Brighton & Hove City Council

Overview & Scrutiny

Title:	**Health Overview & Scrutiny Committee**
Date:	**14 April 2010**
Time:	**2.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Peltzer Dunn (Chairman), Allen (Deputy Chairman), Alford, Barnett, Harmer-Strange, Hawkes, Kitcat, Rufus, Smart, 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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AGENDA

Part One **Page**

63. PROCEDURAL BUSINESS **1 - 2**

(copy attached)

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

Draft minutes of the meeting held on 27 January 2010 (copy attached)

65. CHAIRMAN'S COMMUNICATIONS

66. PUBLIC QUESTIONS

None have been received to date

67. NOTICES OF MOTION REFERRED FROM COUNCIL

No Notices of Motion have been received

68. WRITTEN QUESTIONS FROM COUNCILLORS

A written question has been received from Councillors Maria Caulfield and Jan Young:

"Dear Garry

I would be most grateful if you could consider this letter for inclusion on the agenda of the next meeting of the Health Overview & Scrutiny Committee under Section 13.3 of the Overview & Scrutiny Procedure Rules.

Funding to meet the needs of residents with learning disabilities in Brighton & Hove is based on an assessment of their need. If a person's care needs are assessed as 'Continuing' or they need nursing care the health care costs are the legal responsibility of the Brighton & Hove Primary Care Trust (PCT). If the person's needs are deemed not to be continuing, or social care based, then the cost falls upon Brighton & Hove City Council.

Brighton & Hove City Council has submitted seventeen cases for continuing care assessment for the last two years running and so far the PCT have only assessed six in total. Two of these residents were accepted as requiring 'continuing' health care and the other four were refused.

The delay in assessing these seventeen cases, which the local authority, in all good faith, believe to be valid continuing care applications, means that local council tax payers now face a bill of £1.7 million in the next financial year.

I have tried through other means to get to the bottom of these delays over a period of many months but have been unable to get a satisfactory answer from the PCT. Therefore, I would like to ask that the Health Overview & Scrutiny Committee look specifically into the reason for the delays and also, more generally, at the screening and assessment process to ascertain whether this extremely vulnerable group of people are being put at a significant disadvantage compared to those from other local authority areas in the country.

As you will be aware, the Local Government and Public Involvement in Health Act 2007 provides new powers for council overview and scrutiny committees to look in detail at the work of partner organisations. This is part of a legal framework for Local Area Agreements, which places a 'duty to co-operate' on a range of public bodies (of which PCTs are one), including a duty to respond to council scrutiny. I believe that the learning disabilities issue I have outlined above would be an ideal opportunity to make use of these new powers.

Jan and I would also be more than happy to come and speak at your next meeting to expand on these issues.

With all good wishes.

Maria Caulfield, Cabinet member for Housing

Jan Young, Cabinet member for Finance

69. OUT OF HOURS GP PROVISION **9 - 14**

Report of the Director of Strategy and Governance on city Out Of Hours GP services (copy attached)

70. NHS BRIGHTON & HOVE: ANNUAL OPERATING PLAN 2010-11 **15 - 146**

Report of the Director of Strategy and Governance on NHS Brighton & Hove's strategic commissioning intentions for 2010-11. Amanda Fadero, Acting Chief Executive of NHS Brighton & Hove, will present this item (copy attached)

71. BREAST SCREENING: UPDATE **147 - 160**

Report of the Director of Strategy and Governance on city breast screening services (copy attached).

72. VACCINATION AND IMMUNISATION: UPDATE **161 - 172**

Report of the Director of Strategy and Governance on city uptake of vaccination/immunisation programmes (copy attached)

73. ALCOHOL RELATED HOSPITAL ADMISSIONS **173 - 184**

Report of the Director of Strategy and Governance on the issue of Alcohol-Related Hospital Admissions. This item will be introduced by Dr Tom Scanlon, Brighton & Hove Director of Public Health (copy attached)

74. LICENSING: HEALTH IMPACT ASSESSMENT **185 - 298**

Report of the Director of Strategy and Governance on the recently published Licensing Health Impact Assessment (referred to HOSC from Licensing Committee) (copy attached)

75. CAR PARKING IN HOSPITALS **299 - 306**

Report of the Director of strategy and Governance on Brighton & Sussex University Hospital Trust (BSUHT) car parking policy and provision. This item will be presented by Shaun Innes, Head of Transport, BSUHT, and Duane Passman, 3T Programme Director, BSUHT (papers to follow)

76. MENTAL HEALTH RECONFIGURATION **307 - 312**

Report of the Director of Strategy and Governance on Mental Health Reconfiguration Plans: Co-ordination of Sussex Health Overview & Scrutiny Committee (HOSC) responses (copy attached)

77. 2009/2010 HOSC WORK PROGRAMME **313 - 318**

(copy attached)

78. 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

79. ITEMS TO GO FORWARD TO COUNCIL

To consider items to be submitted to the next Council meeting for information

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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HEALTH OVERVIEW & SCRUTINY COMMITTEE

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, 6 April 2010

Agenda Item 58

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 59

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00PM 27 JANUARY 2010

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

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

Co-opted Members: Jack Hazelgrove (Older People's Council) (Non-Voting Co-Optee); Robert Brown (Brighton & Hove LINk) (Non-Voting Co-Optee)

PART ONE

44. PROCEDURAL BUSINESS

44A Declarations of Substitutes

44.1 There were none.

44B Declarations of Interest

44.2 There were none.

44C Declarations of Party Whip

44.3 There were none.

44D Exclusion of Press and Public

44.4 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.

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

45. MINUTES OF THE PREVIOUS MEETING

45.1 RESOLVED - That the minutes of the meeting held on 30 02 December 2009 be approved and signed by the Chairman.

46. CHAIRMAN'S COMMUNICATIONS

46.1 The Chairman congratulated Robert Brown on being recently awarded an M.B.E.

47. PUBLIC QUESTIONS

47.1 There were none.

48. NOTICES OF MOTION REFERRED FROM COUNCIL

48.1 There were none.

49. WRITTEN QUESTIONS FROM COUNCILLORS

49.1 There were none.

50. PETITIONS

50.1 The Committee received two e-petitions on the subject of Complementary and Alternative Medicine (CAM), and heard from one of the petitioners, Mr John Kapp.

50.2 RESOLVED – That the Committee agrees to receive the two petitions presented.

51. '3T' REDEVELOPMENT OF THE ROYAL SUSSEX COUNTY HOSPITAL

51.1 This item was introduced by Duane Passman, 3T Project Director, and by Duncan Selbie, Chief Executive, Brighton & Sussex University Hospitals Trust (BSUHT).

51.2 Mr Passman told members that the 3T Outline Business Case had been endorsed by the South East Coast Strategic Health Authority (SHA) board and was currently being considered for capital funding by the Department of Health.

51.3 In answer to a query regarding plans to move some ‘standard’ services off the Royal Sussex County Hospital (RSCH) site in order to facilitate the development of tertiary services, Mr Passman told members that breast screening had already been re-located in a community setting, and that plans to move elements of musculoskeletal services were well advanced. BSUHT was working closely with NHS Brighton & Hove (NHSBH) on this and other planned re-locations. Darren Grayson, Chief Executive of NHS Brighton & Hove, confirmed that this was the case and reminded members that it had long been the PCT’s aim to re-provide a range of hospital services in a community setting.

51.4 In response to questions regarding the deliverability of the 3T project given the current financial climate and a potential change of Government, Mr Passman informed the committee that BSUHT still intended that the 3T project should be publicly funded. 3T has been designed in three stages: the main build, the cancer centre, and a car-park. This means that it may be possible to go ahead with 3T without having secured funding for the entirety of the project (although stage 1 is by far the largest element of the build in cost terms). Mr Passman also pointed out that the 3T project would take approximately 10 years to complete, with annual funding requirements never exceeding £100 million. In terms of NHS capital funding (which current stands at around £4 billion p.a.) this is a relatively small amount, given that the development of a regional tertiary care and trauma centre is *the* major capital priority for the South East Coast SHA region. Even if the NHS capital funding programme were to be significantly cut (and there has been no intimation that this is being considered), the 3T project would still be affordable.

51.5 In answer to a question about the degree to which the design of the RSCH re-build had been finalised, Mr Passman told members that the designs currently being circulated were purely indicative: the final design of the re-build would only be determined after extensive consultation with the wider public, local residents and trust staff. The trust is also in discussion with council officers and full cognisance will be taken of the council's Core Planning Strategy. Mr Passman noted that a Hospital Liaison Group had been established for local residents, with the second meeting due to be held on 1 February. Mr Passman thanked the relevant ward Councillors for their input and support in establishing the group.

51.6 Mr Passman told members that the schedule for 3T envisaged stage 1 being completed in 2015, stage 2 in 2019 and stage 3 in 2020.

51.7 Asked whether he had discussed with the leader of the council the possibility of having the planned monorail link stop at the RSCH, Mr Passman told members that he had not yet had the opportunity to have this conversation.

51.7 The Chairman thanked Mr Passman and Mr Selbie for their contributions.

52. SOUTH DOWNS HEALTH NHS TRUST - INTEGRATION WITH WEST SUSSEX COMMUNITY SERVICES

52.1 This item was introduced by Andrew Harrington, Acting Chief Executive of South Downs Health NHS Trust (SDH), and by Dr Rose Turner, SDH Medical Director. Andy Painton, SDH Chief Executive was unable to attend this meeting due to ill health.

52.2 In response to a query regarding the time-scale for integration with West Sussex community services, Mr Harrington told members that he was very confident that the integration would take place on schedule. SDH and West Sussex community services have been working together under a management contract since August 2009 and are effectively already integrated. The main challenge is to ensure that the new organisation is registered swiftly with the Care Quality Commission (currently SDH and West Sussex community services are registered separately). The Care Quality Commission has given assurances that it will expedite this registration.

52.3 In answer to a question concerning how the ongoing stakeholder consultation could be expected to feed in to the integration process, given the brief period remaining before integration takes place, Mr Harrington told members that the bulk of consultation responses thus far had enjoined the organisations to integrate as speedily as possible. However, should there be significant responses in favour of a different approach, this would be reflected in the trust's planning processes.

52.4 Responding to questions about SDH's high vacancy rate, Mr Harrington explained that these vacancies did not equate to unfilled posts; rather, although SDH had a high level of permanent vacancies, the great bulk of these were being filled by seconded staff, staff acting up, bank or agency staff etc. The recruitment difficulties have largely been due to uncertainty about the trust's future, and once SDH is integrated with West Sussex services, it is anticipated that it will be much easier to recruit to a larger and more sustainable organisation (recent successful appointments are already beginning to demonstrate this). The current high vacancy rate does have cost implications (although this is largely in terms of using agency staff, and the bulk of vacancies have been temporarily filled by other means), and also implications for risk, continuity of care etc.

52.5 Mr Harrington told the committee that SDH had found managing the current year's budget challenging, although the trust did not intend to overspend. The costs of integration had inevitably been a factor in this, although there had been PCT support to help meet the costs of integration.

52.6 Mr Harrington told members that integration would allow SDH to make savings, particularly in terms of management costs. This was very important given the anticipated contraction in funding across the next three years. Integration would also facilitate the improvement of a number of services, giving SDH the opportunity to cluster synergetic services together in order to improve outcomes. The integrated trust would also benefit from an increased level of medical input (currently SDH's ratio of doctors to other staff is rather low). In addition, the new entity would be in a position to be much more proactive: developing solutions to local issues rather than simply implementing commissioning decisions.

52.7 The Chairman thanked Mr Harrington and Dr Turner for their contributions.

53. LINK UPDATE

53.1 This item was introduced by Robert Brown, Chair of the LINk Steering Group, and Claire Stevens, LINk Team Manager.

53.2 Mr Brown told members that the LINk had taken longer than expected to become operational, due to poor and conflicting central Government guidance, a high turnover of host staff, problems associated with moving premises, and a good deal of discord amongst members of the original LINk Steering Group. However, things had now stabilised and the LINk had begun doing some positive work.

53.3 The LINk is currently focusing on mental health and on hospital discharges. Mr Brown told the committee that there had already been excellent input from Brighton & Sussex University Hospitals Trust in regard to the latter issue.

53.4 The LINk is also committed to working with NHS Brighton & Hove, investigating areas in which the PCT has underperformed.

53.5 Mr Brown told the committee that, whilst relations with the HOSC were good, LINk members were disappointed that they had not been offered a co-optee's seat on the Adult Social care and Housing Overview & Scrutiny Committee (ASCHOSC). HOSC members agreed that the ASCHOSC Chairman should be approached with regard to inviting a LINK member to sit on ASCHOSC.

53.6 RESOLVED – That the Chairman should write to the Chair of ASCHOSC requesting that she consider inviting a LINk member to sit on ASCHOSC as a non-voting co-optee.

54. MENTAL HEALTH: PROPOSED CHANGES TO SERVICES

54.1 This item was introduced by Darren Grayson, Chief Executive, NHS Brighton & Hove (NHSBH), and by Lisa Rodrigues, Chief Executive, Sussex Partnership NHS Foundation Trust (SPFT)

54.2 Mr Grayson explained that NHSBH and SPFT were still considering how best to reconfigure mental health services for the residents of Brighton & Hove, and were therefore not in a position to present their reconfiguration options to the HOSC at this time. In consequence, the Brighton & Hove aspect of the reconfiguration initiative was being postponed until (probably) the early summer, when NHSBH and SPFT could be confident of putting forward the best possible reconfiguration options/consultation plans.

54.3 Ms Rodrigues told the committee that, although the reconfiguration initiative was on hold in Brighton & Hove, improvements to Mill View hospital were ongoing, particularly in terms of re-designing hospital services in order to be able to offer an 'ageless' service, in line with recent national guidance, and in terms of developing a 'Section 136 Place of Safety Suite' (a facility where people detained by the police under S136 of the Mental Health Act can be appropriately diagnosed).

54.4 In response to a question about the likely consultation period, Mr Grayson told members that this was currently unclear, as elements of the reconfiguration plans had not yet been agreed: the more substantial the changes mooted, the more likely it was that there would need to be a lengthy consultation period. Mr Grayson also reminded committee members that the HOSC had an important statutory role to play in working with NHS trusts in order to determine the scope and detail of public consultations.

54.5 The Chairman thanked Mr Grayson and Ms Rodrigues for their contributions.

55. 2009/2010 HOSC WORK PROGRAMME

55.1 This was noted.

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

56.1 There were none.

57. ITEMS TO GO FORWARD TO COUNCIL

57.1 There were none.

The meeting concluded at 6pm

Signed Chair

Dated this day of

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	Agenda Item 64 Brighton & Hove City Council

Subject:		**Brighton & Hove 'Out Of Hours' GP Provision**
Date of Meeting:		**14 April 2010**
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 Primary Care Trusts (PCTs) are required to commission 'Out Of Hours' GP services to cover the times of the day when local GP surgeries are not open (generally 6pm until 8am).

1.2 Recent national media attention on this topic has highlighted claims that Out Of Hours services vary very considerably in quality between PCT areas, and that some areas offer an inadequate level of service. Given this recent publicity, the Chairman of Brighton & Hove Health Overview & Scrutiny Committee (HOSC) thought that it would be sensible to check on the level of provision commissioned for city residents by NHS Brighton & Hove.

1.3 **Appendix 1** to this report consists of material provided by NHS Brighton & Hove on city Out Of Hours GP services.

2. RECOMMENDATIONS:

2.1 That members note the contents of this report and determine whether they need to take any further action.

3. BACKGROUND INFORMATION

3.1 In 2004 national GP contracts were re-negotiated. The new contract effectively permitted GPs to opt out of providing Out Of Hours services, and the great majority of GPs duly did so.

3.2 To cover the resultant gap, PCTs were required to commission Out Of Hours GP services. Currently, NHS Brighton & Hove commissions these services from South East Health, a not-for-profit independent sector provider. More information on the details of this contract is included in **Appendix 1** to this report.

3.3 It may be worth bearing in mind that GP Out Of Hours services are only one element of city out of hours primary healthcare: other services include the NHS Direct telephone advice and assessment service, community healthcare services (such as District Nurses etc.), the city centre GP-led Health Centre, and the Urgent Care Centre located at the Royal Sussex County Hospital. If the issue is whether Brighton & Hove Out Of Hours provision is adequate, it would seem sensible to look at city services in the round rather than focusing solely on one aspect of care delivery.

4. CONSULTATION

4.1 None has been undertaken.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this report for information.

Legal Implications:

5.2 None to this report for information.

Equalities Implications:

5.3 None to this report for information.

Sustainability Implications:

5.4 None to this report for information.

Crime & Disorder Implications:

5.5 None to this report for information.

Risk and Opportunity Management Implications:

5.6 None to this report for information.

Corporate / Citywide Implications:

5.7 None to this report for information.

SUPPORTING DOCUMENTATION

Appendices:

1. Information provided by NHS Brighton & Hove

Documents in Members' Rooms:

None

Background Documents:

None

Agenda Item 64: Appendix 1

Out of Hours Care in Brighton and Hove

Key points of the media coverage
There is a wide variation in the coverage of out of hours GP services across England, with Brighton and Hove, Wigan and Bolton highlighted as areas where lone GPs serve more than 240,000 residents. This statistic refers only to the period between midnight and 8am.

The articles all refer to various deaths which have occurred out of hours, including that of Joseph Seevaraj aged 3 from Hove who died in January 2008 due to complications arising from tonsilitis.

Further coverage has arisen following publication of a report by the Primary Care Foundation which does not name specific PCTs, but does identify wide variation in some indicators, such as number of GPs, population, cost, percentage of home visits and calls dealt with over the phone. It is not clear from the coverage how these relate to issues such as population density, number of calls, number of people registered with a GP etc. On all of these indicators, Brighton and Hove is not an outlier, i.e. we are roughly in the middle.

Out of hours service in Brighton and Hove
NHS Brighton and Hove commissions an out of hours GP service from South East Health Ltd. It is a 'not for profit' organisation whose members are local GPs.

This service provides cover:

- Monday to Friday, 6.30 pm – 8 am
- Weekends, 24 hour cover (i.e. Friday 6.30 pm – 8 am on Monday)

That cover consists of the following between midnight and 8 am:

- Weekdays – between midnight and 8 am: there's one GP currently based at Outpatients at the Royal Sussex County Hospital
- Weekends – between midnight and 8 am: there's one GP currently based at Outpatients, plus one GP on standby
- The GP is supported by a trained driver and receptionist and backed up by a call centre team which includes nurses who help to assess patients' requirements at night.

Demand for out of hours service

- Weekdays average activity is between 7 and 10 calls between midnight and 8 am. Around 5% will receive a home visit and 20% will have a face to face consultation in a clinic with a GP.
- Weekends average activity is between 10 to 15 calls between midnight and 8 am each day. Around 12% will receive a home visit and 40% will have a face to face.

Monitoring
We have robust monitoring arrangements in place to ensure that the service provided continues to meet ongoing demand and continues to deliver high quality and safe care for patients. We monitor that data on a monthly basis. Given the number of calls that are received and the number that can be dealt with over the phone, we are confident that GP coverage is more than adequate. Should that demand change, then we would work with South East Health to identify how those standards would be met.

Other options available
Other options are also available for people in Brighton and Hove who need medical care or advice outside normal surgery hours

- Urgent Care Centre at the Royal Sussex County Hospital in Brighton (open 24 hours a day, seven days a week)
- Brighton Station Health Centre which is open, with a GP on site, from 8 am to 8 pm seven days per week.
- Anyone with a genuine emergency can also use the 999 service

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

Subject:		**NHS Brighton & Hove Annual Operating Plan 2010-2011**
Date of Meeting:		**14 April 2010**
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 seeks to present the NHS Brighton & Hove Annual Operating Plan 2010-2011. The Plan is included as **Appendix 1** to this report.

1.2 Amanda Fadero, Acting Chief Executive of NHS Brighton & Hove, will give a presentation at the Committee meeting and will explain key aspects of the 2010-11 plan in detail. Slides from Ms Fadero's presentation are included as **Appendix 2** to this report.

2. RECOMMENDATIONS:

2.1 That members note the 2010-2011 NHS Brighton & Hove Annual Operating Plan and consider how to use the Plan for Health Overview & Scrutiny Committee (HOSC) work programming.

3. BACKGROUND INFORMATION

3.1 Primary Care Trusts (PCTs) are required to publish Annual Operating Plans, setting out their main strategic goals for the coming year.

3.2 The NHS Brighton & Hove Annual Operating Plan has recently been published, and is included as **Appendix 1** to this report.

3.3 The Annual Operating Plan contains details of city healthcare priorities for the coming year. It is therefore a key document for determining the

scope of health scrutiny over the next twelve months, and members may wish to reconsider their Committee work programme commitments in light of the priorities identified in the Plan.

4. CONSULTATION

4.1 No formal consultation was undertaken in relation to this report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

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

Legal Implications:

5.2 " There are no adverse legal implications arising as a result of the recommendation/s in this report"

Lawyer Consulted: Anna MacKenzie; Date: 19/02/09

Equalities Implications:

5.3 Addressing inequalities in health is a key NHS priority, both locally and nationally. Where there are significant local inequalities relating to deprivation, ethnicity etc. these should be addressed by the Annual Operating Plan.

Sustainability Implications:

5.4 The NHS is a major local employer and property owner, and as such, has a key role to play in promoting and delivering environmental sustainability within the city. The NHS has recently announced 'Saving Carbon, Improving Health', a national initiative to significantly reduce healthcare related carbon emissions over the next five years. Although the most obviously relevant organisations here are NHS provider trusts, commissioners also have a role in ensuring that the services they buy promote sustainability.

Crime & Disorder Implications:

5.5 None identified.

Risk and Opportunity Management Implications:

5.6 None identified.

Corporate / Citywide Implications:

5.7 The NHS Brighton & Hove Annual Operating Plan is a key document in terms of delivering the council's corporate objectives: 3.3 'improve the

health of our residents' and 3.4 'working together to target the most vulnerable'.

SUPPORTING DOCUMENTATION

Appendices:

1 The NHS Brighton & Hove Annual Operating Plan 2010-2011

2 Presentation slides for the 14.04.10 HOSC meeting

Documents in Members' Rooms:

None

Background Documents:

None

NHS
Brighton and Hove

Annual Operating Plan for NHS Brighton and Hove 2010/11

FINAL 06.04.10

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Appendices

Executive Summary

The Annual Operating Plan (AOP) for NHS Brighton and Hove (the working name for Brighton and Hove City PCT) develops the Strategic Commissioning Plan (SCP) which was first published in October 2008 and refreshed in December 2009. The SCP described our vision to keep people well and ensure that high quality care is provided to the population of Brighton and Hove. The priorities in the SCP were formulated through discussions with our staff, NHS organisations, patients, members of the public, voluntary sector organisations, City Council and other stakeholders. The Annual Operating Plan focuses on what we will do in 2010/11 to deliver these priorities. Our Annual Operating Plan has been developed in partnership with key local providers of health care and the City Council. The financial, workforce and contractual implications are reconciled to their plans. National targets, 'vital signs' and local authority targets are integrated within the document and are separately listed in Appendix C. We are also committed to achieving the NHS South East Coast pledges. These are referred to throughout the document and are described in Appendix E.

The SCP describes the PCT's strategy as 'targeted transformation' to ensure that we deliver:

- Our commissioning goals
- Our priority health outcomes
- A significant rise in quality and productivity
- Financial sustainability

It sets out a number of 'Priority Transformation Programmes' to ensure we deliver these aims covering the following areas: urgent care, primary care, long term conditions and end of life care, planned care, mental health, maternity and children's services, public health and cross cutting efficiency programmes. The Annual Operating Plan further develops these into Delivery Plans for 2010/11. These are described in detail in section 7 of this plan. Implementing these plans will help us to deliver our vision for the people of Brighton and Hove.

The financial impact of our Annual Operating Plan is set out in section 4 and Appendix F. We are investing £11.8m in our Transformational Programmes (with off-setting savings of £24.1m), £4.8m in increased capacity and £3.3m in quality. This is in addition to ongoing funding of services and infrastructure. We have a savings target of £6.4m for the year to enable these investments to be made; specific savings plans will be developed internally and with our partners in the local health economy. These will focus on systems levers, corporate efficiency and quality metrics and are further described in section 7.8.

As well as making changes during 2010/11 in the services we commission, we also have plans for the people and resources within our own organisation. These are described in section 8.

The impact of this plan on equalities has been reviewed. As each initiative is further developed the impact on minority groups will be assessed at a detailed level to ensure that services are available to all and that specific groups are not disadvantaged.

Our track record is strong and foundations are in place to deliver excellent care for the City; this plan sets out how this will be done and how we will measure success.

1 Introduction

The Annual Operating Plan (AOP) sets out the priorities of the PCT and the work the organisation will do in the coming year. It links to the Strategic Commissioning Plan (SCP) by describing year 1 key initiatives and outlining the PCT's plans, targets and financial flows in that year.

2 Context and Links to Strategic Commissioning Plan

The SCP set out the vision, values, commissioning goals and strategic objectives of the PCT. These are summarised in the table below but more detail can be found in the SCP.

Vision	NHS Brighton and Hove is passionate about keeping people well and making sure that high quality care is provided when they are not well
Values	Professional Focused on achievement Working in partnership Driving quality Promoting innovation
Commissioning goals	Adding years to life Maximising life chances for children and families Developing a healthy young city Promoting independence Commissioning nationally recognised best practice
Strategic objectives	• Be the leading advocate for health and healthcare in the city • Improve health and reduce inequalities • Increase service quality and choice • Increase confidence in and engagement with the NHS • Manage resources effectively

Healthier People, excellent care priorities

The SCP further describes the priority health outcomes which have been developed in response to the strategic context and local health outcomes. For further detail refer to the SCP sections 3 and 4. The priority health outcomes are listed below with rationales for their selection. In delivering out priority health outcomes we will assess the impact and barriers to access including socio-economic barriers, on all groups in our community.

Outcome	Rationale
Under 18 conception rate	Teenage pregnancy is a significant issue for the city and is an LAA target. Babies born to teenage mothers are more likely to have a low birth weight, to die in infancy and to suffer accidents Teenage mothers are at increased risk of postnatal depression and are less likely to be in education, employment or training The conception rate for this group is reducing but remains above the national average
Reducing childhood obesity	Childhood obesity levels are expected to rise. This is an issue in the city and halting this rising rate presents a significant challenge It is considered to be a key marker of the future health of the city as it is associated with a wide range of adverse outcomes in later life
Rate of hospital admissions per 100,000 for alcohol related harm	Alcohol misuse is a significant issue for the city and the rate of admissions for alcohol related harm is high Reducing rates is a challenge, given the reliance on changing lifestyles and behaviours and the need for social marketing. We aim to reduce the growth in the rate of admissions in the next five years through a more targeted approach
Coverage of women aged 53-70 offered screening for breast cancer	We are performing below the national average and recent coverage has fallen for operational reasons An action plan remains in place across the health economy to improve capacity which will help us to recover the recent drop in performance and move towards the national average
Delayed transfers of care (DTOCs)	Improvements are being made but performance remains below ONS cluster average performance. We have reviewed with our partners whether we should retain this as a priority health outcome and given that this is a system-wide target we will continue to focus on this. We will demonstrate leadership by increasing community capacity, improving the effectiveness of joint working and increasing personalised care outside of hospital
Proportion of all deaths that occur at home	We will better co-ordinate primary care and acute services in order to offer choice for people at the end of their life. Our performance is very good but we hope to exceed our current performance and provide a nationally excellent service
MRSA infection rate	MRSA has been a considerable concern for the local health economy and reducing MRSA remains a critical target in order to reduce the risk to patients Local rates of infection remain volatile and are the subject of an ongoing health community wide action plan
The percentage of people moving into recovery from IAPT services	Increasing access to psychological therapies has been commissioned to meet mild to moderate need, however referrals to date indicate that the intensity of interventions have been higher than expected We will work to increase access and to ensure that pathways are redesigned to improve the chances of recovery

2.1 Priority Transformation Programmes

The strategy of NHS Brighton and Hove is described by a number of Priority Transformation Programmes (PTPs). These are commissioning activities or initiatives that will help deliver the right future model of care, our strategic vision, commissioning goals and priority health outcomes and will also help us to bridge our future financial gap.

The AOP sets out how the Priority Transformation Programme will be delivered in 2010/11. Each programme has been further split into a number of plans which are listed below. These are further described in section three and Appendix A.

Priority Transformation Programme		Delivery plan
Urgent care		Urgent Care
Primary care		Transforming Primary Care
Long term conditions & end of life care		Long term conditions and case management
		Long term conditions and independence
Planned care		Moving services into the community
		Improving prevention, access and treatment for cancer
		Specialised and tertiary commissioning
		Increasing productivity and efficiency
Mental health		Promoting mental health and wellbeing
		Developing community pathways to support recovery
		Developing effective and efficient care pathways and treatment services
		Managing access to treatment
Maternity & Children's services		Strengthening partnerships
		Access and settings of care
		Children & Adolescent Mental Health Services (CAMHS)
		Improving early intervention and prevention
		youth service provision
		Improve support to children and young people with a disability or complex health needs and their families
		Childhood obesity
		Transforming maternity services
Public health		Sexual health

Priority Transformation Programme		Delivery plan
		Stop smoking
		Health care acquired infections
		Emergency Preparedness & Resilience
		Prevention of CVD and detection of AAA
Cross cutting PTPs		Targeted spend review
		Corporate efficiency
		Use of systems levers

3 A focus on quality

3.1 Commissioning for quality

As commissioners of healthcare services on behalf of our population, we are committed to ensuring that healthcare services provide high quality care which is accessible to all members of the public. We recognise that quality matters to patients, ensures good value for taxpayers and energises staff.
The NHS Operating Framework for 2010/11 confirms that the focus remains on stability and improvement of frontline services, specifically the delivery of safe, high quality services, delivery against national and local priorities and providing cost-effective services to keep people well.

3.2 The quality framework

In association with staff and stakeholder feedback, we have developed an overarching quality framework, informed by both the national and regional policy and our local plans. This framework sets outs the approach we will use to ensure that the services we commission on behalf of the local population are of the highest quality. This framework will apply to all commissioned and contracted services.
Our principles are to:

- Engage, empower and involve patients, carers and the public
- Place staff at the heart of clinical decision making
- Ensure value for money

An overview of the aspects of this framework is represented in the following diagram:

Each element is explored in greater detail below.

3.3 Quality, Innovation, Productivity and Prevention (QIPP)

High Quality for All supports the collaboration between commissioners and clinicians around the principle of quality and to focus efforts in using innovation to drive up both the quality of patient care and the productivity of healthcare services.
Specifically, the NHS Operating Framework sets out the requirement for us to improve efficiency. Specific focus is placed on releasing savings whilst driving up quality in services.

The links between QIPP and our AOP plans are shown in the following table:

Efficiencies		Our response – AOP Initiative
Provider savings	Reduced back office costs	Corporate efficiency Priority Transformation Programme – staff productivity
	Better value from procurement	Use of system levers Priority Transformation Programme - Commercial Support Unit
	Reduced estates running costs and carbon emissions	Corporate efficiency Priority Transformation Programme – estates rationalisation
Commissioners/ Providers shared savings	Releasing savings and driving up quality	Long term conditions and Independence - Self care and community based alternatives to avoid acute hospital admission and to facilitate discharge
		Urgent care - Single point of access and alternatives to acute hospital to avoid A&E attendances and admissions
		Managing Demand Differently - Review and management of planned care referrals to avoid unnecessary acute admissions
		Increasing Productivity and Efficiency - Improved efficiency and productivity of acute hospital episodes as enforced via contractual levers
		Out of hospital care Priority Transformation Programme - Community based alternative to acute services to prevent elective admissions and facilitate timely discharge
		Specialised commissioning - Repatriation of costlier, out of area placements
		Mental health Priority Managing Access to Treatment - Review and management of referrals to mental health services and early intervention to avoid unnecessary admissions where there are community based alternatives
		Children's services - Promotion of healthier lifestyles to avoid health issues in later life and provision of community based alternative to acute hospital for complex conditions
		Transforming maternity services - Reduction in elective caesarean sections where they are not clinically necessary
		Prevention of CVD and detection of AAA - Prevention and early detection to reduce dependence on acute hospital services

3.4 Clinical effectiveness, safety and patient experience

Lord Darzi (2008) defines quality of care as safe, effective and a good experience for patients. Key elements and areas of focus for each of these three dimensions of quality are as follows:
The vision set out in the Brighton & Hove Commissioning for Quality Framework and its associated action plan will support the identification and delivery of local Commissioning for Quality and Innovation (CQUIN) improvements and support the implementation of the Enhancing Quality programme within Brighton & Hove.
The CQUIN for 2010-11 also include two nationally mandated schemes for acute trusts; 'reducing the impact of Venous Thromboembolism' and 'improving responsiveness to personal needs of patients'. The 2010-11 CQUIN payment framework will also incentivise the implementation of the Enhancing Quality Programme.

3.5 Enhancing Quality Programme

To be implemented across the Southeast Coast SHA providers and commissioners, the Enhancing Quality is a PCT Alliance sponsored Programme which builds upon innovative work by North West SHA.
Enhancing Quality is a clinical change Programme which uses triangulated information to drive quality improvements in clinical interventions; patient reported outcomes and patient experience.
From 2010/11 the programme will be a significant component of the local approach towards CQUIN.

A full list of CQUINs for 2010/11 is included as Appendix C

- **HCAI prevention and control** – The 2010/11 Operating Framework sets out a new objective on MRSA infections and a new standard for C Diff will be published in 2010. This is included in the initiative template for HCAI.

- **Safeguarding** – the local health economy safeguarding arrangements will continue to be strengthened to ensure that consistent arrangements are in place to safeguard and promote the welfare of children and vulnerable adults. The PCT will work closely with colleagues within local healthcare and local authority to ensure we are informed of all incidents involving children and adults, including death or harm whilst in the care of the provider.

4 Finance

4.1 Source and application of new funds

The PCT receives 5.2% growth funding in 2010/11 (£22.8m) and has a carried forward surplus of £1m. There is no change in tariff (the prices paid under Payment by Results) and there is a 3.5% efficiency savings requirement to providers. CQUIN increases from 0.5% to 1.5% demonstrating an increased emphasis on quality issues.

Because 2010/11 is set to be a year of consolidation and constraint, it will feel financially tighter than 2009/10. We are required to increase our surplus to 1% (£4,615k), spend 2% (£9,229k) non-recurrently on transformational change and ensure that we have sufficient contingencies to cover risk. In developing the AOP we have also set a contingency reserve of 1% (£4,615k).

The plan for 2010/11 can be summarized as follows and the table below: **-**

	2010/11
Summary use of Growth	£'000's
Source of Funds	
Growth (5.2%) in 2010/11	22,823
Prior Year surplus Non Recurrent	1,000
Underlying Surplus Recurrent	0
Total	**23,823**
Inflation and Tariff	
PbR/Non-PbR	0
CQUIN (+1%=1.5% in total)	3,314
Prescribing	2,021
Capacity (@2.25%)	4,827
	10,162
Service pressures	
PbR exclusions	500
2009/10 NR savings	4,000
Continuing Care	2,000
Carers + Misc.	946
	7,446
New 'Choosing Health' investments/savings	
Investments	798
Savings	(798)
	0
Priority Transformational Programmes	
Investments	11,813
Savings	(24,057)
	(12,244)
Contingency (1%)	4,615
Non Recurrent Spend on Transformational change (2%)	9,229
Total Expenditure	**19,208**
Surplus (1%)	**4,615**
	23,823

Therefore, the AOP for 2010/11 has: -

- 1% Contingency £ 4,615k
- 2% Non Recurrent spend reserve £ 9,229k
- 1% Surplus £ 4,615k
- Total £18,459k

Although a contingency reserve has been set at 1% in the AOP within the savings figure of £24,057k are savings of £6,403k which are yet to be identified. (see Table 1).

We continue to work up initiatives to recurrently secure the full £6403k savings under the leadership of the Director of Finance. This remains the corporate aim as not to do so merely increases the financial challenge in 2011/12.

The AOP has a reserve for non-recurrent spend on transformational change of 2% (£9229k). For 2010/11 this 'Investment Fund' requirement has been agreed across SEC to be 1.25%. Therefore in the FIMS plan submitted to the SHA we have made an adjustment of £3461k reduction to the investment fund which also reduces the 'savings to be identified' figure down to £2942k. We have also identified how this can be found non-recurrently and submitted a balanced FIMS plan with no shortfall in savings.

It is seen as a high corporate priority to ensure that as we move into 2011/12 we have a 1% Surplus, 1% Contingency Reserve and 2% Investment Fund. Therefore the AOP reflects the need to meet this financial challenge in 2010/11 as will the budgets we set for the year.

Given the challenging financial environment there will be no access to any contingency reserve until all the savings are identified and even then the access will be to non-recurrent funding to deliver future savings, thereby ensuring a sustainable financial position with expenditure being contained within budget.

Table 1 **Priority Transformational Programmes**	**2010/11** **Investment**	 **Savings**
Urgent Care	**155**	**(1,540)**
Primary Care	**841**	**(350)**
Long Term Conditions & Case Management	**592**	**(857)**
Long Term Conditions & Independence	**98**	**0**
Moving services into the community	**5,669**	**(6,301)**
Improving Cancer Services	**1,329**	**(239)**
Referral Management	**0**	**(838)**
Acute Care	**0**	**(435)**
Mental Health	**832**	**(341)**
Children's Services	**0**	**(325)**
Maternity Services	**165**	**(263)**
Developing a Healthy Young City	**304**	**(261)**
Adding Years to Life	**20**	**0**
Corporate efficiencies	**0**	**(1,200)**
Use of Systems levers	**0**	**(1,600)**
Targeted spend reviews	**0**	**(1,101)**
Cost Pressures	**1,808**	**(653)**
Public Health Efficiencies	**0**	**(300)**
Dental and Prescribing underspend	**0**	**(1,050)**
Yet to be identified		**(6,403)**
Total	**11,813**	**(24,057)**

The table above as well as summarising the Delivery Plans set out in the rest of this document shows assumed efficiency savings of the Public Health budget, and the under spend in Prescribing and Dental budgets in 2010/11 reflecting the experience of previous years rather than being planned.

5 Equality and Diversity

NHS Brighton and Hove, like all public bodies, has legal duties to promote equality and tackle discrimination in everything it does as an employer and commissioner of health services.

These legal duties are laid out in the Race Relations (Amendment) Act 2000, The Disability Discrimination (Amendment) Act 2005, and the Equality Act 2006. Whilst these specific duties cover Race, Disability and Gender, there are further legislative measures both in force, and coming in the Single Equality Bill 2010 expanding our duties to cover the 'protected characteristics of – Age; Disability; Gender Reassignment; Marriage and Civil Partnerships; Race; Religion or Belief; Gender; Sexual Orientation; Pregnancy and Maternity. Our obligations also now include Socio-Economic inequalities and Carers. The Trust has a Single Equality and Human Rights Scheme (SEHRS), detailing its responsibilities and commitments to include the new 'protected characteristics'.

We assess the impact of changes to NHS services, commissioning and decision making, via our Equality Impact Assessment (EIA) process. The Trust supports staff

networks and provides training and awareness raising activities to ensure the organisation values and supports its diverse staff.

The PCT recognises that no one person can be easily categorised by just one of these definitions or identities. Therefore the organisation's work to promote equality and diversity considers all of these issues simultaneously, whilst acknowledging that some people will experience exclusion and unfair treatment because of their identity within one of these strands.

6 Clinical Commissioning

Our governance arrangements promote and encourage local clinicians to play a central role in the identification and delivery of local quality and efficiency improvement priorities. Clinicians are actively involved in supporting the adoption and development of service specific indicators for quality, ensuring local ownership for reviewing and improving quality so that the needs of the local population are best met. Through this process, commissioners work in collaboration with providers to understand quality issues and identify and implement solutions which facilitate continuous quality care improvement. The key mechanism for supporting this clinical engagement is Practice Based commissioning (PBC).

6.1 Overview of PBC

Local practices in Brighton and Hove have been actively involved in PBC since April 2006. Three active locality commissioning groups are in existence covering the East, Central and West localities population. Governance and strategic decision-making is coordinated via a City wide Joint PBC Board that meets on a monthly basis and is chaired by the PBC locality chairs.

We have committed to maintain the engagement already in place and to work jointly with PBC to develop systems and processes and to change current ways of working. An enhanced operational framework has been developed to ensure PBC collectives have greater engagement in the clinical commissioning agenda linked to our SCP. The PBC Operational Framework 2010/11 focuses on:

- PBC's link to the strategic focus of the PCT (including more clinical engagement in the strategic decision making process)
- The financial framework (including achievement of financial balance and the implications of poor performance)
- The context and outcomes expected through the effective management of PBC across NHS Brighton and Hove by both the PCT and GP Practices (including aligned resources internally within the PCT to support PBC)

The main priorities identified for PBC

- Developing a more cohesive collective structure that manages practices in a more operational way linked to performance management and clinical engagement. The development of collective agreements is being suggested as a practical way forward for ensuring this process is achieved.
- Managing demand, linked to a more cohesive structure. This level of operational management is seen as the minimum level of PBC engagement.
- Clinical Leadership and engagement. The future leaders of PBC should be GPs, supported by operational managers and these GPs will be supported financially to invest the time needed to deliver a more cohesive structure.

- Service redesigns linked to the strategic focus of the PCT. Clinicians should be involved in the whole process of developing the strategy, and should be involved in a way that allows them to take ownership.
- Defining a revised financial framework and budget setting methodology that support PBC and is delivered through high quality data management processes and tools.
- The PCT delivering dedicated resources allocated to support PBC.
- PCT Teams created internally to cover:
    - Service redesign support functions
    - Finance and Data dedicated functions linked to PBC
    - Management Support dedicated function linked to PBC

7 Delivery Plans

7.1 Urgent Care

7.1.1 Urgent Care

Summary

We will transform urgent care services in the city so that they are simple to access, responsive, – consistent and appropriate.

Projects within the initiative

In 2009/10 we

- Implemented Phase 4 of the Urgent Care Centre (UCC)
- Implemented a pilot Roving GP service
- Implemented a pilot RACOP (Rapid Access Clinic for Older People) service
- Re-commissioned STAN (single telephone access number), now known as 'HERMES'.
- Worked with SECAMB to establish 5 paramedic practitioners

In 2010/11 we will:

- Develop the service model for a fully integrated urgent care centre and decide on procurement options
- Work to reduce avoidable admissions and Delayed Transfers of Care across pathways from self-care to hospital discharge including the following:
    - Develop the service model for the rapid assessment and response services.
    - Test acute admission criteria for key pathways.
    - Review and extend where appropriate the RACOP, Roving GP and HERMES services
    - Review and refocus the Integrated Discharge Team
    - Develop and extend community IV clinic supported by IV team
- Ensure people are seen at the right place and time with the right clinician including the following:
    - Develop a targeted communication strategy to influence patient behaviour and use of urgent care
    - Simplify access to all short term services - one referral and one assessment
    - Minimise opportunities for bypassing care pathways by ringing 999/NHSDirect
    - Develop the role of paramedic practitioners
- Develop service model for short term services.

Key Milestones

- Urgent Care Centre service model defined and decision made re procurement options April 2011)
- Work to reduce avoidable admissions and Delayed Transfers of Care across pathways from self-care to hospital discharge (March 2011)
- Ensure people are seen at the right place and time with the right clinician (March 2011)
- Service model for the Rapid Access and Assessment Model defined. (March 2011)
- Test acute admission criteria. (March 2011)
- Service model for short term services (March 2011)

Outcome measures

Measure	Target
Rate of emergency admission per 100000 population by 2013/14	National average
Ambulatory care sensitive conditions 2013	Upper quartile
Shift balance between use of short term services	60% for prevention of admission and 40% for hospital discharge

Quality metrics

Measure	Target
CQUIN measure for SECAMB 1. To complete the piloting of the training programme and develop a roll-out plan to cover all relevant SECAMB staff across all PCT areas.	Pilot training programme completed
2. To work towards improving the communication of palliative care handover notes/DNAR orders from the central database to ambulance crews.	Quarterly progress reports.
South CQUINS relevant to urgent care Reducing variability in patterns of admissions to short term services across the week. Reduce the number of patients readmitted to hospital within 28 days of discharge from a community short term service	
BSUH CQUINS relevant to urgent care: Reducing variability in pattern of discharges across the week Reduction in Avoidable readmissions with 14 days by 10% Reduction of patients falls in hospital by 20% Ensure 95% of patients have an agreed discharge plan within 24 hours of on all elective and emergency admissions	

Principal changes in activity

NEL Admissions	10/11
Roving GP	177
RACOP	142
Reduction in admissions	496
Total	**815**

10/11 shows additional over and above 09/10

Implications for workforce

The potential procurement of a fully integrated urgent care centre could involve contracting with a new provider for this service with implications for TUPE of staff and change of staffing focus. This will be evaluated as part of the procurement process.
A revised rapid access model could involve TUPE of staff from existing services as well as the development of new roles. It may also require staff to work in different locations i.e. on a locality basis and much closely to primary care. We may also seek to change the operating times of services to match patient need eg some service may need to function on a 24/7 basis.

The implementation of acute admission criteria will be dependent on the development of a senior clinician role at the front door of the hospital to stream patients to the most appropriate service to meet their need

The development of a new model for short term services is likely to involve an increase in the

provision of services delivered in the community, reducing reliance on bed based services. We will expect services to be delivered in delivered in different locations, all within the city and from few sites. Developing a single model for short term care may mean staff working under new management arrangements or even for a new provider.

We will need to develop roles such as GPwSI or middle grade doctors with a special interest in elderly medicine to ensure the right medical input to community services that support prevention of admission.

Commentary on financial requirements

	10/11		
	Cost	**Savings**	**Net Savings**
Roving GP	76	377	301
RACOP	79	281	202
Out of hours GP		310	310
Short Term Services		72	72
Reduction in admissions		500	500
Total	**155**	**1,540**	**1,385**

Procurement and market management implications

Procurement options for Integrated Urgent Care will be reviewed this year

Related Vital Signs Measures/ Existing Commitments	CQC EC8 (VSC10) VSC20 VSC11 CQC EC2,3 & 4 CQC EC13 CQC EC14
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Acute Care pledges 1,2 &3

Equalities Impact

High quality care for all will deliver better and fairer outcomes for all patients. We will commission to promote equality and reduce discrimination through carrying out equality impact assessments and continuous stakeholder engagement in the commissioning of services.

7.2 Primary care

7.2.1 Transforming Primary Care

Summary

The overall aim of this initiative is to develop and improve Primary Care services and in particular to reduce the variation in quality and performance between individual contractors. There needs to be a strong foundation in order to enable the strategic shift of services from secondary to primary care.

Projects within the initiative

In 2009/10 we

- Opened a GP led health centre in central Brighton
- Developed a new quality and performance management framework for general practice using a balanced scorecard
- Supported practices to improve patient access and responsiveness through one to one facilitation and support. Improved access to NHS dentistry through additional investment and marketing and communications.
- Continued to invest in primary care estates
- Started to implement the NHS Health Check programme – focusing on the hard to reach and most at risk populations
- Published a new Pharmaceutical Needs Assessment
- Develop new community pharmacy enhanced services and revised several existing services

In 2010/11 we will

- Continue to improve and develop the primary care infrastructure
- Roll out the General Practice quality and performance framework to all practice
- Introduced a quality and performance framework for NHS dentistry
- Develop plans for a quality and performance framework for optometry
- Improve access and responsiveness by continuing to provide individual support to practices and investing in the “Access and Responsiveness” LES
- Ensure 100% of our population in General Practice
- Maximise value from primary care contracts by:
    - Encouraging quality improvements through the balanced scorecard approach
    - Specifically incentivising quality in all new contracts
- Targeting resources and refocusing commissioning activity to focus on:
    - Reducing health inequalities
    - Promoting health and prevention
    - Long term conditions
- Invest further in NHS dentistry to improve access and meet the Vital Signs target set for 31 March 2011
- Review orthodontics services
- Review the PCT’s contract for special care dentistry
- Prepare to procure a more local Emergency Dental Service
- Develop a new quality and performance framework for community pharmacy.
- Target community pharmacy advance services to:
    - Long term conditions
    - Discharge
    - And raise the profile of ‘medicines check ups’ with the general public.

Key Milestones

- Implement new contracts to improve access to NHS dentistry with more focus on prevention and quality incentives - implement September 10
- Full implementation of Quality & Performance frameworks for General Practice and NHS dentistry Apr 10 – Mar 11
- Implement Estates strategy phased 10/11 and beyond
- Implement Restorative Dentistry service – New local emergency dental service procured – by 1 April 2011
- Outcome review orthodontics September 10
- New contract for special care dentistry agreed by 1 July 2010
- Launch new primary care sexual health service – April 2010
- Launch medicines check ups at BSUH and to the general public – Sept 2010
- Implement ETP Release 2 (Electronic Transmission of Prescriptions) – Winter 2010/11
- Emergency Dental service from April 11

Outcome measures

Measure	Measure
Ensure patients can choose a GP practice officering extended access to evening and weekend appointments.	100%
VSC06 Patient reported measure of GP access	91%
No. of patients receiving NHS primary dental services in previous 24 months	60%
QOF exception reporting	6.5%

Quality Metrics

Measure	Target
QOF scores – against maximum points available	94.5%
GP Contractors scoring 'A' in quality scorecard	35%
Dental Contractors scoring 'A' in quality scorecard	35%
Overall satisfaction with GP services	96.5%

Principal changes in activity

n/a

Implications for workforce

Implications for workforce

PCT: Increased access to dentistry will be achieved through contractual arrangements. Skills mix of dental staff will change to emphasise prevention eg additional hygienists. Movement of work from acute to primary care will require increasing clinical specialisation eg GPSis (GP's with Special Interests). We expect this to equate to five new dentists.
Increased focus on health promotion and prevention will change the skills mix towards practice

nurses and healthcare assistants.

Encourage pharmacists to use their teams more effectively in offering and promoting pharmacy based services.

Commentary on financial requirements

	cost	savings
Fye GP Led Health Centre	£429k	
QOF	£78k	
Premises rental increase	£259k	
Premises non-recurrent costs	£75k	
Re contract special care dentistry		£350k
Total	£841k	£350k

Procurement and market management implications

Emergency dental service and dental access procurement will be progressed this year

Related Vital Signs Measures/ Existing Commitments	VSA06 VSA07 VSB18
Related World Class Commissioning outcome measures	Under 18 conception rate
Related *Healthier People Excellent Care* Pledges	Long Term Conditions Pledge 4 Staying Healthy Pledge 2

Equalities Impact

The Access and Responsiveness LES ensures practices take account of patient satisfaction and inequalities of service provision within their practice and take action to ensure access is improved where required. With regard to dental services, social marketing is underway to improve our understanding of barriers to access. We will then target particular groups where access rates are lower. When contracting pharmacy LESs, we ensure coverage across the whole City to meet patient demand.

7.3 Long term conditions & end of life care

7.3.1 Long term conditions and case management

Summary

To provide systematic and integrated primary and community care for patients with a long term condition (LTC) across all levels of care from self care to end of life.

Projects within the initiative

In 2009/10 we

- Agreed a local dementia strategy and action plan
- Improved provision of respiratory services
- Implemented End of Life strategy including LES to ensure GPs sign up to Gold Standards Framework.
- Re provided the anticoagulation service in the community

In 2010/11 we will

- Implement LTC network
- Develop and agree locality based model of care for LTC ,care planning case management , information provision
- Test out the LTC model for 1year
- Identify key priority conditions (patient groups) within LTC where elective activity can transfer into primary and community care e.g. LTC OPAs (cross reference elective care PTP)
- Review current provision of Diabetes, COPD, Dementia and Heart Failure against national best practice to identify opportunities to improve quality and productivity
- Implement insulin pumps as per NICE guidance
- Implement local Carers Strategy
- Explore opportunities for Community tariffs and currency.
- Continue local End of Life Care Strategy roll out
- Continue roll out of Gold Standards Framework across Primary Care
- Implement an electronic End of Life Care Register
- Continue to pilot a dementia demonstrator site including the involvement of learning disabilities, BME and LGBT groups.

Key Milestones

- LTC network operational April 2010
- LTC resource envelope confirmed May 2010
- LTC model developed for each locality Aug 2010
- Testing of model Aug 2010
- Review and explore opportunities for elective activity to be managed within primary / community care
  Jan2011
- Agreement to progress Insulin pumps business case Feb 2010
- Resource allocated for End of Life Care Registers project Feb 2010
- Explore opportunities for Community tariffs and currency March2011
- GSF roll out March 2011
- Electronic end of life care registrar roll out complete March 2011

- Carers Strategy - Ongoing

Outcome measures

Measure	Measure
All patients with a LTC will be offered a personalised care plan	March 2010
Improved hypoglycaemic control by setting target HbA1c at 7, target level to be confirmed (HbA1c was previously 7.5 now 7 target now requires re adjusting? 85%)	March 2011
90% practices signed up and participating within the GSF	March 2011
Patients supported to die at home where this in their preference 23%	March 2011
Number of identified carers referred for a carers assessment	To be developed

Quality Metrics

Measure	Target
Care planning and assessment: • Total number of new referrals. • Total number of new referrals with a personalised care plan in place • Total number of new referrals with a care co-ordinator identified	
Carers • Total number of new referrals • Total number of new referrals who are asked whether they have a informal carer • Total number of new referrals for whom an informal carer is identified and whether carer is under 18, 18-65, or over 65 • Number of the above referred for carers assessments • Number of carers assessments completed by South Downs Staff	
End of Life • Increase patients being managed through Liverpool Care Pathway • Increase number of patients with recorded preferred place of care	

Principal changes in activity

Need to confirm activity for OPD and FU for Diabetes following revisions in year 09/10

Specialty Name	**Localities Reductions (phased)**
Anti Coagulant Service	**-39,840**

Implications for workforce

Provider: With the reconfiguration of existing teams and focus and shift to generic team based models of care the existing community workforce is likely to experience the most change.

Teams will move from nursing only to multi disciplinary teams working across a number of organisational boundaries.

Aspiration to train non-qualified staff to take on a range of roles including assessing for and prescribing equipment and therapy support.

Commentary on financial requirements

Service	Investment £000	Savings £000
Diabetes	122	122
Insulin Pumps	111	
Anticoag	258	735
Carers	101	
Total	**592**	**857**

Procurement and market management implications

Clarification of procurement route for Insulin Pumps required

Related Vital Signs Measures/ Existing Commitments	Vital Signs VSC 11, 12, 13, 14, 15, 20, 21
Related World Class Commissioning outcome measures	Proportion of all deaths that occur at home
Related *Healthier People Excellent Care* Pledges	Long term Condition Pledges 1,2,3,4,5 End of Life Pledges 1-5 Overarching Pledge 7

Equalities Impact

Significant inequalities of provision, access and quality of provision exist within the current services which will be addressed within the longer term commissioning plan
Improve overall performance within primary care for management of LTC
Equity of provision of services for mobile and housebound patients
Reduction in variability of quality of LTC services
Equalities impact assessment will be completed as part of the overall Primary and Community Care Strategy Development

7.3.2 Long term care and independence

Summary
To support people to live independently at home for as long as possible

Projects within the initiative

In 2009/10 we

- Implemented 24/7 provision of thrombolysis therapy for stroke

In 2010/11 we will

- Develop and agree a clear commissioning plan for acute/post acute neuro rehabilitation pathway
- In line with the commissioning plan develop procurement process to deliver plan
- Undertake feasibility study of the national retail model for provision of equipment to determine if savings expected would be achieved locally.
- Review Integrated Community Equipment Store (ICES) service
- Procure future ICES service

Key Milestones

- Development of joint CQUIN measure for improved transfer of care for neuro rehabilitation pathway March 2010
- Commissioning plan developed and agreed for future neuro rehab pathway Apr 2010
- Procurement plan (if required)for neuro rehab implemented Jul 10
- Complete feasibility study of National retail model Jul 2010
- Complete review ICES provision Jul 2010
- Commissioning and procurement of future ICES model completed March 2011

Outcome measures

Measure	Measure
VSA 14 People with a stroke will spend at least 90% of their time on a stroke unit	80% By end of 2010/11
Higher risk TIA cases are treated within 24hrs	60% By 2010/11
VSC 11 Proportion of people with LTC supported to be independent and in control of their condition	Target under review
VCS12 Timeliness of social care assessments VCS13 Timeliness of social care packages	72% By 2010/11 82% by 2010/11
Simple aids to daily living provided by local retailers	100%

Quality Metrics

Measure	Target

Principal changes in activity
Dependent on final neuro rehabilitation model, shift of activity from bed based services to community teams. Likely activity reduction equating to 8 beds BUT this will be re provided within the community with increase in activity for Community Neuro Rehab Intermediate Care BHCC
Implications for workforce
PCT: **Provider:** With the focus on increasing the shift of rehabilitation from a hospital bed setting to the home there are a number of implications for the current workforce. Increased acuity and complexity of patients will require an increase in capacity and skilled multi disciplinary community teams to care for and support these patients within their own home . Increased capacity within home care provision will also be required to manage the 24/7 nature of this level of care Stronger focus on independence and re enablement aligned with BHCC
Commentary on financial requirements
Stroke Thrombolysis £98k investment
Procurement and market management implications
Procurement of ICES services starts December 2010

Related Vital Signs Measures/ Existing Commitments	VSC 11,12 ,13,14,15
Related World Class Commissioning outcome measures	Proportion of all deaths that occur at home
Related *Healthier People Excellent Care* Pledges	LTC pledges 1,2,4 and 5.

Equalities Impact
Equalities' Impact assessment will be completed as part of the Primary and Community Strategy development

7.4 Planned Care

7.4.1 Moving Services into the Community

Summary

These schemes will make services more accessible to patients, in some instances increasing choice and deliver savings for the local economy.

In 2010/11 we have plans to reduce demand by 6% in 2010/11 and move 46% of outpatient activity to primary and community settings.

The services will be re-provided at a reduced cost (target is 20% lower than current cost).

In addition the PCT will increase the level of physiotherapy commissioned, by 20%, to enable the MSK service to be developed.

Projects within the initiative

In 2009/10 we

- Implemented the community eye clinic
- Implemented the ENT pilot
- Tendered for a community gynaecology service

In 2010/11 we will implement the following services:

- Adult Hearing Aids service
- MSK ICATS (Muscular Skeletal Integrated Clinical Assessment and Treatment Service)
- Increase capacity for Physiotherapy
- Community Dermatology
- Other Community services: ENT, neurology and opthalmology

Key Milestones

Phase 1

- Adult Hearing Aids Service is being reviewed to ensure cost effectiveness from April 10
- MSK ICATS commences from April 10
- Increase capacity for Physiotherapy April 10
- Community Dermatology commences from June 10

Phase 2

- Community ENT service commences from September 10
- Community Neurology service commences from September 10
- Community Ophthalmology service November 10

Outcome measures

Measure	Measure
Patient satisfaction	Measure to be developed
Improved access for advice and treatment	Measure to be developed

Reduction in secondary care referrals	Refer to activity section

Principal changes in activity

Principal changes in activity

	Specialty Name	Out-patient Reduction
MSK	TRAUMA & ORTHOPAEDICS	-25,881
	PAIN MANAGEMENT	-1,817
	RHEUMATOLOGY	-6,833
	PODIATRY	-591
Subtotal MSK		**-35,122**
Dermatology	DERMATOLOGY	**-11,805**
Other community clinics	UROLOGY	-129
	ENT	-3,080
	GASTROENTEROLOGY	-173
	CARDIOLOGY	-339
	NEUROLOGY	-574
	GYNAECOLOGY	-1,335
	COLORECTAL SURGERY	-317
	OPHTHALMOLOGY	-3,685
Subtotal other community		**-9,632**
	Total	**-56,559**

*Please note that the PCT will be increasing the commissioned capacity for physiotherapy by 20% in 2010/11 as an enabler for the MSK services.

