sense of priority and an understanding of impact on health inequalities.

36 The health impact assessment (HIA) of the housing strategy is a strong demonstration of the commitment to reducing health inequalities in addressing housing need. The HIA is an impressive attempt to cover all the factors that interact between housing and health and relates these to the various component parts of the draft housing strategy. The HIA contains many recommendations but these have not yet been developed as a prioritised SMART Action Plan whose implementation can be monitored by the partners.

37 Partners are innovative in the use of HIAs for proposed major local developments. The Council and its partners have commissioned health impact assessments of significant developments. The HIA for Brighton Marina is a very good example of a socio-environmental model of HIA and demonstrates that the PCT and the Council are offering a best practice initiative to developers in Brighton. However, the HIA does not contain an economic impact assessment of the development proposed, for instance in calculating the consequential financial impact of health changes resulting from development.

38 The extent of future use of HIAs by the partners is unclear. There is some doubt about the capacity and the capability of the PCT to continue to offer this service in the long term. The use of consultancy is costly without demonstrating specific benefits.

Recommendations	
R5	Review the success measures in the draft housing strategy and supporting strategies to ensure that they: • are SMART and clearly prioritised; • offer assessment of health impacts; and • show outcomes for people and how needs are addressed/reduced. This is a high priority that should be completed in six months.
R6	Use the HIA of the housing strategy to develop an action plan. This is a high priority that should be completed within six months.
R7	Have a clear policy on future use of HIAs, including the assessment of economic impact. This is a medium priority that should be completed within six months.

Delivering on ambition

39 Strategies are now in place, though it is too early to establish whether they are effective. Some actions are being delivered by partners, for instance in the GP practice provision for homeless people. However, more work is required to define the expected impact of key strategies and to establish methods of measurement. In our presentation to HUPG, we emphasised that to ensure delivery of ambitions, the challenge for partners may be encapsulated in the following questions.

- Is there an agreed set of priorities which will test your achievement over time in reducing health inequalities?
- Do your people understand these priorities?
- How will you measure success in addressing needs?
- By what means will you measure impact in the short term?
- How challenging are your targets?
- How do you plan to deal with the economic downturn?

Recommendation
R8 Consider holding a workshop for key partners to address the challenge questions relating to delivery of ambitions ie: • is there an agreed set of priorities which will test your achievement over time in reducing health inequalities; • do your people understand these priorities; • how will you measure success in addressing needs; • by what means will you measure impact in the short term; • how challenging are your targets; and • how do you plan to deal with the economic downturn? This is a medium priority that should be completed within six months.

Follow up of phase 1 recommendations

40 In phase 1 of our health inequalities work we made two recommendations.

41 The first recommendation has been completed. We recommended:

> **Ensure the City Council scrutiny committee receive regular health inequality reports to improve understanding of local health inequality issues and thereby support appropriate challenge.**

The PCT presented a report on health inequalities to the Health Overview and Scrutiny Committee last autumn. This was timed to coincide with the requirement to produce a Joint Strategic Needs Assessment and in accordance with World Class Commissioning requirements.

42 The second recommendation has been partially achieved. We recommended:

> **Include health inequality outcomes in performance reports to demonstrate progress against investment and to indicate if plans have produced effective health outcomes and value for money.**

The PCT has increased its performance monitoring in general using its Programme Office approach and close monitoring by its Delivery Board. Inequality targets such as reducing teenage pregnancy and smoking in particular have been subject to regular scrutiny. More work is required for the PCT to be able to demonstrate value for money from its investments in reducing health inequalities.

Recommendation
R9 Consider the best way in which to report the achievement of value for money from investments in reducing health inequalities. This is a high priority that should be completed within six months.

Way forward

43 We have made nine recommendations for improvement in this report. They are included in an Action Plan at Appendix 2. The Council and the PCT have responded to the recommendations. This response is shown at Appendix 3.

44 We will follow up on the Action Plan in the course of our future audit and assessment work with the organisations, and as part of our Area Assessment work.

