Brighton & Hove City Council

NHS Brighton and Hove

Joint Commissioning Board

Title:	**Joint Commissioning Board**
Date:	**28 January 2013**
Time:	**5.00pm**
Venue	**Council Chamber, Hove Town Hall**
Contact:	**Caroline De Marco** Democratic Services Officer 01273 291063 caroline.demarco@brighton-hove.gov.uk

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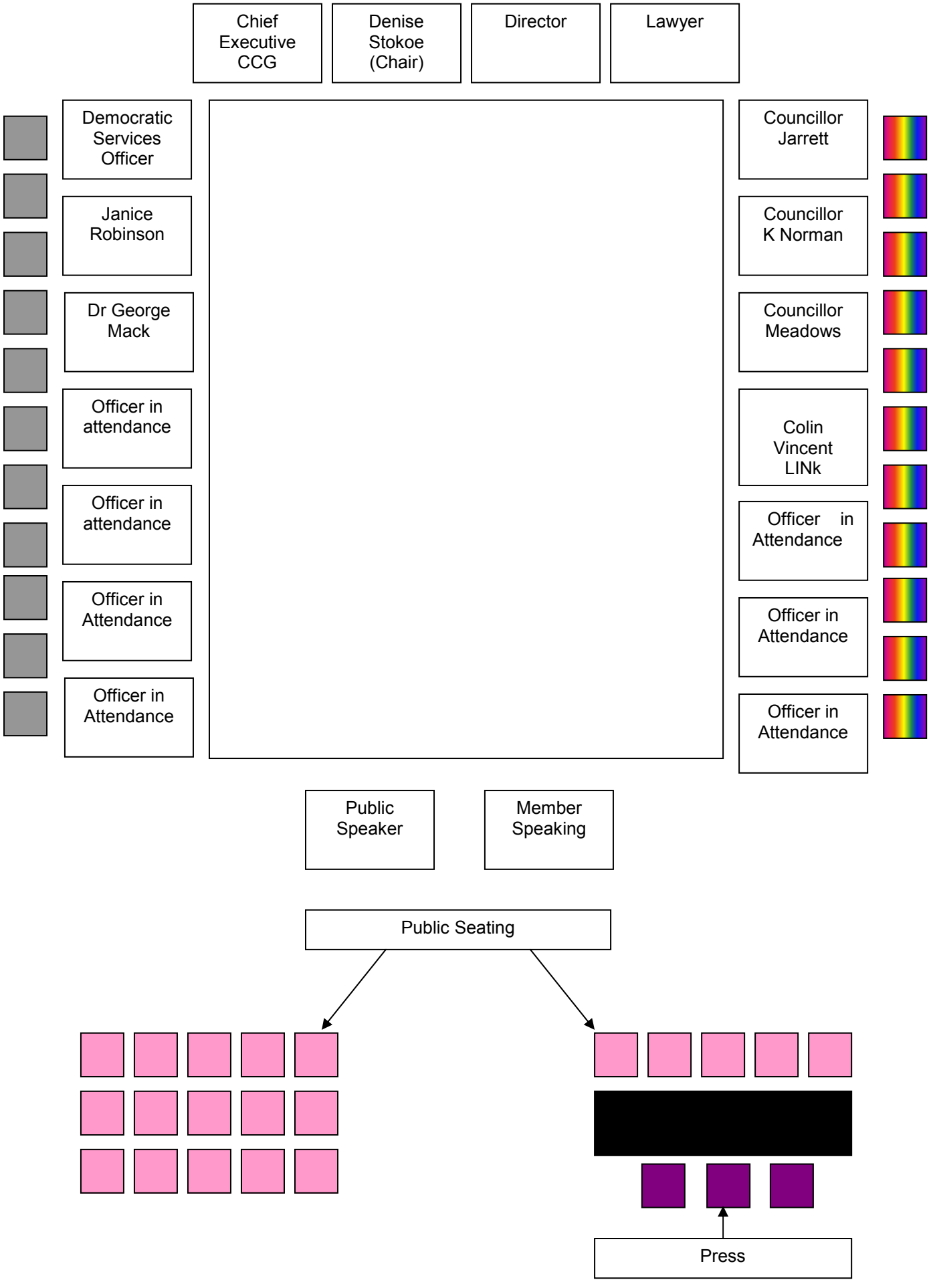

JOINT COMMISSIONING BOARD

The following are requested to attend the meeting:
Brighton & Hove Clinical Commissioning Group Representatives
Denise Stokoe (Chair), Janice Robinson and Dr George Mack
Council Representatives:
Councillor Rob Jarrett (Deputy Chair), Councillor Ken Norman and Councillor Anne Meadows
Co-opted Members:
Colin Vincent, LINk

AGENDA

Part One **Page**

19. PROCEDURAL BUSINESS

(a) Declaration of Substitutes: Where Councillors are unable to attend a meeting, a substitute Member from the same Political Group may attend, speak and vote in their place for that meeting.