Implications for workforce

Provider: In general there should be a reduction in the need for consultants and a growth in non-consultants workforce including specialist nurses, extended scope practitioners, skilled GPs and skilled primary care practitioners.

Commentary on financial requirements

	Cost	**Savings**	**Net**
MSK at BSUH	1,866	(4,106)	(2,240)
MSK – Community	1,4,19		1,419
MSK – Phasing allowance	410		410
MSK – Physiotherapy	218		218
Subtotal MSK	**3,913**	**(4,106)**	**(193)**
Dermatology	919	(1,149)	(230)
Other community	837	(1,046)	(209)
Total	**5,669**	**(6,301)**	**(632)**

Procurement and market management implications

Develop the primary care market to manage increased elective care and utilising the following different approaches:

- NHS preferred provider;
- Integrated care services;
- Any willing provider;
- Market testing for primary and community care services.

Related Vital Signs Measures/ Existing Commitments	Supports the sustainability of 18 weeks, 13 weeks and 26 weeks targets. VSA04, CQCEC12
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Planned Care – Pledge 1 and 3 (part of three year plan) Overarching Pledge 4 (part of three year plan) Planned Care – Pledge 5
Equalities Impact	
In general the initiative reduces inequalities by improving accessibility	

7.4.2 Improving prevention, access and treatment for cancer

Summary

The PCT is committed to delivering the vision for cancer services set out in our Cancer Reform Strategy Action Plan and to reducing the mortality rate from cancer in people under 75 years by 20% by 2010 (from 2005/06 baseline). This will be achieved by:

1. Minimising people's risk of developing cancer in the first place;
2. Encouraging early presentation, detection and diagnosis;
3. Providing the very best cancer treatment including faster access;
4. Improving people's experience of cancer care throughout the pathway.

Projects within the initiative

1. **Minimising people's risk of developing cancer in the first place:**
   - Continue to commission health promotion services that encourage: smoking cessation, healthy diet, physical activity, weight management, sexual health and alcohol awareness
   - Raise awareness of the causes of skin cancer
   - Deliver the HPV vaccination programme to girls in school year 8
   - Links with 6.6.5 Early intervention and prevention in Section 6.6 of Maternity and Children's services; and also 6.7.1 sexual health, 6.7.2 stop smoking, 6.7.3 prevention of cardiovascular disease in Section 6.7 of Public Health

2. **Encouraging early presentation, detection and diagnosis:**
   - Improve local understanding of the population's awareness of cancer and develop a targeted programme of work to improve symptom awareness and promote early diagnosis
   - Introduce the age extension for bowel cancer screening up to 75 years
   - Achieve and maintain the 36 month screening-round-length and age extension for breast screening for local women
   - Achieve the two week turnaround for cervical screening results

3. **Providing the very best cancer treatment including faster access:**
   - Develop an acute oncology service
   - Introduce enhanced recovery programme
   - Develop effective treatment locally e.g. Radio Frequency Ablations
   - Implement outstanding Improving Outcomes Guidance (IOG) measures
   - Increase radiotherapy capacity and deliver waiting time targets
   - Increase chemotherapy capacity by 10% and develop new model of care for chemotherapy
   - Increase capacity for Positron Emission Tomography (PET) scans by 2.5%
   - Undertake peer review for key tumour groups including: rehabilitation and radiotherapy

4. **Improving people's experience of cancer care throughout the pathway:**
   - Establish a community clinic to increase access to treatment for lymphoedema
   - Increase access to psychological support for people living with cancer

Key milestones for each project

1. Minimising people's risk of developing cancer in the first place:
   - HPV programme - complete first round of school visits October 2010, second round December 2010, and third round by April 2011
   - Skin cancer awareness launch May 2010

2. Encouraging early presentation, detection and diagnosis of cancer:
   - NAEDI funded initiative - conduct population survey using CAM March 2010; and awareness campaign August 2010
   - Ahead of the Game (promote awareness of lung, prostate and colorectal cancer in men over 55 yrs) - Project end date June 2010
   - Promote early referral - Pilot Primary care audit (LES) prior to possible roll out - dates TBC
   - Bowel screening - age extension November 2010
   - Breast screening - deliver 36 month target September 2010 and commence age extension November 2010
   - Cervical screening - Achieve two week turnaround for screening results December 2010

3. Providing the very best cancer treatment including faster access:
   - Increased chemotherapy capacity - model and tariff process agreed October 2010
   - Acute oncology - service open 24hours 5 days a week in A&E Oct 2010
   - Increased radiotherapy capacity - CT Simulator operational December 2010; Extended days and Saturdays operational October 2010
   - Radio frequency ablations (RFA) - service established October 2010
   - IOG measures - fully met and activity contracted October 2010
   - Enhanced recovery programme - gynaecology, colorectal and urology pathways completed October 2010; roll out methodology to all cancer pathways March 2011
   - Peer review - self assessment completed October 2010; external validation completed November 2010
   - PET scans - SLA signed off and capacity in place April 2010

4. Improving people's experience of cancer care throughout the pathway:
   - Lymphoedema treatment - access increased October 2010
   - Psychological therapy - capacity and pathway in place October 2010

Outcome measures

Project area	Measures
Improve cancer awareness and early diagnosis	Baseline for population awareness in Brighton and Hove Identify the population groups and types of cancer to be prioritised Increase the number of urgent 2 week referrals Increase the proportion of new cancer cases diagnosed through urgent two week referral Increase the number of new cancer cases with no spread at diagnosis or diagnosed at an earlier stage
Bowel cancer screening	Increase rate of bowel cancers diagnosed through this route Reduce mortality rate for cancer in under 75 yrs in line with national target

Breast screening	Increase breast screening coverage to 72% by end of 2010/11 Achieve 2 week wait for breast symptomatic
Cervical screening	Increase cervical screening coverage to 77% by end of 2010/11
HPV vaccination programme	High coverage of screening programme
Chemotherapy service	Improved survival rate for cancer Continue to meet access targets in line with national guidance
Oncology response times	Reduce emergency admission rate and length of stay for oncology patients
Radiotherapy capacity	Achieve 31 day standard for subsequent radiotherapy Continue to meet access targets in line with national guidance
Effective treatment eg RFA	Reduce length of stay in hospital
Enhanced recovery programme	Reduce length of stay in hospital

Quality Metrics

Measure	Target
IOG measures	100% Compliance for IOG Peer Review
Lymphoedema	Improve experience of people living with cancer
Access to psychological support	Improve experience of people living with cancer

Principal changes in activity

10% growth for chemotherapy against 09/10 outturn;
19% growth for radiotherapy against 09/10 outturn, to achieve 40,000 fractions per 1M population;
10% growth for PET scans against 09/10 outturn;
3.25% uplift on breast screening programme;
30 MRIs for Breast Family History

Implications for workforce

Provider:

- Recruit radiographers for breast screening programme and for radiotherapy service
- Recruit radiologist for breast service
- Review medical physics services
- Recruit increase in oncologist and oncology specialist nurses to meet National Cancer Action Group's acute oncology recommendations

Commentary on financial requirements

The PCT is investing in: minimising the risk of developing cancer; encouraging early presentation, detection and diagnosis; improving the quality of local services (ensuring IOG compliance) and meeting the increase in demand for radiotherapy and chemotherapy.

Minimising people's risk of developing cancer in the first place/
Encouraging early presentation, detection and diagnosis of cancer:

- Additional £105k - Continuation of NAEDI work, promoting screening up-take and skin cancer prevention work
- Current funding £182k – Continuation of Ahead of the Game, health promotion post and Primary care audit (Local Enhanced Service)
- Bowel cancer screening age extension £275k
- Bowel cancer hub £140k
- Breast screening £70k

Providing the very best cancer treatment including faster access;

- PET scans cost uplift - 10% increase on plan
- 10% uplift for chemotherapy
- 19% uplift for radiotherapy
- Improved treatments – reprovision of activity and costs – cost neutral
- IOG Compliant Services £200k (to include lymphoedema)
- CQUINs to fund acute oncology and palliative care measures
- Estimate for horizon scanning £300k (high cost drugs)

Improving people's experience of cancer care throughout the pathway.

- Existing budget - funding Psychological support

Procurement and market management implications	
Develop our local NHS services to meet national standards.	
Related Vital Signs Measures/ Existing Commitments	Cancer mortality target: reducing mortality by 20% in under 75 year olds by 2010 (from 1995/96 baseline) Cancer waiting times including: Radiotherapy waiting time, 2 WW for breast symptomatic services Breast screening – age extension Bowel screening – age extension Cervical screening – 2 week reporting
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	End of Life Care – Pledge 1, 2, 3, 4 and 5
Equalities Impact	

- Work to prevent cancer is targeted at the more deprived populations where lifestyle risk factors are generally higher
- A particular focus is given to promoting the up-take of cancer screening in ethnic minority groups, lesbian and bi-sexual women, and people with learning disabilities.
- The population survey using the Cancer Awareness Measure is looking particularly at the more deprived population
- Cancer early awareness work is focusing on those who are most at risk of late presentation and diagnosis

7.4.3 Managing Demand Differently

Summary

To align need, demand and capacity and ensure that a patient is assessed treated by the right person first time. Utilise the incentives in the PbC Operating Framework with:

1. Develop gateway management;
2. Develop evidence based primary care management guidelines;
3. Increasing capacity in primary care to diver referrals from secondary care;
4. Increase collaboration of practices to treat patient in primary care.

This programme aims to strengthen the primary care system, in terms of aligning incentives, building collaboration, capacity and capability, and improve performance of acute outpatients against national comparators levels.

Projects within the initiative

In 2009/10 we

- Completed one year of BICS operations
- Developed and implement the Map of Medicine

In 2010/11 we will

- Increase self care and empower patient informed decisions with appropriate information tools to manage their own care and make informed choices;
- Improved access to lifestyle advice and support throughout the care pathway;
- Support people to make an informed decision about the choice of diagnostics, treatment and therapy offered across the city from a range of providers;
- Develop gateway and referral management, integrated into the PbC Operating Framework;
- Develop evidence based primary care management guidelines for a number of key pathways
- Increase capabilities and collaboration of practices to treat patient in primary care;
- Transfer pre and post operative assessment and follow up into primary care instead of in the hospital;
- Enable more patient care to be maintained and monitored in primary care through establishing formal support, advise and guidance from consultants to reduce unnecessary visits to the hospital;
- Streamline booking systems that offer choice of provider of healthcare;
- Simple community based access to diagnostics across the city

Key Milestones

- PbC Operating Framework agreed and rolled out – March 10
- Work with BICS to identify opportunities by practices and locality – April 10
- Activity and financial reports by practice implemented, agreed referral thresholds and reviews by peer groups established – April 10
- Development of pathway guidelines – June 10
- Development of gateway process and workforce – June 10
- Establish partnership working arrangements between GPs and practices – June 10
- Sign off service improvement plan and investment – July 10
- Development of advice and guidance with consultants – August 10
- Implement service changes, including direct access to diagnostics – September 10

*Please note that this programme is linked to the out of hospital transformational programme as it

increasing the capacity of alternative clinics in the community for GPs to redirect referrals to.

Outcome measures

Measure	Measure
Delivery of activity reduction	Refer to activity section
Access targets met.	6 wks, 18 wks, 13 wks and 26 wks
Numbers of conditions for which best practice is clarified and communicated	Target being developed

Quality Metrics

Measure	Target
Patient experience feedback	Upper quartile

Principal changes in activity

Reduction in outpatient episodes of 6,784 in 2010/11 on 2009/10 figures

	Benchmarking	
Specialty Name	Reduction	Reductions £
GENERAL SURGERY	-141	-£18,762
UROLOGY	-757	-£99,488
ENT	-1,914	-£161,871
ORAL SURGERY	-493	-£48,774
GASTROENTEROLOGY	-1,219	-£199,539
CARDIOLOGY	-1,136	-£137,582
NEUROLOGY	-290	-£76,694
GYNAECOLOGY	-836	-£95,506
Total	**-6,784**	**-£838,216**

Implications for workforce

Provider:

- Primary care clinicians leadership training
- Numbers of practitioners accredited as PwSI (target: national average per 100k popn)

Commentary on financial requirements

Reduction in outpatients £838,216 saving by delivering bottom of top quartile for outpatient threshold.

Procurement and market management implications

Development of primary care market to manage increase capacity and establish inter-practice working arrangements.
Develop local enhance services following the scoping of referrals rates by speciality.

Related Vital Signs Measures/ Existing Commitments	Supports the sustainability of 18, 13 and 26 week targets. **NHS Constitution** : • To make the transition between services as smooth as possible • To provide services in a clean and safe environment which is fit for purpose
Related World Class Commissioning outcome measures	Commissioning goal 5 – commissioning nationally recognized best practice.
Related *Healthier People Excellent Care* Pledges	**SHA Pledge**: You will be able to have medical tests to help diagnose and manage your illness on your local high street or at home
Equalities Impact	
In general the initiative reduces inequalities by improving accessibility	

7.4.4 Specialised and Tertiary Commissioning

Summary

To improve the management of specialised and tertiary services.

Projects within the initiative

In 2010/11 we will

- Move the management of specific Tertiary contracts from Specialised commissioning to the Sussex Acute Commissioning Service (SACS) with a specific remit to improve the rigour of the key performance indicators and other contract management regimes

- Cardiology and Cardiac Surgery – develop pooled budgets for TAVI procedures and Pulmonary Hypertension. Commission increasing capacity in current treatments and support local provider to innovate with new technologies, to meet growth in demand for cardiac surgery

- Cystic Fibrosis – Work with Specialised Commissioning Group (SCG) to development of a new national tariff and 5 year Cystic Fibrosis strategy to respond to increased demand and change in complexity of care due to increased life expectancy of patient group.

- Haemophilia Services – engage with SCG on the national blood product tendering exercise, development of formal networks and strengthen consortium risk sharing arrangements.

- HIV services – work with SCG to ensure alignment commissioning arrangements to maximise on health outcomes and value for money. Explore the opportunity of central procurement of drugs to reduce spend and review the care pathway.

- Neurosciences – support the relocating services from Hurstwood Park in line with strategic development of BSUH as a specialist centre. Develop robust clinical pathway for head injuries and neurosurgical trauma. Improve the co-ordination of care across all patient pathways for muscular dystrophy.

- Paediatrics - action recommendations from the impact of National safe and sustainable review of paediatric cardiac surgery and neurosurgery. Work with SCG to review the configuration of paediatric surgery across SEC.

- Renal - Increasing local capacity to meet growth in demand for dialysis treatment and develop a satellite unit in Brighton. Commission increase transplant surgery in line with national guidelines and repatriate 1 month transplant follow-ups locally.

Improve the interface between primary, secondary and tertiary care in line with the CKD national framework and look to develop safer and more cost effective prescribing methods. Re-design of transport models for dialysis patients required.

- Specialised Mental Health Services – work with SCG to ensure that services will need to meet enhance standards following designation and increase capacity to meet 5% growth in demand. Develop enhanced local personality disorder services at tiers 1 – 3 to enable people to be maintained at lowest level.

- Spinal Cord Injury – work with SCH and national team to develop a national PbR tariff, review service configuration and designation to ensure timely and appropriate access to services. Reduce the number of patient treatment outside the specialist centres and improve the discharge arrangement from specialist centres.

- Ambulance services - Improve interface of local urgent care pathways with ambulance services and improve response times performance level.

- Gender re-assignment – strategy group established to review this pathway.

Key Milestones

Cardiac Surgery & Cardiology Milestones:
- SEC Strategic Group in place and process for managing new technologies being developed
- GUCH review being undertaken
- Planning assumptions for surgery being developed
- Pooled budgets planned over next 3 years

Cystic Fibrosis Milestones:
- Service specifications for paediatrics, transitional care and adult services completed and ready for ratification
- Pooled budgets planned over next 18 months
- Care pathways being developed
- 5-10 year strategy completed

Haemophilia Services Milestones:
- London leading a strategic review of London haemophilia providers to ensure continuity of care for the future
- A formal network of haemophilia centre's to be developed across SEC with Canterbury at the hub.

HIV service Milestones:
- Review of commissioning arrangements being undertaken
- Clinical network approach for inpatient services

Neurosciences Milestones:
- Develop relocation plans
- Pooled budgets for DBS and SRS being refined
- Head injuries/Trauma pathways being reviewed

Paediatrics Milestones:
- Designation of Neonatal services to take place in 2010
- Review of prices for neonatology to ensure value for money and consistency
- Re-examination of PICU arrangements for SEC
- Development of SEC specialised paediatric strategy
- Develop maternity and newborn pledges with SHA as lead

Renal Milestones
- Transplantation strategy developed, including pooled budget
- Community dialysis unit opens
- Prescribing review completed
- Transport working group established

Specialised Mental Health Services Milestones:

- Refresh the SECSCG Secure Services plan incl. needs assessment
- All units visited and aware of actions required to meet standards; continue to performance manage implementation.
- Need to consider alternative treatment locations, enhancing prison in-reach etc.
- Tier 4 PD - Work with EoE, London & South Central SCG to agree work programme and timetable to implement the Joint PCT Committee decision including commissioning a full equality impact assessment & mapping of all local services

Spinal Cord Injury Milestones

- National PbR tariff developed
- Review treatment pathways and develop options appraisal on outreach services
- Agreeing comprehensive service specification with integrated referral processes

Ambulance services Milestones:

- Interface with urgent care providers improved
- Scoped potential for single digit number & NHS pathways
- Increased skills and better pathways across system including self management

Outcome measures

Measure	Measure
Reduce in mortality rates for cardiovascular diseases	Measure to be advised by Specialist commissioning group
Increase life expectancy and improved quality of live for people with Cystic Fibrosis	Measure to be advised by Specialist commissioning group
Improved quality of life and life expectancy for people living with HIV.	Measure to be advised by Specialist commissioning group
Increase life expectancy and improved quality of live for people with Chronic Kidney Disease.	Measure to be advised by Specialist commissioning group
Improved quality of life and health outcomes for people who have had a spinal cord injury.	Measure to be advised by Specialist commissioning group

Quality Metrics

Measure	Target
Cardiac Surgery & Cardiology Metrics	• Rates of interventions such as TAVI, CABG surgery, Valve surgery • Quality metrics being developed
Haemophilia Services Metrics	Blood product usage information by pct by provider
Neurosciences Metrics	• Rates of intervention for DBS/SRS • Transfer times for head injuries/trauma

Paediatrics Metrics	• 95% of babies to remain within NICU networks Implementation of maternity and newborn dashboards
Renal Metrics:	• % increase in transplantation rates (national target) • Dialysis take-on rates • % of people on home dialysis • Renal NSF standards, including Quality metrics for vascular access, choice of modality and Transport travel times
Specialised Mental Health Services	• Benchmarking across other SCGs re: capacity and price, PbR development work
Ambulance services Metrics	• Response and handover times and clinical performance indicators. Patient experience measures/PROMS

Principal changes in activity

Principal changes in activity

Cardiac Surgery & Cardiology:
- % increase in demand
- Increase interventions such as TAVI, CABG surgery, Valve surgery

Cystic Fibrosis
- % increase in demand

Haemophilia Services:
- Blood product usage information by pct by provider

HIV service
- 10-15% increase in demand

Neurosciences:
- significant increases in demand expected
- Rates of intervention for DBS/SRS

Paediatrics:
- % increasing demand in neonatal activity as birth rate increases
- % increasing prevalence of paediatric diabetes

Renal:
- 75% increase in transplantation rates (national target)
- % increase in demand for dialysis
- % of people on home dialysis

Specialised Mental Health Services
- 5% increase in demand

Ambulance services:
- Greater than 5% increase in demand for service

Implications for workforce

Commentary on financial requirements

The activity implications noted above are the estimates provided by the Specialist Commissioning Group. We will work throughout the year to review the specialist portfolio and ensure that costs are managed within the financial envelope, which includes an additional £1m.

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Over-arching Pledges – Pledge 8

Equalities Impact

7.4.5 Increasing productivity and efficiency

Summary

We aim to reduce spend in secondary elective care by identifying realistic opportunities and systematically implementing efficiency projects via joint PCT, primary care and secondary care working.

Projects within the initiative

In 2009/10 we have

- Reviewed data, agreed measures, agreed process, rolled out to Clinical Reference Groups, reviewed productivity and worked out pilot schemes.

In 2010/11 we will implement the following pilot schemes in partnership with BSUH

- Did not attend (DNA) rates to be reduced by identifying poor performing clinics and trial reminders scheme for the three specialties
- Achieve contracted levels of new to follow up ratios for two specialties
- Reduce pre operative bed days in two specialties
- Increase day case rate for laparoscopic cholecystectomy (gall bladder removal)
- Reduce surgical variation for lumbar spine procedures.

We will also

- Work with SACS to benchmark nurse led outpatient services across the SHA prior to contract negotiations to reduce costs
- Use pharmacy support to lead on the managed entry of new drugs, medicines in commissioning, prioritisation and PBR excluded drugs with a view to managing the risks associated with non PBR costs
- Work with BSUH to develop a joint strategy for the modernization of outpatients looking at 'one stop shop clinics' for long term condition patients and centralizing/streamlining patient booking processes.

Key Milestones

• Implement schemes	June 10
• Implement pilot schemes	Q1 10/11
• Review pilots	Q4 10/11
• Roll out across specialties	2011/11

Outcome measures

Measure	Measure

Reduced DNA rate	2%
Reduced New to Follow up ratio	0.1
Reduced number of pre op bed days	40%
Increased day case rate	10%

Quality Metrics

Measure	Target
Improved satisfaction on patient survey	Measure to be developed
Improved surgical outcomes for cholecystectomy.	Measure to be developed

Principal changes in activity

Reduction in excess bed days of 512 across 2010/11

Reduction in follow up appointments of 1849 in year 1

Reduction of elective ordinary admissions of 68

Implications for workforce

PCT: None

Provider: See provider workforce plans and PWC PODS.

Commentary on financial requirements

Productivity and efficiency savings £435k.
Pharmacist costs will be funded by savings on non PBR drugs costs.

Procurement and market management implications

N/a

Related Vital Signs Measures/ Existing Commitments	18 weeks referral to treatment times. VSA04 – NHS reported waits for elective care.
Related World Class Commissioning outcome measures	N/a
Related *Healthier People Excellent Care* Pledges	Planned Care - Pledges 4,5 and 6

Equalities Impact

Will be assessed if any service changes are proposed.

7.5 Mental health

7.5.1 Promoting Mental Health and Wellbeing

Summary

Improving outcomes and reducing unnecessary demand on treatment services through focusing on well-being and prevention services.

Projects within the initiative

A. Alcohol harm prevention
In 2009/10 we
- Implemented community based brief interventions
- Rolled out an awareness project.
- Established a social marketing campaign for both the general public and specific groups.
- Developed pathways with CYPT to ensure that young people are signposted to appropriate services

In 2010/11 we will
- Commence year 2 alcohol harm prevention initiatives:-
- Rollout of 65+ work identified in findings from social marketing campaign
- Workforce development – skilling key staff
- Continuation of Safe Space project
- Improve LGBT Outreach

B. Suicide prevention
In 2009/10 we
- Implemented the action plan from the Brighton and Hove suicide prevention strategy, focusing on health promotion with at risk groups and training of key workforce.

In 2010/11 we will
- Continue with this work, with future initiatives targeting prisoners, young ex-servicemen, unemployed, victims and survivors of abuse.
- Review the impact of increased demand on services following awareness raising/staff training
- Build capacity within services to meet increased demand

C. Mental Health promotion
In 2009/10 we are currently funding a number of initiatives through Choosing Health. These will be reviewed and prioritised during 10/11 to agree future funding.
Additionally in 2010/11 we will
- Scope and develop a mental health promotion social marketing campaign
- Develop and build capacity of existing domestic abuse initiatives. Implement awareness training for staff to improve mental health services response to domestic abuse.
- Build capacity for LGBT engagement into key mental health promotion functions, e.g. planning process, meetings etc.

D. Substance misuse
We will continue to develop evidence based prevention and health promotion work including training of key workforce, running campaigns and strengthening networks.

Key Milestones

- Commencement of Year 2 alcohol harm prevention initiatives May 10
- Further rollout of suicide prevention specialist training to key workforce commences May/Jun 10

- Expansion of suicide prevention health promotion work to take forward the full remit of activity around at risk/vulnerable groups – Apr 10 – Mar 11
- Review of increased demand on services following awareness raising / training Apr 10 – Mar 11
- Scope and develop a mental health promotion social marketing campaign Apr/May 10
- Improve MH services response to domestic abuse; explore training for staff Apr 10
- Commence LGBT engagement in key functions Apr 10
- Continue rollout of substance misuse training for key staff On-going

Outcome measures

Measure	Measure
Numbers reporting better understanding of alcohol levels and report a reduction in consumption as a result of alcohol campaigns.	
Increase in numbers diverted from A&E and prevented from ambulance use or police intervention as a result of accessing Safe Space	
Numbers of recorded suicides reduced	by 20% by 2010 (from a baseline 3-year average rate in 1995/6/7)

Quality Metrics

Measure	Target
Range and reach of public information	n/a
Individual mental health promotion measures set for each of the 23 work streams	n/a

Principal changes in activity

Reduce the prevalence of hazardous and harmful alcohol consumption.
Reduce alcohol related hospital admissions.
Raise general awareness of suicide particularly among those most at risk. Skill key staff, improve working practices and reduce suicide numbers

The alcohol brief intervention service to deliver 12,000 opportunitistic interventions per year in a wide variety of community settings.

Implications for workforce

Provider: Recruit domestic violence worker
Numbers of key staff trained in suicide awareness and intervention techniques:- 48 participants from un/employment projects
48 participants from housing projects
48 participants from older people's services

Commentary on financial requirements

Alcohol – £106k additional investment
Suicide - £55k additional investment
Domestic violence worker - £70k additional investment

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	VSC26 Hospital admissions for alcohol related harm VSB04 Suicide and injury of undetermined intent VSB14 Number of drug users recorded as being in effective treatment.
Related World Class Commissioning outcome measures	Hospital admissions for alcohol related harm.
Related *Healthier People Excellent Care* Pledges	Mental Health Pledges 1,2,4 and 5

Equalities Impact

Individual initiatives target a range of at risk groups as well as raising awareness amongst the general public.
Target groups include:-

- 25-35 age group
- Older people 65+
- LGBT communities
- Unemployed
- Homeless
- Engaging with domestic violence services

7.5.2 Developing community pathways to support recovery

Summary

Develop primary and community services that maintain people in recovery, supporting individuals to manage their on-going mental health needs.

Projects within the initiative

In 09/10 we

- Increased the provision of treatment places for people with substance misuse issues in primary care (Shared Care NES).
- Scoped the development of a LES for patients with a serious mental illness.

In 10/11 we will

- Introduce a Serious Mental Illness LES that will support the discharge from the mental health services back into the community under primary care-based services
- Develop increased capacity and knowledge within primary care for the management of mental health issues with the introduction of a GPwSI in Mental Health
- Develop a range of community initiatives to support recovery, choice, self directed support and personalisation
- Review and realign the range of aftercare and support services including day and homecare support and support to carers
- Scope services to provide better information, support and early interventions to people with dementia
- Scope the short and long term housing options available for people with both mental health and substance misuse issues.
- Implement the dual diagnosis strategy

Key Milestones

- Implement the serious mental illness LES Apr 10
- Develop a model for a GP with Special Interests (GPwSI) in Mental Health during 10/11; service to start Apr 11
- Develop market management structure for the 3rd sector Sept 10
- Develop dementia management LES Mar 11
- Develop and implement Recovery and Re-integration plans for substance misusers including a peer-support buddying model for aftercare support.

Outcome measures

Measure	Measure
More people with a SMI managed in general practice	12 month trajectory to be agreed – final target 150 patients.
Reduced re-admissions rates for discharged patients (under the SMI LES) into in-patient beds.	Baseline to be established and improvement trajectory to be agreed
More people using direct payments	VSC17 – Adults and older people receiving direct payments and/or individual budgets
More people using self directed support	Construction and information flows to be agreed during Q1 through the Data Quality

	Improvement Plan. Target to apply from Q2.
More carers assessments and services in place	This has been included in the service development and improvement plan An increase in the % of carers receiving an assessment to ensure top quartile performance against NI135. 08/09 Top quartile threshold @ 26.4%.
More people off benefits	IAPT KPI7- the number of people moving off sick pay and benefits 10/11 target: 91
More people with a serious mental illness in work	NI 150 Adults in contact with secondary mental health services in employment (also VSC08) – over 8.94% by the end of Q4
More people who have accessed IAPT moving to recovery	10/11 – 28% of total completions
People with dementia better supported, and have more choice and control	N/A
Planned discharges from substance misuse services	45%
Reduced re-referral rates for substance misuse services	Baseline to be established and then improvement trajectory to be agreed.
Quality Metrics	
Measure	**Target**
Improve patient experience – rate of return for postcard survey scheme	25% increase above baseline
Improve patient experience – response from postcard surveys	80% choose 'agree' or 'strongly agree'
Principal changes in activity	
SMI LES: 150 treatment places in primary care; **Substance Misuse:** Planned discharges from substance misuse services (45% - 10/11) Reduced re-referral rates for substance misuse services	
Implications for workforce	

PCT:
1.0 WTE Project Management support currently allocated to Mental Health and Substance Misuse Commissioning Team will be required for 12 months to assist in delivery of above projects.

Provider:
All contracts to include staff skills and requirements.
Support for general practice to implement LES.
Workforce conditions and skill mix in 3rd sector contracts to be reviewed.

Commentary on financial requirements
Serious Mental health issue LES will be financed from existing budgets

Procurement and market management implications
Market management strategy for 3rd sector to be developed (10/11) and implemented (11/12).

Related Vital Signs Measures/ Existing Commitments	VCS 26, VSC02, VSB04
Related World Class Commissioning outcome measures	Hospital admissions for alcohol related harm. The percentage of people moving into recovery from IAPT services.
Related *Healthier People Excellent Care* Pledges	Mental Health pledges 2and 3

Equalities Impact
Review issues during 10/11 to ensure these are addressed by the GPwSI in 11/12.

7.5.3 Developing Effective and Efficient Care Pathways and Treatment Services

Summary

The development of care pathways and appropriate, evidenced-based treatment services for people who require a structured treatment intervention.

Projects within the initiative

In 10/11 we will

- Complete the ABC contract analysis to achieve costed contract with SPFT
- Agree joint commissioning plan based on need, value for money and outcomes
- Scope need, best practice/evidence base, benchmark costings for complex/specialist psychological therapies (Eating Disorders, Personality Disorders, Apsergers etc)
- Devise specifications and market management strategy for any new pathways and services
- Review alcohol brief intervention LES and volunteer alcohol counselling service and develop plan for ongoing provision.
- Review the inpatient and community services for adults and older people and for people who have dementia
- Establish incentivised elements in the main provider (SPFT) substance misuse contract in relation to key structured interventions (waiting times, planned discharges, retention) and outcome measurement reporting (TOPs)

Key Milestones

- Joint Commissioning Plan agreed by JCB in January 10 with work programmes agreed by April 10
- IAPT funding agreed by Apr 10.
- Complex/specialist psychological therapies reviewed by Sept 10
- Services for market testing to be agreed by Sept 10
- Alcohol brief intervention LES and volunteer alcohol counselling reviewed and tendered agreed by Sept 10

Inpatient and community services as commissioned through SPFT redesign agreed by Sept 10.

Outcome measures

Measure	Measure
Mental health: - commence treatment for complex psychological therapies -reduced length of stay for adult and older people in-patient stay including inpatient detox.	Referral to treatment:<70 working days Adults: <28 days Older people: Organic: <60 days Functional:<50 days
Alcohol: - waiting times for structured psychosocial interventions	90% < 21 days
Substance misuse (including alcohol): - waiting times for structured interventions - planned discharges - outcome data collection (TOPs)	90% < 21 days 45% 90%

Quality Metrics

Measure	Target
Improve patient experience – rate of return for postcard survey	25% increase above baseline

scheme	
Improve patient experience – response from postcard surveys	80% choose 'agree' or 'strongly agree'
GP experience measure	80% approval rating
Carer experience measure	80% approval rating

Principal changes in activity

Implications for workforce

PCT:
1.0 WTE Project Management support currently allocated to Mental Health and Substance Misuse Commissioning Team will be required for 12 months to assist in delivery of above projects. Additional capacity allocated for Programme Management of specialist mental health provider will be required for 12 month period to support transformation agenda.

Provider:
Service redesign to include appropriate skill mix and workforce requirements

Commentary on financial requirements

No new investment

SPT savings £341k assumed

Procurement and market management implications

Market management strategies will be developed for IAPTs and any new pathways/services.

Related Vital Signs Measures/ Existing Commitments	VSC26, VSC02, VSB04
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Mental Health – Pledge 3 Staying Healthy – Pledges 4 and 5

Equalities Impact

All changes to services will undergo an equalities impact assessment

7.5.4 Managing access to treatment

Summary
To provide an efficient and effective gateway and triage system into services.

Projects within the initiative

In 09/10 we have

- Commissioned psychological services for mild to moderate need (IAPT - Improving Access to Psychological Therapies) service with Sussex Partnership NHS Foundation Trust.
- Extended the hospital-based brief interventions alcohol service and established a community based brief intervention alcohol service to reduce alcohol related hospital admissions
- Increased support to carers of people with drug misuse problems

In 10/11 we will

- Re-commission access services (including IAPT)
- Pilot a new referral management gateway into mental health services for all routine referrals to working age mental health services
- Improve access to/response from emergency and priority treatment services
- Introduce a single assessment process for substance misuse
- Scope development of a memory assessment service to increase diagnosis and ensure improved access to services for dementia.
- Expand IAPT in-line with previous plans
- Develop additional referral pathways (including self-referral) for IAPT.

Key Milestones

- 12 month pilot of new referral management gateway completed April 11
- New access contracts to be effective 11/12
- Review gateway pilot Apr 11
- Scope memory assessment service Sept 10
- Single assessment for Substance Misuse (drugs and alcohol) Sept 10

Outcome measures

Measure	Measure
Mental Health access: - Priority assessments to be completed within 5 days of referral - Routine assessments to be completed within 20 days - Emergency referrals to be responded to within 4 hours	95% 100% 100%
WAMHS Gateway – 95% compliance with standardised referral information - <10% DNA/declines assessment (tbc)	95% <10%
Substance misuse access and engagement – problem drug users recorded as in effective treatment: 1%	

increase on 0910 – waiting times to first intervention: target 90%<21 days - engagement: % of problem drug users to be retained in treatment for 12 weeks	1% increase on figure in 09/10 90% waiting <21 days 90% retained for 12 weeks
Improved dementia diagnosis rates	Trajectory to be agreed once memory assessment service scoped

Quality Metrics

Measure	Target
Improve patient experience – rate of return for postcard survey scheme	25% increase above baseline
Improve patient experience – response from postcard surveys	80% choose 'agree' or 'strongly agree'
GP experience measure	80% approval rating
Carer experience measure	80% approval rating
IAPT completed treatments, moving to recovery, off benefits	**28%**

Principal changes in activity

Implications for workforce

PCT:
1.0 WTE Project Management support currently allocated to Mental Health and Substance Misuse Commissioning Team will be required for 12 months to assist in delivery of above projects.

Provider:
Referral management gateway pilot may involve the transfer of 1 wte from SPFT to BICS.
IAPT expansion Staff attrition will have to be offset (trained therapists) 12 staff left in 09/10.

Commentary on financial requirements

IAPTs £601k

Referral management gateway £168k (from Freed up Resources)

Procurement and market management implications

Access services including IAPT likely to be re-commissioned for 11/12 following gateway pilot

Related Vital Signs Measures/ Existing Commitments	VSC26 VSC02 VSB14
Related World Class Commissioning outcome measures	Hospital admissions for alcohol related harm. The percentage of people moving into recovery from IAPT services.

Related *Healthier People Excellent Care* Pledges	Planned Care – Pledge 4 Mental Health – Pledge 3
Equalities Impact	
Equalities Impact Assessments will be carried out on all initiatives. We will aim to improve access for minority communities via a self referral pathway, especially for IAPTs.	

7.6 Maternity & Children's services

7.6.1 Strengthening Partnerships

Summary

To ensure that working arrangements with the CYPT (Children and Young People's Trust) are effective.

Projects within the initiative

In 2010/11 we will

- Strengthen safeguarding arrangements by service level agreements with clear roles of accountability and responsibility and regular reporting to NHS Brighton & Hove Board
- Complete the review of current section 75 arrangements with support from the national commissioning support programme of the DCSF (Department for Children, Schools and Families)
- Ensure that a performance management framework is in place to monitor provider functions

Key Milestones

- New section 75 agreements in place by April 2010
- Commissioning framework agreed and implemented
- Joint commissioning group set up and dates programmed for the year
- Commissioning plans for 2011/12 agreed by winter 2010

Outcome measures

Measure	Measure

Quality Metrics

Measure	Target

Principal changes in activity

N/A

Implications for workforce

PCT:

Provider: Workforce development plan for commissioning implemented during 2010

Commentary on financial requirements

Procurement and market management implications	
Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	Commissioning Goal 2 - Maximising life chances for children and families Commissioning Goal 4 – promoting independence
Related *Healthier People Excellent Care* Pledges	HPEC Pledge on urgent care
Equalities Impact	

7.6.2 Access and settings of care

Summary
To provide care in the most appropriate setting and improve access for children and young people in the city.

Projects within the initiative

- Ensure that high volume conditions such as head injury, gastroenteritis and respiratory illness are managed in the most appropriate environment
- Link in with urgent care strategy communications to ensure that families have clear knowledge of services available
- Empower families and carers to be able to self care for children with long term conditions through the dissemination of advice and information
- Develop training programmes for health professionals who support children and young people outside of hospital
- Review out of area referrals to determine if services can be provided locally
- Review current pathways for children with long term conditions to determine how community capacity can be strengthened

Key Milestones

- Ensure high volume conditions are managed in the right setting - ongoing
- Provide training to health visitors and community staff - Jan 2010
- Develop leaflets and information fro parents and carers – Jan/Feb 2010
- Develop information for primary care – Jan /Feb 2010
- Establish activity levels for other high volume conditions – March 2010
- Implement strategies for enabling parents/carers and families to self care for high volume conditions – April- Sept 2010

Outcome measures

Measure	Measure
Reduction in emergency attendances and admissions realised through urgent care workstream	

Quality Metrics

Measure	Target
Social Marketing initiated to obtain users views	

Principal changes in activity

Reduction of 10% paediatric emergency attendance in 2011 as a result of initiatives

Implications for workforce

PCT:

Provider: Train community workforce (Health Visitors) to support families

Commentary on financial requirements

No new investments/costs	
Procurement and market management implications	
Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Children's Health – Pledges 1 and 3
Equalities Impact	
Equalities Impact Assessments will be completed as new services are commissioned.	

7.6.3 Children & Adolescent Mental Health Services (CAMHS)

Summary

To ensure that a comprehensive CAMHS service continues to be provided for children and young people.

Projects within the initiative

In 2009/10 we

- Ensured waiting time targets met for accessing the service
- Developed an Urgent help team
- Opened a unit at Chalkhill for high risk/severe needs cases
- Began a 12 month pilot of a joint pathway with one point of referral
- Implemented a new model of service for 14-25 year olds
- Implemented new care pathway for looked after children/children in care access to CAMHS

In 2010/11 we will

- Continue to improve support to children and young people with emotional or mental health and their families focusing on:
    - Reviewing the tier 1 & 2 Pathway for school aged children and young people taking account of the Targeted Mental Health in Schools pathfinder
    - Increase psychological support for children with long-term conditions including chronic fatigue syndrome.
    - Palliative care psychological support for children and families

Key Milestones

New pathway developed over the next year in consultation with schools in the light of the targeted mental health in schools project for implementation phased approach starting in Sept 2010 and then in academic year 2011/12

Outcome measures

Measure	Measure
My class my feelings measurement to be offered to all schools	
Sociogram measurement to be offered to all schools	

Quality Metrics

Measure	Target
Evidence based approaches to be offered to schools building on the outcomes from the TaMHS project	
Feedback from pupils teachers parent carers re outcomes/satisfaction	

Principal changes in activity

Provision of more group work and more consultation and training support from area schools and community teams

Implications for workforce

Provider: Workforce development plan for school based staff	
Commentary on financial requirements	
Procurement and market management implications	
Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Children's Services – Pledges 1,2 and 3
Equalities Impact	
We will commission to promote equality and reduce discrimination through carrying out equality impact assessments and continuous stakeholder engagement in the commissioning of services.	

7.6.5 Early intervention and prevention

Summary

To improve early intervention and prevention in community based health care services for children and young people and their families.

Projects within the initiative

- The implementation of the Healthy Child Programme including the health of looked after children and the key public health priorities of uptake of immunisations, reducing childhood obesity and uptake and maintenance of breastfeeding.
- Reviewing engagement between integrated front line services provided and primary health care services and acute services for children and young people
- Breastfeeding
- Immunisation
    - Complete the HPV catch up
        - Work with CYPT, GPs and school nursing team to review the appropriate service model for the school leaving booster
        - Work with CYPT specialist immunisation team when operational to reduce the differences in immunisations uptake.

Key Milestones

- To set up a healthy child programme steering group in Jan 2010 to plan programme of work to monitor and oversee implementation of recommendations.
- To recruit breastfeeding support worker for disadvantaged areas.
- Complete HPV catch up – Sept 10
- Develop appropriate service model of school leaving booster – Jun 10

Outcome measures

Measure	Measure
Increase in breastfeeding coverage and prevalence rates at 6-8 weeks in line with national targets	Prevalence 69.7% Coverage 95%
Increased uptake of immunisations: One year old completed immunisation for baby imms	92%
Two year old completing booster	87%
Two year old completing MMR	87%
5 year old completing imms excl MMR	80%
MMR 2	76%
12-13 year old girls completing HPV	90%
13-18 year olds completing school leaving booster	75%

Quality Metrics

Measure	Target

Target re increasing breastfeeding rates in more disadvantaged areas	
Increase immunisation coverage	

Principal changes in activity
As outcome measures
Implications for workforce
PCT: **Provider**: Additional 0.4 WTE post Immunisations: Posts to be recruited to in CYPT to include:1 etw Band 7, 1 wte Band 4, 0.6 wte Band 3 clerk, 1 wte Band 2 clerk
Commentary on financial requirements
Breastfeeding £62k investment via choosing health funding
Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	Reducing childhood obesity
Related *Healthier People Excellent Care* Pledges	Children's Health – Pledges 1, 2 and 3 Maternity and Newborn – Pledge 6 Staying Healthy – Pledge 1

Equalities Impact
We will commission to promote equality and reduce discrimination through carrying out equality impact assessments and continuous stakeholder engagement in the commissioning of services.

7.6.6 Youth service provision

Summary

To review and enhance the design of youth service provision across the partnership

Projects within the initiative

- Building on the work that has already taken place to date including the development of the Integrated Youth Support Services, the Teenage Pregnancy Action Plan 2009, the Alcohol and Substance Misuse Strategies and the development of 14-19 provision; and
- Including as appropriate a service redesign process with stakeholders and service users

Key Milestones

- To scope the redesign piece of work and develop a project plan by April 2010
- To achieve key milestones in the teenage pregnancy action plan
- To develop a joined up action plan across NI II5 (related) reduction of alcohol and drugs use in year 10 young people.
- To achieve key milestones in the NI 115 joined up plan

Outcome measures

Measure	Measure
To reduce the conception rate	by 45 percent from baseline year of 1998 to 2010 within 15 to 17 /1000 age group
Increase in young parents EET (education, employment and training status)	
Reduction in young people self reporting frequent substance use (including legal highs).	
Targeted teenage pregnancy interventions	demonstrating a intervention outcome profile of 50% by end of 2010 and increasing to 80% by 2011
Young people's substance misuse service	achievement of the 80% treatment outcomes profile.

Quality Metrics

Measure	Target
Evidence based approaches applied to services / actions delivered under the action plans.	
Annual Service user questionnaires	
Auditing process for teenage pregnancy and substance misuse agenda.	

Principal changes in activity

Implications for workforce
PCT: **Provider**: Effective intervention packages reviewed and updates attached to teenage pregnancy and substance misuse annually. Workforce development plan (or training strategy) for teenage pregnancy and substance misuse across wider CYPT partnership

Commentary on financial requirements
Sustained commitment from PCT budgets and Area Based Grant. New Choosing Health Budget £55k

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	VSB08 Teenage pregnancy
Related World Class Commissioning outcome measures	Under 18 conception rate
Related *Healthier People Excellent Care* Pledges	Children's Health, Pledges 2,4 and 5

Equalities Impact

7.6.7 Improve support to children and young people with a disability or complex health needs and their families

Summary

Deliver improved outcomes for children with disabilities and complex needs.

Projects within the initiative

- The implementation of the Every Disabled Child Matters programme
- The review the 2005 Joint Commissioning Strategy for children with a disability and/or special educational needs, including as appropriate a service redesign process with stakeholders and service users

Key Milestones

- A project plan to take forward this piece of work will be produced in the new financial year when strategic commissioner is back from maternity leave
- Produce action plan – May 2010
- Implement actions – May 10 – Apr 2011

Outcome measures

Measure	Measure
Fulfilling obligations within EDCM charter	

Quality Metrics

Measure	Target

Principal changes in activity

Not known

Implications for workforce

Provider: Reviewing skill mix within disability service

Commentary on financial requirements

£325k savings from Chailey contract
Funding for disabled children's therapies will be reviewed on an on-going basis

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	

Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Children's Services – Pledge 1
Equalities Impact	
We will commission to promote equality and reduce discrimination through carrying out equality impact assessments and continuous stakeholder engagement in the commissioning of services.	

7.6.8 Childhood Obesity

Summary

A combination of diet/nutrition and physical activity initiatives are being developed to support children and young people remain fit and active and maintain a healthy weight. Weight management services will target those most in need.

Projects within the initiative

In 2009/10 we have developed a range of diet/nutrition and physical activity initiatives to support children and young people to remain fit and active and maintain a healthy weight. These include:

- Free swimming (with the Local Authority)
- Access to food growing, dietary advice, play and physical activities in areas of inequalities
- Courses in schools for 5-7 and 13-18 year olds in areas of inequalities
- Healthy Choice Award: engaged businesses and food outlets, youth settings, parks etc to offer healthy food choices.
- Implemented protocol and management guidelines for health visitors

In 2010/11 we will:

- Evaluate the impact of existing schemes using the National Obesity Observatory (NOO)
- Deliver weight management training for health visitors, school nurses and youth workers
- Implement weight management clinics with multi-disciplinary teams providing assessment and 1 to 1 weight management in community settings
- Implement Year 2 actions from Childhood Obesity Action Plan taking into account any actions required from the N.O.O evaluation

Key Milestones

- Evaluate the impact of existing schemes using the National Obesity Observatory (NOO) Feb 10 and amend schemes as appropriate.
- Deliver weight management training for health visitors, school nurses and youth workers Feb 10
- Implement weight management clinics with multi-disciplinary teams providing assessment and 1 to 1 weight management in community settings Feb 10
- Implement Year 2 actions from Childhood Obesity Action Plan (to be expanded) from Apr 10 (these are the continuation of year 1 actions as noted above).

Outcome measures

Measure	Measure
Prevalence of obesity	year 6 (10-11 y.o.) 17.5%, reception 8.5%

Quality Metrics

Measure	Target
NOO measures will be implemented with providers.	
Customer satisfaction measure to be developed as part of weight management.	

Principal changes in activity

No. of year 6 recorded = 2,004 (90%) No. of reception recorded = 2,273 (93.7%)
Implications for workforce
Provider: Weight management training for health visitors, school nurses and youth workers.
Commentary on financial requirements
£50k to re-instate MEND funding
Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	VSB09 (Year 6 + reception) LAA (Year 6 only)
Related World Class Commissioning outcome measures	Reducing childhood obesity
Related *Healthier People Excellent Care* Pledges	Staying Healthy Pledge 1 Overarching Pledge 5.

Equalities Impact
Equalities Impact Assessment has been completed.

7.6.9 Transforming Maternity Services

Summary

To support women and their partners prior to conception, throughout the pregnancy and post delivery to optimise a healthy, normal birth. To support the family in those early years to maximise life chances and address inequalities.

Projects within the initiative

In 2009/10 we have

- Developed the maternity pathway to ensure that we meet national best practice and the needs of vulnerable groups
- Worked towards meeting targets on consultants on labour wards (met), support for women by a midwife through labour and birth, informed choice about place of birth and high quality postnatal care.
- Implemented combined screening for Downs syndrome at BSUH.

In 2010/11 we will

- Ensure that pre-conception and pre-natal education is available to maximize healthy foetal development and normal childbirth. We will focus in particular on making contact with women from vulnerable groups.
- We will aim to reduce elective caesarean sections by education and improved midwifery support, promoting normal birth.
- Improving personalised care and support of women during labour and birth.
- We will review access to specialist mental health services with a view to informing commissioning intentions from 2011/12.

Breastfeeding initiatives are covered under the Children transformational initiatives.

Key Milestones

- Establish an enhanced service for GPs to provide pre-conceptual care 1/04/11
- Set up services with providers to provide specialist pre-conceptual advice for specific groups eg teenagers, LGBT community, people with learning or physical disabilities 1/04/11
- Review and agree a service specification for antenatal education 1/09/10
- Procure a new antenatal education service 1/04/11
- Evaluate the options to establish a midwifery led unit within the City 1/04/11
- Complete needs assessment and service review for specialist mental health services 1/04/11
- Implement action plan (already agreed) to reduce caesarean section rate 1/04/11

Outcome measures

Measure	Measure
Reduce c-section rate	from 30% 0910 to 29% 1011.
12 week referral rate to a midwife	90%.
Ratios of births to midwives	1:30.

Quality Metrics

Measure	Target

Principal changes in activity

Caesarean sections reduced by 10 (1%)
Downs screening impact activity 3,182 from specialised contract to BSUH

Implications for workforce

PCT:

Provider: Midwife working arrangements and shift patterns to be examined.
Target ratios of midwifes to births to be achieved.

Commentary on financial requirements

No new investment.
Full year effect of Downs syndrome screening is £106k cost and £238k saving in 10/11.
Reduction in c section – savings £21k

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	Department of Health ' Maternity Matters: Choice, Access and Continuity of Care in a Safe Service' Key principles: • By the end of 2009, the national choice guarantees will be available to all women and their partners. This will ensure women and their partners are given the opportunity to make well- informed choices throughout pregnancy • Modernisation of maternity services : Antenatal and postnatal care is personalised to adapt to individual needs • Reduction inequalities and reaching out to vulnerable groups
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Maternity and Newborn – Pledges 1,2,3,4,5,6

Equalities Impact

Focus on improving access amongst vulnerable groups. Ensure specialist pre-conceptual care and parenting advice is available for specific groups.

7.7 Public health

7.7.1 Sexual Health

Summary

To increase early detection and treatment of infections including Chlamydia and HIV. To improve access to services in community settings and support victims of serious sexual assault.

Projects within the initiative

In 09/10 we

- Increased access to Long Acting Reversible Contraception (LARC) through the community contraception service and primary care
- Started process to reprovide sexual health services to Brighton Station Health Centre
- Explored options for the development of a local Sexual Assault Referral Centre (SARC)

In 10/11 we will

- Ensure that the proportion of young people screened for chlamydia will double from 2008/9 levels to achieve 35%
- Increase the capacity of Level 2 sexual health services in the community
- Ensure that victims of rape and sexual assault have timely and supported access to a local sexual assault referral centre (SARC)

Key Milestones

- Level 2 service commences at Brighton Station Health Centre Apr/May 10
- SARC service procured and commenced Apr 2010
- Tender for a revised Chlamydia screening service date to start April 11

Outcome measures

Measure	Measure
VS NI 113 – Chlamydia prevalence screening	35% 15-24 year olds
Patients requiring an appointment at GUM to be seen within 48 hours	100%
Requirement that residents have access to SARC	

Quality Metrics

Measure	Target

Principal changes in activity

10% reduction in activity which amounts to 2,154 appointments

	10% reduction (GP led health centre)
First	-1,419
Follow up	-735
Grand Total	-2,154

Implications for workforce

Provider: Chlamydia – dependent on retendering of SDH contract (impacts 3 wte band 5/6)
Impact of GUM services at BSUH to be assessed

Commentary on financial requirements

Reprovide level II sexual health service costs £238k, savings BSUH £261k,

Sexual Assault Referral Centre £66k

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	VSB13 Chlamydia prevalence (screening) CQC target – Access to GUM clinics
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Children's Health – Pledge 4 Staying Healthy – Pledge 2

Equalities Impact

Addressed in the JSNA for Sexual Health completed Dec 09.

7.7.2 Stop Smoking

Summary

To improve life expectancy by developing and increasing the capacity of our smoking cessation service.

Projects within the initiative

In 2009/10 we have:

- Reviewed our stop smoking services with the South East Tobacco Control Team.
- As a result of this review, restructured the specialist service to ensure focus on targets.
- Expanded the intermediate service provided by GP practices to 90% of practices.
- Trained staff in five more pharmacies to provide an intermediate service

In 2010/11 we will:

- Train nurses in SPFT to run an intermediate service
- Run the specialist and intermediate services to meet specific outcomes.

Key Milestones

- Appoint to a new Tobacco Control Coordinator post, jointly with the local authority, to be responsible for the Tobacco Control Alliance, young people and smoke free homes. Advertise January 2010 and appoint 01 April 2010
- Train nurses in SPFT to run an intermediate service from April to July initially, then provide quarterly updates and further training when needed
- Maintain an intermediate service in 90% of GP practices and increase numbers of pharmacies offering an intermediate service. From April 2010.
- Provide additional evening groups to suit commuters and all those unable to attend during the working day. From April 2010.

Outcome measures

Measure	Measure
4 week Quitters	2029

Quality Metrics

Measure	Target
Specialist services achieving a 60% quit rate:	62%
Intermediate services achieving a 50% quit rate:	52%

Changes to	Net £k*	
Principal changes in activity		
As a result of restructure from April 2010 the specialist team will be able to work more flexibly, offering more evenings and group sessions. The restructure will also be double admin capacity allowing the specialist team to concentrate on helping people quit rather than monitoring and paperwork.		
Implications for workforce		
Provider: New Tobacco Control Coordinator Post (joint with council). Training will be undertaken with SPFT nurses.		
Commentary on financial requirements		
£25k investment from Public Health budgets.		
Procurement and market management implications		
Related Vital Signs Measures/ Existing Commitments	LAA : N1.115 Young People's Substance Misuse VSB05 - Stopping Smoking	
Related World Class Commissioning outcome measures		
Related *Healthier People Excellent Care* Pledges	Staying Healthy – Pledges 3 and 4	
Equalities Impact		
The service will continue to target areas of inequalities, manual and routine workers and pregnant women.		

7.7.3 Health Care Acquired Infections

Summary

NHS Brighton and Hove currently provide leadership across the local health economy on Healthcare Acquired Infections (HCAI) through the work with partner organisations and the healthcare Infections action group.
This on going work is monitored through the local health economy healthcare acquired infection prevention and control plan and aims to reduce the incidence of Clostridium Difficile (C Diff) and Incidence of methicillin resistant Staphyloccus aureaus (MRSA) in the local health economy (LHE)

Projects within the initiative

In 2010/2011 we will continue to :

Lead the local health community in the reduction of healthcare acquired infections (HCAI) health by ensuring a local health community HCAI monitoring and action plan.

To do this we will:

- Ensure that HCAI penalties in contracts work is on going through the commissioned organisations providing information and evidence through monthly performance monitoring;
- Continue actions on root cause analyses (RCAs) through the established processes across the LHE led by the PCT;
- Continue RCAs for all community acquired C Diff patients if they live in a care home/nursing home.
- Grant ward which looks after C.Diff patients will be continued;
- Do antibiotic review in all RCAs, and antibiotic point prevalence surveys to ensure adherence to the BSUH antibiotic prescribing policy;
- Continue Trust hand hygiene audits with reporting to the weekly action group;
- Continue (RCAs) of all MRSA bacteraemia and all significant hospital acquired and community acquired C.Diff infections.
- E discharge form to be developed and implemented, and to include information on HCAI
- Infection Control Champion Training to expand to cover other practitioners
- Infection Control Nurse Specialist employed by the PCT, who has been in post for just over a year who supports ongoing work.

Key Milestones

- Community RCA summary to be presented monthly to the HCAI action group.
- Monthly reports of hand hygiene audits to the weekly HCAI action group.
- E Discharge Form to be in place by Summer 2010
- Other actions ongoing

Outcome measures

Measure	Measure
Reduction in the rate of MRSA healthcare acquired infections (VSA01)	**NHS Brighton & Hove PCT target (LHE) April 2010 – March 2011 is 11 (Proposed submission to**

	SHA January 2010)
C. Diff three year local target agreed (VSA03)	**NHS Brighton & Hove PCT target (LHE) April 2010 – March 2011 is 193 (Proposed submission to SHA January 2010)**

Quality Metrics	
Measure	**Target**

Principal changes in activity

Implications for workforce
Staff are in place to provide leadership, commissioning expertise, training and analytical skills for the continuing reduction of healthcare acquired infections (HCAI). These roles are clearly defined and are accountable to the Director of Infection Prevention and Control (DIPC) Each organisation across the local health economy has a clinical lead for nursing, an infection control nurse and infection control champions. These roles are supported by administrative support, analytical expertise, pharmacy and microbiology. There are specific responsibilities for liaising with commissioning services and completion of root cause analysis. Contractual arrangements are in place which include organisations having measures in place to ensure that the local health economy workforce have mandatory training arrangements, awareness of infection control policies such as hand washing and dress code. The local health economy infection control group meet weekly to monitor weekly information, share lessons leant, and ensure robust processes in place to manage reviewing of C Diff and MRSA related deaths.

Commentary on financial requirements

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	A healthcare outcome target – MRSA Infection rate Vital Sign Tier 1 VSA 01Incidence of Clostridium Difficile (C Diff) Number of C Diff infections for patients aged 2 or more VSA 03 Incidence of methicillin resistant Staphyloccus aureaus (MRSA)

	Number of MRSA infections
Related World Class Commissioning outcome measures	MRSA infection rate
Related *Healthier People Excellent Care* Pledges	Overarching HPEC pledges 1 and 2 By 2011 there will be no avoidable cases of hospital acquired MRSA By 2011 there will be less than 2,000 cases of C Diff per annum across South East Coast.
Equalities Impact	

7.7.4 Prevention of cardiovascular disease and detection of abdominal aortic aneurysms

Summary

Includes initiatives contributing to improving life expectancy: NHS health checks, adult obesity, CVD prevention and AAA screening.