Appendix 1 – Feedback presentation

Health inequalities – phase 2

Brighton & Hove CC/PCT Healthy Urban Planning Group

23rd March 2009

Marius Kynaston, Stephen Dowsett, Norma Christison
Performance Team, South East

audit commission

Agenda

- In Phase 1 of our work on HI we found:
  - The PCT and City Council have a history of working in partnership and have made good progress in establishing joint strategic arrangements to manage HI.
  - However, not all targets were SMART, and although Performance reporting at both the PCT and Council is improving some areas of weakness remain.
  - We are currently following up the recommendations from Phase1
- In Phase 2 we have evaluated the effectiveness of cross-organisational arrangements to address HI and deliver the outcomes agreed by partners, in particular in relation to housing especially for vulnerable people
- .This is a presentation of initial findings

… and some challenge questions

2 B&H HI Phase 2

audit commission

Strategy: identifying need

- High quality analysis of "Reducing Inequalities" provides sound basis for planning
- Housing strategy based on good needs data

Challenge:

- **Is there direct response to the data provided? E.g. in commissioning services to address specific need identified; targeting services on deprived SOA**
- **Do partners have shared priorities of need?**
- **Are resources invested to best effect?**
  E.g. does extra investment in reducing teenage conceptions potentially reduce housing demand?

3 B&H HI Phase 2

audit commission

Strategy: addressing need

- Draft Housing Strategy / Homelessness Strategy
  - Both tell the story really well of what is the need and how will we address it
  - But the expected outcomes and success criteria are not always clear

Challenge

- **Are partners confident that there is a golden thread within and between the organisations and their plans?**
- **Is there a shared understanding and prioritisation of outcomes?**
- **Is the intent to reduce health inequalities adequately reflected in the housing strategy?**
- **Does the PCT's Strategic Commissioning Plan have due regard to housing?**
- **Will the strategy drive actions by the partners?**

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Strategy: consultation

Consultation on housing strategy

- Processes are good
- Good stakeholder involvement

Challenge

- **What examples are there of impact of consultation on policy and strategy?**

5 B&H HI Phase 2

Partnership working

- Developing shared agenda on housing role in addressing health inequalities
- Recognition that partners are on a journey: getting better at identifying shared issues

Challenge

- **HI agenda is known but not always clearly understood – could it be used more to challenge custom and practice?**

6 B&H HI Phase 2

Partnership working

- Good range of partnership forums
  - Healthy City Group and LSP at high level
  - Strategic housing partnership
  - Healthy urban planning group
  - Partnership groups on the housing strategy themes

Challenge:

- **Strategic Housing Partnership – responsibilities and objectives not clear**
- **BEST targeting of resources – too much emphasis on spending the money rather than targeting its impact?**
- **Are partners clear of their respective roles in delivery given that this is not always explicit in the plans?**

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Data quality and information

- High quality shared data
  - Reducing inequalities – phase 1 and 2
  - PH annual reports
- Positive action taken to share data through the SCS and BHLIS

Challenge

- **How effectively is the data used to drive outcomes?**
- **In terms of health inequalities and housing what gaps exist in the data and how do you plan to address?**
- **BHLIS data is not linked to targets – a weakness?**

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Health impact

- Health Impact Assessments
  - Positive about the commitment
  - HIA recommendations for Draft Housing Strategy need to be SMART if they are to have impact
  - HIAs lack health economics perspectives – absence of cost benefit analysis means its difficult to demonstrate VFM

Challenge

- **Why no health economics analysis – measuring impact and VFM of action for vulnerable groups and cost benefit analysis?**
  - **What Is the most valuable thing we are not doing?**
  - **What is the least valuable thing we are doing?**
- **Do you know what resources each partner is applying to specific health / housing initiatives in each locality aimed at reducing inequalities?**

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Measures of success

- Success measures in housing strategies are:
  - General and not specific, e.g. reduction in homelessness
  - Not clear about the health benefits of actions
  - Not clear about the impact on people

Challenge

- **How can you develop more SMART indicators?**
- **Mix of long and short term outputs and outcomes?**
- **Greater focus on health impacts for people?**
- **Do you know your priority outcomes?**
- **Given the quality of needs data, will you measure success in reducing need?**

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Achievement

Challenge

- Is there an agreed set of priorities which will test your achievement over time in reducing health inequalities?
- Do your people understand these priorities?
- How will you measure success in addressing needs?
- By what means will you measure impact in the short term?
- How challenging are your targets (some examples follow)?
- How do you plan to deal with the economic downturn?