(b) Declarations of Interest:

(a) Disclosable pecuniary interests not registered on the register of interests;
(b) Any other interests required to be registered under the local code;
(c) Any other general interest as a result of which a decision on the matter might reasonably be regarded as affecting you or a partner more than a majority of other people or businesses in the ward/s affected by the decision.

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

If unsure, Members should seek advice from the committee lawyer or administrator preferably before the meeting.

(c) 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 either that it is confidential or the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.

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

20. MINUTES OF THE PREVIOUS MEETING 1 - 6

Minutes of the meeting held on 22 October 2012 (copy attached).

Contact Officer: Caroline De Marco Tel: 01273 291063

21. CHAIR'S COMMUNICATIONS

22. PUBLIC QUESTIONS

The closing date for receipt of public questions is 12 noon on 21 January 2012.

No public questions have been received by the date of publication.

23. FINANCIAL PERFORMANCE REPORT - MONTH 8 **7 - 24**

Report of Director of Finance, NHS Sussex and Director of Finance, BHCC (copy attached).

Contact Officer: *Michael Schofield* *Tel: 01273 574743*
Ward Affected: *All Wards*

24. SHORT TERM SERVICES REVIEW - IMPLEMENTATION UPDATE **25 - 32**

Report of the Chief Operating Officer, Brighton & Hove CCG (copy attached).

Contact Officer: *Anna McDevitt* *Tel: 01273 574841*
Ward Affected: *All Wards*

25. DEVELOPMENTS AT CRAVEN VALE (JCB) **33 - 42**

Report of the Director of Adult Social Services (copy attached).

Contact Officer: *Jane MacDonald* *Tel: 29-5038*
Ward Affected: *All Wards*

26. UPDATE ON THE IMPLEMENTATION OF JOINT DEMENTIA PLAN **43 - 60**

Report of the Chief Operating Officer, Brighton & Hove CCG (copy attached).

Contact Officer: *Joanne Matthews* *Tel: 01273 574685*
Ward Affected: *All Wards*

27. LEARNING DISABILITIES HEALTH SELF-ASSESSMENT FRAMEWORK YEAR 4: 2012 **61 - 70**

Report of the Director of Adult Social Services, BHCC & Chief Operating Officer NHS Brighton & Hove (copy attached).

Contact Officer: *Mark Hendriks* *Tel: 01273 293071*
Ward Affected: *All Wards*

28. DAY ACTIVITIES COMMISSIONING PLAN **71 - 96**

Report of Director of Adult Social Services (copy attached).

Contact Officer: *Anne Richardson-Locke* *Tel: 01273 290379*
Ward Affected: *All Wards*

29. ADULTS SECTION 75 DOCUMENTATION (JANUARY 2013) **97 - 184**

Report of the Chief Operating Officer, Brighton and Hove CCG (copy

attached).

Contact Officer: *Geraldine Hoban* *Tel: 01273 574863*
Ward Affected: *All Wards*

30. FEE LEVELS IN ADULT SOCIAL CARE SERVICES 2013/14 **185 - 192**

Report of the Director of Adult Social Services (copy attached).

Contact Officer: *Jane MacDonald* *Tel: 29-5038*
Ward Affected: *All Wards*

PART TWO

31. PART TWO MINUTES **193 - 196**

To consider the Part Two minutes of the meeting held on 22 October 2012 (copy circulated to Members only).

32. PART TWO PROCEEDINGS

To consider whether the item listed in Part Two of the agenda and the decision taken, should remain exempt from disclosure to the press and public.