Projects within the initiative

In 2009/10 we have:

- Launched community based and workplace based NHS Health Checks
- Launched NHS Health Checks in general practices (PBC lifestyle incentive scheme and a LES)
- Submitted a bid for funding to established AAA screening (with East Sussex PCTs and BSUH)
- Developed an Adult Obesity Framework and reviewed commissioning intentions

In 2010/11 we will:

- Increase the number of Health Checks
- Introduce Abdominal Aortic Aneurysm (AAA) screening for men over 65.
- Pilot a Bariatric Surgery Lifestyle Programme
- Improve the Healthy Weight Referral Scheme (including community weight management services) and exercise referral services

Key Milestones

- Launch revised CVD prevention LES Apr 10
- Establish regular data collection to support monitoring of Vital Sign VSC23 Apr 10 (dependent on agreement of national dataset)
- Review commissioning of community and workplace based NHS health checks Oct 10
- With BSUH, begin AAA screening programme (timescale dependent on bid approval)
- Retender adult obesity contracts as appropriate.

Outcome measures

Measure	Measure
NHS Health Checks (VSC23 from Apr 10)	4,300
Uptake of AAA screening :	60%
Adults supported per year Shape Up	900
Referrals to exercise referral scheme	1,000
Healthy Weight Referral Scheme referrals	1,500

Quality Metrics

Measure	Target
Weight management % measured at 6 months	
KPIs for NHS Health Checks are expected to be issued by 2010/11	

% of currently inactive patients referred to the Exercise Referral Scheme demonstrating an increase in physical activity levels	
Uptake and coverage of AAA screening programme	

Principal changes in activity

Implications for workforce

PCT:

Provider: We will deliver more training to support delivery of NHS Health Checks.

We will need to plan for the workforce impact of fully implementing Health Checks by 2012/13

Commentary on financial requirements

AAA screening £20k cost
Adult obesity initiatives £61k from Choosing Health budgets

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	NHS Health Checks in 2010/11 NHS Operating Framework and NHS Constitution (consultation underway) AAA screening is a national programme Links to: VSB09 – Childhood obesity VSB01 – All age all cause mortality VSB02 CVD mortality rate VSC23 Vascular risk/NHS Health Checks
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	Staying Healthy – Pledge 1 Overarching Pledges – Pledge 8

Equalities Impact

Commissioning will reflect unequal burden of CVD across population groups
Equalities Impact Assessments to be conducted where appropriate
Uptake of services to be monitored by demographic and other groups

7.7.5 PCT Emergency Preparedness & Resilience

Summary

The NHS Annual Operating Framework for 2010 – 2011 lists Emergency Preparedness as one of its main priorities, and provides detail as to how and why this must be addressed by NHS organisations. This involves being prepared for and properly able to respond to Major Incidents and Emergencies, and also being resilient to threats to PCT processes and operations in terms of Business continuity.

The PCT recognises the significance and responsibility of its duty to be proficient in these areas as a 'Category 1 Responder' as defined in the Civil Contingencies Act 2004 (CCA).

The projects listed in this initiative are work-streams determined by the National Operating Framework, the CCA, NHS Business Continuity and Emergency Planning guidance, & SHA Audit.

Projects within the initiative

1. Leading the PCT's Business Continuity (BC) review, so as to implement an updated BC plan and systems conforming to BS25999 by March 2011, to ensure resilience to threats such as severe weather.
2. Further linking of Business Continuity to PCT Risk Management systems so as to ensure that related risks are identified to risk registers and managed appropriately.
3. Participate in suitable training and exercises to improve staff awareness and plan appropriately.
4. Develop and review of other PCT Plans including Emergency, Heatwave, Pandemic Influenza and Winter Surge / Escalation Plans and Mass Vaccination strategies to ensure relevance and appropriateness.
5. (Following the 1st & 2nd waves of Pandemic Influenza), a detailed city-wide review will be led by the PCT.
6. Linking the PCT's preparedness and resilience to emerging work on Climate Change & PCT sustainability, including local multi-agency response to flood-planning.
7. Participate in the SEC SHA Mutual Aid Plan which is due for review.
8. Develop a more detailed understanding of issues such as Radiological Biological Radiological and Nuclear (CBRN), Terrorism, Fuel or Supply Disruption threats to the community, and involvement in a local multi-agency response to these threats.
9. Ensure that Providers and contractors are similarly prepared and resilient.

Key Milestones

1. Business Continuity Review (31/3/11)
2. Linking of Business Continuity to PCT Risk Management systems (31/3/11)
3. training & exercises. (Ongoing – annual)
4. Plan development and review of PCT Plans. (Ongoing – annual)
5. City Flu Plan review (31/12/10
6. Link resilience to Climate Change & sustainability issues. (31/3/11)
7. SEC SHA Mutual Aid review. (31.12.10)
8. CBRN, Terrorism, Fuel or Supply Disruption threats. (Ongoing – annual)
9. Provider / contractors resilience. (ongoing contract reviews)

Outcome measures

Measure	Measure

BC Plan	BS25999 Compliance
SHA EP Audit	SHA Compliance

Quality Metrics	
Measure	**Target**

Principal changes in activity

Implications for workforce
PCT: **Provider:** Dependant on their current level of resilience awareness, training and implementation.

Commentary on financial requirements
Implementation of this initiative has minimal cost impact on the PCT. However the cost implication of not conforming to legislation, not being resilient to business threats, or not ensuring that providers & contractors are similarly resilient could be catastrophically high.

Procurement and market management implications
Business Continuity includes the concept that an organisations level of preparedness & resilience depends partly on that of its supplying organisations and stakeholders. The PCT must ensure that commissioned services and supply contracts require the provider to engage in and practice business continuity.

Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	

Equalities Impact

7.8 Cost saving programmes

7.8.1 Use of System Levers

Summary

We will review contractual and other system levers which will help us identify savings and efficiencies with our provider organisations. This will include a review of the timescale for discussions with providers and implementation of contract changes.

This work will be informed by reviews of service quality, performance and benchmarked cost. We will review performance in areas such bed and theatre utilisation, levels of referrals, admissions and attendances, bed days and length of stay.

Adherence to contract rules and use of the Commercial Support Unit (CSU) will also be key features of this programme and will be managed through Quality and Delivery Boards.

The work will identify 'quick wins' in terms of savings. It will also produce longer term savings supported by implementation/delivery plans which will feed into procurement, contracting and market management processes, organisational development and workforce plans, and enabling strategies such as estates and IM&T.

Projects within the initiative

Initiate discussions with South Downs Health regarding economies of scale and corporate overheads

Collation and analysis of data on provider service performance and service benchmarking

Discussions to start with BSUH regarding plans for capacity reduction supported by redesign proposals

Review of provider performance against contracts and identification of challenges

Review of non PbR agreements to identify potential areas of cost reduction

Continued review of provider contracts

Key Milestones
(dates required)

- Initiate discussions with South Downs Health regarding economies of scale and corporate overheads – March - April 2010
- Collation and analysis of data on provider service performance Q1-2 2010
- Discussions to start with BSUH regarding plans for capacity reduction supported by redesign proposals – April 10 and ongoing
- Review of provider performance against contracts and identification of challenges – All quarters
- Review of non PbR agreements to identify potential areas of cost reduction – All quarters

Outcome measures

Measure	Measure
Achievement of productivity metrics	Range of measures to be implemented under Enhancing Quality

Quality Metrics	
Measure	**Target**
Implementation of phased savings from better care, better value metrics including new to follow up ratios, reduced length of stay, increased day surgery rates and pre-operated bed delays	To achieve top quartile performance in key areas

Principal changes in activity
Not yet known

Implications for workforce
Internal provider efficiencies to be generated

Commentary on financial requirements
£1.6m from SDH already identified. Other savings to be scoped for 2011/12 onwards

Procurement and market management implications
No specific procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	Current contract standards include a range of measures to contract for improved performance, improved coding/data management/CQUIN measures for improvement
Related World Class Commissioning outcome measures	No specific link to priority health outcome measures
Related *Healthier People Excellent Care* Pledges	Use of system levers will cut across all aspects of provider activity but not specifically

Equalities Impact
No direct impact on equalities

7.8.2 Corporate efficiency

Summary

We will undertake a systematic review of our back office, support functions, management costs and accommodation to identify where efficiency savings can be made. The PCT will develop and implement a revised organisational structure in line with national and regional targets for management cost reductions.

The work will identify 'quick wins' in terms of savings. It will also produce longer term savings supported by implementation/delivery plans which will feed into procurement, contracting and market management processes, organisational development and workforce plans, and enabling strategies such as estates and IM&T.

Projects within the initiative

Collation and analysis of financial data, including in year non-recurrent planned and generated savings.

Implementation of Sussex Commissioning Support Unit (SCSU) in line with Sussex wide plans

Discussions to start with partner organisations regarding potential for shared services and facilities.

Review in year non-recurrent savings to identify which can be made recurrent.

Review current and future accommodation requirements and new ways of working to identify opportunities for rationalising accommodation and sharing with local authority and other partner organisations.

Scope opportunities, implement and develop options for reduced management costs inline with locally set SHA targets.

Key Milestones
(dates required)

- Collation and analysis of financial data, including in year non-recurrent planned and generated savings. – Q1-2
- Implementation of Sussex Commissioning Support Unit (CSU) in line with Sussex wide plans – Dates April – September 2010.
- Discussions to start with partner organisations regarding potential for shared services and facilities. – Q1 and ongoing
- Review in year non-recurrent savings to identify which can be made recurrent. - Q1
- Review current and future accommodation requirements and new ways of working to identify opportunities for rationalising accommodation and sharing with local authority and other partner organisations. Q2
- Review overall management costs and agree revised management cost profile Q1, Q2 benchmark back office functions including staffing mix and costs
- Implement revised management structure Q3/Q4 inline with phased reductions.

Outcome measures	
Measure	**Measure**
More efficient and effective use of corporate resources to support commissioning	
Quality Metrics	
Measure	**Target**
To reduce management costs in line with national operating plan guidance	30% management and agency cost reduction by 2013/14
Principal changes in activity	
No specific activity related changes	
Implications for workforce	
The PCT will re-align its workforce in-line with the required reduction in management cost profile	
Commentary on financial requirements	
Indicative £1.2m target identified, including CSU saving. Final target to be agreed following agreement across SHA.	
Procurement and market management implications	
No specific impact identified	
Related Vital Signs Measures/ Existing Commitments	To reduce our management costs to the agreed national standard
Related World Class Commissioning outcome measures	No specific priority outcome measure
Related *Healthier People Excellent Care* Pledges	None
Equalities Impact	
No direct impact	

7.8.3 Targeted Spend Review

Summary

We will undertake a structured, phased review targeting the areas of highest spend identified in our programme budgeting analysis

The review will focus on existing spend in these areas rather than on new investment.

The work will produce a strategic response for reducing spend in each of our high spend areas, specifically improved cost effectiveness and demand management. This response will be supported by implementation/delivery plans which will feed into procurement, contracting and market management processes, organisational development and workforce plans, and enabling strategies such as estates and IM&T.

Projects within the initiative

Further analysis of programme budgeting data and triangulation with other benchmarking data sources

Scoping of overall programme and project initiation

First phase of reviews and implementation plans mental health disorders and infectious diseases

Key Milestones

- Further analysis of programme budgeting data and triangulation with other benchmarking data sources – Q1 and ongoing
- Scoping of overall programme and project initiation – Q1 and ongoing
- First phase of reviews and implementation plans (mental health disorders and infectious diseases) Q1 and ongoing
- Specific Care Pathway review

Outcome measures

Measure	Measure
To reduce areas of highest spend and improve outcomes in key areas	Reduced spend in Infectious Diseases by £500k

Quality Metrics

Measure	Target
To improve overall outcomes for reduced investment	

Principal changes in activity

Not yet known

Implications for workforce

- Potential reduced provider workforce

Commentary on financial requirements

Our plans for 2010/11 are focused on two areas.

Infectious Diseases (Sexual Health Services). This will clarify the actual spend and facilitate benchmarking from clarification to hosting arrangements and identify further opportunities for improving VfM.

Working with SPFT in the redesign of services initially to enable the IAPTS funding (£601k) to be absorbed within the existing funding of Mental Health Services. The PCT is preparing for a further drop in IAPTS funding in 2011/12. The joint working will lead to further benchmarking to ensure VfM.

Procurement and market management implications

Implications

Related Vital Signs Measures/ Existing Commitments	Implications to be assessed following individual reviews
Related World Class Commissioning outcome measures	No specific measures identified
Related *Healthier People Excellent Care* Pledges	None identified

Equalities Impact

No direct impact

8 Enablers

8.1 Working with patients, public, clinicians and local partners

Summary

NHS Brighton & Hove has a well established, innovative programme of patient, carer and public engagement and involvement. This programme supports service commissioning and development by:

- capturing feedback on the quality of healthcare services; and
- helping the organisation listen to a wide range of public views when assessing need, agreeing priorities, designing health services, and reviewing service quality.

Projects within the initiative

In 2009/10 we have:

- established the 'Talking with parents' project to develop a vision of how maternity services could be in Brighton and Hove
- established (or expanded) contracts (or agreements) with third sector 'Gateway' organisations to provide two-way dialogue and engagement mechanisms between the PCT and the following communities: Black & Minority Ethnic people, Lesbian, Gay, Bisexual & Transgender people, Disabled people, Older people, Carers, People experiencing Mental ill Health, Parents of Disabled Children, People of Faith and People with learning disabilities
- signed the PCT up to the Community Engagement Framework via the Stronger Communities Partnership which underpins how multi-sector partners will work together
- piloted 'Picker' hand-held devices to do digital questionnaires in hospital departments
- piloted the use of a 'pink camper van' with a video camera inside to go around the City and record people's views on a variety of health subjects.
- Joined with the City Council and Police in successfully tendering the City Citizens' Panel 'Exchange'
- held a 'healthy living day' open to the public with NHS organisations and key Community and Voluntary sector
- implemented the new national complaints legislation and guidance, and merged the PALS and complaints teams and function;
- 18 Week Patient group identified how best to communicate 18 weeks to Brighton and Hove patients. It engaged clinicians and managers in improving the quality of patient experience and enabled vulnerable groups to understand and benefit from faster patient journeys;
- piloted 'Information Prescriptions' in 4 GP surgeries, plus a number of other sites/services with joint NHS & City Council funding;
- piloted volunteer run 'PALS information Centres' in two GP surgeries;
- continued to develop the Expert Patients Programme (EPP) including mental health and a carer specific course

In 2010/11 we will:

- evaluate 'information prescriptions' and consider rolling the process out to further GP practices;
- evaluate 'PALS information centres' and consider rolling them out to further GP practices;
- engage and communicate around the future shape of mental health services;
- the commissioners and contracting team will develop contracting arrangements to ensure that

every provider has appropriate systems for gathering patient opinion and responding to issues and concerns;

- develop the current Health User Bank ('HUB') to ensure it is representative of the wider community, and provide robust training and familiarisation for members ;
- develop and use PCT website online mechanisms to stimulate and enhance engagement;
- develop more robust systems for learning from complaints, comments and queries; and
- building on the successful 2009 'healthy living day' by holding another in 2010;
- Develop the capacity of the 'Gateway' engagement organisations and possibly tender them;
- hire a community engagement 'bus' to build on and continue the 'Pink camper van' work in 2009;
- fully evaluate and (where possible) continue to expand the Expert Patient Programme (EPP) including considering running tutor training courses which would be an income generator for the PCT.

Key Milestones
Dates required

- evaluate 'information prescriptions' and consider expansion by end of March 2010;
- evaluate 'PALS information centres' by August 2010. If worth expanding write business plan by end of September 2010. Dependent on outcome of business plan, roll out further centres from Jan 2011;
- Enhance engagement website by July 2010;
- engagement and communications around the future shape of mental health services 8 Feb – 2 May 2010;
- developing contracting arrangements to ensure that every provider has appropriate systems for gathering patient opinion and responding to issues and concerns by October 2010;
- developing the current Health User Bank to throughout 2010;
- developing and using participation mechanisms to stimulate and enhance engagement throughout 2010;
- develop more robust systems for learning from complaints and PALS, throughout 2010; and
- 'healthy living day' to be held in approx. May 2010.
- Develop the capacity of the 'Gateway' engagement organisations by August 2010 and possible tender them in September 2010;
- hire a community engagement 'bus' by March 2010 and use throughout 2010-11;
- fully evaluate the Expert Patient Programme (EPP) by March 2010. If worth expanding write business plan by end of September 2010. Dependent on outcome of business plan, roll out further centres from Jan 2011;
- consider running EPP tutor training courses which would be an income generator for the PCT by March 2010. Set up pilot course and evaluate by August 2010. If worth expanding write business plan by end of September 2010. Dependent on outcome of business plan, roll out further centres from Jan 2011;

Outcome measures

Measure	Measure

Quality Metrics

Measure	Target

Principal changes in activity
n/a

Implications for workforce
PCT: **Provider**:

Commentary on financial requirements
All initiatives will be funded from existing budgets

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	

Equalities Impact
The following proposals need to have a full equalities impact assessment (EIA): ✓ mental health services consultation ✓ the engagement 'bus' ✓ the 'healthy living day' ✓ 'Gateway' engagement organisations tender The other proposals have either had historically EIAs or are not changing significantly enough to require an EIA. **Patient & Public Involvement Impact:**

8.2 Building the capacity of the third sector
Summary NHS Brighton & Hove has a long-standing well established relationship with the third sector in

contractual and partnership terms. As a whole NHS Brighton & Hove invests over £5m in services provided by the third sector. It is, therefore, important that NHS Brighton & Hove helps to develop the capacity of third sector organisations both to continue innovation within the sector but also to encourage them to consider taking on other services NHS Brighton & Hove may consider commissioning from them.

Projects within the initiative

In 2009/10 we have:

- invested £10k in one-off research into the value for money and social impact of 6 not-for-profit organisations in Brighton & Hove. The results will be published in 2010/11
- worked with the 'ChangeUp' Consortium to ensure that national money for sharing of 'back-room' costs and potential mergers/consortium working in the third sector is well spent;
- held two workshops to inform the third sector about how NHS Brighton & Hove will procure and commission from 2010 onwards;
- assessed and wrote to all third sector organisations to notify them of NHS Brighton & Hove's intentions regarding any agreements/contracts we had with them for 2010 onwards;
- worked with the engagement 'Gateway' organisations to develop an agreed service specification against which they may be tendered in 2010;
- attended the Dialogue 50:50 partnership meetings to ensure on-going dialogue between the statutory and third sectors;
- signed the updated Compact and Codes of Conduct between the statutory and third sectors including a new code of conduct around funding and commissioning;

In 2010/11 we will:

- Review, close, continue or tender contracts with existing third sector contractors as set out in the letters sent out in 2009;
- Identify third sector organisations who could provide NHS services and assess whether they need specific capacity building support from NHS Brighton & Hove or the support services listed above;
- Market manage third sector organisations in the same manner that other sets of providers are market managed.

Key Milestones
Dates required

- Review, close, continue or tender contracts with existing third sector contractors by 31 March 2011;
- Identify third sector organisations as above - by June 2010;
- Market manage third sector organisations – on-going

Outcome measures

Measure	Measure
All third sector organisations to be included in market management processes	Throughout 2010- 2011
More third sector organisations commissioned to provide services	by 31st March 2011

All existing third sector providers to have had their contract reviewed, tendered, continued or discontinued within agreed contractual terms	by 31st March 2011

Quality Metrics

Measure	Target

Principal changes in activity

n/a

Implications for workforce

PCT:

Provider: Tendering of some third sector organisations may have implications for some of the existing providers depending on whether they are successful or not in the tender process

Commentary on financial requirements

Procurement and market management implications

The PCT will need to support the PCT engagement team and other commissioners in the market management and tendering of third sector organisations

Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	

Equalities Impact

The following closure or tendering of any third sector organisations would require a full equalities impact assessment (EIA).

Patient & Public Involvement Impact:

8.3 IM&T

Summary

Local IT initiatives that support the priority transformation programmes (PTPs) in the strategic commissioning plans 2009 -2014. Funding locally
National IT programmes - some which support the priority transformation programmes. Centrally funded and locally funded

Projects within the initiative

Local IT initiatives

- Sussex Health Hub - a service to support access to and exchange of clinical information between NHS organisations and social services in Sussex. Built upon an IT infrastructure that ensures security and ease of access to information, it will enable clinicians to:
- view a client/ patient record consolidated from multiple organisations;
- access the detailed information in clinical / social services systems if they have the appropriate permission;
- support the exchange of clinical information between systems (e.g. discharge summaries between acute hospitals and GP practice systems that can receive them).
- Practice Based Commissioning Data Warehouse - a service to enable information analysts to support PBC localities.
- Predictive risk analysis - a service that will identify patients at risk so that pre-emptive action can be taken to avoid unnecessary acute episodes and maintain the patient's ability to live at home.
- Service Portal - a service that will enable clinicians and service users to understand the content of, and order, locally available services.
- Contact Centre / unified communications - a service to support the functioning of a telephone and electronic communications contact centre.
- **COIN extension** - extension of the Sussex COIN to general practices, hospices and interconnection with local authorities.

National IT programmes

- **Integrated Care Summary Care Record (SCR)**

This will provide authorised clinicians faster and easier access to reliable information about patients. The SCR will provide a key method of joined up working across multiple care settings and patient will be able to access their own records

The SCR will initially contain basic information derived from electronic patient records held on GP clinical information systems including demographics, current medications, adverse reactions and allergies

Further benefits will be released for patients with long term conditions and HealthSpace users where patients can view their record

- **Electronic Prescription Service (EPS)**

This will enable prescriptions to be generated and processed electronically.

- **GP2GP Electronic Patient Record Transfer (GP2GP)**

This is used to transfer a patient's electronic record when they register at a new GP practice. This system is faster, more reliable and more secure than the current paper-based and the new practice often has the benefit of the patient's medical history when they attend their first consultation.

- **GP Systems of Choice (GPSoC)**

This is a clinical information computer systems provided by suppliers contracted to deliver National Programme for IT functionality. The PCT is responsible for supporting GP practices who migrate to GPSoC systems, contract implementation, managing deployment of NPfIT functionality and training (e.g. the programmes detailed above) and managing any additional services.

Key Milestones

SCR Key Milestones

- Wave 2 SCR Upload (4 practices) – 30/04/10
- Wave 3 SCR Upload (2 practices) – 30/04/10
- Wave 4 SCR Upload (1 practices) – 31/07/10
- Wave 5 SCR Upload (9 practices) – 31/08/10
- Wave 6 SCR Upload (11 practices) – 31/10/10
- Wave 7 SCR Upload (3 practices) – 31/12/10
- Wave 8 SCR Upload (7 practices) – 31/01/11
- Wave 9 SCR Upload (7 practices) – 30/03/11

EPS R2 Key Milestones

- Initial Project Board Meeting – 28/02/10
- Submission of Application SoS Dictation Approval – 17/04/10
- Initial EPS R2 Pilot between 1 GP and Pharmacy – 31/12/10

Milestones for other projects to be defined

Outcome measures

Measure	Measure
Cost Reduction in prescriptions, tests and procedures Commissioning Competence 6: Prioritise investment	Reduce the number of unnecessary prescriptions, tests and procedures
Results in fewer hospital emergency admissions, and so increased capacity of elective care leading to quicker elective treatment for patients and so better performance against the 18 week target Commissioning Competence 6: Work with Community Partners	Enables Clinicians to provide appropriate treatment to patients in emergencies and out of our hour care settings Improved incidence, speed and appropriateness of patient assessment and treatment in urgent care settings
Improvements in Care Commissioning Competence 3: Engage with public and patients	Patients care will no longer be delayed as the summary care records can be accessed by right staff at the right time and patients will not be required to repeat information to different healthcare staff

Quality Metrics

Measure	Target

Principal changes in activity

Implications for workforce
As part of regional PIP, It is specified that Data Manipulation has to be carried out by PCT staff as data will be extracted by NHAIS Training resources are required to provide concept awareness training to 42 practices, which haven't received it so far. Change facilitator support is required to identify benefits related to various SCR projects. Various service leads has to assume Benefit Lead role to measure those identify benefits.

Commentary on financial requirements
EPS R2 approximately £90,000 (excluding workforce costs like PM etc.,) SCR approximately £150,000 (excluding workforce costs like PM etc.,)

Procurement and market management implications

Related Vital Signs Measures/ Existing Commitments	LAA (Local Area Agreement) NI 119 - Self reported measures of people's overall health & well being Patient reported unmet care needs; self reported experience of patient and users • PCT as leader of the local health system; • Evidence based practice and effective care pathways; • GP led commissioning; • Improving the patient's experience Management of Information in accordance with best practices and legislation standards including, Data Protection, Caldicott, Freedom of Information, and Records Management
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	

Equalities Impact

8.4 Continuing and funded nursing care

Summary

The NHS funded care team manages 3 statutory functions on behalf of the PCT – NHS Funded Continuing Healthcare (CHC), Funded Nursing Care (FNC) for individuals resident in a care home with nursing and the process for managing exceptional cases on behalf of individuals. We have joint contractual arrangements with the local authority for Brighton and Hove nursing homes.

Projects within the initiative

In 2009/10 we have

- Ensured adherence to Clinical Quality assurance standards in Nursing Homes
- Fully implemented the Prior Approval proposal and managed the transfer of the process to BICS

In 2010/11 we will
Extend the Clinical Quality Review project into other key areas of commissioned care provision. Specifically:

- Domiciliary sector
- Residential care homes

Adhere to CHC National Framework Guidance including;

- Performance monitor referral pathways
- Performance monitor completion of CHC assessment stages
- Performance monitor reviewing arrangements

Develop the Case Management function within the CHC Assessment Team

Engage with the Care Quality Commission to ensure developments in the City are informed by the National Regulatory Framework and that emerging good practice in Brighton is shared at Regional and National level.

Contribute to Regional and National Data collection on CHC Performance

Deliver Training across the Health and Social Care Community to promote the roll out of the National CHC Guidance

Implement the revised 'Best Practice' policy and process for Individual Funding Requests (IFR), based on the National Prescribing Centre's requirements for the management of IFR's

Key Milestones

- Extension of Clinical Quality Review activity into the Domiciliary sector – Subject to budget being identified June 2010
- Extension of Clinical Quality Review activity into the Residential Home sector – subject to budget being identified, September 2010
- Published Performance Data on adherence to CHC processes – Quarterly
- Training on Case Management function – May 2010
- Implementation of Case Management arrangements – Scoping of Training needs April 2010
- Implementation of Case Management arrangements - June 2010
- Revised Supervisory arrangements – April 2010 and ongoing

- Published Programme of 2010/11CHC Training events across the Health and Social Care economy – April 2010

Outcome measures

Measure	Measure
Annual audit process of all Brighton & Hove Nursing Homes to be extended into named areas of care and linked into contract framework agreement.	
IFR policy and process fully implemented	
Annual audit process of all Brighton & Hove Nursing Homes to be extended into named areas of care and linked into contract framework agreement.	
IFR policy and process fully implemented	

Quality Metrics

Measure	Target
All CHC activity is governed by expectations set out in the revised Continuing Healthcare Framework (DH Oct 2009) Clinical Quality Review audit process endorsed by the Research & Development Unit at Brighton & Sussex University Hospitals Trust.	

Principal changes in activity

All CHC Performance data is collated at a National and Regional level and provides the PCT with data on activity and performance locally that can be benchmarked against comparator PCT's

Implications for workforce

PCT:

Provider: Extending the work into new areas of care will require additional resource, already identified in 2009/10 AOP process, to enable the work to run in parallel with the existing programme.
Introduce revised supervisory arrangements

Address any skill development deficits that are identified through focused training, supervisory and peer support arrangements

Meeting the IFR Best Practice guidelines and timescales will require redefinition of existing roles and recruitment to the existing 0.6 Placement & Referrals Officer vacancy.

Commentary on financial requirements

Additional resource has been recognised as required to deliver an extended Clinical audit process but has not yet been identified within current budget setting exercises
Changes to current supervisory arrangements will be absorbed within budget
The seconded post of the CHC Trainer needs to be financially supported throughout 2010/11.

Training and support to introduce Case Management arrangements will be scoped to identify whether costs can be contained within budget.	
Procurement and market management implications	
Related Vital Signs Measures/ Existing Commitments	
Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	
Equalities Impact	
The extension of the Clinical quality auditing activity is critical to ensuring the PCT can be assured that NHS funded clients benefit from consistent standard setting and monitoring of the quality of care being procured for them. The revised IFR policy and process has been equality impact assessed,	

8.5 Medicines Management

Summary

The overall aim of this initiative is to improve the clinical and cost effectiveness of medicines management within all sectors of healthcare provision within Brighton and Hove, maximising patient safety and improved health outcomes.

The PCT's medicines management team will draw on the professional input from local primary care contractors and colleagues in health and social care to deliver these aims.

Projects within the initiative

- Work with health and social care partners to improve patient safety and reduce patient risk in relation to the use of medicines
- Deliver improved clinical and cost effective medicines management within the local health economy
- Promote action to reduce inequalities in people's health and to improve their experiences of healthcare and access to services in relation to medicines and self care
- Improve the use of information for patients in relation to medicines services and medicines management, and engage with public representatives to deliver the strategy
- Ensure that medicines issues are fully addressed in emergency planning programmes
- Provide training for pharmacists, and contribute to the development of further staff training programmes

Key Milestones

- Implementation of process to provide assurance that primary care contractors are taking appropriate action on all relevant safety alerts (including NPSA and MHRA) by June 2010
- Completion of Controlled Drug self assessment by all GP practices by September 2010
- Policy for improving provision of appropriate medicines to patients and information to GPs following outpatient consultations agreed with (BSUHT) by July 2010
- Audit of PbR excluded prescribing and associated charges at BSUHT to be completed by July 2010
- Process agreed for documenting use of PbR excluded medicines within BSUHT by July 2010
- Horizon scanning and work programme for 2010/11 in place for policy making decisions on the managed entry of new drugs into the local health economy by May 2010
- Scoping exercise undertaken for alternative methods of dressings procurement within primary and community care by December 2010

Outcome measures

Measure	Measure
• Better care better value indicator for lipid modification	Maintain above 79%
• Better care better value indicator for proton pump inhibitors	Achieve 92% target
• Better care better value indicator for renin angiotensin drugs	Increase to 71%
• Reduced prescribing of high risk antibiotics in primary care	Measure being developed
• Reduced benzodiazepine prescribing in primary care	PCT prescribing below 3.5 ADQ per STAR PU (ePACT

	Toolkit figures Jan – Mar 2011)
• Increase generic prescribing for selected drugs to release cost savings	Reduction of 50% in the value of potential savings from increased generic prescribing (ePACT Toolkit figures for Dec 2010 compared with Dec 2009)
• Stop all generic prescribing of drugs where branded prescribing is recommended for clinical patient safety reasons	100% branded prescribing for these drugs
• Improved process in place within BSUHT for recording and charging for PbR excluded drugs.	KPI in contract

Quality Metrics

Measure	Target
• CQUIN for reduction of significant events relating to medication errors in BSUHT	Reduction of 20% in number of reported significant events relating to medication errors

Principal changes in activity

- Undertaking work on improvement of medicines usage and error reduction in Care Homes
- Increased monitoring of implementation of NPSA safety guidance in primary care
- Increased involvement in IFR panel and in management of expenditure on PbR excluded drugs
- Increased activity on horizon scanning and local policy making on drug use
- Increased involvement in development of care pathways to ensure appropriate level of medicines management input
- Increased monitoring of community pharmacy expenditure following devolution of the Global Sum in April 2010
- Develop role of Pharmacist with Special Interest (PwSI) for sexual health in primary care
- Increased training role within local health economy

Implications for workforce

- Assessment of current roles of the Medicines Management Team, with reconfiguration as necessary to ensure delivery of plans for 2010/11 within existing resources.

Commentary on financial requirements

Recent years of cost containment and negative growth in the primary care prescribing bill has left us starting from a lower and more efficient position. There is now scope for continued reductions in drugs bill, and the measures in place for 2010/11 will be used to contain the level of growth in expenditure.

Procurement and market management implications

Opportunities for a change in the procurement method for dressings in primary care will be investigated, but this is unlikely to result in a change of procurement within 2010/11.

Related Vital Signs Measures/ Existing Commitments	

Related World Class Commissioning outcome measures	
Related *Healthier People Excellent Care* Pledges	• Children's services – reduction in teenage pregnancy • Staying healthy – tobacco control programmes • Planned care – diagnostic tests on the high st • Long term conditions - ongoing support, education and training to help patients and carers better manage their own condition • End of life care – improved access to palliative care medicines • Over-arching pledges – improved antibiotic prescribing to reduce rates of MRSA and C difficile
Equalities Impact	

9 Infrastructure and Capital planning

The infrastructure used to deliver acute, community, primary and social care within Brighton & Hove is mixed and a significant part of the acute and community sectors operate from Victorian or outdated facilities. Over recent years the process of renewing this infrastructure has begun, with significant developments on the Royal Sussex County site and the cessation of inpatient care on the Brighton General Hospital site

As a commissioning only PCT, NHS Brighton and Hove has only a limited asset base, comprising office fixtures and computer equipment. The PCT also holds on its books the Sussex Orthopaedic Treatment Centre, an asset which is leased by finance lease from Care UK. In terms of the PCT's own capital plans, a baseline £250k has been identified to fund schemes in 2010/11. These primarily involve the replacement and upgrade of core IT and office systems. In addition it is anticipated that the Trust will facilitate the transfer of £2.6m Learning Disability assets from South Downs Health to Brighton and Hove City Council as part of the Valuing People Now initiative.

The PCT also has a key role in supporting capital programmes and projects across the local health economy and in doing so, influencing the strategic direction of estates and major capital projects within the Brighton and Hove area and ensuring that key local priorities and national objectives such as privacy and dignity are addressed.

The Teaching, Tertiary and Trauma Outline Business Case (OBC), which will drive the modernisation of the Royal Sussex County site, has been approved by the South East Coast Strategic Health Authority. The OBC was developed by Brighton and Sussex University Hospital Trust with oversight by the Local Health Economy Directors of Finance. The final step in the approval process for the scheme involves negotiations with the Department of Health and HM Treasury regarding securing the source of funding for the planned £420m development.

In terms of developing non acute infrastructure, the PCT is participating in developing a proposal for an Express LIFT (Local Improvement Finance Trust) in conjunction with other Health and Social Care organisations in Brighton and Hove and East Sussex. The objective of a consortium approach to the Express LIFT application is to provide the vehicle to ensure a coherent approach to transforming the delivery of services which is underpinned by modernising and maximising utilization of existing estate and developing new facilities where appropriate.

10 Chief Executive's Office

The Chief Executive's Office comprises the Chief Executive, Chair and PEC Chair, the Business Manager, Business Assistant and Executive Assistant.

The Board and the Chief Executive set the organisation's priorities (for example through the Strategic Commissioning Plan and Annual Operating Plan) and oversees corporate governance and risk. Delivery of these strategies, plans and processes are through the directorates on behalf of the Board and Chief Executive's.

The Chief Executive's Office provides administrative support for the Chief Executive, Chair and PEC Chair and runs projects on their behalf; manages Board, PEC and ET meetings; handles MP letters, Freedom of Information Act requests and access to legal advice.

11 Human Resources and Training

The HR and Training & Development teams work to provide PCT management and staff with support, guidance and expert knowledge in the areas of people management and training & development. The HR team deals with a wide variety of issues around the employment of staff, including recruitment, workforce planning, sickness management, performance management, equality and diversity, conflict resolution, pay and reward, and job satisfaction. The Training & Development team support managers and employees with their training and development needs, including the identification and achievement of key competencies and skills. Staff are provided with a range of training and development opportunities advertised in the Corporate Training Programme including the provision of core training. In addition to this staff are supported in other development activities specific to individuals or groups of staff. The team also gives support to our colleagues in Primary Care, providing development and learning opportunities for practice staff within the city. There is £700k in our baseline budgets for training.

12 Communications

NHS Brighton and Hove is supported by a communications function which works to enhance and protect the reputation of NHS Brighton and Hove as the leader of the local NHS. We work in partnership with patients, clinicians, the public and other agencies to promote the best opportunities for healthy living.

Our tools include web sites, printed publications, events and activities as well as working with the media.

Key tasks for 2010/11 include:

- campaigns around early recognition of cancer symptoms, smoking cessation focused on manual and outdoor workers, alcohol intake in older people, public awareness of the range of urgent care services, and uptake of vaccination and immunisation.
- develop our online mechanisms to stimulate and enhance engagement
- work with HR to create an employee awards scheme
- improving our intelligence about the communications' needs in primary care to support practice based commissioning and more effective partnership working

13 Workforce Strategy

The Strategic Workforce Plan for Brighton & Hove outlines the vision and plan for the future health workforce across the Brighton & Hove Local Health Community (LHC)

aligned with NHS Brighton & Hove City's Strategic Commissioning Plan and Annual Operating Plan.

Explicitly linked to the successful delivery of high quality healthcare services is the workforce. Over the past decade, significant improvements in both access and quality have been accomplished, these were enabled by investment and reform but they were delivered by staff working at the frontline.

This Strategic Workforce Plan seeks to identify the workforce implications for the next five years by identifying workforce risks, determining demands, and forecasting capability in aligning the workforce with Strategic Commissioning plans. In collaboration with healthcare providers, local health education institutions and the local authority this workforce development strategy assesses the quality, sustainability and deliverability of the local health economy workforce and identify key strategic health and social care workforce implications of our commissioning (and decommissioning) strategies.

14 World Class Commissioning (WCC) Development Plan

The PCT has developed a clear revised organisational development plan (OD) which sets out the key development interventions to support the Implementation of the Year 2 SCP and operating plan for 2010/11. The OD plans sets out the PCT's organisational strengths to enable delivery, the identification of gaps to delivery of plans and proposed organisational development solutions which will form the basis of revised priorities for the coming year. The focus of the plan includes supportive WCC development plans which include:

- Programme management capacity and capability development
- Developing targeted disinvestment reviews linked to robust continued prioritisation processes
- Capacity and capability enhancement to deliver new models of care and pathway development
- Collaborative commissioning development including maximising the role of the Commissioning Support Unit (CSU)
- Maximising knowledge management resources and evidence to support commissioning

The PCT will be developing a detailed WCC Development plan based on its updated OD plan and the outputs of the year 2 assurance process.

15 Delivering Our Plans

A culture of programme management and accountability is embedded within the organisation. This enables our plans to be delivered in a structured and disciplined way under the PCT's integrated planning and delivery function (IPDF). The PCT's Delivery Board oversees the delivery of the Annual Operating Plan, focusing on critical and high risk elements and also where a coordinated Local Health Economy (LHE) approach is required. The PCT Board has responsibility for the delivery of all plans and will review on an exceptional basis.

As we go through the year an on-going programme of service reviews and savings identification will be implemented. Any new investment requirements will be prioritised and money released to fund these as it becomes available.

16 Providers

Our provider landscape and strategy was described in detail in the Strategic Commissioning Plan. Our key providers are Brighton and Sussex University Hospitals NHS Trust for acute services; Sussex Partnership NHS Foundation Trust for mental health services; South Downs Health NHS Trust for community health services and the Children and Young Peoples Trust for our children's services. Ambulance services are provided by South East Coast Ambulance Services and specialist services are commissioned via the South East Coast Specialist Commissioning Group hosted by NHS West Kent.

As we implement the transformational change identified in this plan our priority will be real quality and value for money. As services are reviewed and redesigned the NHS will be our preferred provider, where quality and value are high, with clinicians leading change and service improvement. Where quality and value does not meet the standards required the current NHS provider will be given the opportunity to improve before we open the market to new potential providers. We are committed to the participation of independent and third sector providers where appropriate, in order to deliver our over-riding principle - to provide high quality care for patients delivered by providers who offer the best care. This approach is expected to drive up quality and standards and to provide patients choice, high quality care and value for money.

17 Partner organisations

NHS Brighton & Hove has a range of different but effective arrangements in place to work with statutory, voluntary sector and private sector providers to deliver high quality health and health care services for the City.

The city's key partnership is the 2020 partnership Local Strategic Partnership (LSP) and the Public Sector Board (acts as the engine room for the LSP), where many of the key issues, including health and associated wellbeing strategies are debated. The LSP is the umbrella for a range of associated partnerships including the Healthy City Partnership (the key cross sector group addressing health inequalities issues), the City Inclusion Partnership (which addresses equality and diversity issues), and the Stronger Communities Partnership (responsible for ensuring that partners work together on engagement issues) the Crime and Disorder Reduction Partnership. As part of the LSP NHS Brighton & Hove has also agreed to a city wide community engagement framework and a Compact with the third sector.

As leader of the local NHS, NHS Brighton & Hove has set up a local health economy wide Strategic Commissioning Board where representatives of the city's key health and social care partners shape commissioning. The Healthcare Standards and Service Quality Committee ensure that commissioned services are of a high quality.

Some commissioning arrangements for adults are carried out through formal (legal) Section 75 agreements with Brighton & Hove City Council including commissioning arrangements for working age adults with mental health issues where NHS Brighton & Hove are the lead commissioner through a pooled budget. For older people, commissioning services is done jointly across Brighton & Hove City Council (Adult Social Care) and NHS Brighton & Hove. This delivers a joint work plan, the commissioning lead sits with NHS Brighton & Hove and the budgets remain totally separate. These arrangements are jointly scrutinised by the Joint Commissioning Board made up of executives from NHS Brighton & Hove and the City Council.

The PCT also has a Section 75 agreement with the Children's and Young Peoples Trust to deliver children's services and these arrangements are currently being reviewed. Revisions should be finalised by April 2010.

18 Risk

As part of the PCT programme management approach, each initiative has its own risk register and its own risk management plan. These identify risks in relation to finance activity and resources. Below we have identified the key corporate risks.

	Impact :	Likelihood
5	Catastrophic	Almost certain
4	Major	Likely
3	Moderate	Possible
2	Minor	Unlikely
1	Negligible	Rare

18.1 Corporate and financial risks

An initial assessment of the high levels risks within the plan has been made. Risks relating to each of the Delivery Plans will be identified as part of the PCTs on-going risk management process

Key AOP risk	Impact	Likelihood	Mitigation	Residual risk	
				Impact	Likelihood
The PCT fails to deliver the savings within its direct control or finds that costs are understated or that cost pressures cannot be contained	5	4	AOP finances have been thoroughly reviewed. We will establish close in-year monitoring and any non-recurrent access to reserves will result in clear actions to find alternative savings	3	2
Focus on delivery of financial savings may compromise ability to deliver key targets	5	3	We will establish close in year monitoring of key targets and associated programmes of work to enable actions to be taken to address any issues.	3	2
Provider resistance to loss of income	5	5	We will ensure we have robust and agreed implementation plans for all PTPs, and work jointly to ensure a	3	2

Key AOP risk	Impact	Likelihood	Mitigation	Residual risk	
				Impact	Likelihood
			LHE approach.		
Reputational risk to the PCT as leader of the local health economy if we do not achieve financial balance and key financial targets	4	3	The Board will continue to provide a leadership role to LHE and ensure that communications are effectively managed with provider and partner organisations and the public`	2	2
The provider market across the community may not be developed sufficiently to deliver our plans	4	3	We will ensure robust and agreed implementation plans are in place and that relationships are effectively managed with providers.	2	2
Plans are unable to be delivered as the workforce and continuing Professional Development implications have not been identified, planned and implemented	4	4	Commissioners to review workforce implications of their plans with providers to identify impact and agree actons to manage. Link to strategic workforce development plan. Regularly monitor delivery of savings and workforce metrics	2	2
The PCT fails to deliver the demand management plans underpinning the financial savings	5	4	We will ensure that plans are robust and agreed with providers and that strong performance monitoring controls are in place to enable any corrective actions to be taken in a timely fashion.	3	2
The further £6.4m required savings are unable to be identified	5	3	The risk in 10/11 is considered low as non-recurrent savings can be readily identified. A programme of work	3	2

Key AOP risk	Impact	Likelihood	Mitigation	Residual risk	
				Impact	Likelihood
			will be established in order to identify recurrent savings for 11/12 and beyond.		

18.2 Risk Management and Assurance Processes

NHS Brighton and Hove has an agreed Risk Management Plan, incorporating the Risk Management Strategy and Policy. It has refined its corporate governance structures during 2009/10 to ensure that there are systematic processes in place and that the organisation is working towards an effective management approach to continually reviewing and mitigating risk within the organisation. Significant assurance has consistently been provided by internal audit relating to the PCT's risk management processes.

The Risk Management Plan describes clearly the arrangements for the escalation of risks to the PCT's Integrated Governance Committee, a formal Board Sub Committee, through risk registers at departmental/team, Directorate and Corporate levels. The highest level risks which impact on the delivery of the organisation's principal objectives are routinely assessed and monitored at a level that should sufficiently alleviate not only financial and operational pressures within the organisation but also identify opportunities to improve reputation, patient safety and equalities across the city.

The Board is responsible for the identification of top down corporate risks through Board level workshops. It is also the Board's task to identify and evaluate key controls intended to manage these risks. Following this the Board receives assurance reports, using the Assurance Map as its key tool, from its Executive Directors on the effectiveness of these controls across their areas of principal responsibility. Any gaps in the control or assurance process are agreed and addressed and plans put in place to mitigate these.

As a key part of the Trust's assurance framework the Board ensures that we maintain a dynamic risk management process including a well-founded risk register. The Board also receives reports from the Integrated Governance Committee to ensure effective working practices.

The PCT has developed an integrated governance structure in order to put in place a comprehensive structure of controls to co-ordinate and manage risks of all types within the organisation. The structure has been approved by the Board and the Professional Executive Committee. The PCT has appointed the Assistant Director of Assurance to lead on risk management, supported by a Risk Management and Incident Reporting Co-ordinator.

Specific roles and responsibilities for risk management are as follows:

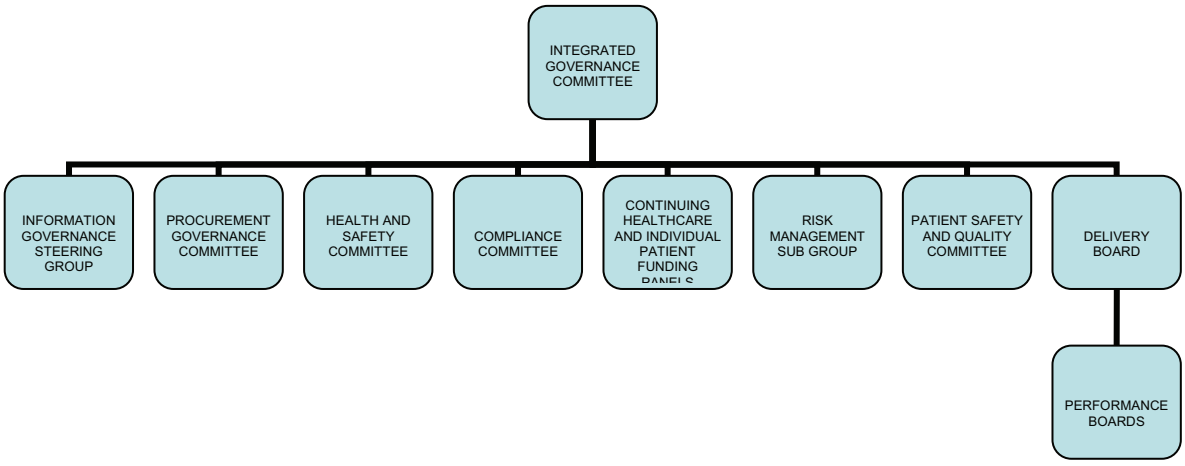
The Board
The Board is responsible for the PCT's system of internal control, including risk management. To discharge this responsibility the Integrated Governance and Audit

Committees have been established. The Board requires appropriate policies on risk management and internal controls to be in place, and to receive regular assurances on whether the system is functioning properly.

The PEC
The PEC is responsible for ensuring that the Board maintains effective control over clinical governance, strategic fit with clinical policies, clinical leadership and scrutiny and development of Practice Based Commissioning.

The Audit Committee
The Audit Committee is a formal sub committee of the Board and the minutes of all meetings are reported regularly at Board meetings. The role of the Audit Committee is to provide scrutiny and an objective view on internal control to the Board that is independent of the PCT's executive. It provides verification and assurance to the Board on internal financial controls based on reports, both written and verbal, from internal and external auditors.

The Integrated Governance Committee
The Integrated Governance Committee is a sub committee of the Board and has been constituted in this way to ensure that the clinical members of the Professional Executive Committee undertake the function of managing clinical risk. The Integrated Governance Committee oversees the management of risks through agreeing and prioritising the Trust risk registers, and reviewing and monitoring the action plans in respect of the most significant risks to the delivery of the organisation's principal objectives as detailed in the corporate risk register. It has a number of sub Committees, as shown in Figure XX below:



The Compliance Committee
This committee is responsible for monitoring compliance with expected standards and performance measures and for reviewing all performance information submitted to external bodies and regulators.

The Patient Safety and Quality Committee
This committee is responsible for reviewing and monitoring all issues concerned with the safety of patients and the quality of services provided by the PCT's commissioned services. This includes monitoring serious untoward incidents, incidents, complaints and audit data and the lessons learned.

The Risk Management Sub Group
This group reviews and challenges all risk registers to ensure that they contain appropriate risks which are consistently evaluated and which have effective action plans to mitigate the risks.

Professional Performance & Support
The General Medical Council (GMC) regulates the medical profession in England and is governed by statute. The GMC and the NHS have ensured that local procedures are in place to detect and act on concerns about doctors. The same applies to dentists, pharmacists, opticians and nurses, and the PCT has a responsibility within the NHS Clinical Governance Framework to have systems in place to register and action concerns about the performance of registered professionals.

The local PCT Professional Performance and Support Group ensures systems are in place to identify concerns about clinicians and that appropriate actions are taken. The PCT has appointed a GP as the Professional Performance Lead, and the work is supported by the Professional Performance Co-ordinator and the Head of Assurance. Systems for approving professionals onto the Brighton and Hove lists are also undertaken within this work area.

Shipman monitoring is a statutory requirement also administered in the Assurance Team, reporting to the Professional Performance & Support Group.

Appeals Panel
The Appeals Panel considers all appeals received by the PCT against the decisions of the Continuing Care and Exceptions Panels. The Appeals Panel is established as a Sub Committee of the Board.

The Panel has delegated authority from the Board to consider all appeals in respect of continuing care and acute exceptions cases. The Panel is authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary.

The Panel may:

- ✓ Confirm the original decision taken
- ✓ Refer the case back to the original decision making panel to reconsider the case
- ✓ *Make a different decision if (a) the Appeals Panel considers that the PCT failed to follow its own procedures or failed to reach a reasonable decision and (b) that there was only one other reasonable decision that the Panel could have reached. In all other cases where (a) is satisfied the Appeals Panel will refer the case back to the originating Panel for further consideration.*

The minutes of the Appeals Panel are formally recorded and submitted in anonymised form to the Board. This work is supported by an Appeals Co-ordinator within the Assurance Team.

NHS
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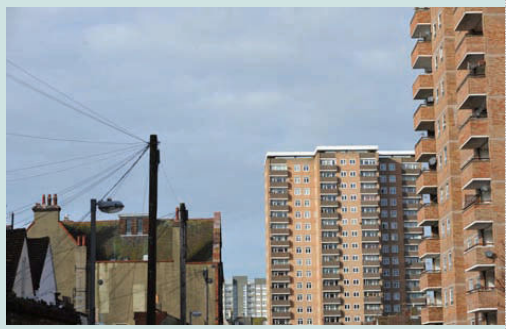
2010/11 Annual Operating Plan For NHS Brighton & Hove



14th April 2010

NHS
Brighton and Hove

Annual Operating Plan

- Builds on Strategic Commissioning Plan
- 1 Year Plan – 2010/11
- Outlines the key initiatives and plans to deliver
  - Improved health outcomes
  - Local priorities
  - Commissioning goals
  - National targets
  - A balanced budget
- For each initiative and plan we outline:
  - Financial implications
  - Impact on workforce
  - How we will measure success

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Specific Plans cover:

- Urgent care
- Primary care
- Long term conditions and end of life care
- Planned care
- Mental health
- Maternity and children's services
- Public health
- Efficiency and spend reviews

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Brighton and Hove

Financial Assumptions

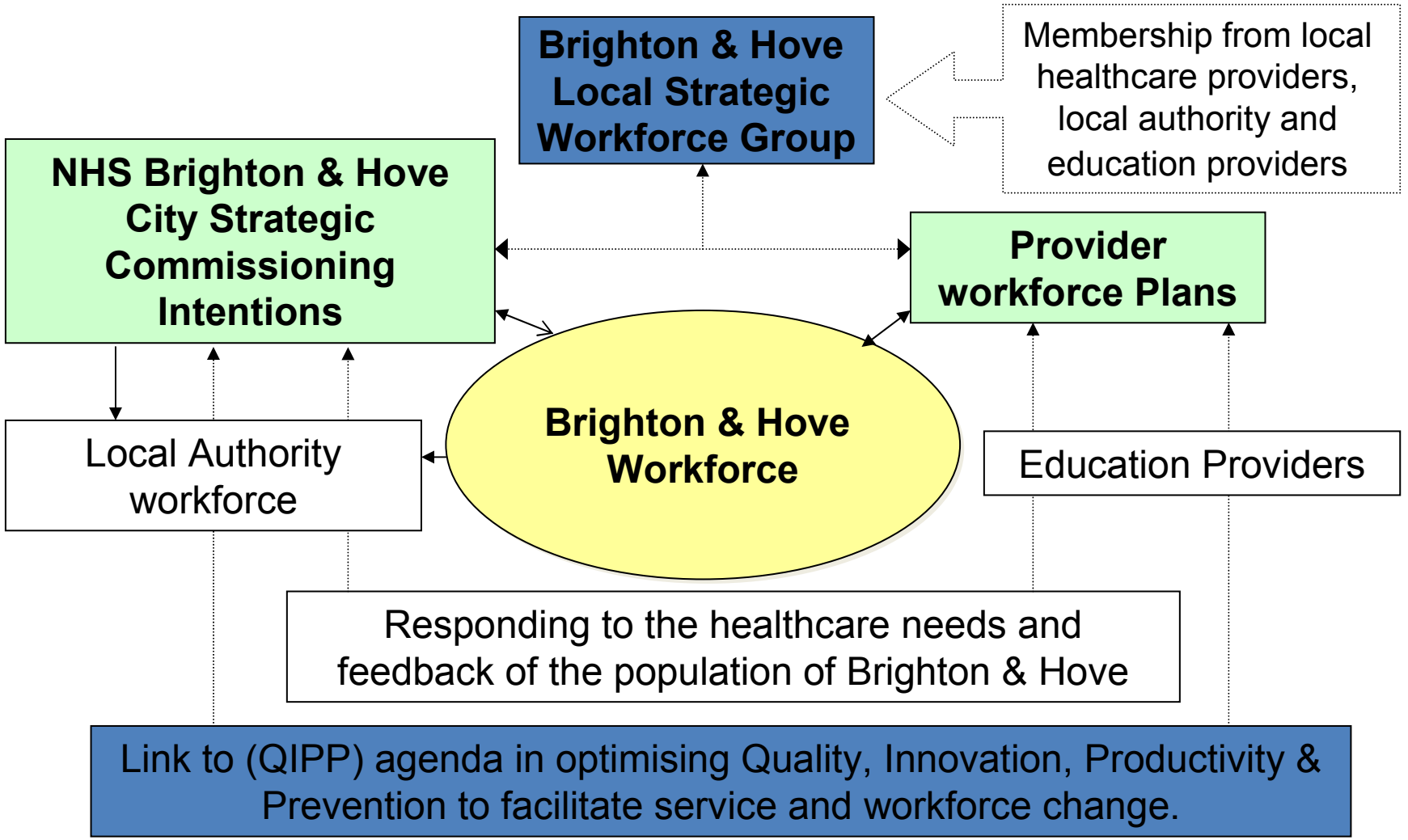
- Total funding is £490m
- 2010/11 is the last year of growth in funding
- PCTs are planning for zero growth in funding thereafter
- We are required in 2010/11 to plan for a 1% surplus and to create a 2% 'investment fund' used to finance future savings initiatives. These total £18.5m.
- Our plans include new spend of £12m and savings plans of £24m
- Areas of above average spend will be examined in order to make further savings – while taking into account areas of high need in the city.

NHS
Brighton and Hove

Examples of Specific Plans – Workforce and Quality

- Explicitly linked to the successful delivery of high quality healthcare services is the workforce.
- The NHS Next Stage Review describes a vision for the NHS delivery of high quality care for all and gives staff the freedom to focus on quality.
- Workforce Development planning to support the Quality, Innovation, Productivity and Prevention (QIPP) agenda.

Workforce Planning and QIPP



NHS
Brighton and Hove

Examples of Specific Plans – Mental Health

Key aims:

- Improve outcomes and reduce unnecessary demand on treatment services through focussing on well-being and prevention services eg prevention of suicide, alcohol and substance misuse.
- Develop primary and community services that maintain people in recovery, supporting individuals to manage their on-going health needs.
- Further develop care pathways and appropriate, evidence-based treatment services for people who require a structured treatment intervention.
- To provide an efficient and effective gateway and triage system into services.

NHS
Brighton and Hove

Examples of Specific Plans – Mental Health

Plans link with Sussex Partnership Foundation Trust's 'Better by Design' programme. This aims to develop a more personalised service for people with mental health problems that is less reliant on inpatient care and where the individual is more in control of their own care.

NHS
Brighton and Hove

Managing Demand Differently

- Strengthening primary care to manage patients within or between practices better:
- Evidence based primary care management guidelines;
- Greater emphasis on self care and informed patient choice;
- Increase collaboration between practices;
- Strengthen function of gateway management;
- Implement revised PBC(practice based commissioning) Framework.

NHS
Brighton and Hove

Reprovision of Outpatients

In 2009/10 we implemented:

- community eye clinic;
- ENT(Ear Nose & Throat) pilot;
- Tender for a community gynaecology service.

In 2010/11 we will implement:

- Integrated Care Organisation for Dermatology;
- Adult Hearing Aids service;
- MSK(musculoskeletal) ICATS(Integrated Clinical Assessment and Treatment Services) (includes increased capacity for physio);
- Community ENT service;
- Community Neurology service;
- Community Ophthalmology service.

NHS
Brighton and Hove

Increasing Productivity and Efficiency

- Work with BSUH around some key productivity areas including:
- Reduction in DNA(did not attend) rates;
- Achieve contracted levels for new to follow up ratios for two specialties;
- Reduce pre-operative bed days in two specialties;
- Implement a policy for the management of PBR(payment by results) exclusions;
- Modernisation of outpatents including one stop shop for long term conditions.