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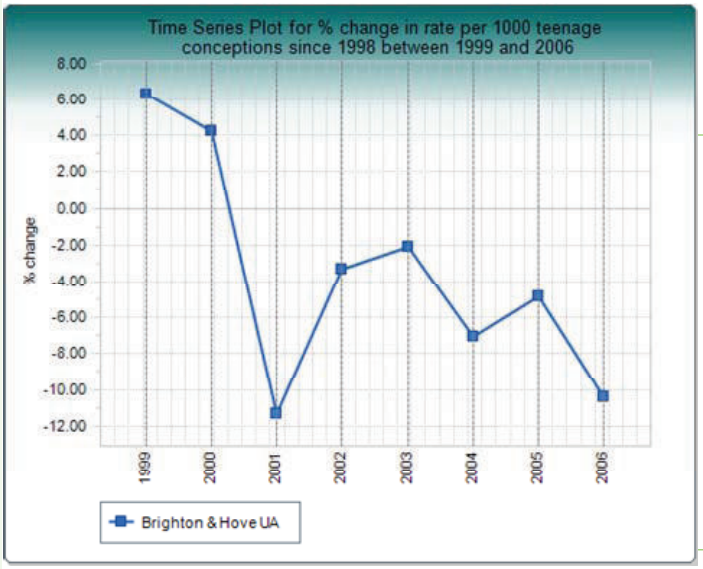
NI 112 – Teenage Conceptions



Target Reductions

- **2008 -28%**
- **2009 -36%**
- **2010 -45%**

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NI 141: Percentage of vulnerable people achieving independent living

- This indicator is being led by Brighton & Hove City Council & Strategic Housing Partnership.
- It measures the number of service users (i.e. people who are receiving a Supporting People Service) who have moved on from supported accommodation in a planned way, as a percentage of total service users who have left the service
- This indicator has been selected in 70 LAAs
- The LAA Baseline is 65% Subsequent targets are:
  - 2008/9 – 66%
  - 2009/10 – 67%
  - 2010/11 – 68%

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Next steps

- NOW - opportunity to comment and respond on the challenge questions.
- We will take on your views in order to develop a draft report

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Appendix 2 – Action plan

Recommendation	Priority	Link to evidence	Link to relevant standards	Positive outcome expected (savings, reduced risks, better value for money)	Consequences of failing to implement recommendation	Cost of recommendation (where significant)	Date reported to the Board/ Council	Officer responsible	Implement by when
R1 Define success criteria in housing strategies more clearly and with a sharper focus on outcomes for vulnerable people.	High	Housing strategies do not define clear success criteria. The homelessness strategy, for instance, does not give a clear indication of the likely impact for vulnerable groups.	UoR KLOE: 2.2	Better outcomes	Inability to monitor success	None	June 2009	Housing Strategy Manager	December 2009
R2 Ensure that the roles and responsibilities of key partnership groups with input to housing strategy are clearly set out and understood; in particular, review and revise the objectives of the Strategic Housing Partnership and BEST to reflect the broader focus on health inequalities issues. This is a high priority that should be completed within six months.	High	With respect to these bodies, there is little evidence of a partnership approach with health or of targeting resources on areas with the greatest health inequalities.	UoR KLOE: 2.3	Greater clarity of responsibilities in tackling joint goals.	Lost opportunity for partnership working	None	June 2009	Head of Strategy, Development and Private Sector Housing	December 2009

Appendix 2 – Action plan

Recommendation	Priority	Link to evidence	Link to relevant standards	Positive outcome expected (savings, reduced risks, better value for money)	Consequences of failing to implement recommendation	Cost of recommendation (where significant)	Date reported to the Board/ Council	Officer responsible	Implement by when
R3 Use partnership fora as a means to challenge further the way in which resources are allocated to address need, and challenge particularly how resources in health and local government can be focused to tackle needs.	High	It is not clear how specific needs will be addressed in a shared way by partner organisations, nor how resources of separate organisations will be prioritised to address shared outcomes.	UoR KLOE: 2.1	Potential for generating better vfm by applying joint resources to joint goals.	Piecemeal approach may mean goals are not so easily achieved.	None	June 2009	Head of Strategy, Development and Private Sector Housing	December 2009
R4 Make shared data work harder by: • making clear links to LAA targets and LSP planned outcomes; and • using it to analyse the way in which resources are allocated for maximum impact.	High	It is not clear how well the shared data enables partners to agree targets and focus the use of separate resources.	UoR KLOE: 2.2	Better targeting of resources with the potential for better vfm.	Lost opportunity to secure best vfm.	None	June 2009	Housing Strategy Manager/ Public Health Development Manager	December 2009