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

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For further details and general enquiries about this meeting contact Caroline De Marco, (01273 291063, email caroline.demarco@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

Date of Publication - Friday, 18 January 2013

JOINT COMMISSIONING BOARD	Agenda Item 20 Brighton & Hove City Council

BRIGHTON & HOVE CITY COUNCIL

JOINT COMMISSIONING BOARD

5.00PM 22 OCTOBER 2012

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Brighton & Hove City Primary Care Trust representatives:
Denise Stokoe (Chair)Janice Robinson and Dr George Mack;

Council representatives:
Councillor Rob Jarrett (Deputy Chair)
Councillor Ken Norman;

Co-opted Members:
Colin Vincent, LINk

Apologies: Councillor Anne Meadows

PART ONE

9. PROCEDURAL BUSINESS

9 (a) Declarations of Substitutes

9.1 There were none.

9 (b) Declarations of Interests

9.2 There were none.

9 (c) Exclusion of Press and Public

9.3 In accordance with section 100A of the Local Government Act 1972 ("the Act), the Board considered whether the press and public should be excluded from the meeting during an item of business on the grounds that it was likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present during that item, there would be disclosure to them of confidential information (as defined in section 100A (3) of the Act) or exempt information (as defined in section 100I(I) of the Act).

9.4 **RESOLVED -** That the press and public be excluded from the meeting during consideration of Item 17.

10. MINUTES OF THE PREVIOUS MEETING

10.1 George Mack referred to paragraph 5.6 in which he asked why the contribution levels were lower in 2012/13 (£85M) than in 2011/12 (£89M). He had been expecting further clarification on this matter. from the finance officer, NHS Sussex.

10.2 The Chief Operating Officer explained that she would check this query with the Finance Officer, NHS Sussex who unfortunately was unable to attend the meeting. The information would be placed in the minutes.

10.3 **RESOLVED** – That the minutes of the Joint Commissioning Board Meeting held on 2 July 2012 be agreed and signed as a correct record.

11. CHAIR'S COMMUNICATIONS

11.1 There were none.

12. PUBLIC QUESTIONS

12.1 There were none.

13. FINANCIAL PERFORMANCE REPORT - MONTH 5

13.1 The Board considered a report of the Director of Finance, NHS Sussex and Director of Finance, BHCC which set out the financial position and forecast for the partnership budgets at the end of month 5.

13.2 The Head of Finance – Business Engagement, BHCC reported that the table at paragraph 3.1 set out the month 5 position. There were a number of areas of underspend. There was an overspend in the Sussex Community Trust in the Intermediate Care Service. A process was in place to deal with this pressure. The budget position for the Sussex Partnership Foundation Trust was improving. There was a 50/50 risk-share arrangement in place between the council and the provider in 2012/13. There was a forecast underspend on Learning Disability Services. The block contract and inflation arrangements were set out in paragraph 3.5.

13.3 The Chair informed the Board that she would expect a much more detailed report to be submitted to the Board at the meeting on 28 January 2013.

13.4 **RESOLVED** (1) That the forecast outturn for 2012/13 as at month 5 be noted.

14. LEARNING DISABILITIES ACCOMMODATION

14.1 The Board considered a report of the Director of Adult Social Services/Lead Commissioner People which informed members that a report had been presented to the Adult Care & Health Committee in June following a three month consultation which recommended the re-modelling of the council's accommodation for people with learning disabilities. The Committee decided to defer a decision pending consultation with the service users and additional information being provided. A further report was submitted

to the Adult Care & Health Committee on 24 September where option 1 was agreed. Option 1 was set out in paragraph 3.1 of the report.

14.2 The Head of Adult Care & Health (Provider) informed the Board that the summary of the consultation prior to and after June 2012 was attached as appendix 1 to the report. The outcome of the consultation was attached as appendix 2. Option 1 had been recommended as it delivered a more efficient service and delivered savings whilst providing homes for an additional 5 people. Alternative options were set out in the report in paragraph 3.2.

14.3 Colin Vincent referred to the consultation and expressed concern and disappointment that the LINk were not directly consulted on the proposals. They had heard about the proposals from an outside source. The LINk were eventually contacted on 30 August and replied in September 2012.

14.4 The Head of Adult Care & Health (Provider) apologised if the LINk had not been consulted and stressed that this was an oversight. As soon as the LINk contacted the council, full details had been sent to the LINK. There would be a full review of the way the council consulted stakeholders and the Head of Adult Care & Health undertook that the LINk would be consulted in future.