NHS
Brighton and Hove

Primary and Community Care Commissioning Strategy

- Sets out a vision for how primary and community services will transform and develop over the next ten years in Brighton and Hove.
- In this strategy we define primary and community care as:

  "Healthcare for all ages, delivered as close as possible to where people live and work''
- Primary and community care services are usually the first level of contact between people and the NHS and includes general practice and primary care teams, community dentistry and a broad range of community services such as district nurses that support people every day to live as independently as possible.

NHS
Brighton and Hove

Primary and Community Care Commissioning Strategy

Seeks to commission and transform Primary and Community healthcare services so that they address what local people have told us are important to them. Notably:

- More information to empower you to make decisions about staying healthy;
- Clearer communication to help you understand your care;
- Greater emphasis on self-care, well-being and health promotion, particularly for people with long-term conditions or mental illness and their carers;
- Being treated respectfully and with dignity and care when you access health services;
- Clear information about charges for NHS dentistry;
- Easier access to mental health services;
- Better co-ordination of end of life care;
- More talking therapies available for mental health service users;
- A greater emphasis on the link between physical and mental health;
- Better co-ordination of maternity services;
- Greater choice of where to have your baby delivered.

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Agenda Item 69
Brighton & Hove City Council

Subject:		**Breast Screening: Update**		
Date of Meeting:		**14 April 2010**		
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 Health Overview & Scrutiny Committee examined the issue of local breast screening services in July 2009, following a Councillor question on the subject. At this meeting it was resolved that: "the Committee should receive an update report on breast cancer screening in 6 months time."

1.2 **Appendix 1** contains information on breast screening supplied by NHS Brighton & Hove (NHSBH) and by Brighton & Sussex University Hospitals Trust (BSUHT), respectively the commissioners and the providers of city breast screening services. **Appendix 2** contains an extract from the minutes of the July 2009 HOSC meeting. **Appendix 3** contains a report drafted by officers of BSUHT and NHSBH for the July 2009 meeting (but not formally included in the meeting papers).

2. RECOMMENDATIONS:

2.1 That members:

(1) note the contents of the report and its appendices;

(2) determine whether they require a further update on city breast screening services.

3. BACKGROUND INFORMATION

3.1 HOSC members initially requested an update on city breast screening services following 2009 media reports detailing poor Brighton & Hove performance in screening for breast cancer. Dr Peter Wilkinson, Deputy Director of Public Health (NHSBH), and Kate Parkin, Director of Screening (BSUHT), attended the July 2009 meeting to answer members' questions. An extract from the minutes of this meeting is attached to this report as **Appendix 2**, and an informal briefing paper circulated to members at the July 2009 meeting is attached as **Appendix 3**.

3.2 At the July 2009 meeting, members were told that delays in the screening programme had largely been caused by a long-standing radiographer recruitment problem (recently exacerbated by a move to a better, but more radiographer-intensive 'two-view' screening system), but that steps had been taken to remedy this problem, such that it was anticipated that the programme would be back on target relatively quickly. The main purpose of this item is therefore to ascertain whether the improvement anticipated in July 2009 has actually taken place.

4. CONSULTATION

4.1 No formal consultation has been undertaken in preparing this report

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this report for information.

Legal Implications:

5.2 None directly, as the report is for noting. The Committee is entitled to request a further update report, if considered appropriate.

Lawyer Consulted: Oliver Dixon; date: 01/03/10

Equalities Implications:

5.3 None directly.

Sustainability Implications:

5.4 None directly.

Crime & Disorder Implications:

5.5 None.

Risk and Opportunity Management Implications:

5.6 None identified.

Corporate / Citywide Implications:

5.7 None identified.

SUPPORTING DOCUMENTATION

Appendices:

1. Information provided by NHSBH and BSUHT
2. Extract of the minutes from July 2009 HOSC meeting
3. Briefing paper circulated to members at July 2009 HOSC meeting.

Documents in Members' Rooms:

None

Background Documents:

None

Appendix 1

DRAFT 15-01-2010

Committee: Health Overview & Scrutiny Committee
Date: 10 March 2010
Regarding: Breast Screening Update
By**:** Paula Rabin, Director of Health Professions, BSUHT and Peter Wilkinson, Public Health Consultant (Public Health lead for cancer screening), NHS Brighton & Hove

Purpose of this paper

This paper provides an update on the progress made with the breast screening programme since July 2009.

Background

The local breast screening service is part of the national breast screening programme. The local programme offers screening to the registered population of 97,000 women aged 50 to 70 years across East Sussex, Brighton and Hove. Women should be offered screening at least every 3 years. NHS Brighton & Hove are lead commissioner for this screening programme across East Sussex. Brighton Sussex University Hospitals Trust provides the programme for women in East Sussex (including Brighton & Hove).

Historically the local programme has provided a high standard of care. However, since 2006/7 the performance of the programme has slipped and the screening round length has increased. This was primarily due to the shortage of radiographers in the unit, compounded by poor facilities and administrative errors.

The breast screening programme moved to new premises, The Park Centre, with digital equipment in November 2008.

Nationally from 2010/11 the age range for women to be invited to the breast screening programme is being extended over the next few years to women aged between 47 and 73 years. This will put additional pressure on the unit

Current position

The screening programme's performance is reported nationally on the situation as at 31st March each year. For 2007/8 this information was released in January 2009.

The Breast Screening coverage (the percentage of women screened within the previous 36 months) for the year ending 31st March 2008 for women aged 53 to 70 years was:

- England 76%
- West Sussex PCT 77%
- NHS Brighton & Hove 64%

The unofficial coverage for Brighton and Hove women for the year ending March 2009 was 67%.

The screening programme has offered screening to all eligible women in Brighton & Hove in the past 3 years. The following table details when the women were offered screening:

Area	**Last screening round**
Brighton central	Aug 07 - March 08
East Brighton	Feb 08 - Dec 08
North Brighton	Nov 08 - April 09
Hove and Portslade	Jan 07 -Sept 07

At the end of November 2009 73% of women aged 53 to 70 years had been screened in the previous 36 months. The screening round length for the remainder of the women in the East Sussex programme is more than 36 months.

Women from Brighton and Hove are now offered screening at The Park Centre rather than through the mobile screening units. East Sussex women are screened using the mobile units, but the possibility of using static sites is being explored.

The planned screening schedule for inviting Brighton and Hove women to The Park Centre for the next screening round is outlined below. Women from Hove and Portslade are currently being invited for screening.

Area	**Planned screening round**
Hove and Portslade	January 2010 – September 2010
Brighton Central	August 2010 – March 2011
East Brighton	February 2011 – December 2011
North Brighton	December 2011 – March 2012

The local programme is working to maintain this improved position for Brighton and Hove women. The programme's recovery plan is on-track to recover the 36 month screening round length across the whole programme by September 2010. The table below shows for the whole of the East Sussex, Brighton and Hove programme the number of women invited for screening during 2009 and how many attended for

screening. As can be seen from the table, with the exception of August, since March 2009 the number of women invited for screening has exceeded the monthly number required to maintain the 36 month round length, for some months by over 1000 women. This clearly demonstrates the unit's success in reducing the delay.

	Number of women to be invited to maintain 36 month screening round length over 36 months	**Number of women actually invited for screening**	**Number of women who attended for screening**
Jan	2708	2436	1447
Feb	2708	2428	1760
Mar	2708	3025	2377
Apr	2708	2961	2322
May	2708	2780	1975
Jun	2708	2875	2111
Jul	2708	3391	2631
Aug	2708	2079	1474
Sep	2708	3798	2953
Oct	2708	3739	2770
Nov	2708	3867	2684
Dec	2708	3238	1860

Screening to assessment

Women who require further assessment after their screening mammogram should be offered an assessment appointment within three weeks of their initial screen. The programme has been failing to meet this target, with the recall to assessment time running between three and six weeks.

Currently women are being invited to assessment within three weeks and the unit are looking at ways of ensuring that this time-frame is sustainable.

The delay in the time taken to carry out the assessments is mainly due to a shortage of radiologist or Advanced Practitioner Radiographer time to read the mammogram films. The unit is addressing this by increasing the number of regular radiologist sessions within the unit; training additional radiographers to film read; and investigating the options to increase mammogram reading capacity by the appointment of a Consultant Radiographer and/or Advanced Practitioner, as two recent advertisements for a Consultant Breast Radiologist have failed to attract applicants.

Steps taken to improve performance

1. Successful recruitment of radiographers and assistant practitioners, but training required before post-holders will be able to fulfil role completely (recent changes to the training availability now mean that Assistant Practitioner training takes 2 years, instead of the one year which was the case when the new appointments were made). However the unit remains 4.75WTE mammographers below recommended staffing levels. Two mammographers are currently on long term sick leave.
2. Successful recruitment of programme manager who started in post December 09
3. Review of working practices including additional screening sessions already being provided on Saturday mornings at The Park Centre.
4. Increased the number of radiologist sessions for breast screening.
5. Promotion of programme to Brighton and Hove women through general practices. With the PCT's Health promotion lead for cancer screening the unit has reviewed the literature and posters sent to practices. Ongoing activity regarding increasing the uptake by traditionally hard to reach groups of women, such as ethnic minorities.

The HOSC are asked to note that:

- The screening programme has offered screening to all women in Brighton & Hove in the past 3 years;
- The ongoing work to ensure the screening round length is maintained.

Paula Rabin and Peter Wilkinson
January 2010

Appendix 2

3. CHAIRMAN'S COMMUNICATIONS

3.1 Following recent critical media reports on city breast cancer screening services, the Chairman asked NHS Brighton & Hove and Brighton & Sussex University Hospitals Trust (respectively, the commissioners and the providers of city breast screening services) to address the committee on this issue.

3.2 Councillor Sven Rufus had also asked a Councillor Question on breast screening (see **Item 6** on this agenda). Cllr Rufus agreed that his questions should be taken together with the Chairman's.

3.3 Dr Peter Wilkinson, Deputy Director of Public Health at NHS Brighton & Hove, and Kate Parkin, Director of Screening at Brighton & Sussex University Hospitals Trust , presented a paper and answered members' questions.

3.4 Dr Wilkinson told the committee that the key local issue was a shortfall in radiographers. This longstanding problem had been aggravated by the recent (mandatory) move from 'one' to 'two view' screening, which provides an improved screening service, but requires more radiographer input. This issue is being addressed, and improvements have been made, with the new screening centre providing a more attractive environment to recruit staff into, but there are still recruitment problems. It is anticipated that the development of a school of radiography as part of the University medical school will address this problem in the medium term.

3.5 In answer to a question as to whether the slippage in the screening regime may have had adverse consequences for any individuals, Dr Wilkinson told members that this was extremely difficult to ascertain, but there was a risk that someone with breast cancer could have been diagnosed later than they should have been due to delays in screening.

3.6 The Chairman noted that, although he was partly reassured by the explanation for why breast screening services had been performing poorly and by NHS trust plans to improve matters, he considered it necessary to revisit this issue in several months time in order to make sure that the anticipated improvements had in fact been made.

3.7 **RESOLVED –** that the committee should receive an update report on city breast cancer screening in 6 months time.

Appendix 3: information supplied to HOSC in 2009

Committee:	Health Overview & Scrutiny Committee
Date:	8th July 2009
Regarding:	Breast Screening
By:	Matt Johnson, Strategic Commissioner, Planned Care, NHS Brighton & Hove Kate Parkin, Director of Screening, Brighton & Sussex University Hospitals Trust Dr Peter Wilkinson, Public Health Consultant (Public Health lead for cancer screening), NHS Brighton & Hove

Background information

Brighton Sussex University Hospitals Trust provides the breast screening programme for women in East Sussex (including Brighton & Hove). The programme offers screening to the registered population[1] of 97,000 women aged 50 to 70 years across East Sussex. Women should be offered screening at least every 3 years. NHS Brighton & Hove are lead commissioner for this screening programme across East Sussex.

The key performance measures for breast screening include:

- Minimum of 70% of women screened in the previous 3 years (target 80%). At the present time the estimated coverage for Brighton and Hove women at March 2009 was 67% and;
- Screening to assessment – 90% of appointments in 3 weeks (target 100%). In March 2009 only 8% were assessed within 3 weeks, but 76% were assessed within 5 weeks.

The Breast Screening coverage for the year ending 31st March 2008 for women aged 53 to 70 years was:

- England 76%
- West Sussex PCT 77%
- NHS Brighton & Hove 64%

The service is provided from a static screening site in Brighton and from mobile units at sites across East Sussex. The mobile units move around the county in a three year rolling programme. Until the move to the new premises in Brighton the screening service was also provided to Brighton women from mobile units.

[1] *With an estimated 27,000 more women aged between 47-49 and 71-73 for the age extension by 2012.*

The service moved from the Royal Sussex County Hospital to the Preston Road Breast Screening unit in November 2008. This saw the service move into a modern health care facility and from analogue to digital mammography equipment. Once the mobile screening vans have been updated to digital in August 2009 the service will be the first fully digital breast screening service in the county.

Current Position

The screening programme has offered screening to all eligible women in Brighton & Hove in the past 3 years. The following table details when the women were offered screening and when they are next due to be invited:

Area	**Last screening round**	**Next screening round due to start**
Brighton central	Aug 07 - March 08	August 10
East Brighton	Feb 08 - Dec 08	February 11
North Brighton	Nov 08 - April 09	November 11
Hove and Portslade	Jan 07 -Sept 07	January 10

The service has historically delivered the screening target year on year. The programme was extended for women between the ages of 50 to 65 years to women up to and including 70 years of age and successfully absorbed the increase in the population screened. The programme began to slip when it moved to taking 'two views'[2] screening in 2006/07. This was expected due to the combined impact of reduced staffing level and the increased time required for two view screening. Because of the mobile van schedule the slippage in screening interval first affected Brighton women. All areas of East Sussex are currently affected.

The trust has focused its resources on minimising the impact of the delay and has been taking corrective action to steer the programme back on track in a sustainable way. Within the past 3 years all eligible women have been offered screening. The service is planning to maintain this position by reviewing the ways in which it invites women to be screened at the static site, including calling some women earlier than three years.

The service manages a 'failsafe' process, to indentify women who have either moved GP practice or are new to the area, on a 3 monthly basis to ensure that all women are screened.

The screening programme is scrutinised by an external team, NHS Breast Screening Programme (NHSBSP) Quality Assurance Team, on a frequent basis**.** The Quality Assurance Team has consistently praised the service for its excellent clinical performance.

[2] *Before 2006/07 a mammogram would only be taken from 'one view' (one angle). Two view screening means that a picture is taken of the breast from two different angles which increases the ability to detect cancer.*

Why problems have developed

The delay experienced by the screening programme was a direct result of the following:

i. Difficulty in recruiting radiographers initially compounded by the move to two views taken per screening;
ii. Poor service facilities;
iii. Administrational errors.

i. Difficulty in recruiting radiographers. There is a national shortage of radiographers. The national recommended level of radiographers for a screening programme of this size is 14.25 WTE radiographic staff against a current staffing level of 7.2WTE.

ii. The service has a long history of difficult working conditions at the RSCH site. The Trust and PCT increased the funding for this service and commissioned a newly refurbished modern unit with digital equipment to re-house the service - this was completed in November 2008. The staff have maintained the clinical quality of the service whilst transferring to a new site and switching to new digital equipment. The training and move resulted in a further slippage in screening round.

iii. Administrative errors occurred in the screening programme in 2007 which resulted in the programme being temporarily suspended from 17 December 2007 to 7 January 2008 to allow for retraining and updating of work instructions.

What are steps being taken to bring about immediate improvement

The Brighton Sussex University Hospitals Trust, Sussex Primary Care Trusts and the external NHSBSP Quality Assurance Team have continued to work closely to manage, and minimise the delay in the screening programme over the past 18 months.

Brighton & Sussex University Hospitals Trust have set up a new Screening Division, under a Director for Screening and a new clinical manager. The following actions have been taken to address the above items:

- Implementing a recruitment plan, including a recruitment and retention premium;
- Recruitment open day to the new unit and visit to Brighton & Hove;
- Increasing the capacity of radiographic staff through bank staff, agency staff and private capacity;
- Develop Assistant Practitioners role to extend the capacity for screening, as more than one assistant practitioners can work with one radiographer;
- Standardising clinical practice and reducing variation in screening;

- Increased breast screening radiologist capacity by purchasing additional external capacity, staff recruitment and by removing the breast screening radiologists from the on-call rota and utilising this capacity within the unit;
- Recruit to Office Manager and Programme Manager post;
- Increase funding for service and invested in digital equipment;
- Refurnish and relocate service to a modern health care unit.
- PCT continues to promote the uptake of the programme for women in disadvantage areas and groups.

The Quality Assurance team visited the unit on the 12 May 2009 and emphasised the excellent clinical standards of the unit but highlighted the need for clear leadership and management to steer the programme back to its previous performance for screening in advance of the latest age extension to women aged between 47 to 73 by 2012.

Through the above actions the Trust has managed to hold the screening round at its current turnover – e.g. 6 months delay (not increasing). The aim is in further increasing capacity by developing a School of Radiotherapy at the hospital and through a successful recruitment campaign, the service will be able to return the programme to the above national target performance it originally held.

The HOSC are asked to note that:

- The screening programme has offered screening to all women in Brighton & Hove in the past 3 years;
- External Quality Assurance acknowledgement of the consistently high clinical quality of service provided by the Trust;
- The Trust and PCTs continued support the management of this service to minimise delays.

24 June 09

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	**Agenda Item 70** Brighton & Hove City Council

Subject:		**Vaccination/Immunisation Update**		
Date of Meeting:		**14 April 2010**		
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 When the Health Overview & Scrutiny Committee (HOSC) formulated its 2009-2010 work programme, one of the items requested was a report on immunisation/vaccination in the city. NHS Brighton & Hove has supplied information on this subject, and this is attached as **Appendix 1** to this report.

2. RECOMMENDATIONS:

2.1 That members note the content of this report and its appendix.

3. BACKGROUND INFORMATION

3.1 Immunisation/vaccination is widely used to protect people against a variety of infectious diseases. However, treatment is optional, and vaccination rates can consequently vary from area to area as individuals (or most commonly parents making decisions on behalf of their dependant children) choose to opt out of certain treatments or fail to arrange the necessary appointments.

3.2 **Appendix 1** to this report contains detailed information on the range of immunisation/vaccination services available to Brighton & Hove residents, and the uptake of these services.

4. CONSULTATION

4.1 No formal consultation has been undertaken in compiling this report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are none to this report for information.

Legal Implications:

5.2 None, as the report is for noting only.
Lawyer Consulted: Oliver Dixon; Date: 01/03/10

Equalities Implications:

5.3 Members may wish to ascertain the degree to which 'poor' uptake of immunisation/vaccination services correlates with membership of specific 'communities' (e.g. BME communities, areas of deprivation etc); and if it does, what ameliorative steps are being taken.

Sustainability Implications:

5.4 None identified.

Crime & Disorder Implications:

5.5 None identified.

Risk and Opportunity Management Implications:

5.6 None identified.

Corporate / Citywide Implications:

5.7 None identified.

SUPPORTING DOCUMENTATION

Appendices:

1. Information provided by NHS Brighton & Hove

Documents in Members' Rooms:

None

Background Documents:

None

Meeting	HOSC
Date	14.04.10
Author	Barbara Hardcastle, Public Health Specialist
Subject	Comparative Report on Brighton and Hove City Immunisation Uptake Rates

1.1. Purpose

The purpose of this paper is to give an over view of the performance of Brighton & Hove City PCT in relation to key immunisations and to compare this against the 2008/09 performance of the South East Coast Health Authority and England. It also provides an update of actions that are currently taking place in the city to improve uptake. Immunisation is a key public health measure in protecting the local population from vaccine preventable illnesses and is one of the PCT's Vital Signs. This paper focuses upon the primary baby immunisations at 2, 3 and 4 months, MMR, preschool booster, HPV and school leaving booster.

UK Routine Vaccination Schedule

2 months — **DTaP/IPV/Hib + PCV**

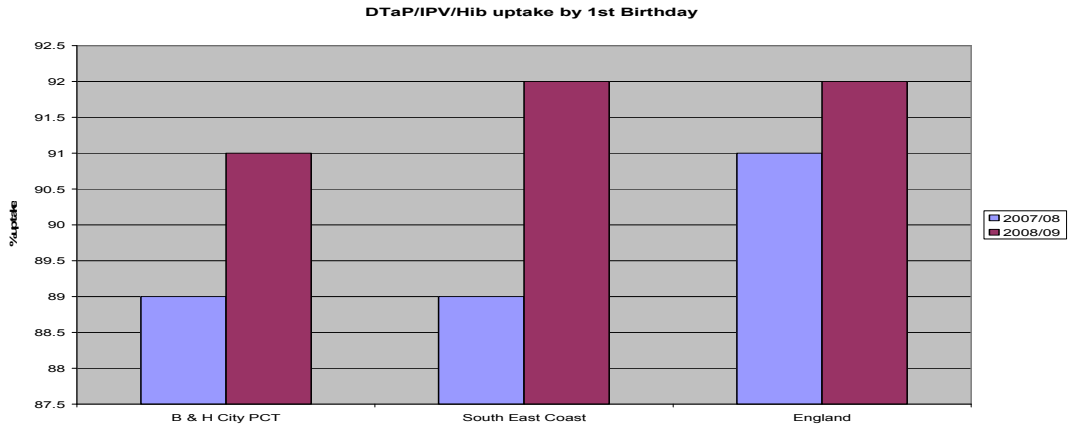
Diphtheria – Can cause breathing problems, damage the heart and nervous system and in severe cases can kill.
Tetanus- Affects the muscles and can cause breathing problems. It can affect the nervous system and in some cases can kill.
Pertussis (whooping cough) – Long bouts of coughing may cause choking and make it hard to breathe. Can kill babies under one year old.
Polio (IPV) – Attacks the nervous system and can affect chest muscles, permanently paralyse muscles and can kill.
Haemophilus influenzae type b (Hib) – Can cause blood poisoning, pneumonia and meningitis and can kill. Hib only protects against one type of meningitis.
Pneumococcal (PCV)- Can cause pneumonia, blood poisoning and meningitis.

3 months — **DTaP/IPV/Hib + MenC**

Diphtheria, tetanus, pertussis (whooping cough), polio, haemophilus influenzae type b and meningitis C
Meningitis C - Meningococcal group C is a type of bacteria that can cause meningitis and blood poisoning. The MenC vaccine does not protect against meningitis caused by other bacteria or by viruses.

4 months	**DTaP/IPV/Hib +MenC +PCV** Diphtheria, tetanus, pertussis, polio, haemophilus influenzae type b and meningitis C and pneumococcal
12 months	**Hib/MenC** Haemophilus influenzae type b and meningitis C
13 months	**MMR +PCV** **Measles –** Measles causes a high fever and rash. Complications include chest infections, fits, swelling of the brain and brain damage. In can also kill **Mumps –** Causes fever, headache and painful swollen glands in face, neck and jaw. It can result in deafness, viral meningitis, swelling of the brain and rarely painful swelling of the testicles and ovaries. **Rubella –** Causes a rash, swollen glands and a sore throat. It can seriously damage the sight, hearing, heart and brain of unborn children.
3 years 4 months -5 years	**DTaP/IPV or dTaP/IPV + MMR** Diphtheria, tetanus, pertussis and polio. Measles, mumps and rubella.
12-13 years (females)	**HPV** **Human Papilloma Virus –** There are over 100 forms of HPV, 13 of which are known to be a cause of cervical cancer.
13-18 years	**Td/IPV** Diphtheria, tetanus, polio
>65 years and at risk groups under 65 years	**PPV/influenza** Flu and pneumococcal (PPV – Pneumococcal polysaccharide vaccine)

1.1.Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b.
Percentage immunised by 1st birthday with DTaP/IPV/Hib

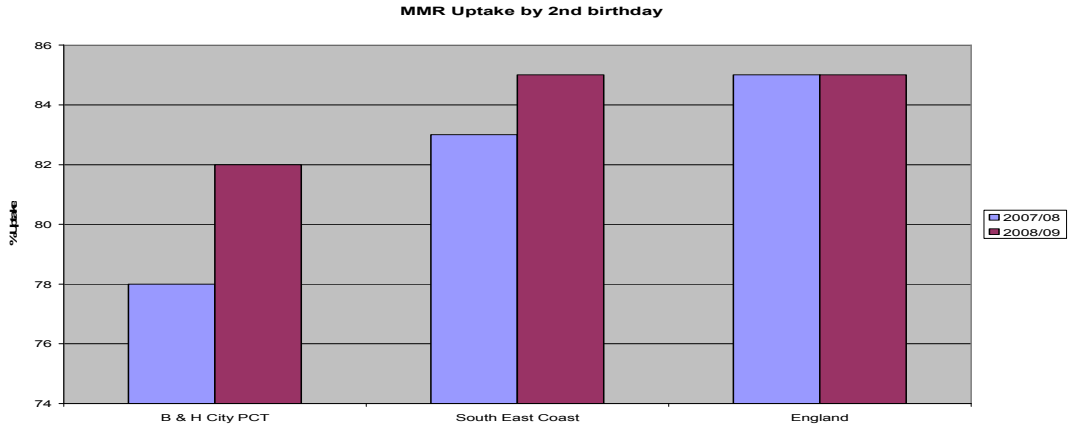


Since April 2003, the uptake for DTaP/IPV/Hib has increased from 85.6% to 89.90% in September 2009.

In 2008/09, out of 3282 eligible children, 2979 were vaccinated for the primary childhood immunisations of diphtheria, tetanus, whooping cough, polio, and Hib. This represented 91% of the eligible child population and was an increase on the uptake in 2007/08 and above the PCT target of 90%. It was just 1% below the regional and England average.

The PCT uptake target for 2009/10 is 91%.

1.2.MMR
Percentage immunised by 2nd birthday with MMR



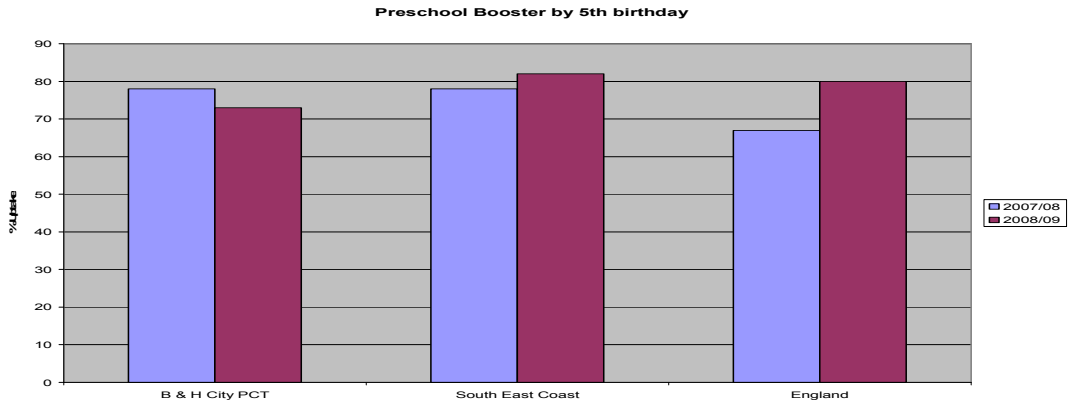
Historically MMR uptake has been badly affected by the negative press associated with the combined vaccine as a result of the now discredited Wakefield paper published in the Lancet in the 1998. There is also a strong "natural health" movement in Brighton and Hove which is anti-vaccination in general and anti- MMR in

particular. Since April 2003 first dose MMR uptake has seen a substantial increase in uptake from 67.3% to 84.30% in September 2009.

In 2008/09, out of 3053 eligible children, 2491 were vaccinated for MMR, representing an 81.6% uptake. This was 3% lower than the uptake rate for the region and England. The PCT annual uptake target for 2009/10 is 84%.

1.3. Diphtheria, Tetanus, Polio, Haemophilus influenza type b. (preschool booster)

Percentage immunised by 5th birthday with DTaP/IPV/Hib



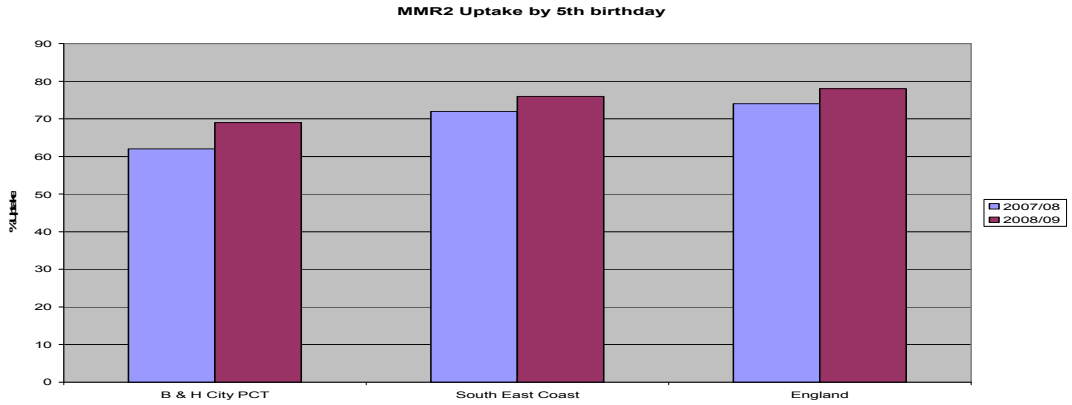
Since January 2007 the uptake of the preschool booster has increased from 69.60% to 79.90% in September 2009.

In 2008/09 there were 2816 children eligible for the vaccine in the city, of whom 2059 were vaccinated, representing a 73.1% uptake which achieved the PCT annual target. In 2008/09 Brighton & Hove City PCT had a lower uptake rate for the preschool booster than both the regional and England averages.

In 2009/10 the annual target will be 76%.

1.4.MMR (2nd dose)

Percentage immunised by 5th birthday with MMR

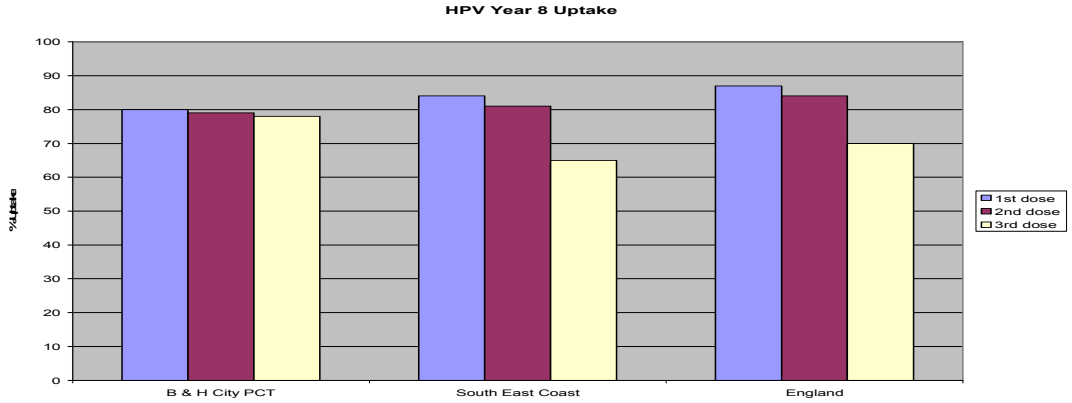


The uptake for the second dose MMR has increased since April 2003 from 58.70% to 77.40% in September 2009. The MMR catch-up campaign introduced in October 2008 has contributed towards an 8% increase in uptake in one year for the MMR2, as people who had received one or no MMRs were followed up.

In 2008/09 there were 2816 children eligible for vaccination of which 2600 were immunised, representing a 68.8% uptake rate. This exceeded the 2008/09 annual target for the PCT of 62%. Brighton & Hove City PCT had a lower uptake rate for the second MMR dose than both the regional and England average. The PCT annual target for 2009/10 is 69%.

1.5. HPV

This is the second year of the HPV vaccination programme for Year 8 girls. Catch-up campaigns are also running for Years 10, 11, 12 and 13 in 2009/10. Years 8, 10 and 11 are school based programmes, the rest are delivered by GP Practices.



Brighton & Hove City PCT had a higher uptake rate for all 3 HPV doses than both the region and England in 2008/09. The Annual PCT Target for 2009/10 is 85%.

1.6.Diphtheria, Tetanus, Polio (School Leaving Booster)

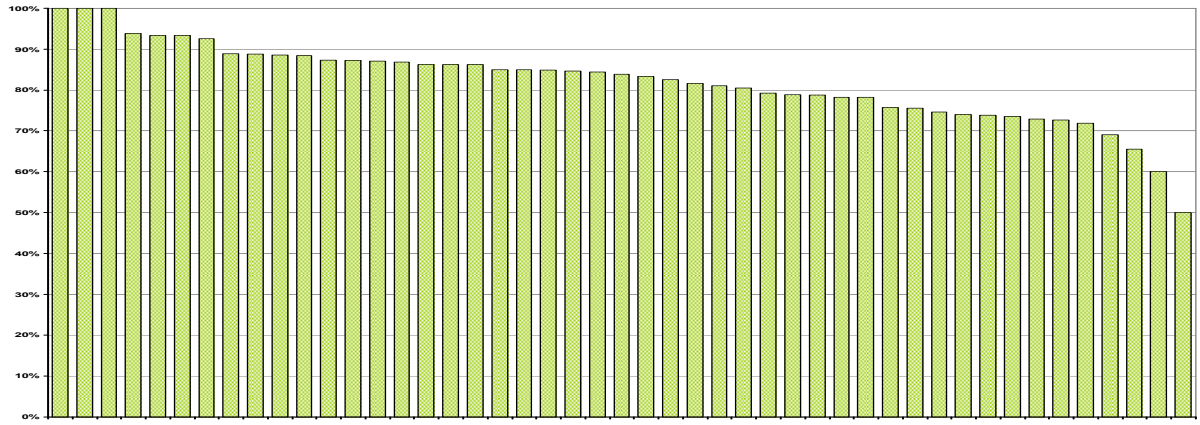
The denominator for measuring the uptake of the school leaving booster is ambiguous as it ranges from 13 to 18 years, but in practice invitations for the vaccination are sent out after the 15th birthday.

The most recent figure we have for uptake in Year 10 is 59% for those children born between September 1st 1992 and August 31st 1993 (as at Jan 13th 2009).

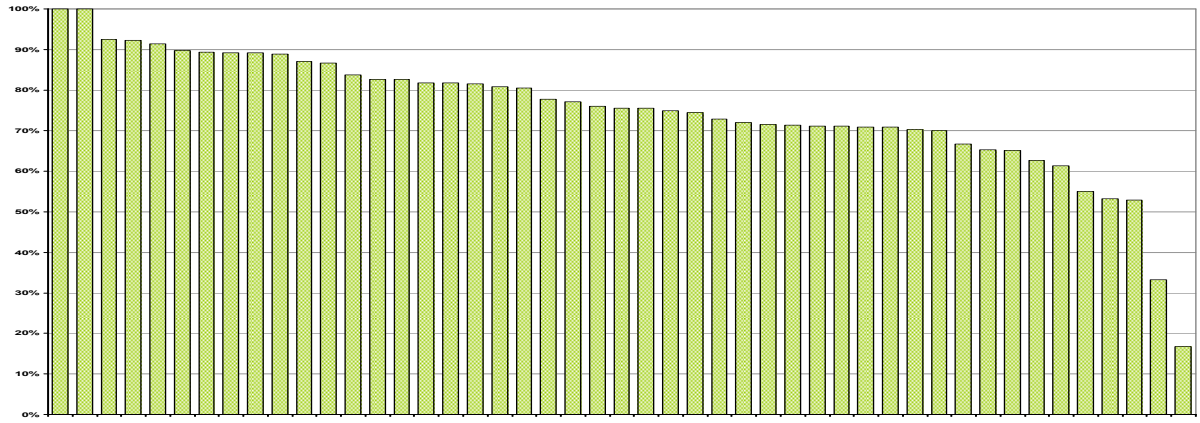
Unlike other childhood vaccinations in the programme this one is currently delivered by GP Practices. Nationally areas that deliver this vaccination in schools tend to have a higher uptake rate, so the PCT/CYPT will be looking at the possibility of transferring the delivery into schools in 2010.

1.7 Immunisation coverage by GP Practice

MMR coverage for 2 year olds by GP Practice 2008/09



Preschool booster for 5 year olds by GP Practice 2008/09



The above graphs show the variation in uptake of the first dose MMR and preschool booster vaccines across GP Practices in the city in 2008/09. The variation for some of the highest and lowest uptakes can be accounted for by the nature of the demography of particular practices. For example two local practices have very low numbers of under 5s registered compared to the rest of the practices in the PCT. Therefore a few children can make a large percentage difference in the uptake for these practices. For example one these two practices has the lowest uptake rate for the MMR but one of the highest uptake rates for the Preschool booster.

1.8.Seasonal Influenza Vaccination
Vaccination against seasonal flu is offered to all people aged 65 and over and those under 65 in at risk groups. The national target is to achieve at least a 70% uptake rate.

	Over 65s (2008/09)	Over 65s (2009/10)	Under 65 at risk (2008/09)	Under 65 at risk (2009/10)
Brighton & Hove City PCT	71%	67.4%	45.3%	51%
South East Coast	73%	-	-	-
England	74%	-	47.1%	-

In 2008/09 the over 65 coverage was 71% and under 65 at risk was 45.3%. The uptake of the seasonal flu campaign in 2009/10 was affected by the H1N1 swine flu pandemic and the swine flu vaccination programme. This programme targeted at risk groups for vaccination which is reflected in the increased uptake of the seasonal flu vaccine by 51% of the at risk population. In contrast the uptake for over 65s fell to 67.4% in 2009/10. Data for South East Coast and England are not yet available for comparison.

2.0. Citizens Panel Results 2009 – Childhood Immunisations

The Citizens Panel survey on immunisation was administered to 821 people in 2009 of whom 24.5% (n=201) had children in the under 18 age group.

- 73% of their children (n=146) had received all the immunisations offered
- 6.5% (n=13) had not had any of the immunisations offered
- 14% (n=28) had some of the immunisations offered
- 75.9% (n=22) to 77.4% (n=24) had received baby immunisations at two, three and four months
- 66.7% (n=18) had received Hib/MenC
- 42.9% (n=12) had received their first MMR
- 28.6% (n=8) had received their Pneumococcal
- 23.1% (n=6) had received their preschool booster and second MMR
- 14.3% (n=2)had received the school leaving booster.

When asked why some or all of the vaccinations had been missed 60% of responders gave the answer “other” to that listed as options in the questionnaire. The other main reasons chosen from the questionnaire list were as follows.

- 22.2% (n=22) responded that they didn’t believe MMR was safe
- 20.2% (n=20) were concerned about overloading their child’s immune system
- 13.1% (n=13) would rather their children developed immunity as a result of catching the illness.

When asked about the information they had received about immunisation

- 86.7% (n=170) felt they had been given enough information about the illnesses vaccines prevent
- 89.7% (n=174) felt they had been given enough information about the benefits of immunisation for their child
- 78.6% (n=151) felt they had been given enough information about the benefits of immunisation to the community as a whole
- 64.8% (n=125) felt they had been given enough information about the risks of immunisation
- 81.4% (n=158) felt they had been given enough information about the risks of not immunising their child.

2.1. Implications of findings

In response to the Citizens Panel report, further work will be developed on communications to ensure parents are better informed of the risks and benefits of immunisation both to their individual children and to the community as a whole. This will also have training implications for Health Visitors and Practice Nurses.

3.0. Action Taken To Date

A multiagency Immunisation and Vaccination Group meets on a quarterly basis to review uptake figures. Part of its role is to co-ordinate immunisation programmes across the city and to develop and implement an action plan to increase uptake. The action plan includes issues such as health promotion, communication campaigns and looking at data quality. The group will also be reviewing the NICE Public Health Guidance 21 on "Reducing the differences in uptake of immunisations" (September 2009). It is also looking into appointment systems and waiting lists for vaccination at practice level. The possibility of opportunistic vaccination in A&E, and Walk-in centres, and of at-risk hospital patients are also being considered.

A specialist immunisation team is being developed in CYPT. This will include a specialist nurse who will work with GPs to follow-up people who have missed their immunisations and if necessary provide an outreach vaccination service. They will also follow up hard to reach groups. The team will also review the possibility of transferring the school leaving booster from a GP to a school based programme to help improve uptake.

An MMR catch-up campaign has been running in GP Practices since October 2008 through a Local Enhance Service. This has led to improvements in the uptake rate for MMR and has improved the accuracy of information on patients eligible for vaccination.

The national MMR Roadshow came to Brighton for the day in August 2009 to promote the vaccination; this was set against the background of a measles epidemic in the city in the summer.

The introduction of the TPP data system to CYPT in 2010 is also being used as an opportunity for data reconciliation between the Exeter database on childhood immunisations and the Child Health Data System. A discrepancy of 2,000 children between these two lists has previously been identified. This reconciliation will lead to

a more accurate denominator hence contributing towards an improvement in uptake figures.

In 2009, the 17/18 year old HPV programme in GP Practices was promoted to young women through bespoke invitations.

As well as the routine childhood immunisation programme the PCT is also engaged in completing the HPV catch-up campaign in 2010 and in delivering the swine flu vaccination programme. This has inevitably put extra pressure on local immunisers and the Department of Health has allowed a delay in the submission of routine childhood immunisation, as part of the Directly Enhanced Service Agreement for the national Swine Flu Programme.

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	Agenda Item 67 Brighton & Hove City Council

Subject:		**Alcohol-Related Hospital Admissions**		
Date of Meeting:		**14 April 2010**		
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 It has long been recognised that excessive drinking has a major impact on Brighton & Hove residents and visitors and on key city services. This impact is felt in many ways across the city, but a particularly important issue concerns the number of people requiring hospital treatment for alcohol-related problems.

1.2 Reducing the rate of alcohol-related hospital admissions is a priority for the Local Strategic Partnership (LSP), and forms one of the targets in the Local Area Agreement (LAA). Progress on meeting this LAA target has been disappointing: the LAA indicator is currently 'red'.

1.3 The Overview & Scrutiny Commission (OSC) is committed to working with city partners to help improve LAA performance, particularly in terms of scrutinising red LAA indicators.

1.4 Health Overview & Scrutiny Committee (HOSC) members had previously expressed an interest in examining the issue of alcohol-related hospital admissions in some detail, perhaps via an ad hoc panel.

1.5 The Director of Public Health has supplied additional information on this topic (see **Appendix 1** to this report).

2. RECOMMENDATIONS:

2.1 That members:

(1) note the information contained in this report and in the additional information supplied by the Director of Public Health (**Appendix 1**);

(2) determine whether to set up an ad hoc panel to investigate aspects of the issue in greater depth;

and if an ad hoc panel is established:

(3) appoint panel members; consider the panel's remit/Terms of Reference; consider when the panel should aim to report back to HOSC.

3. BACKGROUND INFORMATION

3.1 The excessive consumption of alcohol is a growing problem, both nationally and locally. An important aspect of this issue is the impact problematic drinking has on NHS services, in relation to both the long-term treatment and care of people with alcohol-related conditions (e.g. liver damage, heart disease etc.); and the short-term effect that mass drinking (particularly at the weekend) has on NHS capacity - i.e. A&E services. More detailed information on this subject has been supplied by the Director of Public Health (**Appendix 1**).

3.2 This is obviously an important issue, and one which might merit the attention of Overview & Scrutiny via an ad hoc panel. However, in deciding whether to set up an ad hoc panel, HOSC members should also consider whether there is 'value' to be added by so doing – i.e. whether there is a realistic opportunity for an ad hoc panel to make recommendations which might improve things at a local level.

3.3 If members do choose to establish an ad hoc panel, they may also wish to determine/restrict the panel's remit at this stage, as the subject is potentially very wide-reaching. Members may also want to consider when it would be desirable for a panel to present its findings to the HOSC – i.e. effectively to determine the duration of the panel. Clearly the breadth of any panel's remit and the amount of time it has to do its work are closely linked.

4. CONSULTATION

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

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None in general to this report for information. Any resource implications of establishing an ad hoc panel will be managed within the current scrutiny team budget.

Legal Implications:

5.2 None directly as the report is for noting. HOSC is entitled to appoint an ad hoc scrutiny panel to carry out scrutiny work relevant to the committee's functions.

Lawyer Consulted: Oliver Dixon; Date: 01/03/10

Equalities Implications:

5.3 None directly. If an ad hoc panel is established, then equalities issues will inform the panel's work-planning process.

Sustainability Implications:

5.4 None directly.

Crime & Disorder Implications:

5.5 Alcohol is a key factor in much crime and disorder, and, should an ad hoc panel be established, it is likely that members would wish to canvass the views of the police, the Licensing Authority etc.

Risk and Opportunity Management Implications:

5.6 None identified.

Corporate / Citywide Implications:

5.7 Reducing the rate of alcohol-related hospital admissions is an LSP priority, and is one of the targets in the LAA.

SUPPORTING DOCUMENTATION

Appendices:

1. Information provided by the Director of Public Health

Documents in Members' Rooms:

None

Background Documents:

None

Appendix 1

Alcohol and public health in Brighton and Hove

The following short paper includes excerpts from the forthcoming Annual Report of the Director of Public Health

Alcohol and health

Alcohol-related hospital attendances and admissions
Nationally it is estimated that 40% of accident and emergency attendances are alcohol-related, rising to 70% at peak times. There is however under-reporting of alcohol-related accident and emergency attendances including in Brighton and Hove. Nevertheless, just over half of those who attend accident and emergency at the Royal Sussex County Hospital because of alcohol and assault are recorded as Brighton and Hove residents. Most are young men are aged less than 30 years and they typically end up in at accident and emergency between the hours of 6pm and 6 am.

Of equal concern is the apparent rising local trend in alcohol-related hospital admissions and alcohol-related assault. Recorded alcohol-related hospital admissions in Brighton and Hove rose from 855 per 100,000 in 2003/04, to 1709 per 100,000 in 2007/08. Men account for two-thirds of these admissions.

Alcohol-related admissions for accidents and assaults have also been rising. Admissions for acute alcohol problems are most frequent in the less than 15 years and 16-24 years age groups. Alcohol related mental and behavioural disorder admissions are most frequent in the 25-44 years age group, and admissions for chronic alcohol related problems are most frequent in the 45 -75 years + age group.

In other words, this is not just a problem of young people 'going through a phase' that they then 'grow out of'. Younger people are presenting with the acute effects of alcohol intoxication, but as they grow older they present with the chronic effects of alcohol.

There are signs too that the long-term impact of alcohol on the health Brighton and Hove residents is increasing. The number of local residents admitted to hospital for alcohol dependence syndrome has doubled since 2006. An estimated 17 residents of Brighton and Hove received a liver transplant for alcohol-related diagnoses during the last ten years.

Alcohol related road collisions
Younger and older people are most likely to be involved in drink-driving collisions, especially students and the group referred to as 'active older people'. Between 2005 and 2007, there were 149 alcohol-related collisions in Brighton and Hove that involved drink-drivers. Most of the drivers were men aged 18 to 30 years who lived

in Brighton and Hove. As with violent alcohol-related crime (see below), most alcohol-related collisions occurred on weekend evenings.

Mortality

Brighton and Hove also has a higher level of male alcohol-specific mortality than its comparator Primary Care Trusts or Local Authorities. Male mortality from chronic liver disease including cirrhosis in Brighton and Hove is higher than the regional average at 21 deaths per 100,000, and double the England average.

Female mortality from chronic liver disease including cirrhosis is in line with the average across comparator local authorities and is lower than it is in men at 6 deaths per 100,000 (average across 2004/06).

In Brighton and Hove, men mainly die from alcohol-related conditions between the ages of 65 and 74 years of age although there is also a high rate amongst 35-64 year olds. Women tend to die from this condition when aged over 75 years. Alcohol-specific mortality and mortality from chronic liver disease in older people is particularly marked in the more deprived parts of the city. On a more positive note, mortality from chronic liver disease including cirrhosis in both males and females has recently started to decline.

Around 60% of drug-related deaths in Brighton and Hove (in total around 40 per year) also involve alcohol.

The wider consequences of alcohol in Brighton and hove

Alcohol and crime

Brighton and Hove has higher rates of alcohol-related crime than the regional average and almost double the regional average rate of alcohol-related violent crime. (North West Public Health Observatory, 2008)

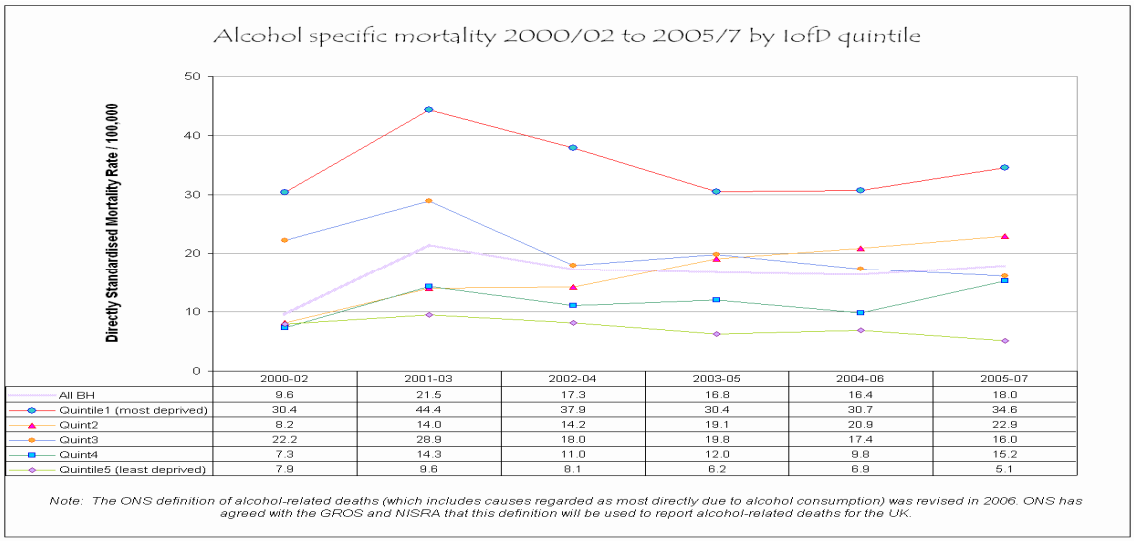
A large proportion of violent crime in public places in Brighton and Hove is perceived by the police to be alcohol-related (37%). Alcohol-related crime figures are not consistently recorded across the country so comparisons need to be treated with some caution. They are probably more reliable as an indicator of local trends. In Brighton and Hove the figures are increasing although the rate of increase has fallen slightly since 2006. This could reflect a slowing down of the rate and / or data recording issues.

There is also an upward trend in the proportion of sexual offences recorded as committed under the influence of alcohol. Most violent crime occurs in central Brighton on Saturday night and Sunday morning, which coincides with weekend drinking habits, and residents of both the City Centre and the Neighbourhood Renewal Areas report that they feel there is an alcohol problem in the city.

A needs assessment of Lewes Prison showed that 63% of male prisoners were hazardous or harmful drinkers in the year leading up to their imprisonment. Brighton and Hove Probation Service assessments of offenders show that 59% had alcohol misuse problems and of these 21% were perpetrators of domestic violence. Just over 60% of perpetrators of domestic violence were males aged 31-50 years.

Alcohol and health inequalities in Brighton and Hove

The prevalence of alcohol abuse and its associations with deprivation in Brighton were made as long ago as 1903 by the then Medical Officer, Sir Arthur Newsholme. A connection remains: the Brighton and Hove Health Counts Survey of 2003 recorded that a third of male heavy drinkers were employed, a third unemployed and 20% had a long term disability/illness.



	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07
All BH	9.6	21.5	17.3	16.8	16.4	18.0
Quintile1 (most deprived)	30.4	44.4	37.9	30.4	30.7	34.6
Quint2	8.2	14.0	14.2	19.1	20.9	22.9
Quint3	22.2	28.9	18.0	19.8	17.4	16.0
Quint4	7.3	14.3	11.0	12.0	9.8	15.2
Quintile5 (least deprived)	7.9	9.6	8.1	6.2	6.9	5.1

Note: The ONS definition of alcohol-related deaths (which includes causes regarded as most directly due to alcohol consumption) was revised in 2006. ONS has agreed with the GROS and NISRA that this definition will be used to report alcohol-related deaths for the UK.

Figure 1: Alcohol-specific mortality by deprivation quintile, 2000/02 – 2005/07. Source: Office for National Statistics.

Alcohol-specific mortality data from the 21st century, illustrated in Figure 1 shows that there is a four to seven-fold difference between the most and least deprived groups in the city, but detecting any other trend in this is more difficult.

Further examination of the 'constituents' of this most deprived group in Brighton and Hove can shed more light on the effects of alcohol consumption. Using the Mosaic classification the most common social groups found in for the most deprived quintile are the 'Under 15s', 'Twilight Subsistence' (older poor people), 'Welfare Borderline' and 'Blue Collar Enterprise'.

Analysis of the recorded alcohol-related accident and emergency attendances by young people aged 13-18 years from January 1st 2006 to October 30th 2008, shows that 149 out of 483 (31%) attendances were made by people from the most deprived

quintile, compared to 18% from the most affluent quintile. The wards with the highest number of attendances were East Brighton, Moulsecoomb and Bevendean and Queen's Park. The Primary Care Trust developed an Alcohol Local Enhanced Service for General Practice with the aim of better identification and treatment of people with alcohol problems. In 2008, 20 out of 47 GP Practices signed up to the Local Enhanced Service but only 2 practices were from areas where the most deprived groups live.

The Count Me in Too Survey of 2007 suggests that alcohol misuse is one and a half times more common in the Lesbian, Gay, Bisexual and Transgender (LGBT) Community than in the general population. The Survey also reported that a relative lack of alcohol free social settings for LGBT people was a particular problem that should be tackled.

The effect of 24-hour licensing on alcohol use in Brighton and Hove

Licensing hours were first introduced in the UK around the time of the Great War. The Licensing Act (2003) allows for flexibility in the times that premises are permitted to sell alcohol. These changes, supported by the alcohol retail industry, were heralded as a way of changing the binge-drinking culture in the UK. Since the launch of the Licensing Act in 2005, there has also been a smoking ban in enclosed public spaces. These two policy initiatives have resulted in changes in drinking patterns and behaviour around the country.

A total of 321 new licensed premises have opened in the city since the introduction of the Licensing Act 2003, so that there are now 1,329 premises serving a population of 256,600. Of these 447 are licensed for off sales, meaning customers must consume their alcohol off the premises. This means there is one on-licensed premise for every 290 residents. This is probably the highest figure in the history of the city even when compared to figures from the early and late 19th century. The price of alcohol has also decreased relative to income. Brighton and Hove also has a high proportion of employees working in bars compared to the national average, and to our nearest statistical neighbours: Southampton, Bristol and Bournemouth. The sale and consumption of alcohol therefore forms a very important part of the local economy.

Following the introduction of new licensing laws in 2005, by April 2008 in Brighton and Hove, there were 78 premises with 24 hour licences. Alcohol-related hospital admissions for Brighton and Hove residents increased markedly in the period following the introduction of the Licensing Act. There was a 30% increase in the rate of alcohol-related admissions in the city between 2005/06 and 2006/07: this compares to only a 7% increase for England over the same period.

Data provided by Sussex Police shows a sharp increase in violent crimes committed under the influence of alcohol immediately after the introduction of flexible

licensing. These increased from 2,996 in 2005 to 3698 in 2006 though these have now dropped back a bit.

Qualitative research undertaken as part of the Health Impact Assessment suggested that residents in the central areas of the city experienced significant impacts on their health and wellbeing. These included disturbed sleep and experiences of threatening, abusive and antisocial behaviour. Residents also expressed concern about the effect of increased access to alcohol on children and young people and suggested that there were insufficient accessible leisure services to keep our young people occupied in alcohol-free activities (Brighton and Hove City Council, 2009).

Recent efforts to tackle alcohol in Brighton and Hove

In recent years alcohol as a public health issue has received much greater prominence across the Primary Care Trust, City Council and Sussex Partnership Foundation Trust. Reducing hospital admissions related to alcohol has been agreed as a Local Area Agreement target. Following the 2007 Public Health Annual Report additional resources were identified to tackle alcohol problems. Of note were the Safe Space project in West Street, a new Alcohol Liaison Service established in Accident and Emergency and new primary care services known as Local Enhanced Schemes (LES) and Directed Enhanced Schemes which reimburse general practitioners for providing additional alcohol support services.

An increasing number of employers in Brighton and Hove, including NHS services and the City Council, have workplace alcohol policies.

Operation Park is a local Police and Council initiative whereby Police Officers and Anti-social Behaviour Workers co-operate to patrol public spaces on Thursday, Friday and Saturday nights. Between June 2008 and December 2009, 575 young people were stopped and of these, 530 were found to be under the influence of alcohol and 320 had alcohol seized. Seventy young people have been stopped twice and 11 three times or more.

In March 2008 a Cumulative Impact Area (CIA) was introduced in Brighton and Hove. New licensing applicants now are also judged against whether or not the granting of such a license would have an adverse cumulative impact on the area. A Controlled Drinking Zone has also been introduced and this allows police to confiscate alcohol from anyone who is not on licensed premises within the zone. More recently the Licensing Committee of the Council considered the merits of establishing an Alcohol Disorder Zone which would allow the City Council to impose charges on licensed premised to pay for the costs of addressing alcohol-related problems. These charges could then be used to provide additional failsafe measures in that locality. To date no alcohol disorder zone has been established. An Alcohol Disorder Zone was not adopted.

A report in June 2009 from the Reducing Alcohol-related Harm to Children Young People Ad Hoc Panel recommended that age-restriction be better enforced in off-licenses and supermarkets. A best practice guide on enforcement was circulated to independent alcohol retailers in the city to encouraging them to challenge anyone trying to buy alcohol who looked under 25 years old.

A White Night event took place in 2008 and in 2009 in an effort to open up the city, through the night, for activities that were not necessarily alcohol-related. The Beacon award made to the city for its handling of the night-time economy was, in part, awarded on the basis of how many partners across Brighton and Hove were engaged in trying to tackle alcohol-related problems.

In summary

It is important to recognise that this is not about trying to stop people from having a good time. Brighton and Hove has long been a destination for pleasure-seekers and people from both inside and outside the city continue to come to have a good time. To a large degree, this sustains the city economically. Alcohol has been an important part of that good time and it would appear that it is becoming ever more important.

Taken in moderation, alcohol can have a positive effect on an individual's health. Taken in excess, it has significant adverse effects not just on the health and wellbeing of the consumer, but also on the family and the community. These effects and wider problems such as nuisance, crime and violence have become very apparent in recent years.

A host of alcohol indicators bear testimony to the adverse short and long-term consequences of alcohol in Brighton and Hove and suggest that Brighton and Hove is not performing better than similar cities across the UK. Health data suggests that many young people suffer adversely from the acute effects of alcohol intoxication but that the problem of excessive alcohol consumption does not stop there and continues throughout people's lives. There is also evidence that residents from more deprived groups are more adversely affected. Put simply, it is not overstating the case to say that in Brighton and Hove an awful lot of people die or fall ill as a result of alcohol consumption while the lives of others are ruined.