Recommendation	Priority	Link to evidence	Link to relevant standards	Positive outcome expected (savings, reduced risks, better value for money)	Consequences of failing to implement recommendation	Cost of recommendation (where significant)	Date reported to the Board/ Council	Officer responsible	Implement by when
R5 Review the success measures in the draft housing strategy and supporting strategies to ensure that they: • are SMART and clearly prioritised; • offer assessment of health impacts; and • show outcomes for people and how needs are addressed/reduced.	High	The proposed measures of success in housing strategies are inadequate being: general rather than specific, eg reduction in homelessness; not clear about the health benefits of actions; and, not clear about the impact on people.	UoR KLOE: 2.2	Better outcomes/vfm	Goals may not be met.	None	June 2009	Housing Strategy Manager	December 2009
R6 Use the HIA of the housing strategy to develop an action plan.	High	The HIA contains many recommendations but these have not yet been developed as a prioritised SMART Action Plan whose implementation can be monitored by the partners.	UoR KLOE: 2.2	Better outcomes/vfm	Goals may not be met	None	June 2009	Housing Strategy Manager/ Public Health Development Manager	December 2009

Appendix 2 – Action plan

Recommendation	Priority	Link to evidence	Link to relevant standards	Positive outcome expected (savings, reduced risks, better value for money)	Consequences of failing to implement recommendation	Cost of recommendation (where significant)	Date reported to the Board/ Council	Officer responsible	Implement by when
R7 Have a clear policy on future use of HIAs, including the assessment of economic impact.	Medium	The extent of future use of HIAs by the partners is unclear. There is some doubt about the capacity and the capability of the PCT to continue to offer this service in the long term.	UoR KLOE: 2.2	HIAs have the potential to provide supporting information for strategic investment decisions.	Decisions may be taken with incomplete information.	Some depending on the number and depth of HIAs undertaken in future years.	June 2009	Public Health Development Manager	December 2009
R8 Consider holding a workshop for key partners to address the challenge questions relating to delivery of ambitions ie: • is there an agreed set of priorities which will test your achievement over time in reducing health inequalities? • do your people understand these priorities? • how will you measure success in addressing needs? • by what means will you measure impact in the short term?	Medium	The partners are faced with challenging questions if they are to deliver their ambitions.	UoR KLOE: 3.3	Partners will become more knowledgeable about the delivery of each others' ambitions.	Missed opportunity to teat the realism of ambitions.	May involve some costs if third party engaged to facilitate the workshop.	June 2009	Housing Strategy Manager/ Public Health Development Manager	December 2009

Recommendation	Priority	Link to evidence	Link to relevant standards	Positive outcome expected (savings, reduced risks, better value for money)	Consequences of failing to implement recommendation	Cost of recommendation (where significant)	Date reported to the Board/ Council	Officer responsible	Implement by when
• how challenging are your targets? • how do you plan to deal with the economic downturn?									
R9 Consider the best way in which to report the achievement of value for money from investments in reducing health inequalities.	High	The PCT has increased its performance monitoring in general but more work is required for it to be able to demonstrate value for money from its investments in reducing health inequalities.	UoR KLOE: 2.1	Demonstration of vfm (or otherwise) will help inform future strategic decision making.	The absence of sound vfm information makes for less robust strategic investment decision making.	None	June 2009	Housing Strategy Manager/ Public Health Development Manager	December 2009

Appendix 3 – Partners' response to draft report

1 The response to the report was received on 21 August 2009, and a summary is included here, not including drafting points or factual amendments.

> **Thank you for your draft report and the time taken by your colleagues and yourself in reviewing our work to develop and embed the health and housing agenda in Brighton and Hove.**
>
> **We very much welcome your report and feel that you have identified and highlighted a wide range of positive practice that encapsulates the change in working practices, culture and outcomes we are hoping to achieve.**
>
> **In working towards linking health and housing we have been very much ahead of national guidance and good practice and it is very pleasing to note that we have made some significant steps in this direction. The issues and recommendations you have identified will help structure and shape our ongoing work and ultimately result in more effective outcomes for local people.**

2 The comments made on individual recommendations are shown below where they indicate the progress since our fieldwork and the approach to implementation. We have also noted where amendments have subsequently been made to the report text in response to the comments received.