14.5 Janice Robinson stated that she considered the arguments for the decision were well made in the report. She was interested to hear that there would not be compulsory redundancies. She asked how the staff in the new set up would be deployed differently and whether they were currently underworked. Ms Robinson noted that several of the women residents and one in particular, were concerned that they might have male carers. Ms Robinson asked for assurance that the requirements of those women would be met.

14.6 The Head of Adult Care & Health (Provider) replied that with regard to staff, the council were working on plans to move service users to their new accommodation. The council did not need to make redundancies as there were staff vacancies and posts had been frozen. The council had an in-house agency called Care Crew which covered vacancies with flexible workers.

14.7 The Head of Adult Care & Health (Provider) explained that there were very few women in the service. There was a proposal to move three young women to a new home where they would be joined by a fourth young woman. Staff would consider very carefully whether to use any male carers. The council would maintain a women's service and would ensure that their needs were met.

14.8 **RESOLVED** - (1) That the decision made by Adult Care and Health Committee to re-model the council's accommodation for people with learning disabilities as set out in Option 1 (paragraph 3.1), be noted.

15. CARE HOME APPROVED PROVIDER ARRANGEMENTS

15.1 The Board considered a report of the Director of Adult Social Services/Lead Commissioner People which proposed a generic care home contract. Some existing care home contracts needed to be reviewed and current arrangements needed updating

to reflect the changes in national policy as outlined in Putting People First and Caring for the Future, together with the new flexibilities around registration categories introduced by the Care Quality Commission.

15.2 The Contracts Manager explained that the council currently had two separate contracts for older people and people under 65 and over 18. The aim was to bring these contracts together and have a policy that spanned all age groups. The terms and conditions remained the same as before but the specifications were more robust. There were different clinical standards for nursing homes.

15.3 The Chair asked what sort of response had been received from the consultation. The Contracts Manager replied that there had been two issues raised by providers. The first issue related to concerns relating to the level of financial information required and health and safety issues. The smaller providers felt that the level of financial information required was inappropriate. This requirement had now been streamlined and a more proportionate system had been agreed for smaller providers. The other concern related to quality. Providers wanted assurance that good quality systems were in place.

15.4 The Chief Operations Officer welcomed the clinical standards in the contract documentation. She asked how officers measured compliance against those standards.

15.5 The Contracts Manager explained that the Clinical Review Nurse would be responsible for reviewing care.

15.6 Councillor Norman asked for clarification as to why the Joint Commissioning Board was being asked to agree the report rather than note it.

15.7 The Chair explained that as the contract in question was a joint health and social care contract, it had been decided that there should be a joint decision.

15.8 **RESOLVED** (1) That the process for procuring & the awarding of the contract and the timescales outlined in this report be agreed.

(2) That it is agreed that the Director of Adult Social Services has delegated authority to award contracts.

(Note: These recommendations were agreed by the Adult Care & Health Committee on 24 September 2012)

16. TRANSFER OF CARE FROM A SHORT TERM BED

16.1 The Board considered a report of the Director of Adult Social Services/Lead Commissioner People which presented the Transfer of Care from a Short Bed Policy. The policy sought to give clarity to the situation when a person was in a short term bed that no longer met their assessed need. It also sought to make the process fair so all cases were resolved using the same principles that were captured in one policy.

16.2 The Commissioning Manager explained that there had been a thorough consultation process and the policy had sought to ensure that people understood the process and moved from their short term bed in a timely way. Paragraph 3.4 of the report related to

guidance on how the process should be managed when a service user refused to move. The Commissioning Manager stressed that this was a very rare occurrence.

16.3 Janice Robinson remarked that the report was very clear but asked why the report was being submitted at this time. She asked if the problem of people not leaving short term beds had increased. The Commissioning Manager explained that the policy had been driven by new contractual arrangements. There had not been an increase in people refusing to leave beds.

16.4 George Mack asked for an explanation of paragraph 3.5. "If a person needs a care home it is important to note that they may have much more choice regarding which care home they will live in, after they have moved out of a short term bed." The Commissioning Manager explained that following the move from a short term bed a person would be re-abled to meet their full potential. Some people might be able to go home, whilst others might need a care home place. People would be given time to look for a care home place and might need to wait in a temporary care home while they looked for their long term home of choice.

16.5 **RESOLVED** (1) That the Transfer of Care from a Short Term Bed policy and the implementation thereof, be agreed.