Public services such as the Police, the City Council, the NHS and some retailers have been working in partnership - in keeping with national policy to address the problem. A number of initiatives have been introduced in an effort to reduce the adverse public health impact of alcohol. However, the scale of the problem is significant and it would be wrong to suggest that we are getting on top of the alcohol problem in Brighton and Hove. Also, the provision of some services, such as general practice services to tackle alcohol problem may not be quite in tune with need.

What more can be done? In some respects the answer to this needs to come from the government as legislation on pricing and on licensing - two areas where action

might have significant public health benefits, is a central function. But it is too easy to blame those further up the line, and it is not enough just to put in safety net initiatives to catch people who already have a problem – we can always do more of that, but it won't stop the problem.

Nor is it enough to simply put out a message that informs people of the adverse effects of alcohol consumption and leave it to them. There is little evidence that this alone has much effect. There is a wider question about whether the city is on the one hand, promoting or at least condoning the easy consumption of alcohol, while on the other the public and public sector laments its consequences. Alcohol has a huge impact on public health but national legislation on alcohol was not passed on the basis of public health. While that remains the case, it is up to the local public sector to find local ways of taking action on alcohol based on the principle of protecting and promoting public health.

Recommendations

Measures to tackle alcohol problems should be better targeted so the right group gets the right message. For example, a different approach is required for those with acute alcohol problems (young people, students, and the LGBT community) from those who have longer-term problems with alcohol consumption (middle aged and some older people).

There should be improved identification and follow-up of particular risk groups, such as recently released offenders.

Effective monitoring should take place so that services introduced for people with alcohol problems, such as local enhanced schemes, do not increase health inequalities.

There should be more effort to identify, develop and promote activities that encourage people of all ages, to have a good time, in public spaces, without having to take alcohol.

The public health aspects of licensing decisions should be scrutinised fully with for example, reference to established powers under the Cumulative Impact Area legislation, and consideration of the benefits of implementing an Alcohol Disorder Zone.

Dr. Tom Scanlon
Director of Public Health

3rd February 2010

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	Agenda Item 68 Brighton & Hove City Council

Subject:	**Licensing: Health Impact Assessment**	
Date of Meeting:	**14 April 2010**	
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 A Health Impact Assessment (HIA) of the impact of flexible licensing hours in Brighton & Hove was recently undertaken. This was reported to Licensing Committee on 26 November 2009. Licensing Committee referred the HIA on to the Health Overview & Scrutiny Committee (HOSC) for information.

1.2 The 26.11.09 report to Licensing Committee (including the Licensing HIA) is attached as **Appendix 1** to this report; an extract from the minutes of the 26.11.09 Licensing Committee meeting is attached as **Appendix 2** to this report; further statistical information supplied by the Head of licensing is attached as **Appendix 3** to this report.

2. RECOMMENDATIONS:

2.1 That members:

(1) note the content of this report and its appendices (in particular the HIA of flexible licensing hours);

(2) consider whether the information contained in the HIA might usefully influence elements the HOSC work programme/HOSC ad hoc panel planning.

3. BACKGROUND INFORMATION

3.1 The Licensing Act (2003) significantly altered the manner in which alcohol licenses are granted, and effectively led to a rapid increase both in the number of premises licensed for on and/or off sales and in the hours during which these premises could open for business.

3.2 There is a good deal of debate as to whether the 2003 Act has had a generally positive or negative impact, with longer licensing hours offering a greater opportunity for hazardous drinking and anti-social behaviour, but also to some extent mitigating the worse aspects of the pre-2003 system (e.g. the stresses placed on services by a blanket 11pm closing time). The issue is further complicated because it is evident that the increase in hazardous drinking pre-dates the 2003 Act, but not nearly so easy to establish whether a move to more flexible licensing has exacerbated or ameliorated the underlying problem. The city Health Impact assessment is, in part, an attempt to provide a local answer to this and related questions.

3.3 More information on this issue may be found in the appendices to this report.

4. CONSULTATION

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

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this report for information.

Legal Implications:

5.2 None directly.

Lawyer Consulted: Oliver Dixon; Date: 01/03/10

Equalities Implications:

5.3 None directly, but members may wish to refer to the implications in the original report to Licensing Committee (**Appendix 1**).

Sustainability Implications:

5.4 None directly, but members may wish to refer to the implications in the original report to Licensing Committee (**Appendix 1**).

Crime & Disorder Implications:

5.5 None directly, but members may wish to refer to the implications in the original report to Licensing Committee (**Appendix 1**).

Risk and Opportunity Management Implications:

5.6 None directly, but members may wish to refer to the implications in the original report to Licensing Committee (**Appendix 1**).

Corporate / Citywide Implications:

5.7 None directly, but members may wish to refer to the implications in the original report to Licensing Committee (**Appendix 1**).

SUPPORTING DOCUMENTATION

Appendices:

1. Licensing HIA report to the Licensing Committee 26.11.09

2. Extract from the minutes of Licensing Committee 26.11.09

3. Additional information supplied by the Head of Licensing.

Documents in Members' Rooms:

None

Background Documents:

The Licensing Act (2003)

LICENSING COMMITTEE (LICENSING ACT 2003 FUNCTIONS)	**Agenda Item 16** Brighton & Hove City Council

Subject:		***Health Impact Assessment of Licensing – Final Report***		
Date of Meeting:		**26 November 2009**		
Report of:		***Director of Environment***		
Contact Officer:	Name:	Jean Cranford	**Tel:**	29-2550
		Tim Nichols		29-2163
	E-mail:	jean.cranford@brighton-hove.gov.uk		
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Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 A report was submitted to licensing members 27 November 2008 and 24th April 2009 relating to work funded by the PCT and commissioned by the city council to appoint consultants to undertake a health impact assessment into flexible licensing hours in Brighton and Hove.

1.2 It had been intended to bring the final report to this committee on 25th June 2009 but discussions with the Director of Public Health identified some additional work required before making the final report, including looking at potential indicators and baseline information to assess the effect of flexible licensing hours. The Director of Public Health requested that the Alcohol Strategy Group considered the report before the next Licensing Committee in order to make recommendations that would form part of a Management Plan for Public Health interventions. This could include recommendations for licensing policy.

1.3 The final HIA includes a Public Health Management Plan at Table 2. At a meeting with the Director of Public Health, 10 key indicators were extracted from the Public Health Management Plan and will be considered as indicated in the stakeholders' column.

1.4 The 10 key public health management aspirations identified for further consideration are listed in the table below.

1.5 These were chosen in the light of current position of improving alcohol related crime trends but worsening alcohol related health and domestic violence trends.

1.6 It should be noted that these recommendations have not been filtered in any way and the legality and resourcing would be critical issues in progressing them further. For instance, members will be aware of the limitations to discretion in the Licensing Act 2003 regarding refusal of licences and funding of some key projects like Safe Space is not guaranteed and its future is only assured in the short term.

Management Action		Stakeholders
11	To consider using section 106 to fund the provision of community facilities that promote a family friendly culture and provide alternatives to alcohol-based entertainment especially for young people.	BHCC Local Planning Authority
14	To integrate strategies for the licensing of sales of alcohol and planning.	BHCC Local Planning Authority and Licensing Committee
21	To consider establishing a limit to the number of licensed premises in Brighton & Hove, having first established what limit is appropriate.	BHCC Licensing Committee
31/32	To extend the Cumulative Impact Area (CIA) to include all locations where there are residents in the vicinity of licensed premises. To designate the London Road area as a Special Stress Area (SSA)	BHCC Licensing Committee
43	To increase enforcement of under-age sales from licensed premises.	Trading Standards, Sussex Police, BHCC Licensing Committee
52	To raise awareness and educate residents about the licensing process.	BHCC Licensing Committee
86	To roll out the concept of the Safe Space in West Street to the area around the railway station	BHCC
93	To explore the potential to encourage a diversification of the night-time economy in Brighton & Hove and increase the amount and range of non-alcohol related leisure activities available in the city e.g. arts-based activities.	BHCC
103/104	To provide education about the effects on health of alcohol consumption, particularly in a community setting and especially for children and young people. To update schools about changes in the pattern of alcohol consumption by children and young people, including the associated risks, so that teaching for PHSE is informed by the current situation in which young people find themselves.	NHS Brighton & Hove, Youth Services, voluntary sector organisations Schools in Brighton & Hove, NHS Brighton & Hove, Youth Services, voluntary sector organisations
121	For licensees to provide a 24-hour telephone number on which it is possible for people to give information on potential infringements on the premises such as under-age drinking	Licensees Licensing Committee

2. RECOMMENDATIONS:

2.1 That the findings from this report are considered by the relevant stakeholders and that findings are used to influence the next review of the statement of licensing policy.

2.2 That the Licensing Committee consider recommending reporting the health impact assessment to Planning Committee and Health Overview and Scrutiny Committee to inform other corporate policies and strategies.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Funding was granted by Brighton & Hove Primary Care Trust and City Council Directorate of Public Health to Brighton & Hove City Council and consultants chosen by competitive tender were Ben Cave Associates Ltd. who are experienced, specialist health impact assessors, recognised nationally and internationally.

3.2 The revised timetable is to report the final Health Impact Assessment report to the Director of Public Health via the Alcohol Strategy Group on 2 November 2009 and from there to the Licensing Committee on 26th November 2009.

3.3 The original indicators to be used in this study were:

1. Reduce impact on acute hospital.
2. Reduce public place violent crime.
3. Reduce domestic violence.
4. Reduce alcohol related offending.

The consultants explored other possible indicators around the licensing objectives, for instance, other crime statistics, noise statistics, enforcement activity, information held by Children's Services, occupational health and safety and further public health information.

3.4 The health impact assessment may be used to inform statement of licensing policy, local alcohol harm reduction strategy, community safety, transport, tourism, economic development, community development and violent crime reduction strategies.

4. CONSULTATION:

4.1 The steering group for the Health Impact assessment comprises:
Cllr Carol Theobald, Cllr Jeane Lepper, Adam Bates, Linda Beanlands, The Healthy City's Manager, Jean Cranford, Barbara Hardcastle (PCT), Steve Hodson (ESFRS), Peter Mills (Sussex Police), Tim Nichols, Chris Owen, Chris Parfitt, Liz Rugg, Becky Woodiwiss (PCT), Mike Taggart, Graham Stevens, Chris Wilson, Nigel Liddell (Brighton Business Forum), Sussex Ambulance Service, Paul Iggulden and Erica Ison (Ben Cave Associates).

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 Financial Implications:

The full cost of delivering this report is covered by the PCT funding of £34,000 already received by B.H.C.C.

In their report, B.C.A. Ltd have put forward many action themes and suggested management actions. Many of these suggestions will have an associated financial implication, for example the provision of free taxis or the extension of the Safe Space concept to the area around the railway station. Before any of these actions could be pursued, consideration would have to be given as to the source of additional funding to cover them, or whether they could be met from within existing budgets.

Finance Officer Consulted: Karen Brookshaw Date: 23/10/2009

5.2 Legal Implications:

There are no direct legal implications.

Lawyer Consulted: Rebecca Sidell Date: 4/11/2009

5.3 Equalities Implications:

Alcohol related crime, violent offences and sexual offences are areas of concern nationally and for the city.

5.4 Sustainability Implications:

Business tourism is the fastest growing domestic market (reference Brighton & Hove Strategy for Visitor Economy 2008 – 2018).

5.5 Crime & Disorder Implications:

40% of recorded violent crime is alcohol related and Brighton & Hove is second highest to Hastings in the South East Coast strategic health authority (reference Annual report DPH 2007). The Community Safety Strategy aims to reduce alcohol related anti-social behaviour.

5.6 Risk and Opportunity Management Implications:

No assessment has been made locally of the impact of the new licensing laws on health.

5.7 Corporate / Citywide Implications:

Alcohol related harm indicators for the city include alcohol related months of life lost, alcohol specific hospital admissions, and alcohol related crime.

SUPPORTING DOCUMENTATION

Appendices:

1. Flexible alcohol licensing hours in Brighton and Hove: Final Report.

Documents In Members' Rooms:

1. None.

Background Documents:

1. The Annual Report of the Director of Public Health 2007.
2. Report to licensing committee 27 November 2008, Agenda item 23 Health Impact Assessment of Licensing.

APPENDIX 1

Final report

Flexible alcohol licensing hours in Brighton and Hove Health Impact Assessment

18th October 2009

Report Authors

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Contents Amendment Record

This report has been issued and amended as follows:

Issue	Revision	Description	Date	Signed
First	V1	For internal QA	7th May 2009	Paul Iggulden
Second	V4	Issue for SG	8th May 2009	Paul Iggulden Ben Cave Erica Ison
Third	V5	Final report	18th October 2009	Paul Iggulden Erica Ison Ben Cave

Prepared by	Ben Cave Associates Ltd
Commissioned by	Brighton and Hove City Council

Acknowledgements

We thank all people who took part in the consultation for the benefit of their experience and insight.

Thank you to Barbara Hardcastle, NHS Brighton, for her support and collaboration.

Thank you to the steering group for their support.

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Abbreviations and acronyms

AUD ..... alcohol use disorders
BME ..... Black and Minority Ethnic
CDRP ..... Crime and Disorder Reduction Partnership
DAAT ..... Drug & Alcohol Action Team
DES ..... Direct Enhanced Services
GP ..... General Practitioner
HIA ..... Health Impact Assessment
HNA ..... Health Needs Assessment
HVVDs ..... High-Volume Vertical Drinking establishments
LAPE ..... Local Alcohol Profiles for England
LNE ..... late night and evening
LSOA ..... Lower Super Output Area
PCT ..... Primary Care Trust
SBI ..... Screening and Brief Interventions
SOA ..... Super Output Area
WHO ..... World Health Organization

1. Introduction and summary

1.1 The Licensing Act 2003 (1) allows for flexibility in the times during which premises can sell alcohol. The rate of alcohol-related admissions for Brighton and Hove residents increased markedly in the period following the introduction of the Licensing Act 2003 in November 2005; there was a 30% increase in the rate for Brighton between 2005/06 and 2006/07 compared with a 7% increase for England over the same period.

1.2 In Brighton and Hove the misuse of alcohol is associated with: an increase in drinking above the Government's weekly recommended amount (in the last 10 years); and increased deaths, mainly resulting from stroke, cancer, liver disease, accidental injury or suicide.

1.3 In May 2008 Ben Cave Associates (BCA) were commissioned by Brighton and Hove City Council and Brighton and Hove Primary Care Trust (PCT) to undertake a Health Impact Assessment (HIA) of the Introduction of Flexible Alcohol Licensing Hours in Brighton & Hove.

1.4 This study has drawn upon interviews and workshops with people living and working in Brighton and Hove and upon a review of local data. We provide findings of the direct and indirect health effects of increasing the availability of alcohol. We make a number of recommendations for monitoring and managing these effects.

Structure of report

1.5 In section 2 we provide some of the context for licensing alcohol in Brighton and Hove. We look at facts associated with alcohol consumption and health in Brighton and Hove and nationally. We also outline the legislation that has prompted this assessment.

1.6 In section 3 we discuss the main findings of the report: these findings come from the consultation and from the data review. We offer a Public Health Management Plan (Table 2 on page 15) for the consideration of the Alcohol Strategy Group and the Licensing Committee.

1.7 Sections 4 and 5 provide analysis of the consultation and the data review respectively. There is further analysis of the stakeholder consultation in Appendix B.

1.8 Each source of information, academic research, policy document *etc* that is referred to in the text is numbered and the full citation is provided in section 6.

1.9 We provide further information in the appendices. The appendices are as follows:

- the methodology used to guide the assessment is outlined in Appendix A of this report;
- further information on the stakeholder engagement, including methodology, is included as Appendix B to this report;
- understanding the health and well being of the local population is a key part of a health impact assessment. An outline profile is provided in Appendix C;
- a review of policy gives the context for Flexible Alcohol Licensing Hours and is reported in Appendix D; and
- text of a briefing note that explains the study is provided in Appendix E.

Conclusions and recommendations

1.10 Some of the issues highlighted in this assessment lie outside the control of the City Council and the PCTs. Lobbying of central Government is required to encourage change.

1.11 The regulatory system is constructed around the issue, the policing and the enforcement of licences for individual premises. This assessment shows that the impact of Flexible Alcohol Licensing Hours has had widespread adverse effects on health and well-being. In most cases it is difficult to use routine data to attribute these effects to individual licensed premises. The majority of impacts identified by stakeholders cannot be managed directly through the regulatory system. It is clear that the regulatory system provides an important role in protecting health and wellbeing and that it can and should be used proactively to prevent harm from occurring.

1.12 The findings from this study show the direct and indirect effects on people living and working in Brighton and Hove of the increased availability and consumption of alcohol. The findings from this HIA are clear that the direct and indirect effects of alcohol need to be monitored so that health, wellbeing and quality of life can be enhanced. Enhancing the monitoring will also allow the different effects on population groups to be followed.

1.13 The Public Health Management Plan (PHMP) suggests ways to address issues arising from the introduction of flexible alcohol licensing in Brighton and Hove (Table 2 on page 15). The actions in this management plan are reproduced from the stakeholder consultation and the review of data and evidence. The actions cannot necessarily be addressed within current legislation or guidance. The steering group will refine this list with the Alcohol Strategy Group and the Licensing Committee.

1.14 Routinely collected information can and should be used. Local data can and should be used to support the management of local services. This could be addressed in partnership with other local authorities.

1.15 Indicators must be relevant to the four objectives of the Licensing Act 2003 (1). We suggest that the Licensing Committee, in partnership with the Director of Public Health, establishes explicit public health objectives for Brighton and Hove. These objectives will inform the refinement of the 'starter pack' of indicators (Table 6). Enhancing the monitoring system will also require the following issues to be considered:

- an organisation and a named officer should be responsible for progressing this work;
- analytical support will be required to collate data and present / publish the information; and
- reporting arrangements.

2. Context for alcohol licensing in Brighton and Hove

2.1 In Brighton and Hove the misuse of alcohol is associated with:

- 200 deaths per year;
- increased deaths, mainly resulting from stroke, cancer, liver disease, accidental injury or suicide;
- children exposed to adverse effects;
- an increase in drinking above the Government's weekly recommended amount (in the last 10 years);
- a local health related behaviour survey of year 10 (age 14 -15) secondary school pupils found that: 51% had consumed at least one alcoholic drink in the past week (higher than in 2005); and 13% of boys and 9% of girls had drunk more than 14 units in the past week (the safe drinking limit for women);

2.2 Nationally, alcohol is associated with

- around a third of all incidents of domestic violence (2);
- two fifths (40%) of violent crimes (2);
- up to 17,000,000 days absent from work (in England) (2);
- 150,000 hospital admissions each year: around 70% of A&E attendance's between midnight and 5am on weekend nights are alcohol related (2); and
- a significant loss to the economy estimated at between £17.7 billion and £25.1 billion per year, and an annual cost to the NHS of £2.7 billion (3).

2.3 Alcohol misuse is associated with poor mental health: heavy drinking is implicated in 65% of suicide attempts (4); a Danish study reports that individuals registered with alcohol use disorders (AUD) are at highly increased risk of completed suicide (5).

2.4 Since the early 1980s, there has been a substantial decline in drinking and driving and in the number of alcohol-related deaths and injuries on the roads. Around half of drink drive casualties are of people other than the drink driver themselves. There were probably an additional 250 people killed in accidents involving drivers and riders with raised blood alcohol levels but still below the current legal limit (6).

2.5 In 2001, £36,6billion was spent on alcohol, equivalent to 5.8% of all consumer expenditure. UK consumers spend more of their disposable income on alcohol than on, for example, personal goods and services, fuel and power or tobacco (7).

2.6 Brighton and Hove City Council is the Alcohol and Entertainment Licensing Authority in Brighton and Hove. The City Council follows laws set out in the Licensing Act 2003 (1). This brought together six licensing regimes and established a single integrated scheme to issue licences to premises which are used:

- for the supply of alcohol;
- to provide regulated entertainment[1]; or
- to provide late night refreshment.

2.7 The Act allows for flexibility in the times during which premises can sell alcohol and provides the potential for 24 hour opening, seven days a week. All decisions are 'subject to consideration of the impact on local residents, businesses and the expert opinion of a range of authorities in relation to licensing objectives.' The stated objectives of the Act are:

- prevention of crime and disorder;
- public safety;
- prevention of public nuisance; and

[1] The provision of regulated entertainment covers the provision of entertainment or of entertainment facilities. The descriptions of entertainment in the Licensing Act are: the performance of a play; an exhibition of a film; an indoor sporting event; boxing or wrestling entertainment; a performance of live music; any playing of recorded music; a performance of dance; or entertainment of a similar description to live music, recorded music or dance (8).

- protection of children from harm.

2.8 Each of these objectives has direct and indirect effects on the health of people living, and working in, and visiting, Brighton and Hove. The Licensing Act does not cater explicitly for public health. In 2007 the Government updated their Alcohol Harm Reduction Strategy for England (9): this includes measures to change attitudes to irresponsible drinking and alcohol-related behaviour, including:

- making the sensible drinking message easier to understand and apply;
- targeting messages at groups such as binge drinkers and chronic drinkers;
- providing better information for consumers, on products and at the point of sale;
- providing more support and advice for employers.

2.9 It identifies the need to:

- ensure that the licensing laws protect young people from alcohol-fuelled crime and disorder;
- sharpen the focus on under 18s, 18-24 binge drinkers and harmful drinkers;
- promote sensible drinking through investing in better information and communication.

2.10 The Government had been keen to show a deregulation measure with freedom and flexibility for customers' expectations, greater choice for consumers including tourists, encouragement of family friendly premises, development of our culture of live music, dancing and theatre, regeneration and a thriving, safe night-time economy, and the necessary protection of local residents but the emphasis has changed in the Department of Culture, Media and Sports most recently issued guidance.

2.11 The Brighton and Hove Drug and Alcohol Action Team (DAAT) aims to reduce any further increase in alcohol related harm. The DAAT consists of senior managers from the City Council, the Police, the PCT, Probation and Treatment service providers. The DAAT has a remit to oversee the delivery at a local level of the national Alcohol Harm Reduction Strategy (9). The local delivery is taken forward by a number of groups responsible for specific areas of the strategy (10).

2.12 The new system began on 24th November 2005. The aim is to help build a fair and prosperous society, properly balancing the rights of people and their communities. It also intends to encourage tourism, reduce alcohol misuse, improve the self-sufficiency of local communities and reduce the burden of unnecessary regulations on businesses (11).

2.13 Premises must support the licensing objectives. Their licence is reviewed if the objectives are not met. This is one of the key protections for local residents. Since transition, there have been 15 reviews including five police closures for disorder. Three off-licences received licence suspensions for persistent sales to children, seven premises had the conditions of their licence modified to prevent noise nuisance or to restore order. Others were given advice or no further action. One public house licence was revoked for persistent disorder.

2.14 On 13th March 2008 Brighton and Hove City Council included a *Special Policy* regarding cumulative impact in their Licensing Policy for 2007-2010. This provides, along with the Act and government guidance and regulations, the basis of licensing decisions (see Figure 1 below).

Figure 1: Summary of objectives in The Licensing Act 2003 – BHCC: Statement of Licensing Policy

There are four main principles behind this system (11):

- to prevent crime and disorder;
- to prevent public nuisance;
- to protect children from harm; and
- public safety.

Prevention of crime and disorder

Applications for personal licences meeting the requirements of the Act must be granted unless the Police issue an objection (para 2.1)

The licensing authority recommends all licensees of on-licensed premises attend training programmes to raise awareness of drugs and violence in licensed premises, and suitable training is extended to all bar and door staff (para 2.2)

A designated premises supervisor needs to spend significant time on the premises, and when not there be contactable (para 2.3)

Cumulative impact is the potential impact upon the promotion of the licensing objectives of a significant number of licensed premises concentrated in one area (para 2.4.1); cumulative impact is a necessary part of the statement of Licensing Policy, adopted as a special policy on 13 March 2008 (para 2.4.2), and refers to the Cumulative Impact Area in Brighton City Centre (para 2.4.3) where the concentration of licensed premises in a small area of the city centre is causing problems of crime and disorder (para 2.4.2)

The licensing authority may receive representations from a responsible authority or interested parties that premises will give rise to a negative cumulative impact on one or more of the licensing objectives (para 2.4)

Applications for new premises licences or club premises certificates likely to add to the existing Cumulative Impact will normally be refused unless the applicant can show the application will have no negative impact (para 2.4.4)

Variation applications will potentially come within this special policy (para 2.4.5)

This special policy also applies to all new premises licences and club premises certificates (para 2.4.6)

The presumption of refusal does not relieve responsible authorities or interested parties of the need to make a relevant representation (para 2.4.7)

The special policy is not absolute; if an application is unlikely to add to the Cumulative Impact of the Area, it may be granted. Impact is expected to be different depending on the type of premises (para 2.4.8)

If an application is to be refused, the licensing authority needs to show that granting the application would undermine the promotion of one of the licensing objectives and conditions would be ineffective at preventing the problems (para 2.4.9)

Two areas of Brighton City Centre that border the Cumulative Impact Area are areas of special concern with respect to crime and disorder and nuisance experienced (para 2.4.10), known as Special Stress Areas (para 2.4.11)

New and varied applications in the Special Stress Areas will not be subject to the presumption of refusal, but operators need to ensure that their operation will not add to the problems in these areas (para 2.4.12)

Applications in Special Stress Areas will be scrutinised and the measures in the operating schedules will be compared with those considered appropriate by the licensing authority, e.g. adoption of a "Challenge 21" policy, policy on searching customers for weapons, drugs, etc., CCTV approved by Sussex police, policies for dispersal of customers (para 2.4.13 & Appendix C)

The licensing authority will keep the Cumulative Impact Area and the Special Stress Areas under review; depending on the level of crime and disorder or public nuisance (increase or decrease), the boundaries of these areas may be revised (para 2.4.14)

The licensing authority will support: diversity of premises; café bars; restaurants with outside service; geographical spread of licensed premises; care, control and supervision of premises; monitoring the management and supervision of premises after a licence has been granted; the use of door supervisors and mobile security units, following guidance and standards; and the development of codes of practice and general operating standards for security companies (para 2.5)

Figure 1 (continued): Summary of objectives in The Licensing Act 2003 – BHCC: Statement of Licensing Policy

Shops, stores and supermarkets will normally provide for the sale of alcohol at any time when the retail outlet is open (unless there are good reasons for restrictions) (para 2.6)

High-Volume Vertical Drinking establishments (HVVDs) may have conditions attached, e.g. prescribed capacity, ratio of chairs and tables to customers, SIA-registered security teams (para 2.7)

Enforcement will be considered taking into account any enforcement policies; there will be close links between enforcing authorities through intelligence sharing and strategy groups (para 2.8)

Applications for regulated entertainment (e.g. performance of dance for sexual stimulation) will be carefully scrutinised with respect to what is in the vicinity of premises (e.g. residences, schools, places of worship, community centres, youth clubs), and the cumulative effect of a number of such premises on the character of an area. Conditions could include a code of conduct for the dancers, rules of conduct for customers, procedures to ensure the conduct of pre-employment checks for all staff, and the exclusion of children and young people under 18 when such activities are taking place. Conditions may also prohibit physical contact between customers and performers (e.g. dressing room security, CCTV) (para 2.9).

Public safety

Club owners and promoters are to have regard for "Safer Clubbing: guidance for licensing authorities, club managers and promoters". Licensed premises need to be designed and run to maximise the safety of customers and staff. Applicants are advised to consult all responsible authorities when operating schedules are being prepared (para 3.1)

To protect public safety, conditions may be imposed, e.g. CCTV and panic buttons, shatterproof vessels, provision of first-aiders (para 3.2)

In determining applications, late-night public transport availability (including taxis) to aid dispersal will be considered (para 3.3)

Operators whose customers contribute to night-time demand for taxis can consider providing resources to help manage queues and control potential disorder (para 3.4)

Police may support large-scale events (commercial, sporting) by using their powers of closure of licensed premises (para 3.5)

Prior to large events, licence holders will attend Safety Advisory Group meetings and be part of Event Liaison Teams (para 3.6)

Prevention of public nuisance

Planning, building control and licensing will be separated; granting of licences does not relieve applicants of the need to apply for planning permission or building control consent, which should be explored before licensing applications are submitted (para 4.1)

The location of premises, type and construction of the building and likelihood of disturbance or nuisance to residents will be taken into account when determining applications for new and varied licences (para 4.2)

If premises use amplified or live music and are in or abut residential accommodation applications for new licences or extensions in size of licensed premises will not normally be granted. For new licences, a condition may be imposed that entertainment noise is inaudible in any residence (para 4.3)

Sound-limiting equipment and insulation may be required to minimise noise disturbance to nearby residents from licensed premises (para 4.4)

Staggered closing times will not be used to manage binge drinking and antisocial behaviour. Zoning will be avoided. Later opening will be promoted. Incidents including violent attacks may be used to justify closing times (para 4.5)

Temporary activities in the open air should have a maximum closure time of 11.00pm, but in sensitive open spaces or near residential areas earlier hours may be imposed (para 4.6)

Late-night public transport availability and location of taxi ranks will be taken into account when determining new licences, extension of hours or terminal hours (para 4.7)

History or likelihood of nuisance will be taken into account. Applications for late hours in the city centre and on busy main roads will generally be considered favourably. Conditions about hours of opening may be imposed to avoid unreasonable disturbance to residents (para 4.8)

Controls are available to premises operators to minimise the impact of noise from customers outside (para 4.9)

Figure 1 (continued): Summary of objectives in The Licensing Act 2003 – BHCC: Statement of Licensing Policy

Protection of children from harm

Harm to children includes moral, psychological and physical harm which may be associated with licensed premises. It is recommended that all licenses work with a suitable "proof of age" scheme; appropriate forms of ID are considered to be passport, photo driving licence or pass ID card (para 5.1)

All staff who sell intoxicating liquor need to receive information and advice on licensing laws relating to children and young people in licensed premises, and are required to take reasonable steps to prevent under-age sales. Unless necessary for the prevention of harm to children and young people, access to licensed premises will not be limited (para 5.2)

Issues of concern with respect to children are alcohol-induced problem behaviour in under-18s, enforcing the underage drinking laws and protecting children from harm. The licensing authority supports police powers to remove alcohol from young people on the street, test purchasing of off-licence sales and age challenges at pubs and licensed venues, promotion of proof of age schemes, support for in-house mystery shopper schemes, and CRB checks for all staff at events catering for unaccompanied children (para 5.3)

Under normal circumstances, children's access to licensed premises will be left up to the licensee. Children will normally be excluded from premises where there have been convictions for serving to minors, there is a known association with drug use or dealing, there is a strong element of gambling, adult/sexual entertainment is provided, and/or primarily or exclusively for the sale and consumption of alcohol. Options include limitations when children may be present, age limitations, limitations or exclusions when certain activities are taking place, need for an accompanying adult and full exclusion of those under 18 (para 5.4)

Arrangements need to be made by licensees of premises giving film exhibitions to restrict children from viewing age-restricted films in accordance with certificates granted by British Board of Film Classification (para 5.5)

Where children attend a public entertainment, adult supervision will be required (normally 1 adult/100 children; 2 if there is music and dancing, licensed by Security Industry Authority) to control their entry and exit and protect them from harm. Licensing Policy does not override child supervision requirements in other legislation or regulations (para 5.6)

3. Discussion

Introduction

3.1 Brighton and Hove City Council is the Alcohol and Entertainment Licensing Authority and as such it implements the Licensing Act 2003 (1). This is in accordance with English law. The steering group observe that the main effects of the move to flexible licensing hours appear to be longer opening (but not 24/7) and an increase in the number of convenience stores that sell alcohol. At transition in November, 2005 there were 1,025 licensed premises in Brighton and Hove. On the 31st March, 2007, there were 1,089 licensed premises.

3.2 This increase in the availability of alcohol in Brighton and Hove must be seen in the context of wider social trends relating to alcohol. For example:

- the real term costs of alcoholic beverages have reduced (12);
- the increased time period over which public drinking occurs; and
- consumption has increased across all age groups, for both males and females.

3.3 The increase in consumption has a number of components:

- increased alcohol consumption in public spaces (streets and open spaces), especially by lower-income groups and children and young people;
- increased levels of binge drinking, in particular amongst younger adults;
- the increased role of alcohol as part of the late night and evening (LNE) economy of many (urban) areas;
- consumption of alcohol into the early hours of the morning; and
- drinking in the home including 'front loading' (whereby people consume alcohol at home before going out either to save money or in some cases as they are not legal age to purchase alcohol).

3.4 These trends have been identified in national research and validated by local stakeholders during this assessment.

3.5 The health and well being effects of Flexible Alcohol Licensing Hours in Brighton and Hove are widespread and largely adverse and affect different stakeholders. In the next paragraphs we provide summaries of what was said in the consultation. We hear from

- residents;
- businesses;
- service providers; and
- elected members.

3.6 These findings are reported in full in Appendix C on page 55. We then consider the implications for monitoring these effects and for managing the increased availability of alcohol.

Key issues

Public views

3.7 National legislation sought to change the drinking culture, the way in which people use alcohol, in England. This was implemented before investment had been made to change drinking culture by other means. The legislation has exacerbated the effects of the traditional drinking culture.

3.8 Increasing the hours during which alcohol is available and the ban on smoking in public places has combined to turn pubs and clubs 'inside out'. Smokers and drinkers congregate outside licensed premises. Residents who live next to licensed premises described how they are unable to open their windows because of tobacco smoke.

3.9 Instead of changing the drinking culture, the effect of the introduction of Flexible Alcohol Licensing Hours has been to extend the negative impacts of alcohol consumption into the early hours of the morning, in particular noise, antisocial behaviour and crime and disorder.

3.10 **Children and young people**: all stakeholders expressed concern about the vulnerability of children and young people to many of the various impacts of the introduction of Flexible Alcohol Licensing Hours. It was reported that a lack of investment in youth services means that many children and young people see alcohol as one of few available leisure opportunities. The absence of alcohol-free leisure opportunities for families exacerbates this situation.

3.11 **Residential areas with licensed premises**: for some residential areas, particularly in, or near, the city centre, residents described severe adverse impacts on their health and well-being as a result of extended licensing hours: noise and threatening, abusive and antisocial behaviour were highlighted as the main contributors to sleep interruption. Residents described loss of sleep, inability to sleep and sleep deprivation. This can have serious emotional, mental and physical consequences for exposed residents.

3.12 Residents stated that their main conflict is with licensees but they also expressed frustration with the council and the regulatory system.

3.13 Residents in the vicinity of licensed premises require support. They need to see action to address the disruption they describe. This will begin to alleviate the adverse effects on health and well-being they are experiencing.

Business

3.14 **Residential areas with licensed premises**: licensees do not feel that the licensing system rewards premises that are responsible, and owing to its nature residents are either intimidated when using the system to complain or make representations about individual premises or are deterred from doing so.

3.15 The availability of alcohol has increased through the following routes:

- extended opening hours, therefore alcohol is now available over a longer time period and into early hours of the morning;
- increased competition among licensed premises, particularly as a result of increase in number of off-licences & supermarkets selling alcohol, which has made alcohol relatively cheap to obtain – price, promotions, etc.

3.16 **Licensees and their staff**: the introduction of Flexible Alcohol Licensing Hours has increased pressure on staff who run, manage and work in licensed premises, mainly as a result of competition from the off-licensed premises, reduced profit margins and changes in working practices from extended opening hours.

3.17 The main source of conflict was described as being with residents but there is the potential for conflict with the council, and the new regulatory system can cause stress.

3.18 The reduced profit margins and stress of maintaining the business' viability can have impacts on mental health, which in some cases have resulted in suicide.

3.19 Licensees and their employees are a group who require support.

Service providers

3.20 Residents & licensees highlighted the inconsistency of approach both strategically and operationally among the regulatory systems under the control of the local authority:

- licensing of premises for the sale of alcohol;
- granting of planning permission for premises that sell alcohol; and
- licensing of seating and tables on the public highway.

3.21 In some cases, this inconsistency of approach can exacerbate the negative effects of one or more of the systems. This presents difficulties for the management of effects and places increased demand on services and pressure on the staff delivering those services.

3.22 **Under-resourcing of services/capacity of services**: some services although having to respond to increased demand do not appear to have made adjustments to the planning and resourcing of those services to manage the changes in the pattern, location and intensity of negative impacts that have arisen as a result of the introduction of Flexible Alcohol Licensing Hours, whether for frontline services or for services dealing with longer term effects (e.g. alcohol treatment services).

3.23 **Dispersal of people who have been consuming alcohol**: a major difficulty with respect to the alleviation of the negative effects of the introduction of Flexible Alcohol Licensing Hours is the lack of some types of public transport, particularly rail services, in the early hours of the morning when most of the people who have consumed alcohol are leaving licensed premises. However, staff working on, and some users of, the public transport that is provided, e.g. late night bus and taxi services, can be vulnerable especially to violent assaults.

3.24 **Managing the impacts:** stakeholders were divided about the efficacy of the Cumulative Impact Area (CIA) and the Special Stress Areas (SSAs). Service providers felt that they served to exacerbate the problems, rather than address them, effectively establishing no-go areas and entrenching current social groupings. They also felt that their existence could contribute to a poor image and reputation for the city which might have implications for the local economy, which is heavily based on tourism.

3.25 By contrast, residents in communities not covered by either of these designations wanted to be included within such areas and thereby receive the benefits of "policing" and other approaches that the designated areas receive.

3.26 Whether a locality was included in a designated area could be a cause of conflict and resentment.

Elected members

3.27 Elected members identified several changes in drinking patterns and culture as outcomes of implementing the legislation:

- the consumption of alcohol over a longer period of time and into the early hours of the morning (sometimes as late as 6 a.m.) due to extended opening hours; and
- increased availability of alcohol through price, particularly through the increase in the number of off-licensed premises, which has led to "frontloading", especially in young people and the displacement of alcohol consumption into public spaces, such as the street and open spaces (e.g. The Level).

3.28 Elected members identified a range of negative impacts on health and well-being particularly for residents who are experiencing sleep disturbance, anger and increased irritability as a result of repeated exposure to noise and antisocial behaviour into the early hours of the morning. This can lead not only to reduced family cohesion but also to reduced social cohesion within the community, with impacts on the amount of social contact and support that people receive. The impacts of the regulatory system, especially in relation to complaints about individual premises, were also highlighted as a source of intimidation, stress and anxiety for residents.

3.29 **Managing the impacts:** staff providing services involved in managing the effects of the introduction of Flexible Alcohol Licensing Hours can be exposed to threatening and abusive behaviour and are at increased risk of physical injury, which can be both intimidating and stressful.

3.30 **Children and young people**: elected members were particularly concerned about the effects of the introduction of flexible hours on children and young people, which has made the consumption of alcohol more visible (in both domestic and non-domestic settings, e.g. on the street outside licensed premises) and more widely available. In combination with the representation of alcohol in some sectors of the media, the consumption of alcohol may appear more attractive as a leisure pursuit. The effects of Flexible Alcohol Licensing Hours can result from children and young people being exposed to other people's consumption of alcohol or their own drinking behaviour, particularly in public spaces. However, elected members also highlighted the potential for the demonization of all young people as a result

of the drinking behaviour of some, which could lead to many young people feeling stigmatized and alienated from society.

3.31 **Residential areas with licensed premises**: the increase in competition among licensed premises, especially as a result of the increase in the number of off-licensed premises, can lead to the closure of public houses, particularly small local pubs or pubs on estates. This can have two effects: the loss of a social hub in a community, and the loss of business and jobs in the local economy, which eventually may affect the whole community adversely.

3.32 Finally, the increase in the number of off-licensed premises has reduced the diversity of the streetscape in some areas, and potentially access to food and other necessities for residential communities in those areas, particularly lower-income groups, older people and people with mobility problems (e.g. London Road).

3.33 **Beneficial effects:** elected members identified several positive impacts on health and well-being arising from the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove, including:

- changes in public house or "pub" culture, e.g. the provision of food, which can encourage responsible drinking and reduce drunkenness, the provision of entertainment, which can lead to the pub being a hub for the community attracting a wide range of customers, and an increase in the attractiveness of the environment, especially with the ban on smoking in public places, all of which will increase social contact and improve social cohesion and contribute to the cultural life of the city, with the potential to increase tourism in the local economy;
- conditions on licensed premises, e.g. those requiring the premises of door supervisors, which can help to reduce antisocial behaviour and minor criminal offences;
- the new regulatory system through which the local authority has control of complaints about licensed premises, which could provide a route for mediation rather than conflict; and
- owing to the highly active night-time economy, increased level of passive surveillance on the streets late at night, which may increase people's feelings of personal safety.

Developing an approach to monitoring health and well being effects

3.34 As part of our assessment work we reviewed local data to identify the extent to which routinely collected data about service provision includes information about alcohol consumption.

- Where knowledge of alcohol consumption is highly relevant to the delivery of the service, the recording of alcohol consumption is perceived to be more complete and of better quality: for example specialist health care treatments and hostels.
- Conversely, where alcohol issues are held as being very much secondary to service provision, providers expressed less confidence in the quality of recording of alcohol issues if they were recorded at all: for example street cleaning and anti-vandalism.

3.35 The indicators we identify use dat that is available locally and nationally. We look at comparator authorities. The comparator authorities are from the Office of National Statistics Local Authority Comparator areas (13) and from the Home Office's Crime and Disorder Reduction Partnership (CDRP) families (14). It was agreed with the steering group that the ideal comparators would be common to both clusters. On this basis we used the following comparator areas:

- Bristol;
- Southampton; and
- Cheltenham.

3.36 Bristol and Southampton are in the same CDRP and the same ONS cluster group; Brighton and Hove, Bristol and Southampton are each classified as 'regional centres' (13). Cheltenham provides comparison with a local authority that is classified as 'somewhat similar' to Brighton and Hove (15). Cheltenham is not in the same CDRP family as Brighton and Hove.

3.37 The Licensing Committee has established a Cumulative Impact Area (CIA). Within this CIA the default position is refusal of additional licensing requests. Brighton and Hove City Council need to develop criteria against which applications are judged to ensure it works as intended and so that it can withstand legal challenge

3.38 Further work will be needed to develop the application process in support of those Public Health objectives. Other Local Authorities are giving consideration to this and it is suggested that links are established with other authorities seeking similar objectives.

3.39 Further consideration needs to be given to the development of rationale for saturation thresholds.

3.40 Closer working with Legal Advisors, Magistrates and with other authorities will clarify how the refusals of license applications can be upheld.

3.41 There are lessons from attempts to control the placement of fast food outlets. Council officers in Waltham Forest, London have developed a supplementary planning document that aims to address childhood obesity by placing limits on fast food outlets opening near schools, parks, leisure centres (16).

Conclusion and recommendations

3.42 Some of the issues highlighted in this assessment lie outside the control of the City Council and the PCTs. Lobbying of central Government is required to encourage change.

3.43 The regulatory system is constructed around the issue, the policing and the enforcement of licences for individual premises. This assessment shows that the impact of Flexible Alcohol Licensing Hours has had widespread adverse effects on health and well-being. In most cases it is difficult to use routine data to attribute these effects to individual licensed premises. The majority of impacts identified by stakeholders cannot be managed directly through the regulatory system. It is clear that the regulatory system provides an important role in protecting health and wellbeing and that it can and should be used proactively to prevent harm from occurring.

3.44 The findings from this study show the direct and indirect effects on people living and working in Brighton and Hove of the increased availability and consumption of alcohol. The findings from this HIA are clear that the direct and indirect effects of alcohol need to be monitored so that health, wellbeing and quality of life can be enhanced. Enhancing the monitoring will also allow the different effects on population groups to be followed.

3.45 The Public Health Management Plan (PHMP) suggests ways to address issues arising from the introduction of flexible alcohol licensing in Brighton and Hove. The PHMP is provided in full in Table 2 on page 15. The PHMP currently provides issues and action themes: a stakeholder, or group of stakeholders, is identified for each recommendation. The actions in this management plan are faithfully reproduced from the stakeholder consultation and the review of data and evidence. The actions cannot necessarily be addressed within current legislation or guidance. The steering group will refine this lengthy list with the Alcohol Strategy Group and the Licensing Committee. In Table 1 we show the stakeholders who are identified in the PHMP.

3.46 Routinely collected information can and should be used. Local data can and should be used to support the management of local services. This could be addressed in partnership with other local authorities:

- other Local Authorities are considering, or are in the early stages of, developing CIA (or equivalents);
- working with peer Authorities will provide comparators for indicators;

3.47 Indicators must be relevant to the four objectives of the Licensing Act 2003 (1). We suggest that the Licensing Committee, in partnership with the Director of Public Health, establishes explicit public health objectives for Brighton and Hove. These objectives will inform the refinement of the "starter pack" of indicators (Table 6). Enhancing the monitoring system will also require the following issues to be considered:

- an organisation and a named officer should be responsible for progressing this work;

- analytical support will be required to collate data and present / publish the information; and
- reporting arrangements.

3.48 We suggest that a panel is established to support development of the indicator set. This could include representation from key stakeholder groups covering the breadth of consultees engaged in our consultation work, including local residents. This will ensure that the indicators are supported and are considered to cover the wide spectrum of issues involved.

3.49 Routinely collected data may be inadequate for fully monitoring health and well being impacts. This presents the opportunity to consider local survey work using local resources. Training local residents as community researchers provides valued and valuable skills development opportunities for the community researchers and opportunities for community development and service improvement (17).

Table 1: Stakeholders named in the PHMP

1.	BHCC
2.	BHCC Licensing Committee
3.	BHCC Licensing Committee and Trading Standards
4.	BHCC Local Planning Authority
5.	BHCC Local Planning Authority and Licensing Committee
6.	BHCC Youth Services
7.	BHCC, including Youth Services and Social Care
8.	British Transport Police
9.	Bus transport providers
10.	Colleges and universities in Brighton & Hove
11.	Community organisations and representatives
12.	Elected members
13.	Highways
14.	Licensees
15.	Licensees and staff at off-licensed premises
16.	Licensing Department
17.	Licensing Officers
18.	Magistrates' Court
19.	NHS Brighton and Hove
20.	Noise Patrol
21.	Parents & carers
22.	Public sector
23.	Public transport providers
24.	Rail transport providers
25.	Residents associations
26.	Schools in Brighton & Hove
27.	Sussex Police
28.	Taxi transport providers
29.	Tertiary education providers
30.	Trading Standards
31.	Transport providers
32.	Voluntary Sector Organisations
33.	Voluntary sector organisations with a focus on young people
34.	Voluntary sector: service providers
35.	Youth Services

This list is sorted in alphabetical order.
There is some intentional overlap between the categories of stakeholder.

Table 2: Public Health Management Plan

Issues	Action themes	Management actions*		Stakeholders
National Alcohol Harm Reduction Strategy	Lobbying national government	1.	To lobby national government to increase the age of legality for alcohol consumption to 21 years	BHCC NHS Brighton and Hove
		2.	To lobby national government to limit the availability of high-strength alcohol	BHCC NHS Brighton and Hove
		3.	To lobby national government to increase the cost of alcohol	BHCC NHS Brighton and Hove
		4.	To lobby national government to abolish promotions on alcohol, including low prices and offers such as "happy hours"	BHCC NHS Brighton and Hove
National Taxation Policy	Lobbying national government	5.	To lobby national government to increase taxation on sales of containerised alcohol and sales of alcohol from off-licensed premises	BHCC NHS Brighton and Hove
		6.	To lobby national government to increase the tax on alcoholic beverages, and to hypothecate the increase in revenue to fund services which have to manage the effects of alcohol consumption, i.e. police, health and social services	BHCC NHS Brighton and Hove
National Broadcasting Policy	Sporting events	7.	To lobby national government to facilitate & enable more sports coverage on the BBC to avoid the development of licensed premises which provide sports coverage as entertainment and thereby expose people to the risk of irresponsible alcohol consumption	BHCC NHS Brighton and Hove
Local Planning System	Local Planning Policy	8.	To control the impacts of the introduction of Flexible Alcohol Licensing Hours through the land use classifications/designations which are to be granted planning permission, and to use the test of "public amenity" to assess the burden that could be experienced by a residential community when planning permission is being considered for the types of premises that will require a licence to sell alcohol	BHCC Local Planning Authority
		9.	To review Planning Policy with the aim of using the planning system to develop and maintain a balance between the establishment and extension of large chains of licensed premises and that of SMEs including small local public houses	BHCC Local Planning Authority
		10.	To ensure that any change of use to an external area associated with licensed premises is subject to planning permission (e.g. waste storage area to beer garden)	BHCC Local Planning Authority
	Section 106 agreements	11.	To consider using section 106 to fund the provision of community facilities that promote a family-friendly culture and provide alternatives to alcohol-based entertainment especially for young people	BHCC Local Planning Authority

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Issues	Action themes	Management actions*	Stakeholders
	Enforcement of planning permissions granted with respect to licensed premises	12. To enforce the land-use designations made in planning applications, i.e. challenging any change to implementation of land-use category A4 when the category A3 was applied for & granted planning permission	BHCC Local Planning Authority
Integrated policy and strategic approach at a local level	Integration of Licensing and Planning	13. To ensure that the Licensing and Planning Departments at BHCC work together	BHCC Local Planning Authority and Licensing Committee
		14. To integrate strategies for the licensing of sales of alcohol and planning	BHCC Local Planning Authority and Licensing Committee
		15. To integrate decision-making about licensing sales of alcohol and planning applications	BHCC Local Planning Authority and Licensing Committee
		16. To ensure planning permission is in place for premises before any application for a licence to sell alcohol is considered	BHCC Local Planning Authority and Licensing Committee
	Integration of Licensing and Highways	17. To coordinate the approach between the licensing of premises to sell alcohol and the licensing of chairs and tables outside licensed premises – the responsibility of Highways – such that any conditions placed on the licence to sell alcohol are not undermined by the licence granted by Highways	BHCC Licensing Committee Highways
		18. To review the impacts that the granting of licences for chairs and tables outside licensed premises has had on the existing conditions on the licences of premises selling alcohol	BHCC Licensing Committee Highways
	Integration of Licensing, Planning and Highways	19. To coordinate and integrate the way in which decisions are made to grant premises permission/licences with respect to planning, the sale of alcohol and the presence of tables and chairs on the highway outside premises such that the granting of one type of permission or licence does not have an adverse effect on or undermine the intended effects of another type of permission or licence	BHCC Local Planning Authority Licensing Committee Highways
Licensing of premises that sell alcohol	Licensing Policy	20. To introduce a policy of no extension to opening hours beyond 11pm (including Saturday nights) for licensed premises in residential areas, e.g. Westminster City council	BHCC Licensing Committee

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Issues	Action themes	Management actions*	Stakeholders
		21. To consider establishing a limit to the number of licensed premises in Brighton & Hove, having first established what limit is appropriate	BHCC Licensing Committee
		22. To provide appropriate and effective incentives to responsible licensed premises[2], e.g. reduce the annual cost of the licence fee, & provide support from police to reduce security costs	BHCC Licensing Committee
		23. To develop a system whereby the licensees and staff of responsible licensed premises can be praised/rewarded.	BHCC Licensing Committee
		24. To support applications for licensed premises that sell food in addition to alcohol	BHCC Licensing Committee
		25. To reduce the number of off-licensed premises, particularly retail units, licensed to sell alcohol	BHCC Licensing Committee
		26. To reduce the number of hours during which alcohol can be purchased	BHCC Licensing Committee
		27. To refuse 24-hour licenses to off-licensed premises	BHCC Licensing Committee
		28. To remove licences to sell alcohol from off-licensed premises that are late-night shops after 10pm	BHCC Licensing Committee
		29. To place the same conditions on off-licensed premises as on on-licensed premises	BHCC Licensing Committee
		30. To reduce the time taken to process minor variations to licenses for on-licensed premises	BHCC Licensing Committee
	Special Policy for Brighton & Hove	31. To extend the Cumulative Impact Area (CIA) to include all locations where there are residents in the vicinity of licensed premises	BHCC Licensing Committee
		32. To designate the London Road area as a Special Stress Area (SSA)	BHCC Licensing Committee
	Representations about licensed premises	33. To establish a mechanism whereby people are able to make representations about particular licensed premises anonymously (i.e. without their name & address being divulged to the licensee)	BHCC Licensing Committee
	Conditions on licensed premises	34. To ensure that the licensee and associated manager/other staff are able to enforce any conditions placed upon the licence for particular premises	BHCC Licensing Committee Licensees

[2] Criteria for responsible premises could include those that are well-ordered, and have a good record on challenging under-age drinking.