Table 1 Comments on recommendations

Received from Council and PCT August 2009

Recommendation	Comment
1	(para 26) We have taken this on board and improved the success criteria in the final drafts of the Housing Strategy, Older People's Housing Strategy and LGBT People's Housing Strategy which are being presented to Council and the Local Strategic Partnership for approval in the Autumn. Our previously published strategies relating to Supporting People and Homelessness etc are already accompanied by more detailed action plans that translate the success criteria into SMART actions that are subject to ongoing review. In respect of the lack of clear health outcomes - such as for example reducing suicide or mental illness this can only be stated as an aim as at a local level as it would be incredibly difficult to robustly measure reductions in suicide.

Recommendation	Comment
	We could look at mental health but that would involve surveys of residents before and after re-housing which would be tantamount to an experiment and not something that could be done routinely. Again the routine markers of mental health would not be able to be related to any housing intervention. One area we are exploring where we may be able to link housing interventions directly to health improvements is through our single homeless work, and in particular tackling alcohol and substance misuse. However, on the whole, our review of the evidence base highlighted the need for further research on the impact of housing interventions on health outcomes.
2	(para 29) The objectives of the Strategic Housing partnership are closely aligned to the Improving Housing and Affordability block of the Local Area Agreement and the citywide Housing Strategy. In addition the SHP has acted as the Project Board, overseeing the development of the strategy. (para 32) The BEST partnership recognises that good quality homes are important for the health and well-being of those living in them. The partnership is committed to improving the overall quality of the private sector housing stock in Brighton and Hove and East Sussex, to achieve our vision that every resident lives in a 'warm, safe and secure home'. To assist our private sector housing managers and partners in Health in achieving a better understanding of the links between health and housing, we are piloting the use of the Building Research Establishment toolkit which demonstrates the cost benefits of some specifically linked housing and health issues. The partnership in years 2 and 3 of the programme are targeting funding at improving health, by improving insulation and heating in homes to reduce excess winter deaths, removing hazards in the home which will reduce hospital admissions due to falls, allow people to stay in their own homes and facilitate hospital discharge by funding disabled adaptations. **We have amended recommendation 2 and paragraphs 29 and 32 in response to comments.**

Appendix 3 – Partners' response to draft report

Recommendation	Comment
3	(para 31) Across the Council and PCT it has been noted that there is now a need to develop a structure that will maximise the impact of JSNAs in driving improvements in local service and outcomes. As a result, a JSNA Steering Group is being set up that is being jointly chaired by senior officers of NHS Brighton and Hove and Brighton and Hove City Council. One of the key priorities of the group will be to produce a summary overview of the health and wellbeing needs of the city, including identified health inequalities and evidence of unmet need which will inform strategic commissioning and planning and particularly the PCT Strategic Commissioning Plan. Housing has been invited to become a founding member of the new JSNA Steering Group and the lack of comment on housing in the NHS Brighton and Hove Strategic Commissioning Plan has been noted and will be discussed within NHS Brighton and Hove. More effective partnerships are starting to be seen such as the JSNAs of Working Age Mental Health, Physical Disabilities and accompanying Commissioning Strategies. Additionally, joint work on the Local Area Agreement, 2020 Community Strategy Review and new Healthy City Strategy will help improve the joint and shared approach to tackling the city's issues. However, to be realistic, it will take more than six months to achieve this.
4	(para 34) The potential of BHLIS has been noted and the JSNA Steering Group is planning to explore the use of BHLIS to host and present health inequality data to complement the summary overview document of the health and wellbeing needs of the city. This work will in part be supported by a new Head of Public Health Research and Analysis has been appointed by NHS Brighton and Hove who will be working closely with their City Council counterpart. The need for common performance management software across the Local Strategic Partnership to manage the Local Area Agreement has been recognised and is in the process of implementation. BHLIS contains the background needs data for the partnership with the new Interplan carrying out the performance management function.
5	(para 35) As per our response to Recommendation 1.

Recommendation	Comment
6	(para 36) Two half-day workshops for Housing and Health staff were held at the end of July and beginning of August. These brought together Public Health and Housing staff to discuss and agree how the recommendations from the HIA of the new Housing Strategy will be taken forward. An Action Plan is being developed which will become part of the Housing Strategy which is currently going through its approval process. We have included a recommendation in the HIA around the possibility of commissioning a piece of work to conduct a health economics study.
7	(para 38) NHS Brighton and Hove and the Local Authority Planning Department are developing a strategy to take forward future HIA work. The strategy will outline a small set of options including integrating HIA into the scope of Environmental assessment where appropriate. NHS Brighton and Hove and the Local Authority Planning Department are drafting best practice guidance for developers and planners.
8	(para 40) As per our responses to Recommendation 1 and Recommendation 6. Across the Local Authority, Primary Care Trust and wider stakeholders the need to have an agreed set of priorities for the city aligned with clear targets for improving the health and wellbeing of local people has been already identified. To address this, the 2020 Community Strategy is being refreshed and work to develop a Health City Strategy has begun. The first draft of the refreshed Community Strategy has recently started its public consultation.
9	(para 43) As per our response to Recommendation 3.