Note: The recommendation above was agreed by the Adult Care & Health Committee held on 24 September 2012)

Part Two Summary

17. RECOMMENDATION - AWARD OF FUNDING AGREEMENTS FOR COMMUNITY MENTAL HEALTH SUPPORT SERVICES - EXEMPT CATEGORY 3.

17.1 The Board considered a report of the Director of Adult Social Services/Lead Commissioner People and Chief Operating Officer, Brighton & Hove Clinical Commissioning Group, NHS Sussex concerning the evaluation and recommendation for the award of funding agreements for Community Mental Health Support Services.

17.2 **RESOLVED** - (1) That the recommendations detailed in the Part Two confidential report be accepted.

18. PART TWO PROCEEDINGS

18.1 The Board considered whether or not the above item should remain exempt from disclosure to the press and public.

18.2 **RESOLVED** – That item 17 contained in Part Two of the agenda, remain exempt from disclosure to the press and public.

The meeting concluded at 6.08pm

Signed Chair

Dated this day of

JOINT COMMISSIONING BOARD	**Agenda Item 23** NHS Brighton & Hove Brighton & Hove City Council

Subject:		**Financial Performance Report – Month 8**		
Date of Meeting:		**28th January 2013**		
Report of:		**Director of Finance, NHS Sussex** **Director of Finance, BHCC**		
Contact Officer:	Name:	**Michael Schofield**	**Tel:**	**01273-574743**
	E-mail:	michael.schofield@bhcpct.nhs.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report sets out the financial position and forecast for the partnership budgets at the end of month 8 and contains the proposed 2013/14 budget strategies for consultation.

2. RECOMMENDATIONS:

2.1 Board members are requested to note the forecast outturns for the s75 budgets as at month 8.

2.2 To consider the budget strategies for the health and social care arrangements set out for development and agreement by Budget Council and NHS Sussex Board.

3. RELEVANT INFORMATION:

Financial Position – Month 8 – 2012/13

3.1 The table below shows the month 8 forecast outturn variance by client group:

Month 8 Forecast Outturn Variance by Client Group

	SCT £'000	SPFT £'000	PCT £'000	BHCC £'000	Total £'000
PCT:					
Intermediate Care	224	0	0	0	224
HIV / AIDS Services	(226)	0	0	0	(226)
Integrated Equipment Store	28	0	0	0	28
Older People Mental Health	0	(441)	0	0	(441)
Working Age Mental Health	0	(36)	0	0	(36)
Substance Misuse Services	0	(24)	0	0	(24)
	26	**(501)**	**0**	**0**	**(475)**
Council:					
Learning Disabilities Services	**0**	**0**	**0**	**(633)**	**(633)**
Total Forecast Outturn	**26**	**(501)**	**0**	**(633)**	**(1,108)**

3.2 Services commissioned from SCT are reporting an overspend of £26k. There are significant staffing pressures against Intermediate Care services, Knoll House is now under the management of the Council. The overspend is being partially offset by savings against the HIV/AIDS budget which is a continuation of the position in 2011/12.

3.3 An underspend of £501k is currently being forecast in respect of services commissioned from SPFT. The budget strategy savings target of £0.326m has already been achieved. On top of this, savings of £0.202m have been achieved through robust vacancy management and tight budgetary control and a further £0.154m from the community care budget as a result of increased funding through the assessment process and robust review of all placements. There continue to be pressures against the Adult Mental Health Community Care budget from a lack of suitable accommodation, which has been highlighted as part of the budget process for 2013/14. In line with the agreed risk-share arrangements for 2012/13 any overspend or underspend will be shared 50/50 between SPFT and BHCC.

3.4 Learning Disabilities are showing an underspend of £0.633m due mainly to the full year effect of management decisions taken during 2011/12 and over-achievement of financial recovery plan targets for the current financial year. There are risks against delivery of budget strategy savings on Learning Disabilities Accommodation (£0.311m) as a result of the delays in implementation. Also, there has been a delay in developing proposals on day activities.

The PCT contracts with SCT and SPFT are currently forecast to breakeven. Regular discussions are being held with the Trusts during the year to ensure there are no surprises and pressures materialising are addressed.

Council Planning for 2013/14

3.5 The Council draft budget strategies for 2013/14 were presented to the Council's Policy & Resources Committee on 29 November 2012 and set out funding changes, information on specific investment in services and savings proposals. These proposals are a work in progress and are in the process of consultation. A revised set of proposals will be presented to Policy & Resources Committee on 14 February 2013 taking into consideration the feedback from further consultation and scrutiny and the most up to date financial information. The final responsibility for agreeing the council's budget for 2013/14 rests with Full Council when it meets on 28 February 2013.