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Issues	Action themes	Management actions*	Stakeholders
	Appeals process	35. To review the appeals process for licences in the Magistrates' Court such that it does not favour any particular group of licensees (i.e. "big players")	BHCC Licensing Committee Magistrates' Court Licensees
	Capacity for enforcement of licensing conditions	36. To ensure that the capacity and resources for enforcement of licensing conditions matches the conditions placed on licences, and there is no need to rely on members of the public	BHCC Licensing Committee
	Enforcement of licensing conditions	37. To undertake regular inspections of licensed premises	BHCC Licensing Committee Licensing Officers
		38. To "police" all licensed premises where children and young people are able to obtain alcohol, e.g. supermarkets	Trading Standards Sussex Police BHCC Licensing Committee
		39. To increase enforcement of licensing conditions but not simply through prosecution	BHCC Licensing Committee
		40. To increase policing and enforcement of licensing conditions for on-licensed premises where customers are allowed to consume alcohol irresponsibly and then participate in crime & disorder	Sussex Police BHCC Licensing Committee
		41. To establish greater accountability for licensees whose business practices encourage irresponsible alcohol consumption	Sussex Police BHCC Licensing Committee
		42. To remove licences from licensed premises where there have been 3 infringements of licensing conditions (apply a "3 strikes & you're out" rule)	BHCC Licensing Committee
		43. To increase enforcement of under-age sales from licensed premises	Trading Standards Sussex Police BHCC Licensing Committee
		44. To consider applying a policy of zero tolerance to premises found to be selling alcohol to under-age young people	BHCC Licensing Committee
		45. To review the balance of test purchases made at on-licensed premises and at off-licensed premises to ensure there is even-handed regulation of both	BHCC Licensing Committee and Trading Standards

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Issues	Action themes	Management actions*	Stakeholders
		46. To ensure that staff at off-licensed premises do not sell alcohol to people who have a dependency on alcohol	BHCC Licensing Committee and Trading Standards
	Training for staff at licensed premises	47. To provide training to staff working at off-licensed premises	Licensing Department Licensees and staff at off-licensed premises
		48. To educate staff at off-licensed premises about the potential harms of selling alcohol to customers who have a dependency on alcohol	Licensing Department Licensees and staff at off-licensed premises NHS Brighton and Hove
		49. To increase the level of understanding of the responsibilities entailed in a licensee's Duty of Care	Licensing Department Licensees
	Licensing Reviews	50. To consider low-level impacts and noise levels as a result of alcohol consumption during licensing reviews	BHCC Licensing Committee
	Licensing Committee	51. To review the Constitution of the Licensing Committee To include residents on the Licensing Committee	BHCC Licensing Committee
	Awareness raising	52. To raise awareness and educate residents about the licensing process	BHCC Licensing Committee
	Specific information needs of residents	53. To develop a mechanism to address the specific information needs of residents about the introduction of Flexible Alcohol Licensing Hours, such as: Mechanism by which it is possible to reduce the number of hours during which licensed premises can sell alcohol; Mechanism by which it is possible to revoke a licence once granted; Grounds necessary for a licence to be revoked; Whether information is publicly available about the number and nature of complaints about particular licensed premises; Action taken when nuisance from noise/light pollution is reported; Which roads/areas fall within the CIA and SSAs.	BHCC Licensing Committee
Management of on-licensed premises	Management of activity outside licensed premises	54. To nominate a person/people responsible for drinking and smoking activity outside the licensed premises	Licensees
	Security	55. To increase the level of visible security outside licensed premises	Licensees
	Family-friendly	56. To provide deals for families on pub meals	Licensees

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Issues	Action themes	Management actions*	Stakeholders
	practices	57. To restrict the alcohol consumption of adults when visiting licensed premises in the company of children	Licensees
	Safety of young people	58. To develop socially responsible procedures to ensure that young people who are drunk can get home safely	Licensees Youth Services Transport providers Sussex Police
Offer at on-licensed premises	Strength of alcohol available	59. To provide alcohol products of lower strength	Licensees
	Non-alcohol-related offer	60. To provide milk bars/cafes in association with licensed premises to encourage visits by families	Licensees
		61. To provide non-alcohol alternatives for the duration of opening hours	Licensees
Voluntary code for licensees	Marketing strategies	62. To comply with the voluntary code for licensees and in particular with respect to price promotions and the provision of free alcohol	Licensees
Ban on smoking in public places	Combined effects of introduction of Flexible Alcohol Licensing Hours and ban on smoking	63. To review and consider a controlled relaxation of the ban on smoking in public places	BHCC Licensing Committee NHS Brighton and Hove
Service provision	Management of the night-time economy	64. To align the provision of key services, including enforcement, with the change in demand as a result of the introduction of Flexible Alcohol Licensing Hours and the 24-hour economy, in particular the night-time/early hours economy	BHCC NHS Brighton and Hove Sussex Police
		65. To review the funding for services involved in the management and control of the impacts associated with the introduction of Flexible Alcohol Licensing Hours	BHCC NHS Brighton and Hove Sussex Police
	Police services	66. To increase the policing of alcohol-related violence	Sussex Police
		67. To enforce the regulations on street drinking (where the police have powers to remove any alcohol being consumed)	Sussex Police
		68. To consider applying the principle of "zero tolerance" to the enforcement of regulations on street drinking	Sussex Police
		69. To work with the Noise Patrol with respect to complaints about noise or incidents generating a disturbance from noise and to consider the balance of appropriate deployment for the police especially in outlying areas of the city	Sussex Police Noise Patrol

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Issues	Action themes	Management actions*	Stakeholders
	Public transport	70. To review the network of public transport provision for the 24-hour economy, particularly during the night-time/early hours economy, and seek to address unmet transport needs	BHCC Public transport providers
		71. To invest in the rapid and effective dispersal of people who have vacated licensed premises, particularly by taxi and bus services	BHCC Public transport providers
		72. To consider reducing the length of some night bus routes to ensure greater frequency of services and therefore faster dispersal of people who have vacated licensed premises	BHCC Bus transport providers
		73. To provide conductors on late-night buses to help manage the behaviour of some users	BHCC Bus transport providers
		74. To consider providing free taxi services for short journeys and therefore faster dispersal of people who have vacated licensed premises	BHCC Taxi transport providers
		75. To explore the potential for extending rail services over a longer time period into the night to facilitate the dispersal of people who come to Brighton & Hove for the night-time economy	BHCC Rail transport providers
		76. To consider introducing initiatives such as the "train taxi" (in use in the Netherlands) and taxi-sharing	BHCC Taxi transport providers
	Control of dispersal after people have vacated licensed premises	77. To reinstate the taxi-marshalling system	BHCC Taxi transport providers
		78. To provide CCTV in taxis	BHCC Taxi transport providers
	Noise Patrol	79. To increase the hours of operation of the noise patrol	BHCC
		80. To extend the coverage of the Noise Patrol to include special promotion nights	BHCC
		81. To extend the powers of the Noise Patrol	BHCC
		82. To render anonymous any complaints about noise when the Noise Patrol is reporting the complaint to the premises which are the source of the noise	BHCC
	Waste management	83. To provide more litter bins in the station area to help reduce littering and environmental degradation in the area	BHCC
		84. For licensees, to provide bins outside licensed premises to reduce the amount of littering and environmental degradation by people smoking and drinking outside licensed premises	Licensees

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Issues	Action themes	Management actions*	Stakeholders
	Emergency Planning	85. To review emergency planning arrangements in view of the demands associated with a 24-hour economy, and in particular an active night-time/early morning economy	BHCC NHS Brighton and Hove Sussex Police British Transport Police
	Safe Space	86. To roll-out the concept of the Safe Space in West Street to the area around the railway station	BHCC;
	Alcohol-related Services	87. To increase investment in alcohol-related services, particularly health services and including counselling	BHCC NHS Brighton and Hove service providers in voluntary sector
		88. To invest in initiatives focussing on harm reduction from alcohol consumption and associated behaviours	BHCC NHS Brighton and Hove service providers in voluntary sector
		89. To invest in the management of hidden harms of alcohol treatment particularly for children and young people	BHCC, including Youth Services and Social Care NHS Brighton and Hove service providers in voluntary sector
		90. To produce leaflets detailing the alcohol-related services available and distribute them to off-licensed premises	BHCC NHS Brighton and Hove service providers in voluntary sector licensees of off-licensed premises
	Location of leisure opportunities	91. To provide leisure opportunities in parts of Brighton & Hove other than the city centre	BHCC
		92. To identify and implement initiatives to encourage students to stay on campus to a greater extent than at present	Tertiary education providers
	Non-alcohol-related leisure opportunities	93. To explore the potential to encourage a diversification of the night-time economy in Brighton & Hove and increase the amount and range of non-alcohol-related leisure activities available in the city, e.g. arts-based activities	BHCC
		94. To apply the learning from the White Knights event, which provided entertainment for families	BHCC

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Issues	Action themes	Management actions*	Stakeholders
		95. To repeat the White Knights event	BHCC
		96. To provide a greater number of socialising settings for young people, supervised by adults, that do not involve alcohol consumption	BHCC service providers in voluntary sector
		97. To provide a greater number and range of non-alcohol-related and safe leisure opportunities for children and young people in Brighton & Hove, e.g. a skate park	BHCC service providers in voluntary sector
	Youth Services	98. To increase investment in Youth Services in Brighton & Hove	BHCC
		99. For licensees, to provide funding to BHCC to support Youth Services	BHCC licensees
		100. To provide a network of dedicated facilities for young people across the city	BHCC voluntary sector organisations with a focus on young people
		101. To develop a service level agreement that provides increased funding for voluntary youth work	BHCC voluntary sector organisations with a focus on young people
Alcohol awareness and education	For general public	102. To provide education about responsible and irresponsible drinking culture (?)	
		103. To provide education about the effects on health of alcohol consumption, particularly in a community setting and especially for children and young people	NHS Brighton and Hove Youth Services voluntary sector organisations
	School setting	104. To update schools about changes in the pattern of alcohol consumption by children and young people, including the associated risks, so that teaching for PHSE is informed by the current situation in which young people find themselves	Schools in Brighton & Hove NHS Brighton and Hove Youth Services voluntary sector organisations

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Issues	Action themes	Management actions*	Stakeholders
		105. To provide education, especially during PHSE, about responsible alcohol consumption and the effects of alcohol consumption, including the changes in patterns of drinking behaviour and associated risks for children and young people	Schools in Brighton & Hove NHS Brighton and Hove Youth Services voluntary sector organisations
		106. To include hard-hitting messages about the effects of irresponsible drinking	Schools in Brighton & Hove
	Tertiary education setting	107. To develop educational initiatives to reduce the harm from alcohol consumption and associated behaviours in young people	Colleges and universities in Brighton & Hove
	For parents and carers	108. To provide guidance to parents and carers on safe levels of adult alcohol consumption when in a domestic setting and when on licensed premises	NHS Brighton and Hove parents & carers
		109. To provide information, guidance and practical advice to parents and carers about how to help their children learn to consume alcohol responsibly, including in a domestic setting	NHS Brighton and Hove parents & carers Youth Services
		110. For parents and carers, to provide guidance to their children on controlled or responsible alcohol consumption/drinking behaviour in the domestic setting	NHS Brighton and Hove parents & carers Youth Services
	At licensed premises	111. For licensees, to communicate to customers the health consequences of irresponsible and harmful/hazardous alcohol consumption	Licensees NHS Brighton and Hove
	Creating positive role models	112. To create positive role models of responsible alcohol consumption and drinking behaviour, especially for children and young people	BHCC Youth Services NHS Brighton and Hove voluntary sector organisations with a focus on young people schools in Brighton & Hove colleges & universities in Brighton & Hove
Impact identification and monitoring	Good-quality information for the management of the effects of introduction of	113. To identify the potential impacts of implementing the Licensing Act 2003, including changes in the patterns of alcohol consumption and the locations in which alcohol consumption takes place	BHCC NHS Brighton and Hove
		114. To investigate the hidden harms of alcohol consumption particularly in children and young people	NHS Brighton and Hove;

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Issues	Action themes	Management actions*	Stakeholders
	Flexible Alcohol Licensing Hours	115. To consult young people about the introduction of Flexible Alcohol Licensing Hours and the effects it has upon them, and the support they need to be able to cope with those effects	BHCC Youth Services NHS Brighton and Hove voluntary sector organisations with a focus on young people schools in Brighton & Hove colleges & universities in Brighton & Hove
		116. To identify the main dispersal routes of people vacating licensed premises	BHCC
		117. To identify areas along dispersal routes where street lighting is poor	BHCC
Provision of infrastructure	Street lighting	118. To increase the level of street lighting, especially in areas where it is poor and along the main dispersal routes for people vacating licensed premises	BHCC
	Street furniture	119. To increase the amount of street furniture, especially along the main dispersal routes of people vacating licensed premises	BHCC
Communication and understanding among stakeholders	Residents' concerns	120. To understand and consider the nature of residents' concerns about the effects of the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove	BHCC
	Contact between licensees and residents	121. For licensees to provide a 24-hour telephone number on which it is possible for people to give information on potential infringements on the premises such as under-age drinking	Licensees Licensing Committee
	Communication with customers	122. For licensees, to communicate with customers about behaving responsibly, and with consideration to the surrounding residents, when outside or leaving licensed premises	Licensees
	Contact between schools and licensees	123. To improve communication between schools and the licensed trade: To encourage a shared responsibility towards the health and well-being of young people with respect to alcohol consumption/drinking behaviour; To improve the content of vocational course	Schools in Brighton & Hove NHS Brighton and Hove Youth Services Voluntary Sector Organisations
	Partnership working	124. For the public sector and licensees, to work in partnership to manage and address the impacts of the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove	Public sector Licensees
		125. For the public sector, licensees and communities, to establish a compulsory partnership to address the effects of the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove and to establish a mechanism by which funds can be raised by partners to finance initiatives/interventions to address impacts	Public sector Licensees Community organisations and representatives

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Issues	Action themes	Management actions*	Stakeholders
	Liaison with licensees	126. To liaise closely with the larger chains that manage licensed premises, especially as in some areas small local public houses have closed	Licensees Licensing Committee Sussex Police
	Mediation	127. To consider the potential for elected members to act as mediators between residents and licensed premises where noise and other nuisance/disturbance occurs late into the night/early morning	Licensing Committee Elected members Residents associations Licensees

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4. Stakeholder consultation – key findings

4.1 This section summarises the findings from the stakeholder engagement activities undertaken as part of this HIA. The full report of stakeholder engagement activities in included as Appendix C on page 55. These impacts may affect residents, tourists and visitors to Brighton & Hove, licensees, employers and employees at licensed premises, other types of businesses and residential communities and in some cases the wider population of Brighton & Hove. Vulnerable groups include:

- children;
- young people;
- women;
- families;
- people with mobility problems;
- Black and Minority Ethnic (BME) groups;
- lesbian, gay, bisexual and transgender (LBGT) community;
- people with alcohol use problems;
- street drinkers; and
- staff in frontline public and voluntary sector services, e.g. police, Accident & Emergency, public transport operatives.

Concerns

4.2 Stakeholder groups consulted during the HIA expressed a large number of concerns. Some are shared between the various stakeholder groups; others are specific to particular stakeholder groups. Service providers expressed the largest number of concerns, closely followed by residents.

4.3 All groups – residents, licensees, service providers and elected members – expressed concerns about antisocial behaviour, particularly the increase in antisocial behaviour since the introduction of Flexible Alcohol Licensing Hours and the increase in the length of time over which such behaviour takes place. Service providers were concerned about the difficulties in managing alcohol-related antisocial behaviour.

4.4 Residents, licensees and service providers were concerned about noise, in particular the level of noise in residential areas and the length of time during which that noise is generated (which carries on into the early morning) since the introduction of Flexible Alcohol Licensing Hours.

- residents voiced concerns about the impacts on their health and well-being arising from loss of sleep, inability to sleep and sleep deprivation as a result of disturbances due to noise and/or antisocial behaviour; and
- residents and service providers were particularly concerned about the adverse effects of such disturbances on vulnerable groups in the community such as children, older people and families.

4.5 The increased availability of alcohol (by various means, e.g. 24-hour availability, increased number of venues and outlets, promotions, low prices) was of particular concern to both service providers and residents, especially as it could lead to increased or excessive consumption and drunkenness.

- residents highlighted that increased availability could also lead to the consumption of alcohol in a wider range of settings (e.g. domestic); and
- service providers were concerned that it resulted in greater ease of access for young people with the potential for increased under-age drinking and binge drinking.

4.6 Service providers and elected members highlighted a range of alcohol-related health impacts as a source of concern:

- hazardous drinking;
- alcoholism;

- alcohol-related accidents and absenteeism; and
- use of other substances.

4.7 Service providers and elected members were concerned about alcohol-related crime and disorder and the associated costs, not only in terms of demand for services but to society as a whole.

4.8 Service providers and residents expressed concerns alcohol-related vandalism, littering and environmental degradation.

4.9 Licensees and service providers had concerns about the effects of competition, especially reduced profits, among licensed premises including

- the lowering of standards;
- closure of premises (loss of business/jobs); and
- pressure to increase sales of alcohol (thereby increasing its availability).

4.10 Licensees, service providers and residents had concerns about the welfare of all staff involved in the sale of alcohol, especially since the introduction of Flexible Alcohol Licensing Hours.

4.11 Residents had a large number of concerns about the regulatory system for licensing and the policing and enforcement of licensing conditions since the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove, some of which were echoed by service providers.

4.12 Service providers had concerns about the pressure on resources and demand for certain public sector services since the introduction of Flexible Alcohol Licensing Hours

- enforcement agencies;
- police and other emergency services;
- health services; and
- transport.

4.13 Finally, elected members and service providers expressed concerns that the legislation underpinning the introduction of flexible hours is incompatible with the drinking culture currently exhibited in England and may actually encourage the continuation of, or exacerbate, such a culture. Licensees and elected members were concerned that the combination of the ban on smoking in public places and the introduction of Flexible Alcohol Licensing Hours had had several unintended and unwanted effects.

Positive expectations

4.14 Far fewer positive expectations than concerns were expressed by all groups of stakeholders. Service providers expressed the greatest number of positive expectations, followed by residents.

4.15 Both residents and elected members welcomed the potential to increase the number of family-friendly outlets (e.g. cafes, bars, public houses) and the potential for more premises to sell food in addition to alcohol.

4.16 Service providers and elected members saw the potential for developing a more responsible drinking culture, reflecting a continental approach.

4.17 Licensees felt that Flexible Alcohol Licensing Hours provided an opportunity to enrich Brighton and Hove as a city principally through strengthening the economy, and thereby was a way of contributing to the city's success. Service providers had expectations around aspects of this issue, such as increased employment opportunities in the city.

4.18 Residents had a relatively large number of positive expectations in relation to the regulation, policing and enforcement of licensing conditions, and of an open and responsive approach on behalf of BHCC to resolving some of the impacts of the introduction of Flexible Alcohol Licensing Hours.

4.19 Service providers also expressed expectations that the introduction of Flexible Alcohol Licensing Hours would reduce binge drinking, antisocial behaviour and crime and disorder,

which in turn would reduce pressure on public sector services (especially police and other Emergency Services).

Barriers to success

4.20 A large number of barriers to the successful introduction of Flexible Alcohol Licensing Hours were identified: service providers identified the greatest number, followed by licensees. The majority of the barriers were identified by only one stakeholder group. Just over a fifth of barriers were identified by two stakeholder groups.

4.21 Licensees and elected members highlighted the lack of awareness and knowledge about the Licensing Act 2003. Licensees and service providers noted not only public perceptions but also the lack of supportive residents as further barriers.

4.22 Residents and elected members emphasised the intimidatory nature for residents of the regulatory system for the licensing of premises that sell alcohol. Indeed, the majority of barriers identified by residents were related either to regulatory systems or to the policing and enforcement of the licensing system. These are under the control of Brighton and Hove City Council. Stakeholders noted a lack of consistency across these systems. Licensees observed that one deficiency of the regulatory system was that it was not possible to regulate people's behaviour, especially in public areas, by using a mechanism through which conditions were placed on licences for individual premises.

4.23 Licensees and service providers mentioned difficulties associated with measuring and monitoring the impacts of Flexible Alcohol Licensing Hours: these included problems with definitions and a lack of data. Service providers also mentioned barriers relating to service provision, such as the cost of providing services to manage the problems, the lack of investment in some services, e.g. Youth Services and alcohol treatment services, and the lack of capacity for policing and enforcement of the introduction of Flexible Alcohol Licensing Hours.

4.24 Residents and service providers saw the dependence of the economy in Brighton & Hove on the trade of licensed premises as a barrier, as was the relatively low price of alcohol, a combination of competition among premises (both on- and off-licensed) and increased availability.

4.25 Licensees identified several issues relating to a change in working practices since the introduction of Flexible Alcohol Licensing Hours as barriers, which in turn contributed to another barrier, that of the cost to licensees of introducing the policy. With respect to the effects of the introduction of Flexible Alcohol Licensing Hours, they also highlighted the exacerbation of these effects by the ban on smoking in public places as a barrier and the lack of public transport to support the dispersal of customers between 12 midnight and 4 a.m.

4.26 Service providers viewed the CIA as a barrier locally, in that its effect was to highlight the problems associated with the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove rather than help to address them, but the lack of investment in cultural change by central Government prior to the introduction of the Licensing Act 2003 was a significant national barrier that had had local consequences.

Conflicts

4.27 Of the four main stakeholder groups, service providers identified the largest number of conflicts arising from the introduction of Flexible Alcohol Licensing Hours, followed by licensees.

4.28 All four stakeholder groups identified two major conflicts arising from the introduction of Flexible Alcohol Licensing Hours: that between residents and licensees over issues such as noise, disturbances and antisocial behaviour of customers, and that between the unintended consequences of the ban on smoking in public places and the unintended consequences of the introduction of Flexible Alcohol Licensing Hours.

4.29 Two conflicts identified by licensees, service providers and elected members referred to competition among businesses: that between on- and off-licensed premises (especially over the pricing of alcohol), and that among on-licensed premises. Service providers also

mentioned the competition between large chains of licensed premises and smaller businesses.

4.30 Licensees and service providers noted the competition between Brighton & Hove and other leisure destinations, especially other coastal cities and towns, for visitor/tourist income.

4.31 Residents and service providers highlighted the potential conflicts between the unintended consequences of the introduction of Flexible Alcohol Licensing Hours and some of the aims of the Cultural Strategy and the Tourism Strategy, although it was pointed out that the Cultural Strategy can be used as a reason for granting licences.

4.32 Licensees and service providers noted the conflict between the aims of public health policy and some of the effects of the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove. Residents and licensees highlighted the disparities between the planning system and the regulatory system for licensing, and residents also drew attention to the disparities between the regulatory system for the licensing of premises that sell alcohol and the licensing system for tables and chairs on the public highway. Licensees and service providers mentioned the potential for conflict between licensees and the various regulatory authorities.

4.33 Service providers highlighted the potential for conflict due to the different approach taken in the cumulative impact area (CIA) and the special stress areas (SSAs) and that taken in other areas, especially for the residents in those areas. They also noted the likelihood of conflict between employers and employees on licensed premises, whereas licensees identified the potential for conflict between staff on licensed premises and customers, especially those who had consumed excessive amounts of alcohol either on or off the premises. Residents identified the conflicts over parking between residents in an area and customers visiting licensed premises in that area.

4.34 Finally, service providers remarked on the conflict between centrally driven policies and the effects of their implementation and regulation at a local level.

5. Monitoring

5.1 This section considers two approaches to monitoring the impacts of Flexible Alcohol Licensing Hours. The first approach responds to the request in the consultant's brief that consideration be given to monitoring progress against the following local impact parameters:

- reduce impact on acute hospital;
- reduce public place violent crime;
- reduce domestic violence; and
- reduce alcohol related offending.

5.2 The second approach considers a developmental approach which could be followed by partners to address some of the shortcomings of the first approach.

Measuring progress against local impact parameters

5.3 The indicators are a mix of local and nationally available data. Where possible we look at comparator authorities. The HIA Steering Group advised that comparators be taken from the Office of National Statistics Local Authority Comparator areas and the Home Office Crime and Disorder Reduction Partnership families. On this basis we used the following comparator areas:

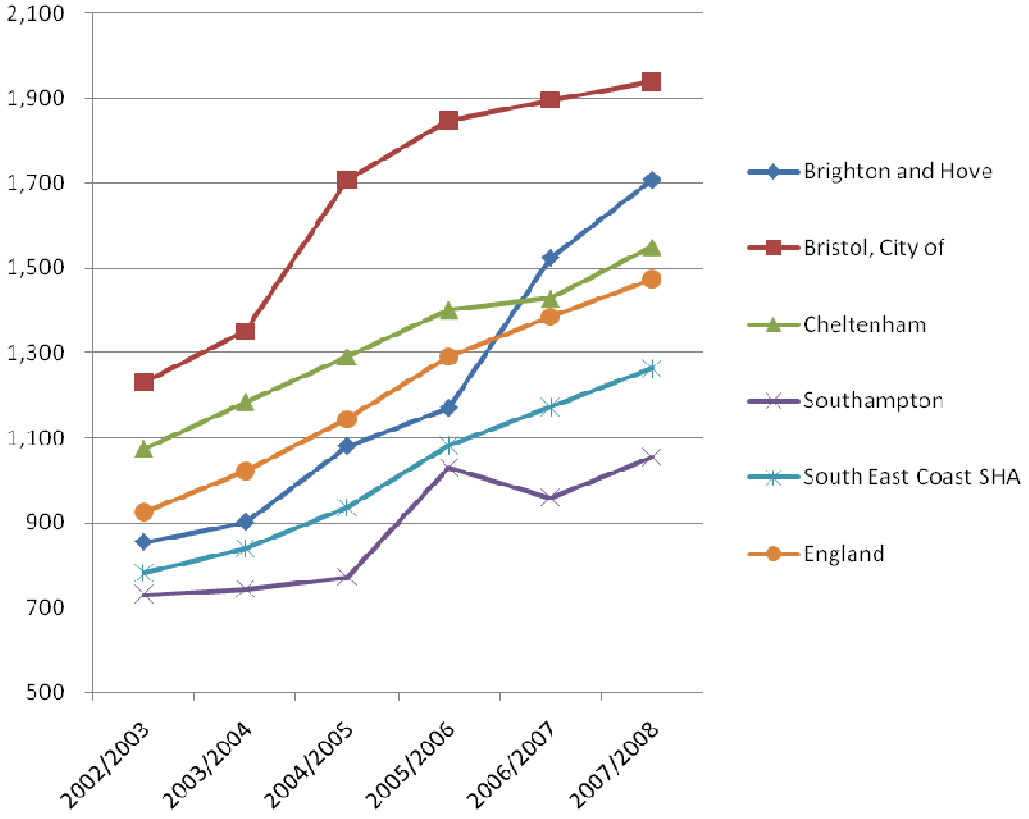
- Bristol;
- Cheltenham; and
- Southampton.

Monitoring impact on acute hospital

5.4 Figure 2 shows that the rate of alcohol-related admissions for Brighton and Hove residents for 2007/08 is higher than that for England as a whole and for the South East Coast SHA. The rate is higher than the comparator areas of Cheltenham and Southampton, but lower than that for Bristol.

5.5 The general trend over the period shown in Figure 2 (from 2002/03 to 2007/08) is upwards with the England rate showing an average 10% yearly increase. The rate of alcohol-related admissions for Brighton and Hove residents increased markedly in the period following the introduction of the Licensing Act 2003 in November 2005; there was a 30% increase in the rate for Brighton between 2005/06 and 2006/07 compared with a 7% increase for England over the same period.

Figure 2: Rate of alcohol-related admissions per 100,000 population by Local Authority District



5.6 In the three year period 2004/05 to 2006/07, 100 Brighton and Hove residents under the age of 18 were admitted to hospital due to alcohol-specific conditions. The crude rate per 100,000 population for that period is similar to the England and Regional level. Rates for the comparator areas of Brighton and Hove, Bristol and Cheltenham are similar; the rate for Southampton is significantly higher than the other comparator areas (at the 95% confidence level) (Table 3).

Table 3: Hospital admissions due to alcohol-specific conditions for persons under 18 years

Local Authority	Hospital admissions due to alcohol-specific conditions for persons under 18 years*	Lower 95% CI	Upper 95% CI	Number of persons aged under 18y admitted with alcohol specific conditions
Brighton and Hove	72.0	58.6	87.6	100
Bristol	63.4	53.7	74.3	151
Cheltenham	61.5	44.5	82.8	43
Southampton	131.8	112.8	153.2	170
South East	62.1	60.0	64.2	3,350
England	72.5	71.6	73.5	23,991

* Crude rate per 100,000 under 18 population
Source: NWPHO Local Alcohol Profiles for England www.nwph.net/alcohol/lape/pctProfile.aspx?reg=q37 accessed 27th April 2009

5.7 The rates of alcohol related admissions in Table 3 do not include Accident and Emergency attendances. The Alcohol Needs Assessment for Brighton and Hove City PCT (May 2009 version) reports the trend for such attendances since January 2006. Local hospital

information systems did not record whether attendances were alcohol related prior to 2006 meaning we are unable ascertain a baseline for this important impact area.

Monitoring impact on public place violent crime

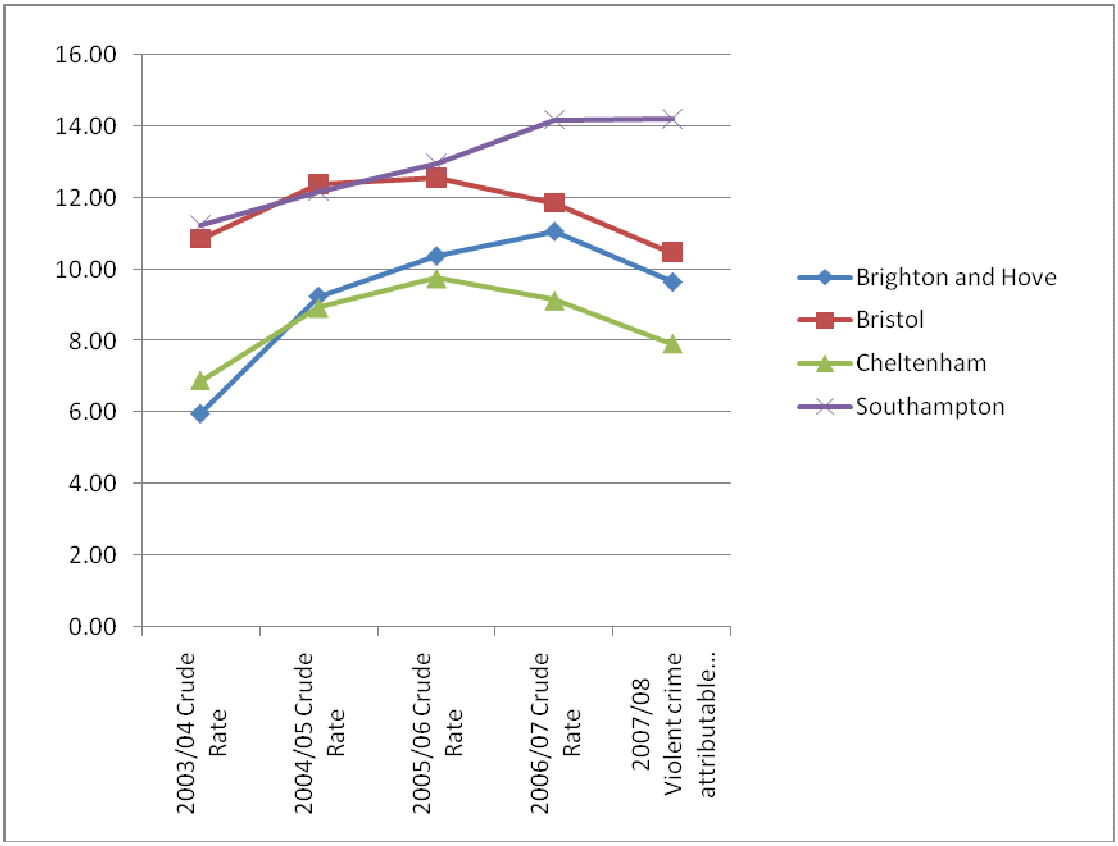
5.8 It is important to consider both measures of violent crime and indicators of the public's perception of levels of violent crime; both have the potential to impact on health and well being.

5.9 The Audit Commission reports Brighton as being in the 4th quartile of Local Authorities in 2005/06 for violent offences committed per 1000 population, *ie* the lowest or worst quartile.

5.10 More recent data published by the North West Public Health Observatory and based on Home Office recorded crime statistics shows the 2007/08 crude rate of violent crime attributable to alcohol per 1000 population for Brighton and Hove to be significantly higher than that for England and the South East region.

5.11 Trend data comparing the crude rate of violent crime attributable to alcohol per 1000 population for Brighton and Hove and the three comparator areas (Figure 3) shows a reduced rate in the latest period (2007/08) for Brighton and Hove, Bristol and Cheltenham. The rate for Southampton is the highest amongst the comparator areas.

Figure 3: Alcohol-related recorded crimes, crude rate per 1,000 population



Alcohol-related recorded crimes, crude rate per 1,000 population. (NWPHO from Home Office recorded crime statistics 2007/08). Attributable fractions for alcohol for each crime category were applied, based on survey data on arrestees who tested positive for alcohol by the Strategy Unit. Primary care organisation values were estimated as a population weighted average of component local authority values.

5.12 Local data provided by Sussex Police for Brighton and Hove (Table 4:) shows a sharp increase in all violent crimes committed under the influence of alcohol in 2006, the latest data for 2008 shows a fall back to 2005 levels.

Table 4: Violent crimes committed under the influence of alcohol in Brighton & Hove

	Year				
Type	**2004**	**2005**	**2006**	**2007**	**2008**
Robbery	64	51	63	57	135
Sexual Offences	79	77	77	71	100
Violence against the person					
105A Assault without injury	235	341	580	594	806
8G Actual bodily harm and other injury	1,419	1,455	1,391	916	1,088
9A Public fear, alarm or distress	163	602	1,057	595	312
Total violence against the person	2,219	2,868	3,558	2,563	2,668
All violent crimes committed under the influence of alcohol	2,362	2,996	3,698	2,691	2,903

Source: Sussex Police, July 2009 unpublished data

5.13 Public fear, alarm or distress in relation to violent crimes committed in Brighton and Hove under the influence of alcohol rose sharply between 2004 and 2006 from 163 to 1057. Since 2006 the level has declined to 312 in 2008.

5.14 Public perceptions of safety are recorded by the British Crime Survey. Figure 4 details the percentages of Brighton and Hove residents who say that they feel fairly safe or very safe outside. More residents feel fairly safe or very safe outside during the day than at night. At night, in 2005/06, 3 out of every 10 residents surveyed felt unsafe (not fairly or very safe) at being outside. Brighton and Hove is in the 2nd best national quartile for the percentage surveyed feeling fairly or very safe outside after dark (2005/6) and in the 1st quartile for the percentage surveyed feeling fairly or very safe outside during the day.

5.15 Public perception of safety is likely to lag behind – is informed by – the events and or reports that influence the perception.

Figure 4: Brighton residents' perceptions of safety

	Year			
	2003/4	**2004/5**	**2005/6**	**2006/7**
Residents surveyed who say that they feel fairly safe outside after dark (%)	70.4	72.6	71.7	Data not available
Ranking against national*	2nd quartile	3rd Quartile	2nd Quartile	71
Residents surveyed who say that they feel fairly safe outside during the day (%)	97.3	Data not available	98.1	98.4
Ranking against national*	3rd Quartile		1st Quartile	1st Quartile

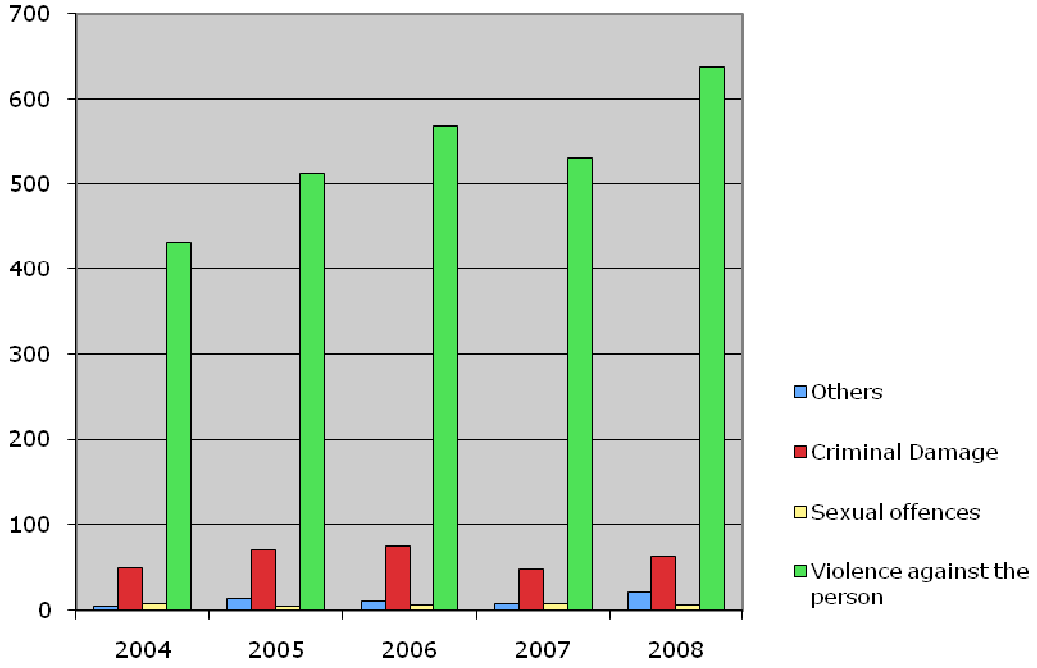
* national ranking 1st quartile = 4
Source: Home Office, British Crime Survey
Taken from http://www.areaprofiles.audit-commission.gov.uk

Monitoring impact on domestic violence

5.16 Local crime data provided by Sussex Police identifies a range of offences recorded as domestic abuse. The two main types of offence recorded as domestic abuse are violence against the person and criminal damage.

5.17 Domestic abuse committed whilst under the influence of alcohol shows nearly a 50% increase over the five year period 2004 to 2008 (Figure 5).

Figure 5: Brighton and Hove domestic abuse crimes committed under the influence of alcohol

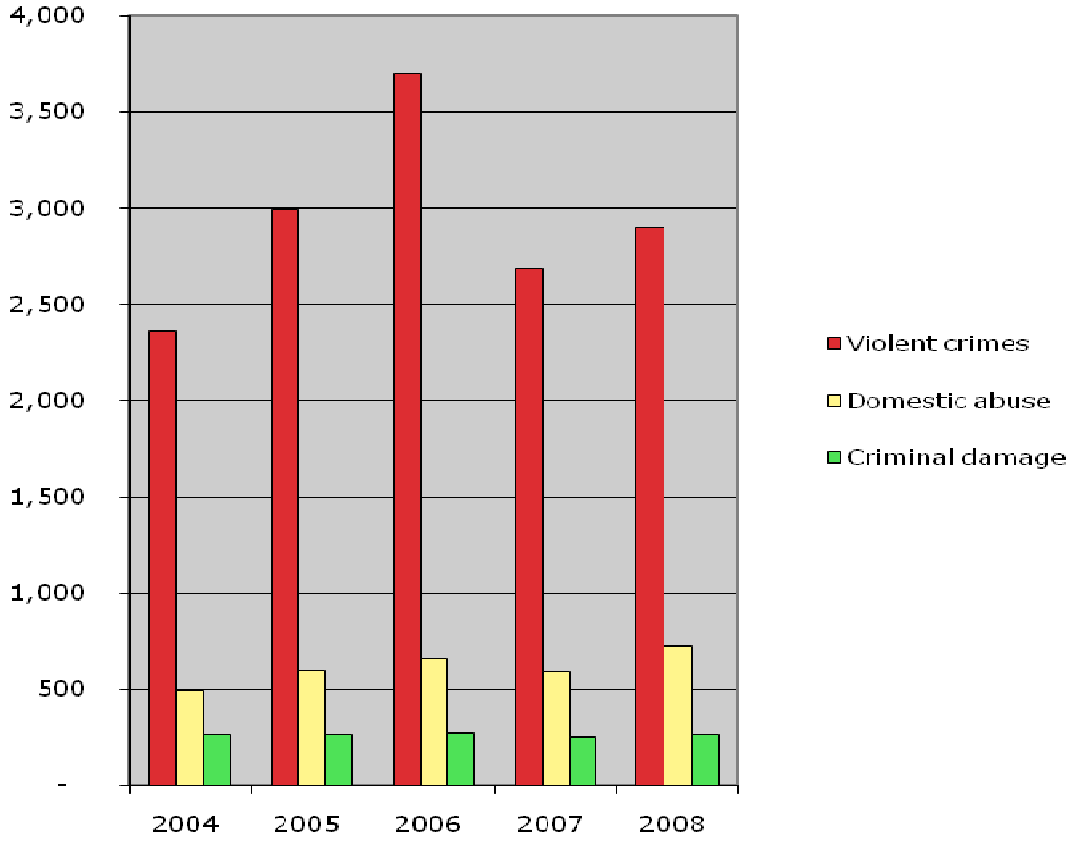


Monitoring impact on alcohol related offending

5.18 The 2007/08 crude rate of recorded crime attributable to alcohol per 1,000 population for Brighton and Hove is significantly higher than that for England and the South East region (18). There is no clear trend amongst the four comparator areas (Figure 3), though Brighton and Hove and Cheltenham consistently show lower rates than Bristol and Southampton.

5.19 Local crime data provided by Sussex Police shows violent crimes to be the major type of crime committed whilst under the influence of alcohol. Over the five year period – 2004 to 2008 – the overall level of crime under the influence of alcohol shows a sharp peak in 2006. The peak in that year related to high levels of violent crimes (Figure 6).

Figure 6: Local crimes under the influence of alcohol



5.20 Contravention of licensing requirements is an important aspect of alcohol related offending. The sale of alcoholic beverages to underage persons is a particular area of concern. Figure 7 shows a gradual decline in the percentage of failed test purchases from nearly 4 out of 10 in 2006/7 to 2.4 out of 10 in 2008/9. The increased number of test purchases conducted in 2008/9 is notable.

Figure 7: Licensing offences in Brighton and Hove

	Year		
	2006/7	**2007/8**	**2008/9**
Number of test purchases	198	124	873
Number failed	76	33	88
% failed	38.4%	26.6%	23.6%

Source: Brighton and Hove City Council Environmental Health, unpublished data.

Reflections on the indicators for measuring progress against the four prescribed impact parameters

5.21 We can see:

- alcohol-related hospital admissions are high and rising;
- alcohol-related recorded crime increased in the year after the introduction of Flexible Alcohol Licensing Hours and has decreased more recently; and
- Brighton and Hove alcohol-related recorded crime is lower than that in Bristol and Southampton but is higher than Cheltenham.

5.22 Much of the data presented above is routinely available. This has advantages in terms of the ease and low costs of obtaining data, and the potential for comparisons with other areas.

5.23 The local crime data provides a greater level of detail and greater potential for further analysis. It also is more time consuming to produce and analyse local data.

5.24 How should these indicators be interpreted? What story do they tell? What can we conclude about the impacts of flexible alcohol licensing from this information?

5.25 Using time trend data we may observe associations between indicators and a stimulus such as the introduction of Flexible Alcohol Licensing Hours. However, from limited analysis such as this it would be unwise to conclude that Flexible Alcohol Licensing Hours was the cause of the observation. For example, alcohol-related hospital admissions have been rising for a number of years prior to the introduction of Flexible Alcohol Licensing Hours.

5.26 Furthemore, these indicators consider a very limited set of parameters: the stakeholder engagement undertaken during this impact assessment identified a wide range of potential positive and adverse impacts of the introduction of flexible alcohol licensing in Brighton and Hove.

5.27 The following sections report on a review of local data to support monitoring across the breadth of impacts identified through our policy and literature review, and engagement activities. The review concludes with a range of suggestions for how the monitoring impacts might be progressed; we refer to this as a "developmental approach".

A developmental approach to monitoring the impacts of Flexible Alcohol Licensing Hours in Brighton and Hove

5.28 We identified the potential impacts of Flexible Alcohol Licensing Hours in Brighton and Hove through literature review and discussion and engagement with local stakeholders. In addition to the evidence cited in the policy section of this report we reviewed publications that focus on data relating to the use and effects alcohol. Sources included an Association of Public Health Observatories report on alcohol (19), Local Alcohol Profiles for England (LAPE) (18), Alcohol Concern Night time economy factsheet, Local Alcohol Strategy Toolkit (20) and Home Office guidance for local partnerships on alcohol-related crime and disorder data.

5.29 There is significant potential overlap between this review work and the Alcohol Health Needs Assessment (HNA) work being undertaken in parallel by the PCT. We maintained close contact with the PCT about the HNA.

Conceptual framework

5.30 Figure 8 shows the conceptual framework used to support the data review work. Figure 8 presents potentially adverse impacts of alcohol. The diagram currently contains a mix of harm related elements and data representing alcohol related harm.

Figure 8: Alcohol related harms

Assessment of routinely available local data

5.31 Based on the framework in Figure 8 we established a long list of indicator topics and assessed what data is available locally to support production of these indicators. In the main telephone interviews were undertaken and contacts were questioned about local data. Key questions asked about local data included:

- source of data;
- geographic level of data – *eg* PCT / ward / Super Output Area / postcode;
- is a male/female split available;
- age breakdown; and
- how regularly produced / what period is data available for?

5.32 Table 5 summarises this review with local service providers: the information is provided by impact theme, possible indicators for monitoring and a narrative of the routinely collected local data.

Findings

5.33 This review identified potential indicators and made initial inquiries into the strengths and weaknesses of local data sources to support the monitoring of those indicators. In general, locally collected data is limited to, and is focussed on, the needs of central reporting purposes. This situation is similar to other local authorities and health service organisations. As a consequence the data rarely enables reliable monitoring of factors such as the impacts of changes in alcohol licensing.

5.34 We found that where knowledge of alcohol consumption is highly relevant to the delivery of services, the recording of alcohol consumption is perceived to be more complete and of better quality: for example in specialist health care treatments or hostels. Providers of services such as street cleaning and vandalism which see alcohol as secondary to the

services they provide tended to express less confidence in the quality of recording of alcohol issues.

5.35 In the following section we consider how a developmental approach to monitoring impacts might be progressed.

Table 5: Long list of indicator topics

Impact theme	Subtopic	Findings / assessment	Geography - internal to Brighton and Hove	Geography – external to Brighton and Hove
1 cultural	1.1 mono-culture (other entertainments cannot afford rates/rents)	Would need analysis of Licensed Premises certificates; possible to do but time consuming	Should be able to postcode	Check Annual Business Inquiry ONS / NOMIS
2 crime and disorder	2.1 drink driving offences	B&H data available through police	Postcode recorded by incident address	Crime comparator data available on Home Office Atlas; exploring publication of alcohol related crime
2 crime and disorder	2.2 licensing offences	B&H data available through police	Postcode recorded by incident address	Crime comparator data available on Home Office Atlas; exploring publication of alcohol related crime
2 crime and disorder	2.3 alcohol-related public disorder offences	B&H data available through police public order sections under 1983 Act	Postcode recorded by incident address	Crime comparator data available on Home Office Atlas; exploring publication of alcohol related crime
2 crime and disorder	2.4 alcohol-related violence	B&H data available through police	Postcode recorded by incident address	Crime comparator data available on Home Office Atlas; exploring publication of alcohol related crime
2 crime and disorder	2.5 fear of crime	Collected as part of annual community safety audit	LAT matrix reports provide loca larea intelligence	Local Area Agreement National Indicator list
2 crime and disorder	2.6 confiscation of alcohol from young adults	B&H data available through police	Postcode recorded by incident address	Crime comparator data available on Home Office Atlas; exploring publication of alcohol related crime
2 crime and disorder	2.7 alcohol-related anti-social behaviour	B&H data available through police	Postcode recorded by incident address	Crime comparator data available on Home Office Atlas; exploring publication of alcohol related crime
2 crime and disorder	2.8 alcohol-related vandalism	B&H data available through police	Postcode recorded by incident address	Crime comparator data available on Home Office Atlas; exploring publication of alcohol related crime

Impact theme	Subtopic	Findings / assessment	Geography - internal to Brighton and Hove	Geography – external to Brighton and Hove
3 education	3.1 fixed exclusions	Sarah Oxenbury: fixed and permanent exclusions from LA schools for children up to 16.	Reasons for exclusion are coded by school (single main reason). Drug and alcohol related category; though may not be seen by school as main reason - issues with completeness of data and cann't breakdown category to alcohol	Available from: http://www.dcsf.gov.uk/rsgateway/nat-stats.shtml
3 education	3.2 attainment	Research findings indicate correlation but insufficient routine data to monitor link to (family) alcohol use		
3 education	3.3 childhood development	Research findings indicate correlation but insufficient routine data to monitor link to (family) alcohol use		
4 employment	4.1 alcohol-related sickness / absence	NWPHO published data came from DWP – not collected by local offices	Further investigation / follow up with DWP required	Published by NWPHO
4 employment	4.2 alcohol-related loss of employment	NWPHO published data came from DWP – not collected by local offices	Further investigation / follow up with DWP required	Published by NWPHO
4 employment	4.3 loss of income due to alcohol-related vandalism	Unable to locate national or local routine data on this		
5 environment	5.1 noise nuisance complaints	EH collected data – time trending should be possible	Concerns over completeness; complainant has to give name for official complaint	Recent move to new CIEH codes plus concerns over completeness of records
5 environment	5.2 fires where alcohol a factor		No meaningful local data collected	Needs further research
5 environment	5.3 street cleaning related to alcohol		Local "intelligence" but lack of data capture	Needs further research
5 environment	5.4 waste from licensed premises / in vicinity of		Local "intelligence" but lack of data capture	Needs further research
6 families	6.1 children in problem drinking households	No response from local key contact (3 attempts made)	Unable to ascertain	Needs further research
6 families	6.2 domestic violence	No response from local key contact (3 attempts made)	Unable to ascertain	Needs further research
6 families	6.3 drinking during pregnancy	No response from local key contact (3 attempts made)	Unable to ascertain	Needs further research

Impact theme	Subtopic	Findings / assessment	Geography - internal to Brighton and Hove	Geography – external to Brighton and Hove
6 families	6.4 children accessing child specific support - alcohol related	No response from local key contact (3 attempts made)	Unable to ascertain	Needs further research
6 families	6.5 parents / carers referred to treatment / support services	No response from local key contact (3 attempts made)	Unable to ascertain	Needs further research
7 health services	7.1 primary care	Data should be recorded by GPs; accessing this ay be problematic	Post coded patient level data should be regularly collected	
7 health services	7.2 hospital admissions	Routinely collected by NHS and Foundation Trusts	Postcoded data should be available locally	NI39 available at Local Authority level from http://www.nwph.net/alcohol/lape/
7 health services	7.3 A&E attendances	Routinely collected by NHS and Foundation Trusts	Postcoded data should be available locally	Local Authority / PCT comparisons available http://www.nwph.net/alcohol/lape/
7 health services	7.4 ambulance callouts	Routinely collected by NHS and Foundation Trusts	Postcoded data should be available locally	Will need further investigation
8 housing	8.1 homeless/rough sleepers with alcohol problems	Contact now made with local service: local includes alcohol issues Local data collected, reporting / access needs to be explored		Will need further investigation
8 housing	8.2 housed tenants with alcohol problems			Will need further investigation
8 housing	8.3 tenancies lost where alcohol is a factor			Will need further investigation
9 individual health and well being	9.1 lifestyle - alcohol consumption		Local Health Counts Survey every 10 years	Local Authority / PCT comparisons available http://www.nwph.net/alcohol/lape/
9 individual health and well being	9.2 stress and mental well being (as result of environmental problems)	Will need further investigation		
9 individual health and well being	9.3 alcohol-related mortality	Routinely available information	Postcode level data held by PCT	Local Authority / PCT comparisons available http://www.nwph.net/alcohol/lape/

Impact theme	Subtopic	Findings / assessment	Geography - internal to Brighton and Hove	Geography – external to Brighton and Hove
9 individual health and well being	9.4 risk-taking sexual activity	Local Authority / PCT comparisons available (http://www.nwph.net/alcohol/lape/)		
9 individual health and well being	9.5 risk of accidents	Will need further investigation	Will need further investigation	Local Authority / PCT comparisons available http://www.nwph.net/alcohol/lape/
9 individual health and well being	9.6 road traffic accidents		Available from local Police data	Local Authority / PCT comparisons available http://www.nwph.net/alcohol/lape/

Considerations for next steps towards monitoring the health and well being impacts of Flexible Alcohol Licensing Hours

5.36 Table 5 on page 40 identifies a number of issues regarding the locally available data. These should be considered as caveats when using information rather than reasons for not developing the use of that data.

Developing a baseline

5.37 In this section we report initial suggestions for such a set of indicators. We also raise a range of issues which we recommend be addressed before additional work is undertaken to develop a baseline and begin monitoring using such indicators.

Links with other local activities

5.38 There are many requirements placed on the City Council and PCT to monitor performance. Where possible, re-use of already published data is preferable.

5.39 The National Indicator set available for Local Strategic Partnerships provides one example of a source of information from which re-use of data may be possible. PCT activities such as local lifestyle surveys and Health Needs Assessment (HNA) work are other examples.

5.40 Detailed investigation of such links has not been possible as part of this assessment; we recommend that these potential links are reviewed as part of the next steps in developing the indicator set.

Developing the local management culture

5.41 Our review work of local data involved interviews with a mix of service managers and 'data custodians'.

5.42 Our interviews have suggested that there is scope for developing the role of data in the management of local services.

5.43 In common with many other local services we have worked with, national data requirements for central monitoring have become the focus of local data collection. We suggest that these central requirements should be seen as a minimum requirement and consideration be given to what data is required locally to inform management of services.

5.44 Our review found a number of instances in which local managers were unable to recall having seen reports based on the data. Data custodians also were unaware of regular or ad hoc reporting of information.

5.45 We suggest that there is scope for local exploitation of routinely collected information. Whilst we emphasise the use of local data to support management of local services, we anticipate this is a development need shared with other local authorities and as such could be addressed collaboratively.

An objectives based approach

5.46 Indicators for monitoring are typically developed in the context of stated objectives. The Licensing Act 2003 has four stated objectives:

- to prevent crime and disorder;
- to prevent public nuisance;
- to protect children from harm; and
- public safety.

5.47 Whilst the national Act is explicit that the Licensing Act 2003 cannot be used for Public Health objectives, Brighton and Hove City Council is not alone in wishing to see this changed at review. We suggest Brighton and Hove collaborate with others, nationally, regionally and at local levels to lobby for this change in the Act.

5.48 Given the commitment of local partners in Brighton and Hove to Public Health aims, it will be instructive for the City Council to consider what Public Health objectives it might wish to

adopt in due course as / when the Licensing Act is amended. In Table 6 we suggest possible indicators for monitoring. These are presented by theme / objectives of the Licensing Act 2003. Indicators are suggested on the basis of a combination of considerations:

- addressing stakeholder issues identified during our engagement activities (reported in section 5);
- creating a balanced portfolio of process and outcomes;
- the of availability of data; and
- scale of the health and well being impacts.

5.49 The "starter pack" of indicators will need refinement and development. The following issues will need to be considered:

- an organisation and a named officer should be responsible for progressing this work;
- analytical support will be required to collate data and present / publish the information; and
- reporting arrangements will need to be agreed.

5.50 We suggest that a panel is established to support development of the indicator set. This could include representation from key stakeholder groups covering the breadth of consultees engaged in our consultation work, including local residents.. This will ensure that the indicators are supported and are considered to cover the wide spectrum of issues involved.

Developing the indicator set

5.51 During this review work a number of issues have arisen which provide useful 'pointers' or considerations for developing an indicator set for monitoring the health and well being impacts of flexible alcohol licensing. These are discussed in the following points.

5.52 As introduced above, the Licensing Act 2003 provides four objectives for which monitoring indicators can be considered. The local aspiration to consider Public Health impacts is welcomed; we suggest the Licensing Committee in partnership with the DPH, establish an explicit local objective. Health and well being indicators to support that objective can then be identified. We anticipate many of these will have been considered in the local Alcohol HNA work.

5.53 Discussions within the impact assessment team and with key officers in the City Council suggest that developing criteria against which applications are judged is an important next step which the indicator development work can inform.

5.54 There is an important legal aspect to supporting Licensing Committee decisions. We are not in a position to advise on legal aspects but recognise the importance of a detailed understanding of the law to enable Committee decisions to withstand legal challenge.

5.55 We recommend that the City Council develops it's approach to monitoring in collaboration with other local authorities. The rationale for this is as follows:

- other Local Authorities are considering or are in the early stages of developing CIA (or equivalents);
- working with peer authorities will provide comparators for indicators;

5.56 Crime & Disorder Reduction Partnership (CDRP) Families have been established by the Home Office to facilitate comparisons. Each CDRP is joined by its 14 most similar CDRPs (based on criteria defined by the Home Office) to form a family group consisting of 15 CDRPs. Brighton and Hove CDRP family includes neighbouring South Coast cities of Portsmouth and Southampton.

5.57 Routinely collected data may be inadequate for fully monitoring health and well being impacts. This presents the opportunity to consider local survey work using local resources; there are examples of residents being trained as community researchers to survey their local population. This provides valued and valuable skills development opportunities for the community researchers and an important community development opportunity.

Table 6: Indicator 'starter pack' for monitoring the impacts of Flexible Alcohol Licensing Hours

Theme / Objective	Commentary / notes	Suggested indicators
To prevent crime and disorder	Crime and disorder data is collected by the Police. This is a relatively well developed local data area. Local data will support area based and time trend analysis. Home Office publications enable comparison with other Local Authorities.	1.1 Social disorder incidents where alcohol is a recorded factor (by youth and non-youth) by location and time of day 1.2 Street nuisance incidents 1.3 Analysis of police (LAT) matrix questionnaires 1.4 Number of licensing offences 1.5 Level of ASBOs *Note: the spread of incidents over a longer time period is an improved scenario for Police but not for local residents.*
To prevent public nuisance	There is an interaction between the Licensing Act and the smoking ban. Concerns have been raised regarding the interpretation of local noise complaints data. Residents are uncomfortable with the process and so an improved process may initially lead to an rise in number of complaints.	2.1 Number of noise nuisance complaints by location and time of day 2.2 Proportion of noise nuisance complaints resolved 2.3 Levels of street cleansing call outs 2.4 Level of conditions placed on licensees 2.5 Number of enforcement visits per 100 licensees 2.6 Ratio of conditions: enforcement visits 2.7 Number of homeless with alcohol problems 2.8 Numbers of tenants with alcohol related support needs
To protect children from harm		3.1 Number of children on child protection register in problem drinking households 3.2 Rate of fixed term school exclusions where drugs / alcohol a factor 3.3 Rate of permanent school exclusions where drugs / alcohol a factor 3.4 Rate of young people accessing specialist alcohol treatment services 3.5 Number of test purchases carried out 3.6 Failed tested purchases as proportion of tests 3.7 Ratio of failed test purchases: premise reviews

Theme / Objective	Commentary / notes	Suggested indicators
Public Safety	There is a link with Health and Safety legislation	4.1 Fear of alcohol related violence and disorder 4.2 Analysis of police (LAT) matrix questionnaires 4.3 Number and rate of employee accidents in licensed premises 4.4 Levels of employee and DPS training sessions attended 4.5 Number (percentage) of motorists failing breath test
Public Health	This theme contains a range of health and well being related indicators. There will almost certainly be overlap between these and Alcohol HNA monitoring data	5.1 Levels of ambulance call outs for alcohol related assaults 5.2 A&E attendances for alcohol related injury 5.3 Alcohol consumption levels by age and sex 5.4 Alcohol related sickness / absence from work 5.5 Mix of licensed premise types (are local community pubs declining? Is there an increased in the number of family friendly licensed premises)

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7. Appendices

Appendix A: Methodology

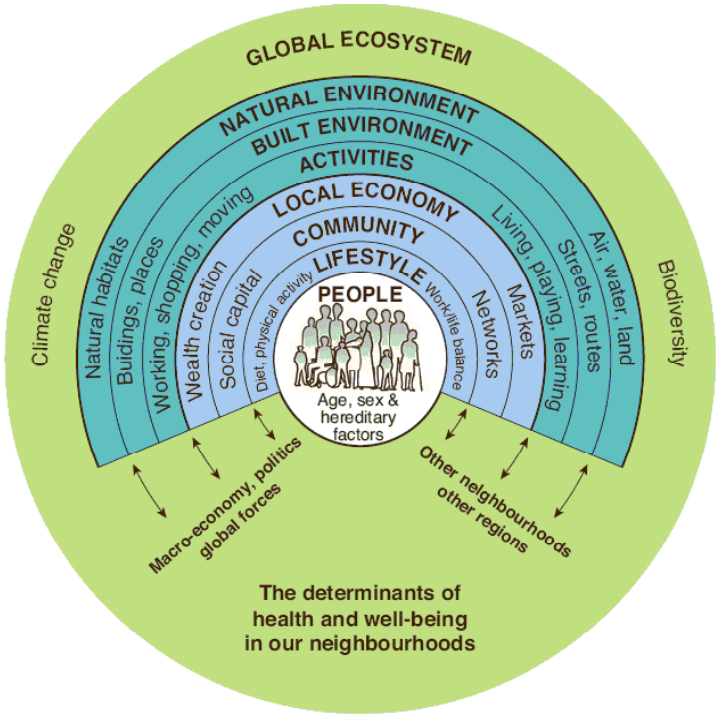
7.1 HIA is based upon a socio-ecological model of health. The HIA framework moves beyond analysing healthcare services, which help people when they are ill, to assessing the effects of development upon major health 'assets', which help people stay healthy (21).

7.2 Health Impact Assessment (HIA) may be defined as (21)

… a combination of procedures, methods and tools that systematically judges the potential, and sometimes unintended, effects of a policy, plan, programme or project on the health of a population and the distribution of those effects within the population. HIA identifies appropriate actions to manage those effects.

7.3 HIA is guided by the World Health Organization (WHO) definition of health as not just the absence of sickness but the attainment of a complete state of mental and physical well being. Thus, the emphasis is upon factors that make people healthy and prevent them from becoming sick (health assets) rather than on those that help them once they are ill (healthcare). This socio-ecological model is based on individuals and society as co-producers of health (see Figure 9).

Figure 9: Health map of the human habitat



See Barton and Grant (22)

7.4 The outline proposal for the assessment identified four key stages as:

- First stage: project start up;
- Second stage: Literature review - scoping and review of key documents and evidence;
- Third stage: Stakeholder consultation; and
- Fourth stage: Appraisal and analysis and preparation and presentation of final report.

7.5 Key outputs for each stage were identified and agreed at an inception meeting (14th July 2008). The outputs are included as Appendix A to this report.

7.6 This is the final report of the assessment work, building on the report of the second stage (September 2008) and the interim report to the April 2009 Brighton and Hove Licensing Committee.

HIA Steering Group

7.7 The HIA has been supported by a multi disciplinary Steering Group and a HIA Management Team comprised of key PCT and City Council Officers.

7.8 The Steering Group have provided quality assurance input to this final report. A face to face meeting has been held with the HIA Management Team (May 2009) to discuss key findings and recommendations.

7.9 A briefing for the Brighton and Hove Council press team has been prepared (Tim Nichols, see Appendix A on page 52) and the press team advised of the need to consider a communications strategy around this agenda.

Stakeholder consultation

7.10 A series of six interactive consultation events was undertaken as part of the health impact assessment (HIA) of the introduction of Flexible Alcohol Licensing Hours in Brighton and Hove commissioned by Brighton and Hove City Teaching Primary Care Trust (PCT) and managed by Licensing in BHCC.

7.11 Four main groups of stakeholders were agrred with the Steering Group and consulted with:

- General public, including residents associations/networks;
- Licensees and other business interests and associations;
- Service providers including Public sector staff on "frontline" – ambulance, A&E, police & fire & rescue, including dedicated team for West Street and Drug and Alcohol Action Team & their extended networks, e.g. Community Safety Partnership, Crime & Disorder Reduction Partnership, Magistrates Court, and Services for Children and Young People;
- Elected members.

7.12 Apart from service providers, who were consulted using a workshop format, stakeholders were consulted using focus groups (two for residents, two for licensees and their staff, and one for elected members of BHCC).

7.13 All stakeholders were asked the following questions.

- What are your concerns about the introduction of Flexible Alcohol Licensing Hours in Brighton and Hove?
- What are your positive expectations about the introduction of Flexible Alcohol Licensing Hours in Brighton and Hove?
- What do think are the impacts on health and well-being (positive and negative) of the introduction of Flexible Alcohol Licensing Hours in Brighton and Hove?
- What can be done to address the impacts of the introduction of Flexible Alcohol Licensing Hours in Brighton and Hove?

Data and monitoring

7.14 Based on the framework in Figure 8 we established a long list of indicator topics and assessed what data is available locally to support production of these indicators. In the main telephone interviews were undertaken and contacts were questioned about local data. Key questions asked about local data included:

- source of data;
- geographic level of data – *eg* PCT / ward / Super Output Area / postcode;
- is a male/female split available;
- age breakdown; and
- how regularly produced / what period is data available for?

7.15 Table 5 summarises this review with local service providers: the information is provided by impact theme, possible indicators for monitoring and a narrative of the routinely collected local data.

7.16 We consider two approaches to monitoring the impacts of Flexible Alcohol Licensing Hours. The first approach responds to the request in the consultant's brief that consideration be given to monitoring progress against the following local impact parameters:

- reduce impact on acute hospital;
- reduce public place violent crime;
- reduce domestic violence; and
- reduce alcohol related offending.

7.17 The second approach considers a developmental approach to be followed by partners to address shortcomings of the first approach.