Source: PCT/CC response to draft report

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HOSC Work Programme 2009/2010

Issue	Date to be considered	Referred/Requested By?	Reason for Referral	Progress and Date	Notes
Dental Services	02 December 2009	HOSC (March 09)	Update requested re: outstanding performance issues		
Sussex Partnership NHS Foundation Trust "Better By Design"	02 December 2009	SPFT	Brief HOSC members on major reconfiguration of Sussex MH services		
LINk Update	02 December 2009	HOSC	Regular HOSC item		
Health Inequalities	02 December 2009	Audit Committee	Referred from Sep 09 Audit Committee due to relevance to HOSC		
NHS Brighton & Hove Annual Operating Plan/Working Age Mental Health Commissioning Strategy	02 December 2009	NHS BH	Update of PCT's commissioning intentions		

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Annual Health Check Report Back	02 December 2009	HOSC	Report for information on 08/09 Healthcare Commission performance scores for local NHS trusts		
3T Progress Report/Transfer of RSCH acute services to community settings	27 January 2010	BSUHT/Cllrs Mitchell and Turton	Update on progress re: the redevelopment of the RSCH site		Item to include the issue of transferring acute services into community settings
Immunisation/Vaccination	27 January 2010	Cllr Kitcat	Report on city vaccination rates compared to national/regional rates		
Breast Cancer Screening	27 January 2010	HOSC	Update on screening services (following recent underperformance)		
South Downs Health Trust Integration with West (and East) Sussex Community Services	27 January 2010	SDH	Update on plans to integrate SDH with community provider arms of WSPCT and (potentially) ES PCTs		

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Alcohol Related Hospital Admissions	10 March 2010	HOSC	Examine red LAA indicator with view to setting up an ad hoc panel		
Car Park Charges at NHS trusts	10 March 2010	Cllr Peltzer Dunn	Examine local (acute) trust policy for visitor car parking at hospital sites		
BSUHT emergency planning	10 March 2010	Cllr McCaffery	Examine BSUH planning for acute care in emergencies		To include plans for healthcare provision after a major incident at RSCH site
Public Health	10 March 2010 (possible)	Director of Public Health	Update on public health priorities for the city		Timing may depend on severity of flu pandemic
Sussex Orthopaedic Treatment Centre Update	05 May 2010	HOSC	Update on SOTC performance (as some performance issues remained unresolved following last meeting in Nov 08)		
Transfers of Care	05 May 2010	Cllr McCaffery	Examine delays in transferring patients out of acute care		

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Swine Flu	05 May 2010	HOSC/Cllr McCaffery	Determine lessons to be learnt from swine flu pandemic, including maintaining acute care provision in an outbreak		
Fit For the Future	05 May 2010 (estimated date)	Joint HOSC	Final results of the Joint HOSC on reconfiguration of West Sussex acute care		
Ad Hoc Panel on GP-Led Health Centre	1st meeting post May 2010	HOSC	12 monthly update on the GP-Led Health Centre (to incorporate report on how the PCT ensures the commercial competitiveness of local health care providers)		
Older People in Hospital	1st meeting post May 2010	Cllrs McCaffery and Barnett	Report on acute care provision for older people		
Older People's Mental Health Care	1st meeting post May 2010	Cllr Barnett	Report on nursing (EMI) provision for older people		

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Patient Experience/Measuring Outcomes	2nd meeting post May 2010	BSUHT/NHS BH	Report on how NHS organisations are increasingly focusing on patient experience, and on measuring outcomes rather than processes		
Community Mental Health Services	2nd meeting post May 2010	Cllr Meadows	Examine how the NHS policy of providing MH services in the community whenever possible impacts upon other services (e.g. police, housing, ASC) and how any costs/risks are shared by partners		
Health Visitors, Midwives and Breast Feeding	2nd meeting post May 2010	Cllr McCaffery	Examine breast feeding uptake and effectiveness of the integration of pre, peri and post natal services		