3.6 Many of the proposals for 2013/14 were considered last year as part of a 2-year set of proposals. However, recent government announcements concerning funding and council tax, together with the estimated impact of Business Rate Retention, have substantially increased the budget savings requirement and therefore 2013/14 savings have had to be re-examined and augmented.

The provisional Local Government Finance Settlement for 2013/14 was announced on 19 December and the full implications cannot be determined until all details are available. The initial assessment indicates that the level of savings required across the Council will be approximately £21m in 2013/14.

3.7 The Joint Commissioning Board is asked to consider the S75 elements of the strategy for Adult Social Care and related savings proposals (Appendix 1). The strategy sets out the strategic financial context, expected changes in legislation and progress against Council priorities. The savings proposals set out to achieve better value for money and improve customer service whilst meeting the nationally driven reforms to adult social care including self directed support and personalisation of service provision and budgets. There is a commitment to maintain focus on prevention services, to look at the effectiveness of current provision and opportunities to work in partnership with NHS colleagues across the city.

The key risks associated with the Adult Social Care budget strategy to be developed jointly with health are:

- Reducing the number of people paced in long term care will require delivery of services that promote independence and customer need to be assessed consistently and managed on a case by case basis to ensure that people with a disability and/or mental health needs are not disadvantaged

- Working with the housing sector in identifying suitable accommodation alternatives in the form of Supported Living, Extra Care Housing and other available schemes
- Developing alternative day activities will link people to universal services and mainstream them. Will require focus on the most vulnerable and acceptance of community based options
- Explore future models for delivery of services that deliver statutory services in the most cost effective way, and explore models of provision for non statutory services for vulnerable people.

Equalities Impact Assessment budget screenings have been carried out against these savings covering the above risks and full Equality Impact Assessments will be completed before implementation.

3.8 Adult Social Care (including Learning Disabilities and S75) is expected to generate savings of £5.7 million in 2013/14 (with a full year effect of £6.5million). The s75 arrangements with Sussex Partnership Foundation Trust and Sussex Community Trust fall within the remit of the Head of Adults Assessment and are included with the savings for this unit of £4.6 million in 2013/14. The proposed savings within Adults Assessment that directly impact on S75 arrangements are:

- Community Care- potential to increase move on through short term interventions and better use of Telecare
- Plan to reduce the number of people placed in residential care through the use of Sheltered Accommodation/Extra Care Housing, Shared Lives and other accommodation
- Options for remodelling staffing arrangements across assessment services

Proposed savings within Assessment and Provider services against the Learning Disabilities S75 arrangements include:

- Implementation of the Learning Disabilities accommodation and support strategy

3.9 There are significant financial and service pressures across Adult Social Care which are estimated to exceed £1.0 million relating to transitions and demographic growth. Funding of £1.0million has been set aside in the budget proposals to mitigate the associated risks. The allocations to S75 are estimated at

- Learning Disabilities £0.6 million Assumes an increase of 19.30 Whole Time Equivalents (WTE) for growth in transitions - to be reviewed case-by-case.
- Mental Health £0.35 million -Increase in Long Term Conditions (dementia) based on 10 WTE and in Mental Health placements based on increase of 8 WTE

3.10 The Local Government Finance Settlement includes a funding transfer from the NHS to local authorities which for BHCC is £4.4 million. At this stage an assessment is being made of how much of this is new funding . A condition of the funding transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment.
The NHS Commissioning Board may use the funding transfer to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment.

3.11 In 2013/14 councils will also gain responsibility for Public Health and the government has stated that they are committed to ensuring that local authorities are adequately funded. The Department of Health has awarded a ring fenced grant for BHCC of £18.3 million for 2013/14 and £18.7 million for 2014/15 intended to cover the public health responsibilities which are transferring to the local authority. The principle of prioritising services for the young, elderly and vulnerable should make a positive contribution to public health.

CCG Planning for 2013/14 and future years

3.12 The NHS Commissioning Board has published it's planning framework for CCGs. The core document "Everyone Counts: Planning for Patients 2013/14" replaces the National Operating Framework of the previous year and sets a number of objectives for NHS Commissioners.