7.18 The indicators are a mix of local and nationally available data. Where possible we look at comparator authorities. The HIA Steering Group advised that comparators be taken from the Office of National Statistics Local Authority Comparator areas and the Home Office Crime and Disorder Reduction Partnership families. On this basis we used the following comparator areas:

- Bristol;
- Cheltenham; and
- Southampton.

Appendix B: Detailed analysis of stakeholder consultation

7.19 In this appendix we look at the impacts that people identified in the consultation events. We show the findings in tables: for each theme we show whether the identified impact is positive or adverse, shorter or longer term, and who is affected.

7.20 One of the main outcomes of the introduction of Flexible Alcohol Licensing Hours has been the increase in the availability of alcohol through several routes including extended opening hours at licensed premises, an increase in the number and range of off-licensed outlets and increased competition among different types of licensed premises leading to lower prices. This has had a range of effects and subsequent impacts on health and well-being.

7.21 Suggestions to enhance any positive effects and to minimize adverse effects are in the Public Health Management Plan in Table 2 on page 15.

Impacts identified by residents

7.22 The negative impacts of the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove on the health and well-being of residents are shown in Table 7. The inter-relationship of these effects is shown in Figure 12 on page 72.

7.23 Major negative impacts on the health and well-being of residents are related to sleep disturbance, loss of sleep and sleep deprivation, as a result of exposure to noise, especially during the early hours of the morning. The effects of sleep loss can be serious, with implications for not only the home life (e.g. irritability, lack of patience, anger, frustration, increased risk of accidents) but also the working life of the residents affected (poor performance at work). These impacts on mental health can lead to stress, anxiety and depression.

7.24 Another group of negative impacts on the health and well-being of residents are the feelings of fear, intimidation and lack of safety as a result of exposure to antisocial, threatening and abusive behaviour, vandalism and crime and disorder. All of which have a considerable effect on the emotional, mental and physical quality of life of residents, but in particular on families with children and older people, including increased social isolation and reduced social contact and support. It may also affect levels of exercise and physical activity taken, particularly in open spaces frequented by street drinkers and especially for women, children and people with mobility problems.

7.25 The combined effects of noise and antisocial behaviour on residents can also lead to reduced social cohesion in residential communities.

7.26 Residents also described how the negative impacts of the introduction of Flexible Alcohol Licensing Hours had been exacerbated by the introduction of a ban on smoking in public places and the licensing of seating and tables by Highways, both of which encourage the congregation of smokers and drinkers outside licensed premises.

7.27 In addition to the negative impacts on health and well-being of the introduction of Flexible Alcohol Licensing Hours, residents also identified negative impacts on their health and well-being as a result of the new regulatory system for licensing premises for the sale of alcohol. The main difficulty is the lack of anonymity when residents wish to make representations or complaints about individual premises. This can lead to a difficult relationship with the landlord or premises owner, which has sometimes resulted in the intimidation of the residents involved by the premises owner, landlord or their associates.

7.28 The intimidation of residents can result in fear and depression, and a feeling of powerlessness, especially with respect to the regulatory system. Fear may also lead to under-reporting of nuisance and/or infringements of licensing conditions which will present regulators with a distorted view of situation/conditions for residents. Overall, there can be a feeling that justice is not done which leads to resentment and disempowerment.

7.29 Finally, residents also mentioned the negative impacts on the health of people consuming alcohol to excess, especially for under-age drinkers.

Table 7: Negative impacts on health and well-being - identified by residents

Outcome of the introduction of Flexible Alcohol Licensing Hours	Effects of proposal implementation	Determinants of health and well-being affected	Affecting …
Extended opening hours for licensed premises	***Availability of alcohol over longer time period*** Increased: consumption of alcohol; levels of drunkenness; binge drinking; antisocial behaviour into early hours of morning; noise into early hours of morning; vandalism to private and public property; environmental degradation (litter, vomit, urine); crime and disorder, including violence.	Sleep disturbance Sleep loss Inability to sleep Sleep deprivation Increased irritability Lack of patience Anger Frustration Intimidation Fear of crime Fear of antisocial behaviour Reduced feelings of personal safety Increased social isolation Decreased social cohesion Stress and anxiety Depression Poor performance at work Increased risk of accidents	Residents Residential communities *Vulnerable groups:* Families; Children; Older people, especially those already socially isolated
Increased number and range of outlets selling alcohol	***Increased availability of alcohol through price*** Increased competition among licensed premises leading to pressure on licensed premises: to reduce price of alcohol; to offer promotions on alcohol; to stay open longer (*see above for impacts*); to offer entertainment (potential source of noise – *see above for impacts*). Alcohol consumption in public spaces by street drinkers and under-age drinkers	Intimidation Fear of crime Fear of antisocial behaviour Reduced feelings of personal safety Increased social isolation Reduced social contact Reduced levels of social support Reduced levels of physical activity and/or exercise	Residents *Vulnerable groups:* Women Older people Children Young people Families People with mobility problems
Combination of introduction of Flexible Alcohol Licensing Hours, licensing of seating/tables on highways and ban on smoking in public places	Infringement of licensing conditions Congregation of smokers and drinkers outside licensed premises Exacerbation of noise levels Obstruction to pavements and highways	Intimidation Fear of antisocial behaviour Reduced feelings of personal safety Increased social isolation Reduced social contact Reduced levels of social support Reduced levels of physical activity and/or exercise Increased risk of accidents	Residents Residential communities *Vulnerable groups:* Families; Children; Older people, especially those already socially isolated People with mobility problems

Outcome of the introduction of Flexible Alcohol Licensing Hours	Effects of proposal implementation	Determinants of health and well-being affected	Affecting ...
New regulatory system for the licensing of premises to sell alcohol	Lack of anonymity for residents who wish to make representations or a complaint about individual premises Under-reporting by residents of infringements of licensing conditions Failure to make representations	Intimidation Stress & anxiety Exposure to abusive or threatening behaviour Fear Depression Powerlessness Resentment Disempowerment	Residents

7.30 Residents identified very few positive impacts on health and well-being as a result of the introduction of Flexible Alcohol Licensing Hours, and the positive impacts they identified were associated with the increase in the number of licensed premises that sell food, which they felt could encourage the consumption of food with alcohol and may ameliorate the effect of alcohol consumption.

Impacts identified by licensees

7.31 The negative impacts on health and well-being from the introduction of Flexible Alcohol Licensing Hours as identified by licensees are shown in Table 8.

7.32 One of the main outcomes of the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove identified by licensees has been a change in drinking behaviour and culture, resulting from the longer time period over which people are able to drink and the increased availability of alcohol through price, which has led to "frontloading" (the consumption of alcohol at home or in other private settings before going out to drink later). The main effect of these changes is to displace and extend the negative effects of drunkenness into the early hours of the morning, which has implications not only for residents but also for service providers in the public sector including the police and transport operatives. It is also possible that the negative impacts of drunkenness will affect tourists and visitors and, f they cease to visit Brighton & Hove, the city's economy.

7.33 In addition, the increased availability of alcohol through an increased number and greater range of outlets has led to the consumption and increased consumption of alcohol in different settings, such as the domestic setting or in public spaces. Consumption of alcohol in a domestic setting may have "hidden" effects such as an increase in domestic violence, reduced family cohesion and a breakdown in family structure. By comparison the consumption of alcohol in public places exacerbates other outcomes of the introduction of Flexible Alcohol Licensing Hours, e.g. increased antisocial behaviour.

7.34 Licensees also identified the impacts of the introduction of Flexible Alcohol Licensing Hours on people working at licensed premises, most of which resulted in stress including the increasing amount of legislation and regulation, the changes in working patterns associated with extended licensing hours and the conflict with residents and the local authority as regulatory agency.

7.35 Furthermore, licensees highlighted the stress from trying to maintain the viability of their businesses, including the cost of compliance, increased overheads (from longer opening hours) and reduced profits (as a result of competition from a greater number of outlets including off-licences and particularly supermarkets). This stress can be so great some licensees have committed suicide.

7.36 Finally, licensees identified the stress of becoming a social pariah and scapegoated for the effects of increased availability of alcohol, even though the majority of licensees work hard to fulfill the conditions of their licences.

Table 8: Negative impacts on health and well-being - identified by licensees

Outcome of the introduction of Flexible Alcohol Licensing Hours	Effects of proposal implementation	Determinants of health and well-being affected	Affecting …
Extension of opening hours	***Change in patterns of drinking behaviour*** Consumption of alcohol over a longer period of time leading to: increased levels of drunkenness; displacement & extension of impacts – noise, antisocial behaviour & crime – into early hours of morning	Sleep disturbance Loss of sleep Stress	Residents Tourists Visitors *In addition:* Stress will also affect police on duty
Increased number and range of outlets selling alcohol giving rise to competition and a relatively low price for alcohol	***Change in patterns of drinking behaviour*** "Frontloading" – consumption of alcohol at home or in other private setting before going out later leading to: Increased levels of drunkenness; Displacement & extension of impacts – noise, antisocial behaviour & crime – into early hours of morning	Sleep disturbance Loss of sleep Stress	Residents Tourists Visitors
Increased number and range of outlets selling alcohol giving rise to competition and a relatively low price for alcohol	***Change in patterns of drinking behaviour*** Increased alcohol consumption in a domestic setting	Reduced family cohesion Breakdown of family structure Increased risk of domestic violence	Families *Vulnerable groups:* Women Children
Increased number and range of outlets selling alcohol giving rise to competition and a relatively low price for alcohol	***Change in patterns of drinking behaviour*** Increased alcohol consumption in public spaces leading to: Increased drunkenness; Increased antisocial behaviour; Threatening and abusive behaviour	*For those subject to behaviour of drinkers:* Intimidation Fear of antisocial behaviour Social isolation Reduced social contact & support *For those drinking alcohol:* Increase in risk of: alcoholism; alcoholic liver disease; misuse of other substances, e.g. illicit drugs; mental health problems.	Residents *Groups vulnerable to effects of alcohol consumption:* Street drinkers Children Young people *In addition:* Parents, carers and families of young people who drink will experience stress

Outcome of the introduction of Flexible Alcohol Licensing Hours	**Effects of proposal implementation**	**Determinants of health and well-being affected**	**Affecting ...**
Increased availability of alcohol	Potential increase in underage drinking	Harm to health during physical development Increase in risk of risk-taking behaviour, which could lead to: substance misuse; sexually transmitted diseases; unwanted pregnancy.	Children Young people *In addition:* Parents, carers and families of young people who drink will experience stress
Extension of opening hours	Changes to working patterns: later opening hours; different shifts;	Loss of sleep Stress and anxiety Irritability Short temper "Burn out" Lack of capacity to plan: reduced leisure opportunities; less social contact and support.	Licensees Employees at licensed premises, including designated premises supervisor (DPS)
Increased number and range of outlets selling alcohol giving rise to competition & changes in drinking behaviour	Increased overheads from longer opening hours Reduced profit margins for licensed premises Closure of licensed premises Loss of jobs Reduced amount of money in local economy	Stress & anxiety Increased risk of suicide Reduced level of disposable income	Licensees Employees at licensed premises, including DPS
New regulatory system	Cost of compliance (financial and human) Risks of non-compliance Reduced profit margins Conflict with residents Potential conflict with regulatory authority	Stress & anxiety Reduced level of disposable income Increased risks of health impacts from: loss of business; loss of jobs.	Licensees Employees at licensed premises, including DPS
Residents exposed to negative effects of introduction of Flexible Alcohol Licensing Hours	Stigma attached to certain aspects of and jobs in the leisure industry	Loss of social status and respect Feelings of injustice Stress & anxiety	Licensees Employees at licensed premises, including DPS
Tourists and visitors exposed to negative effects of introduction of Flexible Alcohol Licensing Hours	Poor image and reputation of Brighton & Hove Reduced tourist & visitor numbers	Reduced amount of money in local economy Loss of jobs Closure of businesses Reduced family cohesion Stress & anxiety Increased demand for some public and voluntary sector services	Residents Employers Employees Public sector providers Voluntary sector providers

7.37 Licensees were able to identify several positive impacts on health and well-being following the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove, particularly with respect to boosting the local economy as follows: increasing the number of tourists, increasing the job opportunities available, increasing the retention of money in the local economy through increased income and contributing to the retention of graduates in the city, thereby improving the quality of the workforce, due to its night-time economy.

7.38 Other potential positive impacts of the introduction of Flexible Alcohol Licensing Hours identified by licensees are a reduction in some types of crime in Brighton & Hove as a result of greater security and policing in the city centre. It is also possible that increased security arrangements at licensed premises have reduced stress on police services. Both these effects may reduce the number of people becoming victims of crime and suffering the mental and/or physical impacts of crime.

7.39 Finally, with the staggered closing times now in operation there may be two further positive effects: the potential to reduce binge drinking due to a reduced imperative to "drink up" and a reduction in "flashpoints" for crime and disorder as customers are no longer vacating premises all at the same time.

Impacts identified by service providers

7.40 The identification of impacts on health and well-being of the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove was discussed by service providers in relation to the four objectives in the Licensing Act 2003: the prevention of crime and disorder; public safety; the prevention of public nuisance; the protection of children from harm.

The prevention of crime and disorder

7.41 The service providers discussing the objective of the prevention of crime and disorder in relation to the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove also identified changes in drinking patterns and culture as one of the main outcomes of implementing the legislation. These changes are the consumption of alcohol over a longer period of time and into the early hours of the morning (but sometimes as late as 6 a.m.) and increased consumption of alcohol in the domestic setting.

7.42 The negative impacts on health and well-being of the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove identified by service providers discussing the prevention of crime and disorder are shown in Table 9.

7.43 The consumption of alcohol into the early hours of the morning has lead to the extension of crime and antisocial behaviour into the early hours of the morning, leading to intimidation, fear and the potential for social isolation in residents, and to a reduced social cohesion in communities.

7.44 Indiscriminate violence was of particular concern, and those at increased risk, especially of physical injury, were police officers, public transport operatives, A&E staff and people with alcohol use problems. The lesbian, gay, bisexual and transgender community were thought to be at increased risk of hate crime.

7.45 The increased consumption of alcohol in a domestic setting could lead to reduced family cohesion, a breakdown in family structure and an increased risk of domestic violence.

7.46 If tourists and visitors to Brighton & Hove are exposed to the negative effects of the introduction of Flexible Alcohol Licensing Hours this could mar the image and reputation of the city and have adverse effects on the local economy eventually affecting the entire population. The establishment of the CIA and SSAs might contribute to a poor image and reputation for the city, and they may also mean that some of the community avoid these areas, thereby reducing social cohesion further.

7.47 Finally, the development of a 24-hour economy with a highly active night-time economy, which led to changes in patterns of drinking behaviour, has increased demand for certain public services during the early hours of the morning, especially police services, health services and the noise patrol. However, a lack of resources and capacity to respond to the changes in demand may have reduced the quality and effectiveness of those services

during the early hours, which not only has impacts on service provider and service users but also concomitant effects on the community.

Table 9: Negative impacts on health and well-being - identified by service providers focussing on the prevention of crime and disorder

Outcome of the introduction of Flexible Alcohol Licensing Hours	Effects of proposal implementation	Determinants of health and well-being affected	Affecting …
Extension of opening hours	***Change in patterns of drinking behaviour*** Consumption of alcohol over a longer period of time leading to extension into early hours of morning of: antisocial behaviour; violence; other crimes, e.g. damage to property; potential for hate crime.	Intimidation Fear of crime Fear of antisocial behaviour Social isolation Reduced social contact & support Reduced social cohesion Physical injury Stress & anxiety *For public sector workers:* Loss of employment through incapacity Reduced disposable income	Residents *Vulnerable groups with respect to violent crime:* Police officers Taxi drivers Bus drivers Staff in Accident & Emergency People with alcohol or drug use problems *Vulnerable groups with respect to hate crime:* Lesbian, gay, bisexual and transgender community
Increased availability of alcohol	***Changes in patterns of drinking behaviour*** Increased consumption of alcohol particularly in a domestic setting	Reduced family cohesion Breakdown of family structure Increased risk of domestic violence	Families *Vulnerable groups:* Women Children
Increase in number of off-licences selling alcohol	Increase in antisocial behaviour	Intimidation Fear of antisocial behaviour Social isolation Reduced social contact and support Reduced social cohesion	Residents *Vulnerable groups:* Children Older people Women
Tourists and visitors exposed to negative effects of introduction of Flexible Alcohol Licensing Hours	Poor image and reputation of Brighton & Hove Reduced tourist & visitor numbers	Reduced amount of money in local economy Loss of jobs Closure of businesses Reduced family cohesion Stress & anxiety Increased demand for some public and voluntary sector services	Residents Employers Employees Public sector providers Voluntary sector providers

Outcome of the introduction of Flexible Alcohol Licensing Hours	**Effects of proposal implementation**	**Determinants of health and well-being affected**	**Affecting ...**
Introduction of CIA and SSAs	Poor image and reputation of Brighton & Hove Reduced tourist & visitor numbers	Reduced amount of money in local economy Loss of jobs Closure of businesses Reduced family cohesion Stress & anxiety Increased demand for some public and voluntary sector services	Residents Employers Employees Public sector providers Voluntary sector providers
Introduction of CIA and SSAs	Avoidance of CIA and SSAs	Reinforcement of existing social groupings Reduced social contact and support Reduced social cohesion	Population of Brighton & Hove
Development of a 24-hour economy with a highly active night-time economy	Changes to drinking behaviour and culture Changes to pattern of crime and disorder Increased demand for public services especially into early hours of morning	Lack of capacity and resources to respond to demand Reduced quality and effectiveness of services *Public service staff:* Stress & anxiety	Public services including: Police services; NHS services; Noise patrol. *In addition:* Some service users may experience poor outcomes

7.48 Service providers discussing the prevention of crime and disorder did not identify any positive impacts on health and well-being arising from the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove.

Public safety

7.49 The service providers discussing the objective of public safety in relation to the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove identified a further aspect of the change in drinking behaviour and culture since the implementation of the legislation: the displacement of lower-income groups to the street and other public spaces to consume alcohol due to the increased cost of drinking in licensed premises.

7.50 The negative impacts on health and well-being of the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove identified by service providers discussing the prevention of crime and disorder are shown in Table 10.

7.51 The displacement of lower-income groups to the street and other public spaces to consume alcohol exposes residents and others to antisocial and threatening behaviour and the people who are drinking to an increased risk of being a victim of crime and to other substances including illicit drugs.

7.52 Other negative impacts identified were associated with the "hotspots" of noise, antisocial behaviour and crime and disorder, including violence and damage to property, that have developed as a result of the combined effects of the introduction of Flexible Alcohol Licensing Hours and the ban on smoking in public places where smokers and drinkers congregate on the street outside licensed premises. These can become "no go" areas, and are difficult to manage due to their transience. The effects are experienced mainly by residents, with some groups at greater risk of social exclusion. In addition, children and young people can be exposed to a model of drinking behaviour, which if followed could harm their health and well-being in future.

Table 10: Negative impacts on health and well-being - identified by service providers focussing on public safety

Outcome of the introduction of Flexible Alcohol Licensing Hours	Effects of proposal implementation	Determinants of health and well-being affected	Affecting ...
Greater cost of drinking at licensed premises compared with cost of purchasing alcohol from off-licensed premises	***Changes in drinking culture*** Lower income groups drink on street or in public spaces	Intimidation Fear of antisocial behaviour Fear of crime Social isolation Reduced social contact & support Stress & anxiety *For people drinking in public places:* Increased risk of exposure to other substances, e.g. illicit drugs Increased risk of being a victim of crime	Residents *Groups vulnerable to effects of alcohol consumption:* Street drinkers Children Young people
Combined effect of Licensing Act 2003 and ban on smoking in public places	***Changes in drinking culture*** Large groups of smokers & drinkers on street outside licensed premises	"Drinking" schools a model for future behaviour patterns	Residents *Vulnerable groups:* Children Young people
Combined effect of Licensing Act 2003 and ban on smoking in public places	Increase in number of "hotspots" of noise, antisocial behaviour and crime & disorder including violence and damage to property Transience of "hotspots" Difficulties managing "hotspots"	Intimidation Fear of antisocial behaviour Fear of crime Social isolation Reduced social contact & support Stress & anxiety Increased risk of accidents Physical injury	Residents *Vulnerable groups:* Families Children Older people *Groups vulnerable to violence:* Taxi drivers

7.53 Service providers discussing public safety did not identify any positive impacts on health and well-being arising from the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove.

The prevention of public nuisance

7.54 The service providers discussing the objective of the prevention of public nuisance in relation to the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove identified changes in drinking behaviour, including "frontloading".

7.55 The negative impacts on health and well-being of the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove identified by service providers discussing the prevention of public nuisance are shown in Table 11.

7.56 Service providers focusing on the prevention of public nuisance highlighted the negative impact of noise, especially into the early hours of the morning, on the quality of life and mental health of residents. Antisocial behaviour was also noted as a source of negative effects including the potential for social isolation and reduced social contact through fear and feeling unsafe particularly in older people and women. At a community level, this could also lead to a lack of social cohesion. Those who become socially isolated may also increase their consumption of alcohol at home.

7.57 The negative effects of Flexible Alcohol Licensing Hours on staff working at licensed premises were also identified resulting from a change in working patterns which could also lead to social isolation and reduced leisure opportunities.

7.58 The increased competition as a result of the increase in the number and range of outlets selling alcohol could result in the closure of businesses especially small local public houses unable to compete with larger chains. The loss of income not only will affect the mental health of employers and employees but will also affect the local economy.

7.59 Other negative effects of the introduction of Flexible Alcohol Licensing Hours include an increase in the number of fast food outlets, reducing the quality of people's diets, an increase in littering, which can increase the risk of accidents, and the congregation of smokers and drinkers outside licensed premises (a result of the smoking ban in public places), which can obstruct pavements and highways and thereby increase the risk of accidents, particularly road traffic accidents.

7.60 Apart from the nuisance from the noise and antisocial behaviour in the early hours of the morning, the potential for crime, particularly violence, during the dispersal of people who have been drinking is a further negative effect, particularly for people operating, waiting for or using public transport.

7.61 Finally, the image and reputation of Brighton & Hove might suffer as a result of the negative effects of the introduction of Flexible Alcohol Licensing Hours, which in turn might harm the local economy including business and job opportunities for local people.

Table 11: Negative impacts on health and well-being - identified by service providers focussing on the prevention of public nuisance

Outcome of the introduction of Flexible Alcohol Licensing Hours	**Effects of proposal implementation**	**Determinants of health and well-being affected**	**Affecting ...**
Extended opening hours for licensed premises	***Availability of alcohol over longer time period*** Noise into early hours of morning Antisocial behaviour into early hours of morning	Poorer quality of life Reduced mental health Fear of crime Fear of antisocial behaviour Reduced feelings of personal safety Increased social isolation Reduced social contact & support Reduced social cohesion	Residents *Vulnerable groups:* Families Children Older people Black and minority ethnic (BME) groups Lesbian, gay, bisexual and transgender (LGBT) community
Increased number and range of outlets selling alcohol	***Increased availability of alcohol through price*** "Frontloading" Noise into early hours of morning Antisocial behaviour into early hours of morning	Fear of crime Fear of antisocial behaviour Reduced feelings of personal safety Increased social isolation Reduced social contact & support Reduced social cohesion	Residents *Vulnerable groups:* Families Children Older people BME groups LGBT community
Residents exposed to negative effects of introduction of Flexible Alcohol Licensing Hours	Increased social isolation Reduced mental health	Potential for increased consumption of alcohol in domestic setting Increased risk of: alcoholism; alcoholic liver disease.	*Vulnerable groups:* Women Older people Other people already socially isolated

Outcome of the introduction of Flexible Alcohol Licensing Hours	**Effects of proposal implementation**	**Determinants of health and well-being affected**	**Affecting ...**
Extension of opening hours	Changes to working patterns: later opening hours; different shifts.	Potential for social isolation Reduced social contact & support	Licensees Employees at licensed premises, including designated premises supervisor (DPS)
Increased number and range of outlets selling alcohol giving rise to competition	Increased overheads from longer opening hours Reduced profit margins for licensed premises Closure of licensed premises, especially small local public houses Loss of jobs Reduced amount of money in local economy	Stress & anxiety Increased risk of suicide Reduced level of disposable income	Licensees Employees at licensed premises, including DPS
Combined effect of Licensing Act 2003 and ban on smoking in public places	Large groups of smokers & drinkers on street outside licensed premises Obstruction of pavements and highways Littering & other hazards e.g. broken glass	Increased risk of accidents, including road traffic accidents Physical injury Increased exposure to vermin	Residents People smoking/drinking outside Drivers Cyclists Pedestrians *Vulnerable groups:* Young people People with mobility problems
Dispersal of people who have been drinking into early hours of morning	Increase in violence	Physical injury	Users of public transport Public transport operatives
Increased activity in night-time economy	Increase in number of fast food outlets	Increased intake of energy-dense foods Increased risk of overweight & obesity	People who purchase food from fast food outlets
Increased activity in night-time economy	Increase in number of fast food outlets Increased littering	Increased risk of accidents Increased exposure to vermin	Residents *Vulnerable groups:* People with mobility problems
Tourists and visitors exposed to negative effects of introduction of Flexible Alcohol Licensing Hours	Poor image and reputation of Brighton & Hove Reduced tourist & visitor numbers	Reduced amount of money in local economy Loss of jobs Closure of businesses Reduced family cohesion Stress & anxiety Increased demand for some public and voluntary sector services	Residents Employers Employees Public sector providers Voluntary sector providers

7.62 Service providers discussing the prevention of public nuisance identified a few positive impacts on health and well-being arising from the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove. Staggered closing times meant that people drinking on licensed premises can phase their alcohol consumption over a longer period of time and there are no longer flashpoints for crime and disorder at 11 p.m., the previous closing time. Owing to increased activity in the night-time economy, the greater number of people in the city

centre could reduce fear of crime and antisocial behaviour. Finally, some consumer groups, e.g. people who work in the evenings, can now have access to alcohol in their leisure hours

The protection of children from harm

7.63 The service providers discussing the objective of the protection of children from harm in relation to the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove identified changes in drinking behaviour relating to increased consumption in a domestic setting as a result of the increased availability of alcohol through an increase in the number and range of outlets selling alcohol leading to lower prices.

7.64 The negative impacts on health and well-being of the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove identified by service providers discussing the protection of children from harm are shown in Table 12.

7.65 The negative impacts identified are the harms to children and young people when their parents or carers consume increased amounts of alcohol in a domestic setting as a result of off-sales. Not only does this provide a model for drinking behaviour in children and young people but the children and young people could experience a range of hidden harms including a poor diet, lack of nurturing and an interrupted education, which could result in a failure to thrive and may affect a child's life-course.

Table 12: Negative impacts on health and well-being - identified by service providers focussing on the protection of children from harm

Outcome of the introduction of Flexible Alcohol Licensing Hours	Effects of proposal implementation	Determinants of health and well-being affected	Affecting ...
Increased number and range of outlets selling alcohol	***Increased availability of alcohol through price*** Increased consumption of alcohol in a domestic setting Open use of alcohol by parents & carers	Use of alcohol by parents & carers a model for future behaviour patterns "Hidden" harms including: poor diet; poor dental health; lack of or interrupted education; missed health checks; reduced levels or lack of nurturing. Failure to thrive Potential for binge drinking	Children Young people *Particularly vulnerable groups:* Children & young people with pre-existing disadvantage, including health & other inequalities

7.66 Service providers discussing the protection of children from harm did not identify any positive impacts on health and well-being arising from the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove.

Impacts identified by elected members

7.67 Elected members identified several changes in drinking patterns and culture as outcomes of implementing the legislation. These changes are the consumption of alcohol over a longer period of time and into the early hours of the morning (sometimes as late as 6 a.m.) due to extended opening hours and increased availability of alcohol through price, particularly through the increase in the number of off-licensed premises, which has led to "frontloading", especially in young people and the displacement of alcohol consumption into public spaces, such as the street and open spaces (e.g. The Level).

7.68 The negative impacts on health and well-being of the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove identified by elected members are shown in Table 13.

7.69 Elected members identified a range of negative impacts on health and well-being particularly for residents who are experiencing sleep disturbance, anger and increased

irritability as a result of repeated exposure to noise and antisocial behaviour into the early hours of the morning. This can lead not only to reduced family cohesion but also to reduced social cohesion within the community, with impacts on the amount of social contact and support that people receive. The impacts of the regulatory system, especially in relation to complaints about individual premises, were also highlighted as a source of intimidation, stress and anxiety for residents.

7.70 Staff providing services involved in managing the effects of the introduction of Flexible Alcohol Licensing Hours can be exposed to threatening and abusive behaviour and are at increased risk of physical injury, which can be both intimidating and stressful.

7.71 Elected members were particularly concerned about the effects of the introduction of flexible hours on children and young people, which has made the consumption of alcohol more visible (in both domestic and non-domestic settings, e.g. on the street outside licensed premises) and more widely available. In combination with the representation of alcohol in some sectors of the media, the consumption of alcohol may appear more attractive as a leisure pursuit. The effects of Flexible Alcohol Licensing Hours can result from children and young people being exposed to other people's consumption of alcohol or their own drinking behaviour, particularly in public spaces. However, elected members also highlighted the potential for the demonization of all young people as a result of the drinking behaviour of some, which could lead to many young people feeling stigmatized and alienated from society.

7.72 The increase in competition among licensed premises, especially as a result of the increase in the number of off-licensed premises, can lead to the closure of public houses, particularly small local pubs or pubs on estates. This can have two effects: the loss of a social hub in a community, and the loss of business and jobs in the local economy, which eventually may affect the whole community adversely.

7.73 Finally, the increase in the number of off-licensed premises has reduced the diversity of the streetscape in some areas, and potentially access to food and other necessities for residential communities in those areas, particularly lower-income groups, older people and people with mobility problems (e.g. London Road).

Table 13: Negative impacts on health and well-being - identified by elected members

Outcome of the introduction of Flexible Alcohol Licensing Hours	Effects of proposal implementation	Determinants of health and well-being affected	Affecting ...
Extended opening hours for licensed premises	***Availability of alcohol over longer time period*** Increased: consumption of alcohol; levels of drunkenness; noise into early hours of morning; antisocial behaviour into early hours of morning; disorder including vandalism.	*For residents:* Sleep disturbance/interrupted sleep patterns Increased irritability Anger/shortness of temper Tension Reduced family cohesion Breakdown in family structure Poor performance at work *For staff in public & voluntary sectors:* Exposure to threatening & abusive behaviour Intimidation Stress Increased risk of physical injury	Residents Residential communities Staff in public & voluntary sectors, e.g. police, A&E and transport operatives *Vulnerable groups:* Families Children Older people

Outcome of the introduction of Flexible Alcohol Licensing Hours	**Effects of proposal implementation**	**Determinants of health and well-being affected**	**Affecting …**
Increased number and range of outlets selling alcohol	***Increased availability of alcohol through price*** "Frontloading" Increased number of off-licensed premises Reduced diversity in the treetscape Noise into early hours of morning Antisocial behaviour into early hours of morning Vandalism Littering People consuming alcohol in public spaces	Exposure to abusive and threatening behaviour Intimidation Reduced feelings of personal safety Fear of crime Fear of antisocial behaviour Increased social isolation Reduced social contact & support Reduced social cohesion Stress & anxiety *For people drinking in public places:* Increased risk of exposure to other substances, e.g. illicit drugs Increased risk of being a victim of crime	Residents *Vulnerable groups:* Families Children Older people especially those already socially isolated *Groups vulnerable to effects of alcohol consumption:* Street drinkers Children Young people
Increased number and range of outlets selling alcohol leading to increased competition among outlets selling alcohol	Increased availability of alcohol through price Closure of local public houses, especially on estates Potential to displace alcohol consumption into the domestic setting	Loss of business Loss of jobs Reduced level of disposable income Reduced amount of money in local economy Reduced social cohesion	Residential communities Licensees Employers Employees *Vulnerable groups:* Families with children
Increased number and range of outlets selling alcohol	Reduced diversity in the streetscape Reduced number of outlets for food and other necessities Reduced number of facilities for community	Reduced access to food and other necessities Reduced access to community facilities	Residents *Vulnerable groups:* Lower-income groups Older people People with mobility problems
Combined effect of Licensing Act 2003 and ban on smoking in public places	Large groups of smokers & drinkers on street outside licensed premises	Intimidation Reduced feelings of personal safety Fear of antisocial behaviour Fear of crime Social isolation Reduced social contact & support Increased risk of accidents Physical injury	Residents *Vulnerable groups:* Children Young people
New regulatory system for the licensing of premises to sell alcohol	Lack of anonymity for residents who wish to make representations or a complaint about individual premises	Intimidation Stress & anxiety	Residents

Outcome of the introduction of Flexible Alcohol Licensing Hours	**Effects of proposal implementation**	**Determinants of health and well-being affected**	**Affecting …**
Combined effect of Licensing Act 2003 and representation of alcohol and leisure in some sectors of the media	Promotion of drinking culture, especially to young people	*For children & young people:* Potential to encourage underage drinking, particularly in public spaces Increased risk of being a victim of crime Physical injury Increased risk of exposure to other substance use, e.g. illicit drugs *For parents & carers:* Stress & anxiety Fear *For families:* Reduced family cohesion Potential for breakdown of family structure	Children Young people Parents Carers Families
Residents exposed to negative effects of underage drinking	Poor reputation of young people in relation to alcohol consumption	Demonisation of all young people Stigma Feelings of alienation from society	Young people

7.74 Elected members identified several positive impacts on health and well-being arising from the introduction of Flexible Alcohol Licensing Hours in Brighton & Hove, including:

- changes in public house or "pub" culture, e.g. the provision of food, which can encourage responsible drinking and reduce drunkenness, the provision of entertainment, which can lead to the pub being a hub for the community attracting a wide range of customers, and an increase in the attractiveness of the environment, especially with the ban on smoking in public places, all of which will increase social contact and improve social cohesion and contribute to the cultural life of the city, with the potential to increase tourism in the local economy;
- conditions on licensed premises, e.g. those requiring the premises of door supervisors, which can help to reduce antisocial behaviour and minor criminal offences;
- the new regulatory system through which the local authority has control of complaints about licensed premises, which could provide a route for mediation rather than conflict; and
- owing to the highly active night-time economy, increased level of passive surveillance on the streets late at night, which may increase people's feelings of personal safety.

Figure 10: Impacts of regulating system on residents

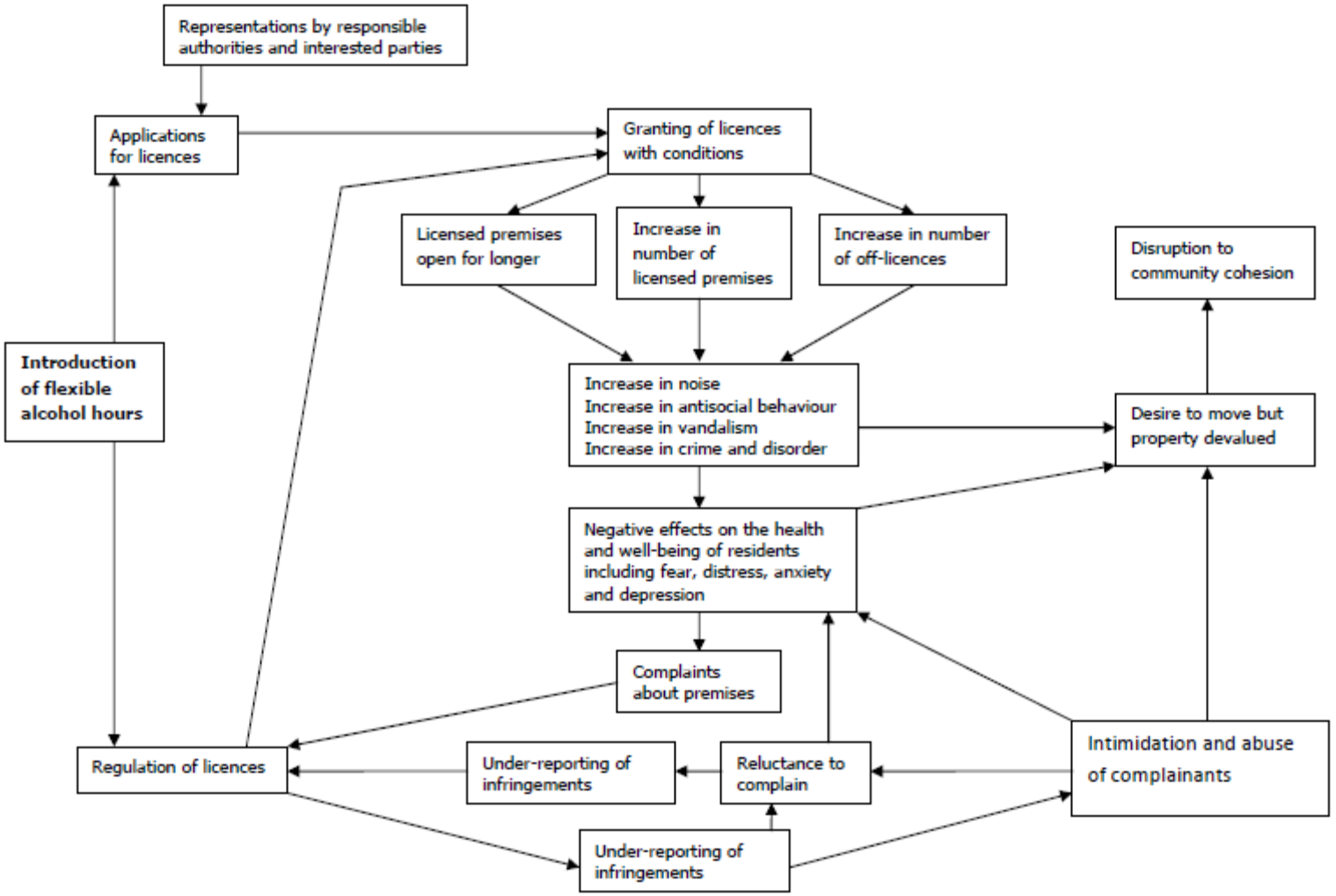


Figure 11: Crime and disorder

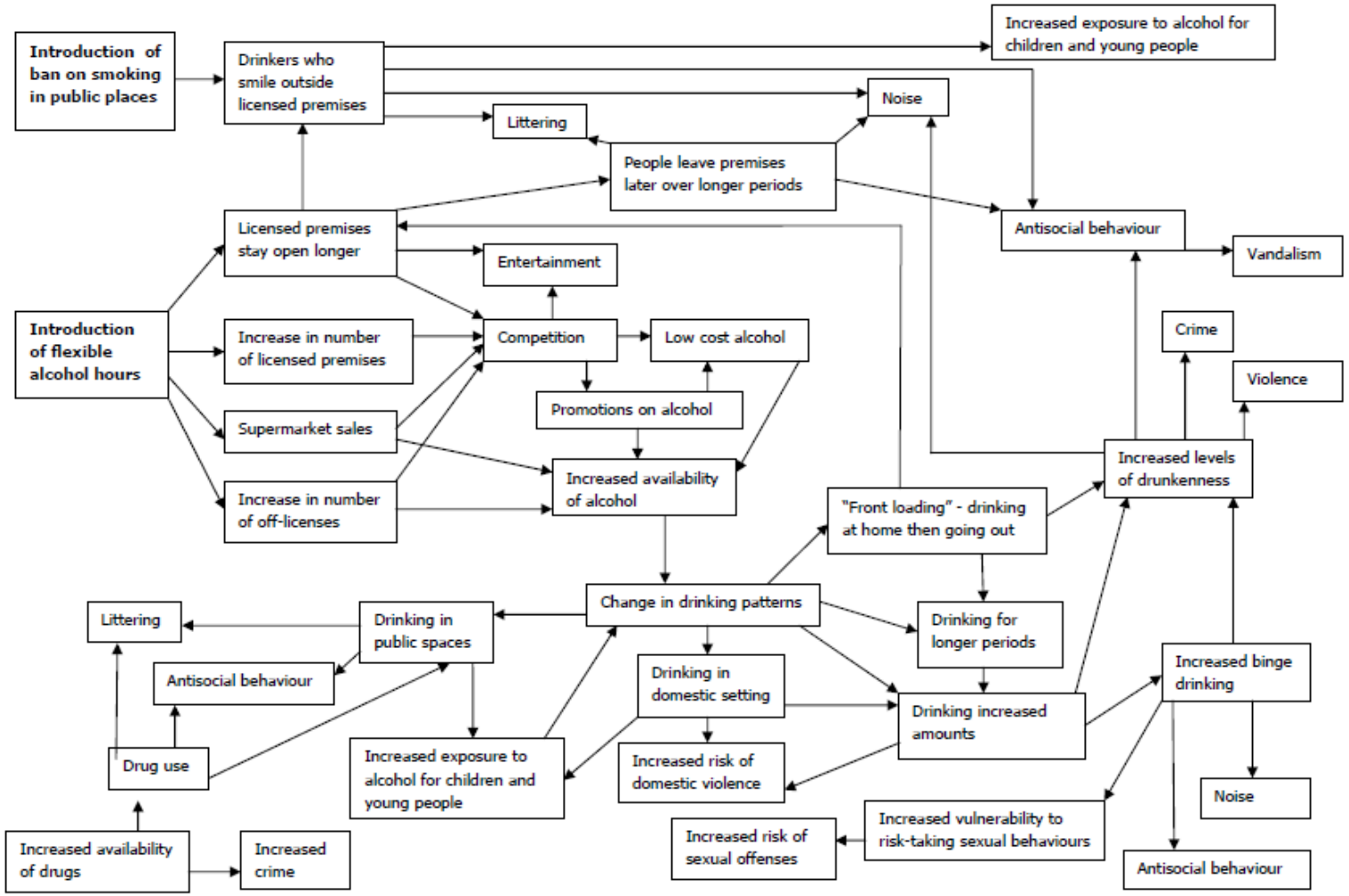
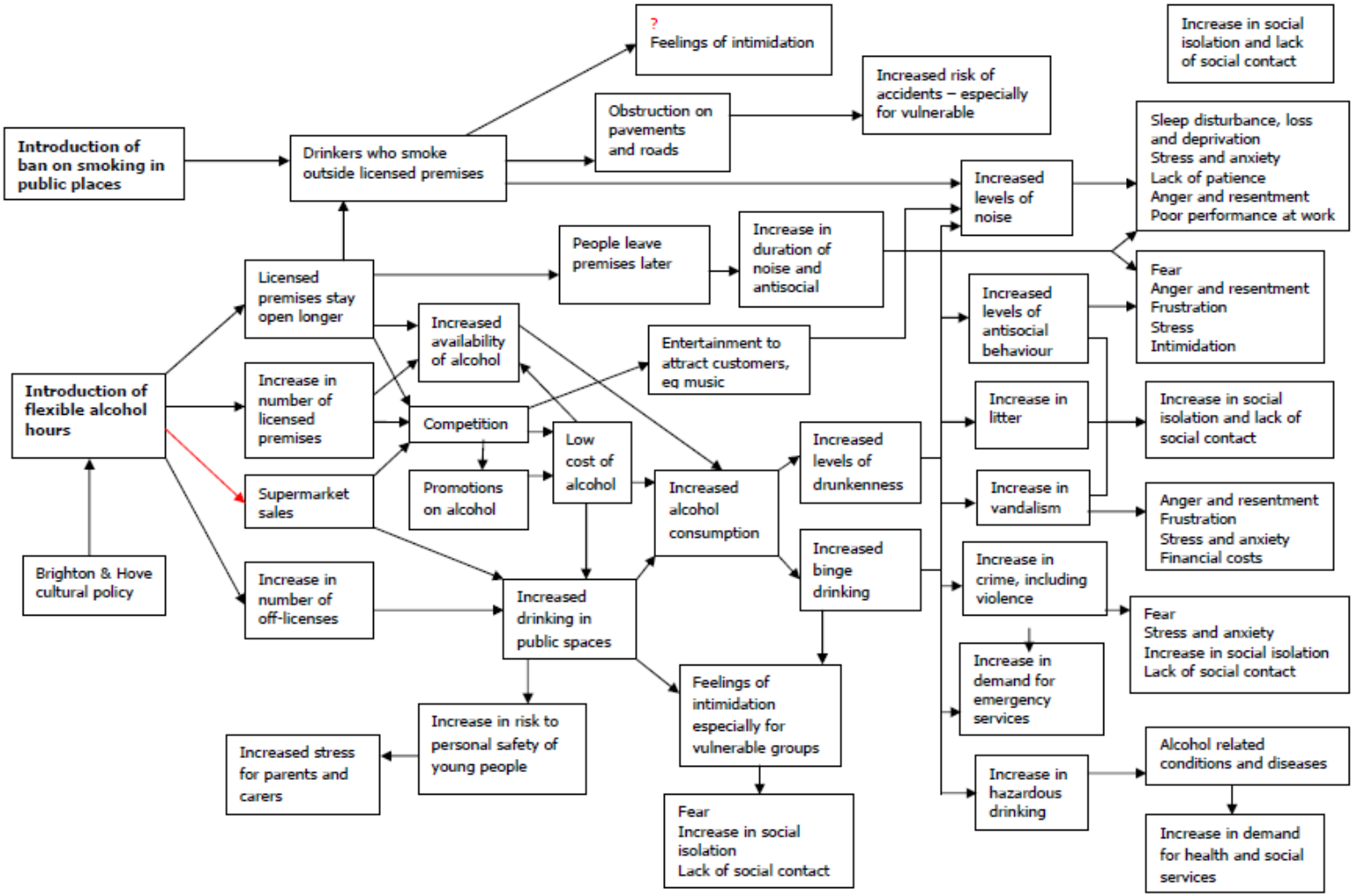


Figure 12: Adverse effects as described by residents



Appendix C: Population health profile for Brighton and Hove

Key demographic data

7.75 The population of Brighton and Hove City differs from the national population by having a higher proportion of young adults and fewer children. This is particularly the case among the more deprived parts of the city (23;24).

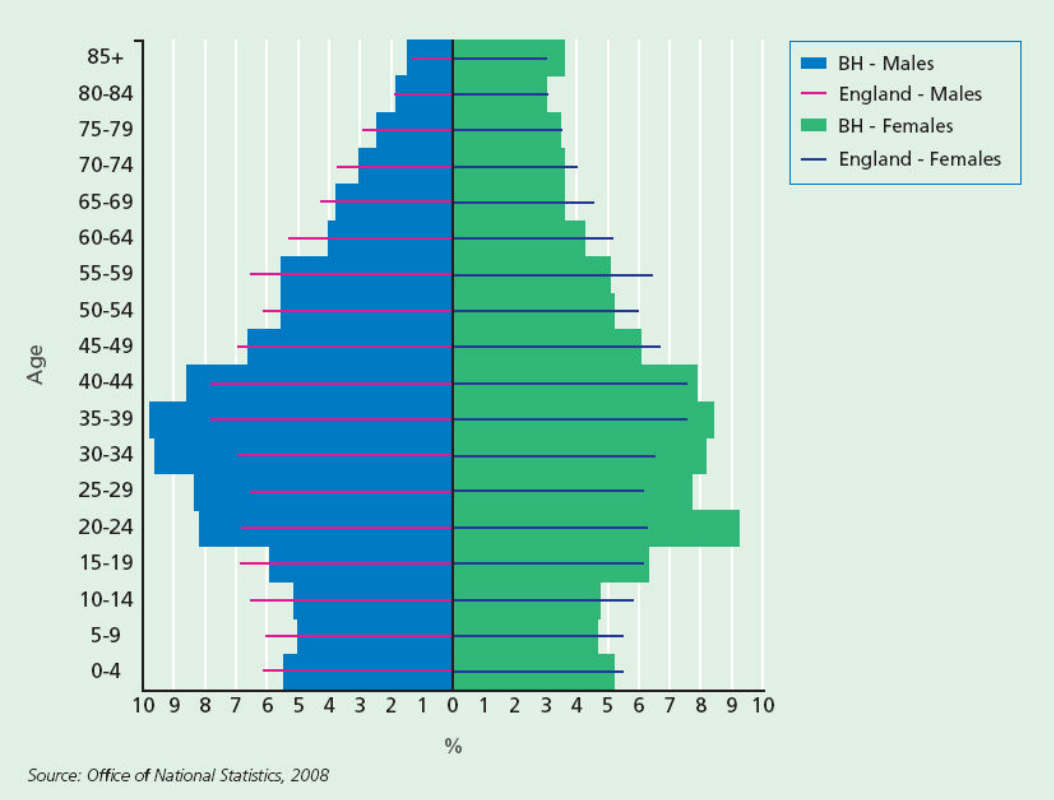
7.76 The resident population for Brighton and Hove City in 2001 was recorded as 247,817. Compared with the national picture there is a higher proportion of young adults (aged 16 to 44 years) and elderly (over 75 years) compared with England and Wales and relatively fewer children (under 16 years) and older working age adults (aged 45 to 64 years). Between the 1991 and 2001 Censuses, the growth rate of Brighton and Hove was similar to the national growth rate (2%), but lower than the average growth in the South East (4%) (25;26). Estimates for mid-2005 indicated that there were 255,022 people living in Brighton and Hove (27).

7.77 Figure 13 shows the population age and sex structure for Brighton and Hove in comparison with England as a whole. Brighton and Hove have a relatively young population compared with England, though this is not because of an above average proportion of children. The proportion of children less than 16 years of age (16.65%) is substantially less than the rest of the South East (19.93%), and England and Wales (20.16%). However, the city has a relatively high proportion of 16-44 year olds. This may be partly attributed to the high proportion of university students who live in Brighton and Hove (27).

7.78 The proportion of children aged 15-19 years is projected to decrease over the next ten years whereas the population aged 10–14 years, 5–9 years and particularly 0–4 years is set to increase. This has obvious implications for services such as maternity services, health visiting services, primary school services, and in later years, services for teenagers and adolescents including secondary school services (27).

7.79 There are more females (51.6%) than males (48.4%) in Brighton and Hove (25). Women generally have greater morbidity, but longer life expectancy than males.

Figure 13: Population of Brighton and Hove compared with England mid-year estimate 2006



7.80 Eighteen percent of the population of the city (or 44,893 people) were migrants in 2001 (25), placing Brighton and Hove as the area with the highest percentage of migrants in the South East and the 15th highest percentage nationally. A migrant is defined as a person whose address one year before the census was different from their address on census day. Migrants are people who either moved into the area, out of the area or within the area in the year before the census was undertaken. The city had a net in-migration of 5,139 people over this period (26).

7.81 Among Black and Minority Ethnic (BME) groups, nearly a third (29.8%) were migrants, compared with 18% for the city on average (25). This is higher than the percentage of all people in BME groups who are migrants in the South East and considerably higher than the percentage for England and Wales. This means that BME groups are far more likely to move, either within the city or in or out of the city, than people of white ethnic background. There was a net in-migration of 885 people belonging to a BME community (26).

7.82 Approximately 10% of the total population in Brighton and Hove belong to a BME group. However, among 16-24 year olds this figure is much higher (17.5%). This may be influenced by the high student population, although even in the younger 0-15 year age range there are more children and young people from BME groups than there are among adults. The BME population in Brighton and Hove is very diverse and there are no outstanding groups (27). BME populations often experience poorer health and have unequal access to health services compared with the general population.

7.83 The white non-British population is larger overall than the non-white population in the city. Over one quarter of white non-British residents were born in Ireland and the remainder in other EU countries, with an estimated 1000 white residents originating from Eastern Europe (27). Eastern European migrant workers have unique health needs, compared with the White British population.

Key health indicators

7.84 On the average, residents of Brighton and Hove do not enjoy the same level of health as the population of England. Although all-cause mortality and stroke and heart disease deaths have decreased for both men and women over the last 10 years, life expectancy in men, infant deaths and early deaths from cancer are worse than the England average (28).

7.85 The percentage of people with a limiting long-term illness in the city was estimated to be 18.3% at the 2001 Census. Limiting long-term illness includes any long-term illness, health problems or disability, which limits daily activities or work. At that time, the percentage was similar to the national average for England and Wales, though greater than the 15.5% in the South East. Among those of working age, 13% of Brighton and Hove residents had a limiting long-term illness compared with 10.6% in the South East generally (25;26).

7.86 When asked about their health, the majority of residents responded that they were in good health (68%), which is similar to the average of England and Wales. The proportion of those who were not of good health (9%) was also similar to the national average (25;26).

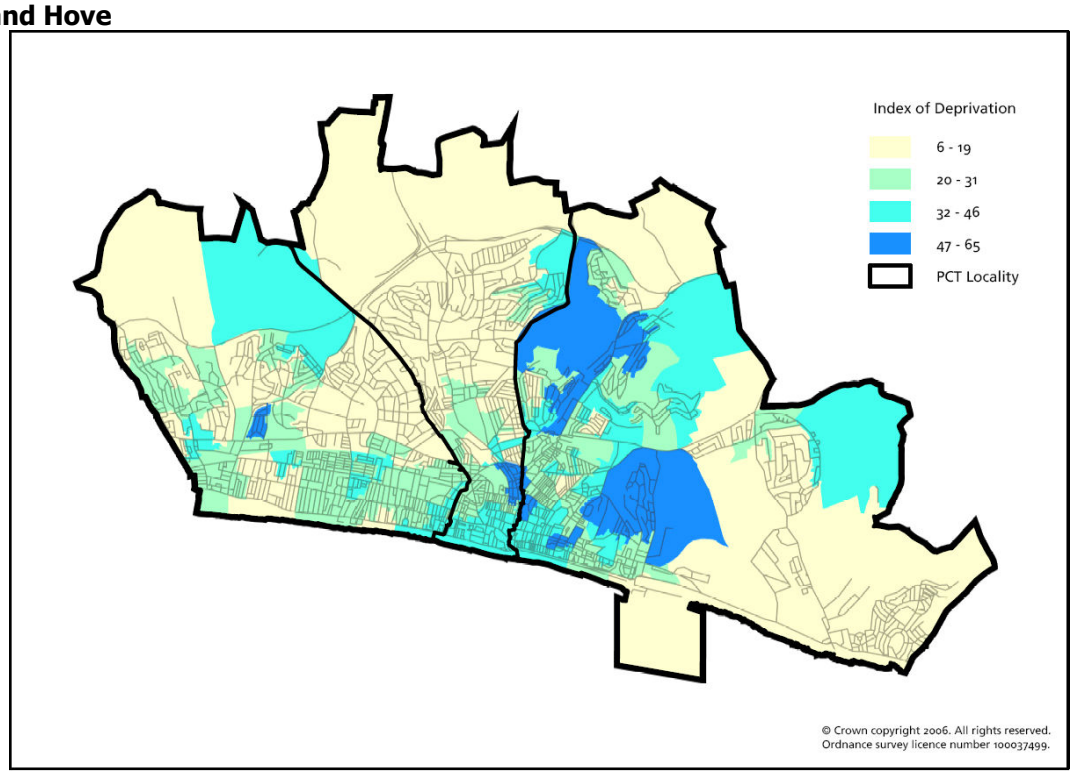
7.87 People in Brighton and Hove engage in several adverse health-related behaviours. More than 1 in 4 adults are estimated to smoke which is higher than the England average. The rate of hospital stays related to alcohol is high with 1,200 admissions a year. Drug misuse is more common than in England, though binge drinking is similar. The level of people recorded with diabetes, however, is better than the England average. Also lower than average, an estimated 1 in 5 adults are obese. The percentage of children in Reception classified as obese is again lower than the England average (28).

7.88 Brighton and Hove has relatively high levels of deprivation compared with regional and national averages. Fifteen of the 164 lower layer super output areas (LSOAs) in the city are in the 10% most deprived across England and 35 (21%) LSOAs are among the 20% most deprived in England (see Figure 14). Children with multiple needs, children with disability and children of lone parents are heavily concentrated in the most deprived areas of the city. More than half of lone parents and carers in the city are out of work and 30% of all Brighton and Hove's children and young people live in a lone parent household where the parent is out of work (27).

7.89 Location, gender and deprivation contribute to health inequalities in Brighton and Hove. Life expectancy for men is reduced by seven years for those living in deprived areas and by four years for women. Child poverty is on the average significantly worse than in the England population (27).

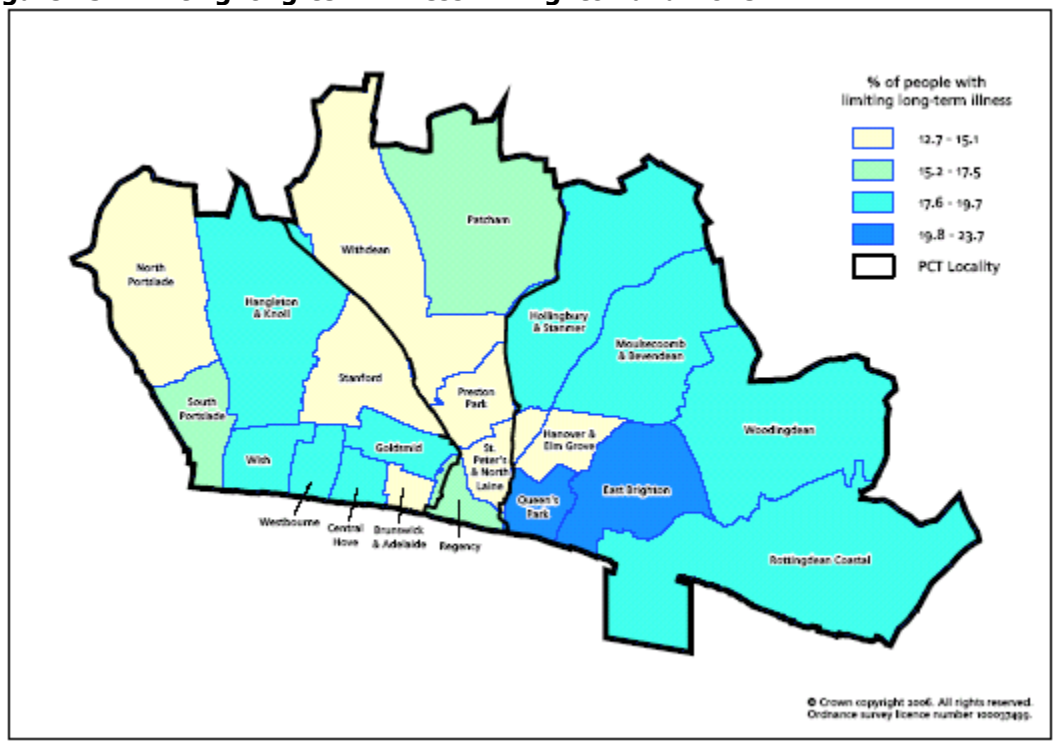
7.90 The pattern of self-reported limiting long-term illness in Brighton and Hove is shown in Figure 15.

Figure 14: Index of multiple deprivation (2004) by super output area in Brighton and Hove



Source: Public Health Directorate, Brighton and Hove City PCT

Figure 15: Limiting long-term illness in Brighton and Hove



Source: Citystats, Census 2001.

Alcohol-related Harm in Brighton and Hove

"Pubs and clubs play an important role in our city's culture and economy but alcohol is a factor in at least 40% of violent crime… Through Operation Athlete almost 200 parents of children who have had alcohol confiscated have been sent information about alcohol, young people and risks … Brighton & Hove is known as a good place to enjoy pubs and clubs but people want to be confident drunken behaviour won't spoil their enjoyment." (29).

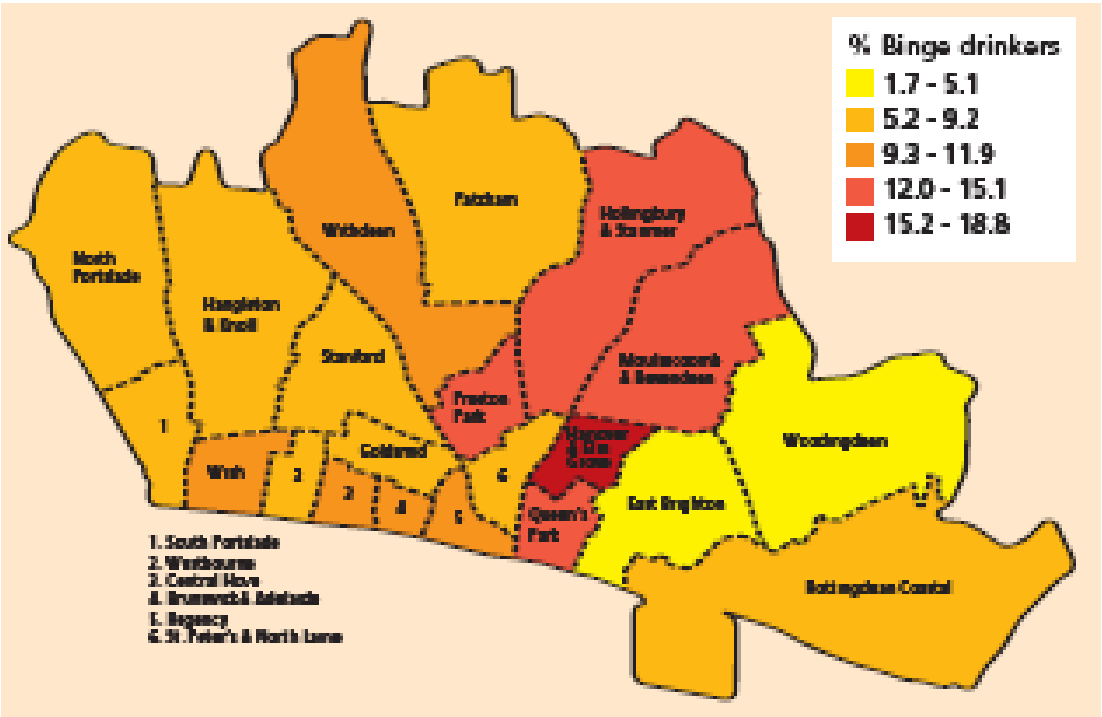
7.91 The alcohol-related harm profile is significantly worse in Brighton and Hove compared with the national average. Among men, there are significantly greater alcohol-specific mortality and hospital admission rates. Among women, hospital admission rates are higher compared with the England population (30).

7.92 Compared with regional averages, residents of Brighton and Hove have:

- lost more months of life due to alcohol
- greater alcohol-specific mortality, alcohol attributable mortality and mortality from chronic liver disease
- been admitted to hospital more frequently due to alcohol-related harm or other alcohol-specific or alcohol-attributable reasons
- committed more alcohol related crimes, including violent crimes and sexual offences
- more frequently made alcohol related claims for incapacity benefits among working-age people
- been more likely to engage in hazardous, harmful and binge drinking
- more employees that work in bars
- fewer alcohol attributed land-transport accidents
- fewer alcohol-specific hospital admissions for under 18s (30)

7.93 The Sustainable Community Strategy for Brighton and Hove plans to address the city's alcohol problems by educating residents, especially children and young people, about sensible drinking; developing an Alcohol Harm Reduction Strategy; and by increasing the availability of drug and alcohol treatment (31).

Figure 16: Percentage of residents reporting binge drinking in previous 7 days



From Brighton and Hove PCT (24)

Note: The definition of binge drinking is drinking over twice the daily guidelines in one day (8+ units for men and 6+ for women) (2).

Appendix D: Policy context

National Context

Health and wellbeing

7.94 In 2004, the Government published *the Alcohol Harm Reduction Strategy for England* (32). It was the first cross-government statement on the harm caused by alcohol, which included a shared analysis of the problem and the programme of action to respond. In June 2007, the Department of Health and the Home Office jointly launched an updated government alcohol strategy, *Safe Sensible Social: The next steps in the National Alcohol Strategy* (9), setting out clear goals and actions to promote sensible drinking and reduce the harm that alcohol can cause. The strategy outlines a coordinated response across a wide range of areas including local communities, the police, local authorities, the NHS, voluntary organisations, the alcohol industry, the wider business community and the media.

7.95 The *Choosing Health White Paper* (33) stresses the role of the individual in improving and maintaining health:

'Interventions and policies designed to improve health and reduce health disadvantage should provide the opportunity, support and information for individuals to want to improve their health and well-being and adopt healthier lifestyles. Policy cannot – and should not – pretend it can 'make' the population healthy. But it can – and should – support people in making better choices for their health and the health of their families. It is for people to make the healthy choice if they wish to'.

7.96 The *Wanless review* (34) outlines the rights and responsibilities between the individual and government:

"… people need to be supported more actively to make better decisions about their own health and welfare because there are widespread, systematic failures that influence the decisions individuals currently make … These failures can be tackled not only by individuals but by wide ranging action by health and care services, government – national and local, media, businesses, society at large, families and the voluntary and community sector. The main levers for Government Action include taxes, subsidies, service provision, regulation and information".

7.97 *The Commissioning Framework for Health and Well-being* (35) builds on the White Paper *Our health, our care, our say* (36), which promised to help people stay healthy and independent, to give people choice in their care services, to deliver services closer to home and to tackle inequalities. The Framework identified alcohol-related disease to be a major contributor to health inequalities. It also emphasized the need for the education of children and young people about alcohol. The Framework will include an interactive web-based commissioning tool; a web-based local alcohol profile; data on the contribution of alcohol to different types of health and crime harm; guidance on developing local indicators; and guidance on the Commissioning Framework for Health and Wellbeing and alcohol.

7.98 The Department of Health has stated in *Alcohol Misuse Interventions: Guidance on developing a local programme of improvement* (37) that it will provide guidance on developing local programmes for screening and brief interventions of hazardous and harmful drinkers, together with guidance on treatment for dependent drinkers. The Department of Health will also work with the regulatory bodies to support local health and social care organisations in responding to the findings of any reports produced by the regulatory bodies.

7.99 *Alcohol Needs Assessment Research Project* (38) was commissioned by the Department of Health. It presents information at a national and regional level to highlight the range of alcohol use disorders in the population and the range of services currently available to offer treatment for alcohol problems. The report identifies gaps in services and the regional variations in access to current treatment.

7.100 The report, *Indications of Public Health in the English Regions 8: Alcohol (19)*, produced alongside the national strategy, contains 84 separate measures (comprising 36 different indicators) relating to individual, community and population implications of alcohol use, with various measures of the effects this has on health and wellbeing, focusing on the nine English regions. Where possible, the situation in England has been put into a wider European context with comparators across the rest of the UK and other EU countries.

7.101 The *Local Government and Public Involvement in Health Act 2007* (39) requires PCTs and local authorities to produce a Joint Strategic Needs Assessment (JSNA) of the health and wellbeing of their local community. As of April 2008, PCTs will also be required to include alcohol in their JSNAs (40).

7.102 The Department of Health launched a *National Alcohol Harm Reduction Campaign* on May 19, 2008 to raise awareness of alcohol units and the health risks of regularly exceeding Government 'lower-risk' drinking levels (41).

7.103 A new NHS guidance document has been released, *Clinical directed enhanced services (DES) guidance for GMS contract 2008/09* (42), to support the delivery of clinical directed enhanced services, alcohol being one of the five key health and service priorities. The DES allows specific funding for GPs to deliver Screening and Brief Interventions (SBIs) to newly registered patients. The DESs began in April 2008 and are scheduled to run for 2 years (40).

7.104 The launch of the *Prison Service Alcohol Strategy* (43) for prisoners was in response to the wider Government policy, *Alcohol Harm Reduction Strategy for England* (32). The Strategy provides a framework for addressing prisoners' alcohol problems balancing treatment and support with supply reduction measures. The focus of the Strategy is to improve consistency and build on good practice for the delivery of services within existing resources.

Community Safety

7.105 *The Police and Justice Act 2006* (44) has helped to build safer communities by making sure key elements of the government's police reform programme and the Respect Action Plan are implemented. The Act is also helping to sustain further improvements in police performance at neighbourhood, force, national and international levels. Notably, the Act has already helped to amend the Crime and Disorder Act 1998 to make Crime and Disorder Reduction Partnerships (CDRPs) and Community Safety Partnerships (CSPs) more effective at tackling crime, anti-social behaviour and substance misuse in their communities.

7.106 In addition, the Home Office *'Guide to Effective Partnership Working'* (45) provides new statutory requirements and recommended best practice for CDRPs in the form of 'Hallmarks for Effective Partnership Working', including the role of PCTs and Local Health Boards in tackling drug and alcohol misuse. From April 2008, Home Office declared a statutory duty for CDRP to have a local alcohol strategy (40).

7.107 *The Tackling Violent Crime Programme* (TVCP) (46) focuses on alcohol-related and domestic violence because together these make up the majority of violent crime incidents. Research shows that domestic violence accounts for 16-25% of all violent crime, and that approximately half of violent crime incidents are alcohol-related. Geographically the programme focuses on a relatively small number of areas, in which research has shown a significant percentage of violent crime to occur. The aim is that targeting activity in these areas should produce a reduction in the national level of violent crime. Partnership working is a key focus of the TVCP.

7.108 The National Probation Service has an important part to play in tackling alcohol misuse within its wider role of protecting the public and preventing further offending by rehabilitating offenders. A great deal of good work is already being done. *Working with Alcohol Misusing Offenders – A Strategy for Delivery* (47) aims to develop more consistent and co-ordinated delivery.

7.109 Under the *Criminal Justice Act 2003 (48),* a caution with specific conditions attached to it may be given where there is sufficient evidence to charge a suspect with an offence which he or she admits, and the suspect agrees to the caution. The Act also stipulates that the courts can make an alcohol treatment requirement (ATR) one of the possible requirements.

The court may not impose an alcohol treatment requirement unless the offender expresses willingness to comply with its requirements.

7.110 *Arrest Referral* (9) is one of a growing number of initiatives intended to disrupt the link between substance misuse and offending. It aims to do so by improving the uptake of substance misuse treatment and care services among arrestees whose offending may be related to drug use or drug and alcohol use.

7.111 The National Probation Service (NPS) has two substance misuse group work programmes, which address alcohol-related offending behaviour: 1) the *Drink Impaired Drivers* (DID) scheme, which is aimed at drink drivers with no other criminogenic need; and 2) the *Lower Intensity Alcohol Module* (LIAM) for those offenders whose alcohol misuse and offending needs might require referral to another programme (e.g. tackling violent behaviour), but where there is still a need for alcohol-related offending to be addressed (9).

Licensing

7.112 The *Rogers Review* (49) identified alcohol licensing as one of the five main national enforcement priorities. Alcohol licensing seeks to prevent risks, such as anti-social behaviour and violence, that could affect all parts of society particularly the young and vulnerable.

7.113 The Department for Culture, Media and Sport are responsible for alcohol and entertainment licensing policy. The *Licensing Act 2003* (1) was created to provide a new system of licensing for the sale and supply of alcohol, the provision of regulated entertainment and the provision of late night refreshment. The Act does not prescribe days or opening hours when alcohol can be sold, rather it aims to promote four fundamental objectives:

- the prevention of crime and disorder;
- public safety;
- the prevention of public nuisance; and
- the protection of children from harm.

7.114 The measures in the *Licensing Act* will be complemented by provisions in the *Violent Crime Reduction Act 2006*, sections 21–22 of which will allow licensing authorities to fast-track licence conditions, on the application of a senior police officer, in cases of serious crime and disorder (9).

Industry Voluntary Codes and Campaigns

7.115 The Portman Group's Code of *Practice on the Naming, Packaging and Promotion of Alcoholic Drinks* (50) was introduced in 1996 following a public consultation. The Code, which is supported throughout the industry, seeks to ensure that drinks are marketed in a socially responsible way and to an adult audience only. The Code has an open and accessible complaints system. Complaints under the Code are ruled on by an *Independent Complaints Panel* (50). If a product is found in breach of the Code, a Retailer Alert Bulletin is issued, asking retailers not to stock the offending product unless and until it has been amended to comply with the Code.

7.116 *Social Responsibility Standards for the Production and Sale of Alcoholic Drinks in the UK* (51) were launched in November 2005. The Standards were drawn up by the Wine and Spirit Trade Association, the British Beer and Pub Association and the Scotch Whisky Association and have had full support and input from thirteen other trade bodies and several Government departments. The Standards set out best practice for the promotion of sensible drinking, responsible marketing and promotions and responsible retailing of alcoholic drinks. They are based on a set of social responsibility principles around the promotion of responsible drinking and the avoidance of promoting or condoning illegal, irresponsible or immoderate drinking.

7.117 In April 2007, the alcohol industry agreed with the Department of Health additions to labelling to support sensible drinking. During 2008, the Government will continue to consult on the extent to which these additions – along with a pregnancy message – have been implemented. It will also consider consultation on possible legislative options should insufficient progress have been made by then (9).

7.118 On November 16, 2007 Ofcom and Advertising Standards Authority (ASA) jointly published a research report on the impact of alcohol advertising on young people following the tightening of the Advertising Codes in October 2005. The new rules were designed to make alcohol advertisements less appealing to the under 18s and, in particular, to prevent alcohol advertisements from being associated with or reflecting youth culture (9).

7.119 For over two years, the *British Beer & Pub Association's Challenge 21* campaign (52) has been raising awareness of the underage sales issue among publicans, their staff and pub goers alike. The BBPA and its members have now issued over 350,000 Challenge 21 posters to British pubs. The Challenge 21 message - that if you look 21 or under you should expect to be asked for ID if you try to buy alcohol - now has a strong and visible presence right across the country.

Children and Young People

7.120 *Every Child Matters: Change for Children* (53) is a new approach to the well-being of children and young people from birth to age 19. The Government's aim is for every child, whatever their background or their circumstances, to have the support they need to: Be healthy; Stay safe; Enjoy and achieve; Make a positive contribution and; Achieve economic well-being.

7.121 With respect to alcohol, young people were first introduced as a priority in the updated Alcohol Strategy: *Safe. Sensible. Social* (9). Following this, a *Youth Alcohol Action Plan* (54) was developed to take further actions on reducing young people's drinking and related anti-social behaviour and health harms. This Action Plan sets out how the Government will address youth problems with alcohol through a strong partnership with parents, industry, criminal justice and law enforcement agencies and communities.

7.122 In July 2005 the government launched its green paper *Youth Matters* setting out proposals designed to improve outcomes for 13-19-year-olds. A consultation on Youth Matters was run from July to November 2005. With over 19,000 responses from young people, this is one of the largest responses to a government consultation from any one group. The government's response to the consultation, *Youth Matters: Next Steps* (55), set out the vision for empowering young people, giving them "somewhere to go, something to do and someone to talk to". Acknowledging the hardships and risks that can limit the opportunities available to youth, the government has dedicated several programmes of work to help limit the problems associated with substance misuse, offending, teenage pregnancy and homelessness.

7.123 The *NICE guidance on community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people* (56) calls for anyone who works with young people to identify those who are vulnerable to drug problems and intervene at the earliest opportunity. It gives advice on stepping in and helping young people access the right support and services and outlines effective individual, family and group-based support which can improve motivation, family interaction and parenting skills.

7.124 The *NICE guidance on school based interventions to prevent and reduce alcohol use* (57) is aimed at anyone who works with children and young people in schools and other education settings. It gives advice on incorporating alcohol education into the national science and personal, social and health education (PSHE) curricula, and helping children and young people access the right support. It also looks at how to link these interventions with community initiatives, including those run by children's services. There are no national guidelines on what constitutes safe and sensible alcohol consumption for children and young people, so the recommendations focus on: encouraging children not to drink, delaying the age at which young people start drinking and reducing the harm it can cause among those who do drink.

7.125 Since 2006 the Department of Health and Home Office have jointly worked on the advertising campaign, *Know Your Limits* (58), which urges young drinkers to know their limits and to stay within them. It is aimed at 18 to 24 year olds, although it also reaches out to younger, illegal drinkers.

South East Regional Context

7.126 At the regional level, the South East of England is following the strategies outlined at the national level, namely *The Alcohol Harm Reduction Strategy for England* and *Safe, Sensible, Social. The next steps in the National Alcohol Strategy* (59).

7.127 The *National Alcohol Strategy Implementation Toolkit* is a resource provided by the national authority to help regional and local teams develop strategies to address alcohol-related crime, ill health and other harm in line with the National Alcohol Strategy. It has been written specifically to help alcohol leads and others within local authorities, primary care trust (PCTs), children's services and delivery partnerships such as Crime and Disorder Reduction Partnerships (CDRPs) and Drug and Alcohol Action Teams (DAATs) (59).

7.128 *The Vision for the South East* is to reduce the excessive drinking of the minority who drink in a way that is a nuisance or a danger to others and themselves to a level that is safe, sensible and social. Specifically they are targeting: under age drinking, binge drinking, and harmful drinkers. They are currently working on supporting South East partnerships with the implementation of their Alcohol Strategies, sharing good practice and co-ordinating the delivery of the updated National Alcohol Strategy across the South East through a new strategic regional programme board (59).

7.129 Work is currently underway to address alcohol misuse by (59):

- Producing a GOSE statement of priorities on Alcohol
- Organising a regional Alcohol event
- Ensuring that a cross-cutting alcohol strategy and plan that is fit for purpose is produced in each upper tier/unitary authority
- To maintain the networking forum of alcohol practitioners in the region
- To set up an internal committee to scrutinise current and future Local Authority alcohol strategies/action plans ensuring they are fit for purpose
- To ensure cross-cutting targets are embedded in the Local Area Agreements as appropriate

7.130 The Regional Public Health Group in GOSE is also developing a *Regional Alcohol Manager* function which will be used to (59):

- Support LAA NI39 target setting and delivery by local partnerships
- Support SHA performance management of LAA NI39 NHS Indicator targets
- Influence the development and support delivery of local PCT targets related to NI39
- Enable regional co-ordination and joint working with CSIP for targeted and enabling support commissioned by DH to reduce alcohol-related admissions
- Co-ordinate and target action to support local social marketing initiatives

Brighton and Hove Local Context

7.131 *Local Area Agreements* set out the priorities for the local area. LAAs are agreements between central government, local authorities and their partners, through the Local Strategic Partnership, to improve services and the quality of life in a particular place. The 35 targets for the period 2008-11 in the Brighton & Hove Local Area Agreement include targets around alcohol harm, drugs misuse, perceptions of anti-social behaviour, first time entrants to the youth justice system, domestic violence and prolific offenders (60).

7.132 Brighton & Hove's *Sustainable Community Strategy* (31) sets out the vision and plans of the agencies, organisations and communities who work together through the *2020 Community Partnership* to improve the quality of life of local residents. The Strategy has eight priority themes, three of which have specific goals related to alcohol: 'Reducing Crime and Improving Safety', 'Children and Young People', and 'Improving health and well-being'. The Strategy plans to:

- Educate residents, especially children and young people, about sensible drinking
- Develop an Alcohol Harm Reduction Strategy

- Increase the availability of drug and alcohol treatment, partly through establishing a treatment centre targeting parents and carers and recognising many people have joint alcohol and drug misuse issues
- Increase enforcement against alcohol sales to under-18s and improve alcohol advice and treatment options;
- Reduce harmful levels of drinking and continue high visibility policing at recognised hotspots;
- Use planning policy to prevent over-concentration of super-pubs; and
- Involve the Licensees' Association and the Business Crime Reduction Partnership to promote good practice in pubs and clubs and help prolific offenders with drug and alcohol problems into treatment.
- Reduce the number of alcohol-related criminal offenses

7.133 In April of this year the Crime and Disorder Reduction Partnership (CDRP) of Brighton and Hove published its *Brighton & Hove Community Safety, Crime Reduction and Drugs Strategy 2008-11 (60)*. This strategy aims to make the city safer by

- reducing crime, disorder and anti-social behaviour;
- reducing fear of crime;
- reducing harm from drugs and alcohol; and
- improving community safety

7.134 Brighton and Hove Drug & Alcohol Action Team (DAAT) has a membership consisting of senior managers from the City Council, the Police, the PCT, Probation and from Treatment service providers. The DAAT has a remit to oversee the delivery at a local level of the Government's National Alcohol Harm Reduction Strategy (2004). The local delivery is taken forward by a number of groups responsible for specific areas of the strategy (10).

7.135 One of DAAT's initiatives, *Sussed about Drink,* is a website designed to engage a younger audience by highlighting immediate, rather than long term, impacts of drinking to excess. There is also an over-18s section where people can learn about sensible drinking, take on-line drink tests and find out where to get help in Brighton & Hove (10).

7.136 The City Council is the Alcohol and Entertainment Licensing Authority in Brighton and Hove. It follows laws sent out in the national *2003 Licensing Act*; however, on 13 March 2008 Council included in the Licensing Policy for 2007-2010 a *Special Policy* regarding cumulative impact which provides, along with the Act and government guidance & regulations, the basis of licensing decisions. There are four main principles behind this system (11):

- to prevent crime and disorder
- to prevent public nuisance
- to protect children from harm
- public safety

7.137 The new system began on 24 November 2005. The aim is to help build a fair and prosperous society, properly balancing the rights of people and their communities by following the above principles. It also intends to encourage tourism, reduce alcohol misuse, improve the self-sufficiency of local communities and reduce the burden of unnecessary regulations on businesses (11).

Appendix E: HIA Press briefing

Health Impact Assessment of the Introduction of Flexible Alcohol Licensing Hours in Brighton & Hove

BHCC has been granted funding by Brighton & Hove Primary Care Trust and City Council Directorate of Public Health. Consultants chosen by competitive tender are Ben Cave Associates Ltd. who are experienced, specialist health impact assessors, recognised nationally and internationally.

The Licensing Act 2003 establishes a single integrated scheme for licensing premises, which are used for the supply of alcohol, to provide regulated entertainment or to provide late night refreshment. The Act contains measures to provide more flexible opening hours for premises, with the potential for up to 24 hour opening, seven days a week, subject to representations from local residents, businesses and responsible authorities.

The stated objectives of the Act are: Prevention of Crime and Disorder, Public Safety, Prevention of Public Nuisance and Protection of Children from Harm.

The Government's Alcohol Harm Reduction Strategy includes measures to change attitudes to irresponsible drinking and behaviour, including:

- making the sensible drinking message easier to understand and apply;
- targeting messages at groups such as binge drinkers and chronic drinkers;
- providing better information for consumers, on products and at the point of sale;
- providing more support and advice for employers.

Safe. Sensible. Social – the next step in the National Alcohol Strategy (DH, 2007) identifies the need to:

- Ensure that the licensing laws protect young people from alcohol-fuelled crime and disorder;
- Sharpen the focus on under 18s, 18-24 binge drinkers and harmful drinkers;
- Promote sensible drinking through investing in better information and communication.

The Public Health White Paper, Choosing Health, includes measures to work with the alcohol industry to promote sensible drinking.

At the 31/3/2007, there were 1089 licensed premises and there were 1025 at transition in November 2005. The main effects or the new Act appear to be longer opening hours (but not 24/7) and more convenience stores becoming "off-licences". One of the key protections for local residents for premises not supporting licensing objectives (crime prevention, public safety, public nuisance and protecting children) is the review process where a licence can be reviewed. Since transition, there have been over 20 reviews including five police closures for disorder. The results were that two licences have been revoked (a violent pub and an off licence persistently selling to young people – u 18s) three off licences received licence suspensions for persistent sales to children, many licences had conditions modified to either prevent noise nuisance or restore order, others were given advice or no further action.
The Director of Public Health reported last year that our city was in the worst quintile in England for alcohol related months of life lost, alcohol specific hospital admission, alcohol related violent and sexual offences and an estimate of binge drinking (adults consuming > double daily recommended level in one sitting). Recent trends of violent crime show decline. As at end of June 2008 violent crime in a public place is down 32% compared
to same time last year (source – Paul Knight, Crime Reduction Officer, John Street Police Station, Brighton).

Indicators to be used in this study are:

1. Reduce impact on acute hospital
2. Reduce public place violent crime
3. Reduce domestic violence
4. Reduce alcohol related offending

Impacts that can also be measured, indirectly impacting on health, include enforcement outputs like reviews, fixed penalty notices, legal action etc. plus alcohol linked suicide and noise complaint and enforcement statistics.

The time scale is for an interim report in October (literature review) and final report in this financial year).

The health impact assessment may be used to inform statement of licensing policy, local alcohol harm reduction strategy, community safety, transport, tourism, economic development, community development and violent crime reduction strategies.

Tim Nichols, Head of Environmental Health & Licensing.

Appendix 2

BRIGHTON & HOVE CITY COUNCIL

LICENSING COMMITTEE (LICENSING ACT 2003 FUNCTIONS)

3.30PM 26 NOVEMBER 2009

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillors Cobb (Chairman), Lepper (Deputy Chairman), Allen, Harmer-Strange, Hawkes, Hyde, Kitcat, Older, Phillips, Pidgeon, Simson, C Theobald, Watkins and West

Apologies: Councillor Marsh

PART ONE

16. HEALTH IMPACT ASSESSMENT OF LICENSING

16.1 The Committee considered a report from the Director of Environment regarding the Health Impact Assessment of Licensing (for copy see minute book).

16.2 The Head of Environmental Health and Licensing presented the report and noted that the assessment had already been considered at the Alcohol Strategy Group where colleagues from the Police had reviewed the findings. The Alcohol Strategy Group felt that lobbying of Central Government on the issues would not be particularly helpful at this current time, given the impending general election. The Group also expressed concern over the management of the actions, given there were so many. However, it was recognised that these were unfiltered responses from members of the public and whilst they were honest accounts, they were not necessarily legally achievable, funded, practical or in some cases, desirable.

In terms of the action points that related to the licensing function of the Council, the Head of Environmental Health and Licensing noted that the Statement of Licensing Policy was due to be reviewed by December 2010, and the Cumulative Impact Area to be reviewed by April 2010. The aspirations in this document could be used to inform these policies.

16.3 Dr Scanlon, Director of Public Health for Brighton & Hove City Council and Brighton & Hove PCT addressed the Committee and stated that this had been an independent report commissioned by Brighton & Hove Primary Care Trust and the Brighton & Hove City Council Directorate of Public Health. The work had been tendered out to expert consultants in health inequality assessment. The original consultation process had produced fairly subjective results and the consultants had been asked to obtain statistical data in support of this.

However, Dr Scanlon felt the data still did not clearly reflect the trend in alcohol related health issues over a significant period, as the information did not adequately pre-date the introduction of the Licensing Act. There was however, some valuable data in the report and the findings did show a significant increase in alcohol related hospital admissions, an increase in alcohol related domestic abuse and an increase in alcohol related violent crimes over the period assessed.

Dr Scanlon added that consultation had been undertaken with the general public, licensees, relevant service providers and elected Members regarding the effects of the Licensing Act, and the general perception was largely negative. Some positive effects of the Act were recognised however, including the increase in tourist trade to Brighton and Hove and the positive economic effects of the licensed trade on the city. Dr Scanlon recognised there was a large amount of recommended actions in the assessment and so a more manageable action list had been drafted as part of the Officers report to consolidate the actions.

16.4 Councillor Lepper agreed that the assessment was interesting, but felt the number of actions that had been produced was unreasonable, and many were impossible to implement. She felt that increasing the number of Noise Patrol Officers was highly desirable but financially unachievable, as was the case with many of the action points.

16.5 Dr Scanlon agreed that the actions did represent a 'wish list' from residents and local businesses and understood that many of the actions could not currently be implemented. The truncated list in the Officers report represented more attainable goals however.

16.6 Councillor Simson agreed with Councillor Lepper and felt that even the truncated list was still a 'wish list' in some respects as there was no money to pay for many of the actions. She noted the cultural change in drinking habits over the last few years, and felt that this played a large part in contributing to the problems. Councillor Simson added that home drinking and 'pre-loading' was as much a problem for society as street drinking, and tackling irresponsible parents was one of the major issues for the authority. A follow-up scheme for young people who had been admitted to hospital as a result of underage drinking had been set up in conjunction with the Health Authority and Councillor Simson felt this was an excellent example of how the local authority could combat anti-social drinking.

16.7 Councillor Older noted that one of the actions was to limit the number of licensed premises across the city and asked how this would be achieved. She also raised the issue of anonymous representations from interested parties to Licensing Panels, and asked if this was being considered as an option. The Head of Environmental Health and Licensing stated that the only legal way to cap the number of licensed premises in the city would be to impose a city-wide Cumulative Impact Area (CIA), but this would need evidential proof before it could be imposed.

He added that whilst the actions were not always practical or in some cases legally defendable, they did represent the unfiltered wishes of the local community with regard to licensing issues, and as such were a valuable tool for informing the development and

review of the Statement of Licensing Policy. He believed that it would be worthwhile lobbying Central Government in the near future on the issues raised.

The Head of Environmental Health and Licensing went on to add that consideration could be given to the submission and acceptance of anonymous representations at Licensing Panels, but added that the Police and the Local Ward Councillor were able to make representations on behalf of individuals who had safety concerns in this respect. If anonymous representations were accepted an amendment would need to be made to the Statement of Licensing Policy.

16.8 Chief Inspector Nelson addressed the Committee and stated that Sussex Police ran a comprehensive test purchase programme of licensed premises to help ensure that underage young people were not sold alcohol, and added that this was now being rolled out to the testing of proxy purchasing. He stated that once a licence had been granted to a premises the Police were also responsible for ensuring that the licensing objectives were upheld and if they gained information that a premises was acting irresponsibly then they would take action.

16.9 Councillor Hyde felt that increasing the availability of any product would increase its consumption, and local authorities were now dealing with the impact of this, which she believed was a result of the Licensing Act 2003. She noted the recommendation for referral to Planning Committee and welcomed the report, adding that consideration could be given to directing S106 monies into community facilities that mitigated the effects of increased alcohol consumption.

16.10 The Chairman was not sure that an increase in the number of licensed premises necessarily related to an increase in alcohol consumption. She felt that the change in people's lifestyles and attitudes towards alcohol had a more direct impact than the availability of alcohol.

16.11 Councillor West was concerned that the value of the report was being disregarded because some of the actions were not currently achievable or affordable. He recognised that it represented a 'wish list' in some respects but felt that this should not detract from the evidence that had been gathered about the negative effects of alcohol on local communities. He felt this was a desperate problem for Brighton & Hove and the authority needed to find imaginative answers to deal with it.

16.12 Councillor Wrighton agreed and felt the report represented a damning indictment of the Licensing Act 2003. She noted the 30 per cent increase in alcohol related hospital admissions, the increase in alcohol related crime and the increase in noise complaints and felt these were directly related to the Licensing Act. Councillor Wrighton felt that the Council needed to lobby government for public health to be included as a licensing objective. Councillor Wrighton proposed, and Councillor Phillips seconded, amendments to 2.2 of the recommendations, and to include an extra recommendation at 2.3, as follows:

2.2 That the Licensing Committee refers the Health Impact Assessment to the Planning Committee, the Health Overview and Scrutiny Committee, the Environment and Community Safety Overview and Scrutiny Committee and to

Full Council under Procedure Rule 24.3a for information and to inform other corporate policies and strategies.

2.3 That the Licensing Committee refers the Health Impact Assessment report to the relevant government minister and requests that due consideration is given to enabling 'public health' impacts to be considered as a Licensing Act objective.

16.13 Councillor Watkins felt that the amendments were extremely useful and believed that the Health Impact Assessment was an excellent document. He hoped that A&E departments were keeping their own records of under-age alcohol related hospital attendances, and also of attendances related to illegal drug usage. Councillor Watkins referred to the recent White Night festival as an important example of how communities should be using city facilities at night, and believed that action needed to be taken to ensure that the streets of Brighton & Hove were safe and welcoming for everyone to use whenever they wished.

16.14 A vote was taken on each of the recommendations, as amended and proposed, and each vote was carried.

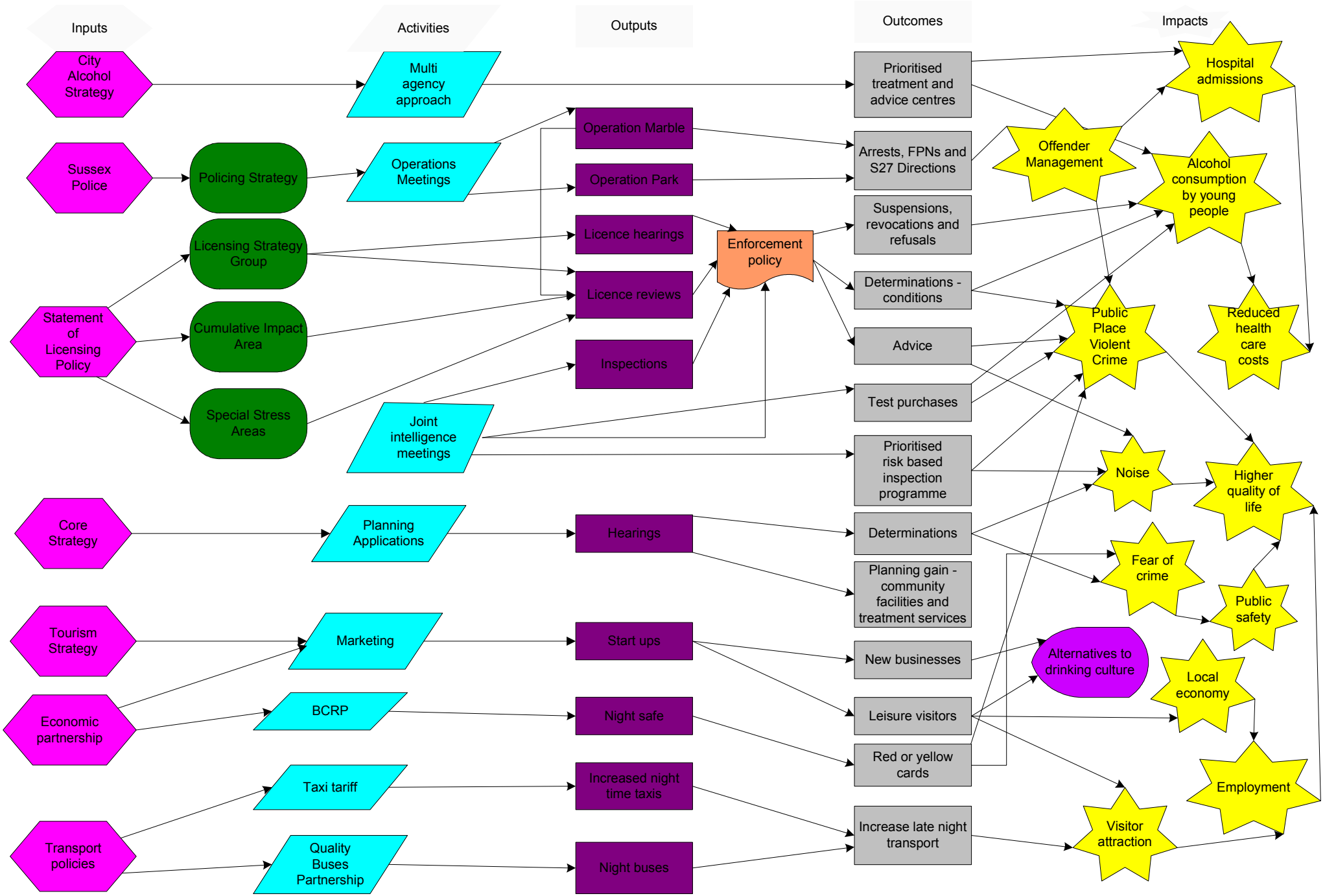
16.15 **RESOLVED** –

1. That the findings from this report are considered by the relevant stakeholders and that findings are used to influence the next review of the Statement of Licensing Policy.

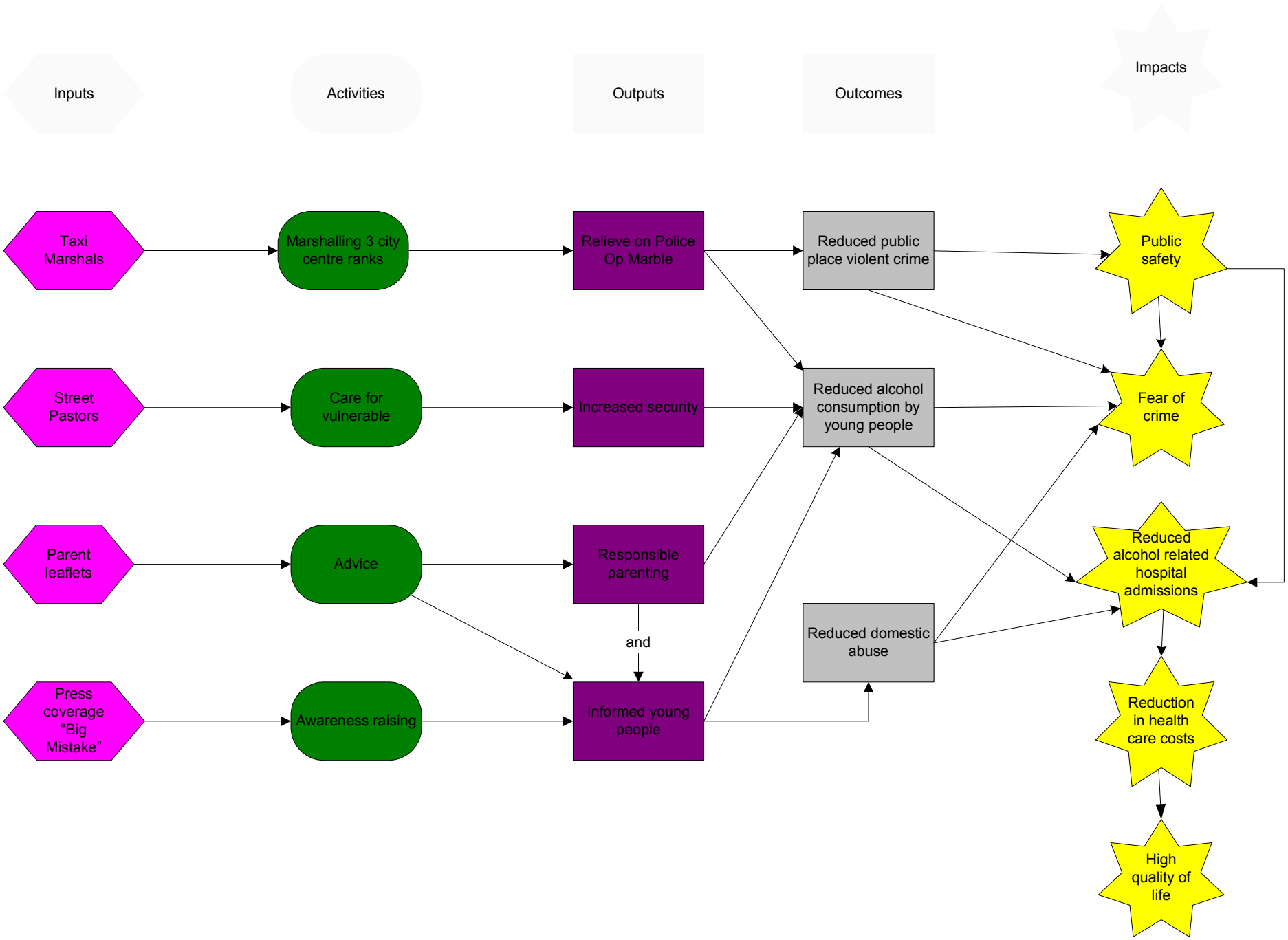
2. That the Licensing Committee refers the Health Impact Assessment to the Planning Committee, the Health Overview and Scrutiny Committee, the Environment and Community Safety Overview and Scrutiny Committee and to Full Council under Procedure Rule 24.3a for information and to inform other corporate policies and strategies.

3. That the Licensing Committee refers the Health Impact Assessment report to the relevant government minister and requests that due consideration is given to enabling 'public health' impacts to be considered as a Licensing Act objective.

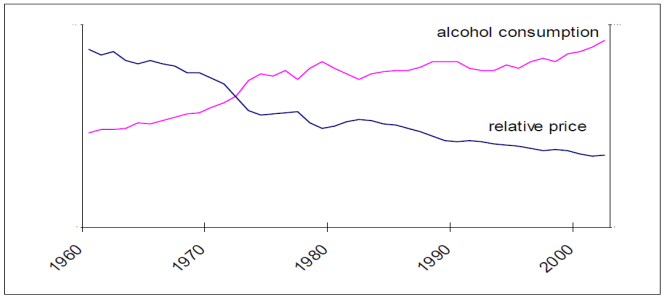
Beacon pathway



Alcohol Support Programme pathway

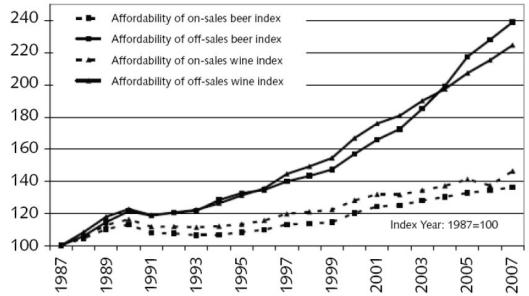


Are we drinking more? And why?



Royal College of Physicians

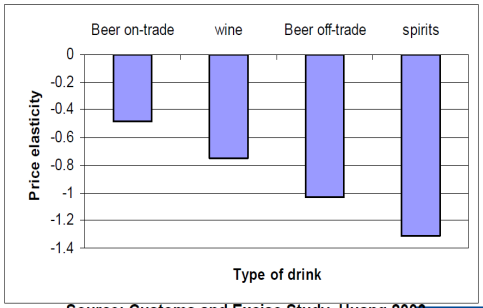
Affordability of alcohol, beer and wine, on- and off-trade comparison



Source: Independent Review of the Effects of Alcohol Pricing and Promotion Report on Phase 1. School of Health and Related Research, University of Sheffield, June 2008

Royal College of Physicians

ESTIMATED PRICE ELASTICITIES IN THE UK



Source: Customs and Excise Study, Huang 2003

Huang 2003

Royal College of Physicians

Ref: Professor Ian Gilmore - President RCP December 2008

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

Subject:		**Hospital Car Parking**		
Date of Meeting:		**14 April 2010**		
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 issue of parking at hospitals is one which is frequently in the national news, with concerns expressed about the capacity of hospital car parks, the fees charged for parking, and whether some types of patients and/or visitors should be able to park at reduced rates or for free.

1.2 In light of this national interest, the Chairman of the Health Overview & Scrutiny Committee (HOSC) has asked Brighton & Sussex University Hospitals Trust (BSUHT) to provide some information on its car parking policy and provision.

1.3 **Appendix 1** to this report consists of material provided by BSUHT with regard to this issue.

2. RECOMMENDATIONS:

2.1 That members note the contents of this report and determine whether they need to take any further action.

3. BACKGROUND INFORMATION

3.1 Car parking at hospital sites has long been a contentious issue, with some people arguing that there should be more provision, and that parking fees should be lower or waived for particular groups of patients and/or visitors (e.g. cancer patients, in-patients etc).

3.2 The Department of Health is currently undertaking a national consultation on the issue of hospital car parking. This issue was raised at a recent meeting between the South East Coast Strategic Health Authority (SHA) and regional HOSC Chairmen (Kent, Medway, East Sussex, West Sussex, Brighton & Hove, Surrey). HOSC Chairmen agreed that there should be no co-ordinated regional response to this issue, as questions about appropriate hospital parking capacity, charging regimes etc. were best made on a case-by-case basis, since hospitals across the region differ so widely in terms of their size, location etc.

3.3 Particular local issues (i.e. issues relating to parking at the Royal Sussex County Hospital: RSCH) may include: parking capacity at the hospital; plans for parking re: the 3T development programme; the impact on the local community of 'overflow' parking from RSCH; queues for the main RSCH car-park; access to disabled parking bays in the main RSCH car-park; Pay and Display Vs Pay on Departure parking; the location of parking payment machines, and parking charges

4. CONSULTATION

4.1 None has been undertaken.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this report for information.

Legal Implications:

5.2 None to this report for information.

Equalities Implications:

5.3 None to this report for information.

Sustainability Implications:

5.4 None to this report for information.

Crime & Disorder Implications:

5.5 None to this report for information.

Risk and Opportunity Management Implications:

5.6 None to this report for information.

Corporate / Citywide Implications:

5.7 None to this report for information.

SUPPORTING DOCUMENTATION

Appendices:

1. Information provided by Brighton & Sussex University Hospitals Trust

Documents in Members' Rooms:

None

Background Documents:

None

Report on Car Parking at Brighton & Sussex University Hospitals NHS Trust

Introduction

1. The purpose of this report is to update the members of Brighton & Hove City Council's Health Overview and Scrutiny Committee with regard to car parking at the Royal Sussex County Hospital.

2. The original hospital was completed in 1828 and has seen various phases of development since that time – as has the wider city. The hospital is now bounded by residential areas on all sides. The hospital is located on numerous main bus routes into the City Centre and the Marina.

3. As the only Teaching Hospital in the South East Coast region, we provide specialist and tertiary services for patients across Sussex and the south east as well as local acute services for Brighton & Hove City (at the Royal Sussex County) and Mid-Sussex (at the Princess Royal Hospital in Hayward's Heath).

4. The Trust introduced parking charges in 1996 to combat a growing number of commuters and non-Hospital users using the car parks for free to avoid paying the City Centre parking charges or to get round the parking congestion in the local area. This is a common issue for most NHS hospitals. Car parking and car parking charges amongst the most polarising issues in the NHS.

5. The Trust believes that charging for parking is the fairest way to maximise the usage of our parking spaces for users of the Trust's services. Prices are set inline with the average stay at an out patient appointment and have been kept in line with local tariffs for the same time period. Long time periods are charged at higher rates to deter commuters. There are reduced rates for long stay patients.

Current Car Parking Provision

6. There are currently 497 parking spaces on the Royal Sussex County Hospital site distributed as follows:

Car Park Area	Spaces	Comment
Multi-storey car park	352	Shared between patients, visitors and staff. Includes 16 disabled bays, 7 renal bays and 3 renal oncology bays.
Barry/Jubilee buildings	60	Patients and visitors only. Includes 4 disabled bays near main entrance.
Latilla Building	41	Patients, visitors and staff. Includes 12 disabled bays for patients/visitors only. 29 spaces here are staff only.
Sussex House	44	Staff (25) and Trust vehicle (19) only.
Total	**497**	Dedicated patient spaces (72), Trust staff and vehicles (73), shared (352).

7. There are also a further 25 dedicated spaces for oncology patients in the Sussex Cancer Centre car park, but these are operated by the MacMillan Cancer charity.

Car Parking Charges

Patients and Visitors

8. The current charges for patients and visitors using the Trust's car parks are:

Period	Charge
Up to 2 hours	£1.50
Up to 4 hours	£2.50
Up to 6 hours	£3.50
Up to 12 hours	£6.50
Up to 24 hours	£14.00

9. These tariffs shadow the car parking charges levied in other car parks in the city and are reviewed when those change.

10. Discounts and exclusions to these charges are offered as follows:

- Long stay patients up to 21 days are offered a discount and are charged £10 per week (renewable weekly) Proof of stay must be provided. This is also offered to the main carers/visitors to the patient;

- Long stay patients over 21 days are offered a further discount and are charged £20 per month (renewable monthly) Proof of stay must be provided. This is also offered to the main carers/visitors to the patient;

- Free parking is provided to certain patient groups (for example renal dialysis and radiotherapy patients) who come for two or more visits per week for extended periods of time. There are seven dedicated bays in the Multi-storey car park for renal patients. Renal patients may also use any of the disabled bays free of charge when displaying the appropriate badge.

11. The Trust also applies discounts and exemptions on an individual basis depending on circumstances.

Staff

12. Staff wishing to park on site can apply for a permit, but must meet certain criteria for a permit to be issued. Charges for staff permits are £120 per year if the member of staff earns under £25,000 per year and £240 per years if they earn over £25,000.

Income and Expenditure

Income

13. The income raised from car parking across the Trust (including permit income) is used in three key areas:

    - Maintaining, and running the car parks;
    - Green transport initiatives;
    - Security (including car park security).

14. In the last two years, income raised is shown below (being the two most recent years for which the Trust has audited accounts at the time of writing):

Year	Income (£)
2007/08	871,000
2008/09	969,000
Total	1,840,000

15. Within the total shown above, staff permit income for the period was just under £500,000.

Expenditure

16. Within the same two year period, expenditure across the Trust was as shown in the table below:

Item	Expenditure (£)
Maintaining and Running Car Parks	
Dedicated traffic officers	70,000
General maintenance (signage, lighting, cleaning)	140,000
Equipment replacement at RSCH	95,000
Sub-Total	*305,000*
Green Transport Initiatives	
40X Bus Service	300,000
Pool Cars, City Car Club Membership and usage	40,000
Cycle Parking PRH	15,000
Car Share scheme	3,000
Pool car data base	7,000
Permit system costs	100,000
Sub-Total	*465,000*
Security	
Security cover, CCTV	160,000
Sub-Total	*160,000*
Grand Total	**930,000**

17. All remaining income is used to enhance the general security of the Trust's sites.

Duane Passman
Director of 3Ts, Estates and Facilities

Shaun Innes
Head of Patient Transport

March 2010

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	Agenda Item 71 Brighton & Hove City Council

Subject:		**Mental Health Reconfiguration Plans: Co-ordination of Sussex Health Overview & Scrutiny Committees (HOSCs)**		
Date of Meeting:		**14 April 2010**		
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 provides some details about the current Sussex-wide reconfiguration of mental health in-patient beds, and about Sussex Health Overview & Scrutiny Committee (HOSC) responses to these reconfiguration plans.

1.2 The report also proposes that Brighton & Hove HOSC nominates some members to represent the Committee in informal discussions with East and West Sussex HOSCs, and to sit on a Joint HOSC (JHOSC) should the Committee decide at some later date that a JHOSC ought to be convened.

2. RECOMMENDATIONS:

2.1 That members:

(1) note the contents of this report;

(2) determine whether to appoint a working group of (possibly 3) members to liaise informally with East and West Sussex HOSCs, and also to represent the Brighton & Hove HOSC on any Joint HOSC that may be convened;

And, should the Committee agree to appoint a working group of members:

(3) determine which HOSC members should sit on this working group.

3. BACKGROUND INFORMATION

3.1 The Sussex Partnership NHS Foundation Trust (SPFT), together with Sussex Primary Care Trusts (PCTs), is currently (or in the case of Brighton & Hove will shortly be) consulting on plans to make significant changes to Sussex mental health services, including the provision of in-patient beds across the patch.

3.2 The Health and Social Care Act (2001) requires NHS trusts planning to make "significant variations" in service to consult local Health Overview & Scrutiny Committees (HOSCs) on both the substance of their plans, and on the arrangements they have made to engage with stakeholders and members of the public. Should a HOSC consider that NHS trust plans for public consultation are inadequate, it may refer the issue to the Secretary of State for Health. A similar power of referral is available should the HOSC consider that a planned change would prove detrimental to the health interests of local residents. Such referrals should only be used after careful consideration and must be thoroughly evidenced to stand any chance of being successful.

3.3 There is no statutory definition of what constitutes a 'significant variation' in service. However, East Sussex HOSC has already decided that NHS plans constitute a significant variation for its residents, and it seems certain that West Sussex HOSC will come to a similar conclusion. Since consultation for Brighton & Hove is not scheduled to commence until summer 2010, it is not yet possible to determine whether local plans are 'significant'.

3.4 SPFT operates across the whole of Sussex, and Sussex PCTs jointly commission working age mental health (WAMH) services from SPFT as, essentially, a single Sussex-wide contract (with NHS West Sussex acting as lead commissioner). However, the reconfiguration of in-patient mental health beds is being undertaken as three discrete initiatives across the West Sussex, East Sussex and Brighton & Hove PCT areas.

3.5 Patient flows into NHS services do not necessarily 'respect' local authority boundaries. For example, people living in the western part of East Sussex may well access acute health care at the Royal Sussex County Hospital in Brighton rather than at an East Sussex hospital. In terms of NHS reconfiguration plans this can mean that changes to a service based in one local authority area have significant implications for other areas (and hence other HOSCs). This is also often the case for specialist services, which may be based in one locality but provide services for a much broader area: changes to such services are of interest to the whole area they serve, not just to where they happen to be based.

3.6 It is therefore quite possible that several HOSCs should have an interest in a particular plan to change NHS services. In such instances it may be that the NHS can successfully negotiate with each individual HOSC. However, this may not always be practicable or possible. For instance, it may be the case that regional development plans depend on the upgrading of services in one locality and a concomitant downgrading in another area; even if there was unanimous agreement that the plan improved services across the region, it might be quite properly challenged by individual HOSCs in the areas where services were to be downgraded: when making decisions HOSCs are not expected to take account of the interests of any populations other than their own.

3.7 In order to mitigate the risk of parochial decision-making in a context requiring a broader approach, and more generally in order to avoid undue complication in the context of major reconfiguration plans, the Health and Social Care Act (2001) includes provision for the formation of joint HOSCs (JHOSCs). A JHOSC is formed by local HOSCs either at the behest of local NHS trusts or because two or more HOSCs consider that a single NHS plan constitutes a substantial variation to services for their residents. A JHOSC assumes the statutory powers of its constituent HOSCs (in relation *only* to the specific issues being examined) for the duration of its existence, including the power(s) to refer to the Secretary of State. JHOSC members are also required to make decisions in the health interests of the residents of the whole of the area covered by the JHOSC rather than simply reflect their own local interests.

3.8 Sussex HOSC Chairmen have met informally to consider whether the plans to reconfigure Sussex mental health in-patient beds should be scrutinised separately or via a JHOSC. After having received assurances from SPFT that the mental health patient-flow between East Sussex, West Sussex and Brighton & Hove is relatively negligible, and that cross-border issues (e.g. capacity for dealing with emergency 'overflow' from one area to another) have been factored in when planning the initiative, the Chairmen agreed that they would not seek to form a JHOSC at this stage, but would reserve the right to do so at a later date should the need arise.

3.9 Both East and West Sussex HOSCs plan to appoint some of their HOSC members to mental health 'taskforces'. These taskforces will scrutinise the East and West Sussex initiatives as they develop, and will contribute to the membership of a JHOSC should one be convened. It is recommended that Brighton & Hove HOSC should consider appointing some members to take lead responsibility for scrutiny of the local mental health reconfiguration initiative. Although there are currently no plans to establish a Brighton & Hove taskforce, nominating members in this way would potentially simplify our liaison with East and West Sussex County Councils, as members of the taskforces may well wish to meet

informally with one another (and with Brighton & Hove representatives). These members would also sit on a JHOSC should one be created. It should be stressed that members are not being asked to approve the formation of a JHOSC at this point in time. If such a move is mooted, Brighton & Hove participation will need to be formally agreed by the full Brighton & Hove HOSC at a future committee meeting.

4. CONSULTATION

4.1 No consultation has been undertaken in preparing this report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are none to this report for information.

Legal Implications:

5.2 "The legal framework governing the Council's power to establish and/or participate in Joint Health Overview and Scrutiny Committees is covered in the body of the report. There are no additional legal implications to note."

Lawyer Consulted: Elizabeth Culbert; Date: 01.04.10

Equalities Implications:

5.3 None directly, although members may wish to consider equalities issues when they come to scrutinise NHS plans to reconfigure MH in-patient beds.

Sustainability Implications:

5.4 None directly.

Crime & Disorder Implications:

5.5 None directly, although members may wish to consider crime and disorder issues when they come to scrutinise NHS plans to reconfigure MH in-patient beds, particularly in terms of assessing the crime and disorder implications of an increased focus on community provision of MH care.

Risk and Opportunity Management Implications:

5.6 JHOSCs are sometimes necessary to facilitate effective scrutiny of wide-ranging NHS initiatives. However, they pose considerable administrative challenges and can take up a disproportionate amount of officer and member time. They should therefore not generally be considered as a first resort, and where there is the possibility of a JHOSC being convened, it is generally wise to plan for it as far in

advance as possible. Doing so minimises the risk of being required to convene special meetings etc. should a JHOSC be required.

Corporate / Citywide Implications:

5.7 It is important that Brighton & Hove HOSC maintains good working relations with the HOSCs in East and West Sussex, particularly since local NHS services are increasingly being organised on a county-wide basis. These good working relations may include formal partnership vehicles such as a JHOSC, but also the maintenance of less formal links.

SUPPORTING DOCUMENTATION

Appendices:

None

Documents in Members' Rooms:

None

Background Documents:

1. The Health and Social Care Act 2001

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	Report 02 Dec 09	Further update required in 6/12 months
Mental Health – commissioning and provision	02 December 2009	SPFT/NHSBH	Brief HOSC members on major reconfiguration of Sussex MH services – presentation by SPFT; paper from NHSBH	Report 02 Dec 09	SPFT will bring their options for consultation back to a later meeting (Jan 2010)
Health Inequalities	02 December 2009	Audit Committee	Referred from Sep 09 Audit Committee	Report 02 Dec 09	Referred to OSC
NHS Brighton & Hove Strategic Commissioning Plan	02 December 2009	NHS BH	Update of PCT's commissioning intentions	Report 02 Dec 09	

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
LINk Update	27 January 2010	HOSC	Regular HOSC item		Postponed from 02 Dec at request of LINk
Annual Health Check Report Back	02 December 2009	HOSC	Report for information on 08/09 Healthcare Commission performance scores for local NHS trusts	Report 02 Dec 09	
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	10 March 2010	Cllr Kitcat	Report on city vaccination rates compared to national/regional rates	Moved from Jan 2010	
Breast Cancer Screening	10 March 2010	HOSC	Update on screening services (following recent underperformance)	Moved from Jan 2010	
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**
Better By Design	27 January 2010	SPFT	SPFT presenting reconfiguration options to HOSC		Public consultation delayed until summer
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	2010	Cllr McCaffery	Examine BSUH planning for acute care in emergencies	post May 2010	To include plans for healthcare provision after a major incident at RSCH site
Sussex Orthopaedic Treatment Centre Update	2010	HOSC	Update on SOTC performance (as some performance issues remained unresolved following last meeting in Nov 08)	post May 2010	
Transfers of Care	2010	Cllr McCaffery	Examine delays in transferring patients out of acute care	post May 2010	

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Swine Flu	2010	HOSC/Cllr McCaffery	Determine lessons to be learnt from swine flu pandemic, including maintaining acute care provision in an outbreak	post May 2010	
Fit For the Future	2010	Joint HOSC	Final results of the Joint HOSC on reconfiguration of West Sussex acute care	post May 2010	
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		