3.13 CCGs will receive 2.3% growth on their 2013/14 opening allocation, which is equivalent to 0.3% in real terms. 2.5% of these allocated funds are required to be held in reserve for non-recurrent use in year, 2.0% of which is intended to provide initial support to new developments, while 0.5% is a general contingency fund to mitigate any cost pressures arising during the year.

3.14 The 2013/14 tariff adjustment reflects the requirement for Providers to generate a 4% efficiency, this is partially offset by an allowance for cost inflation of 2.7% , giving a net tariff adjustment of -1.3%.

3.15 Providers will continue to receive a 2.5% payment under the Quality and Innovation Initiative (CQUIN) in recognition for the achievement of quality improvements, reflecting both national and local priorities.

3.16 The CCG is currently developing firm plans for 2013/14. An early review of the impact of planning assumptions on the CCG budgets suggests that the CCG has a savings target of approximately £10m. Initial summary plans are due to be submitted to NHS Area Teams in January. The budget setting process for 2013/14 starts in February 2013. Detailed budgets in respect of the PCT's

section 75 contribution will be presented to the Board as soon as the process has been completed.

4. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

4.1 The financial implications of the report are found in the text, highlighting the performance against the pooled budgets in 2012/13 and the budget strategy for 2013/14.

Finance Officer consulted: Anne Silley/Debra Crisp Date 11/01/13

4.2 Legal Implications:

There are no specific legal implications (including Human Rights Act and Equalities) which arise out of this report other than those raised in the main body of the Report in relation to the duty to the public purse in terms of the budget pressures arising in some areas of provision and the resulting impact on provision of statutory services. In addressing this impact, through the methods proposed in this report, regard must be paid to ongoing statutory Care and Health duties and individual's Rights enshrined in Human Rights and Equalities legislation.

Sandra O'Brien Senior Lawyer Date 7 January 2013

Equalities Implications:

4.3 Equalities Impact Assessment budget screenings have been carried out against the savings described covering the risks and full Equality Impact Assessments will be completed before implementation.

Sustainability Implications:

4.4 Sustainability implications are considered in developing savings options.

Crime & Disorder Implications:

4.5 There are no direct crime and disorder implications arising from this report.

Risk and Opportunity Management Implications:

4.6 There are no direct risk and opportunity management implications arising from this report. Both organisations have extensive risk management frameworks which address the risks arising from the section 75 agreement.

Public Health Implications

4.7 From 1 April 2013 public health functions are due to transfer to local authorities and the Department of Health has allocated a ring fenced grant to cover the new responsibilities.
There are a wide range of proposals within this budget that have potential implications for public health in its broadest sense. The principle of prioritising services for the young, elderly and vulnerable should make a positive contribution to public health.

Corporate / Citywide Implications:

4.8 There are no direct corporate/ citywide implications arising from this report.

5. EVALUATION OF ANY ALTERNATIVE OPTION(S):

5.1 The budget process allows parties to engage in the scrutiny of budget proposals and to feedback before updated proposals are presented.

6. REASONS FOR REPORT RECOMMENDATIONS

6.1 The Council is under a statutory duty to set its budget and council tax before March 11 each year and engages in full consultation of budget proposals.

Appendix 1

Budget Strategy for Adult Social Care

Strategic Financial Context

Adult social care continues to deliver services through personalised care and support plans, prevention and supporting carers.

There are important demographic changes in the population of Brighton & Hove which affect our spend. In summary these are:

- A reducing number of Over 65s, but an increased proportion of Over 85s with high and complex needs.
- A growing number of young adults with a complexity of need including mental health, Substance Misuse and homelessness.

Through Personalisation we are continuing to increase choice to individuals about their care and we are supporting them to live as independently as possible.

The focus on adult social care services has been on commissioning. We have re tendered homecare services and we will continue with this approach for care homes and community meals. We carefully consider the unit cost and the value for money services offer, and where these are provided in house we need to demonstrate the rationale for retaining these services, focussing on effectiveness and efficiency, and how they complement other provision in the city. This has enabled the Council to maintain eligibility criteria under Fair Access to Care at the current level-' substantial and critical 'rather than to tighten this.

Through the Extra Care Steering Group, work is underway to identify suitable sites to allow choice and value for money options for providing care and support and we will continue to promote other forms of supported living including the 'shared lives' initiative.

The multi agency work on 'Troubles Families' and Adults will in the longer term see savings delivered across key partner agencies and local authorities. This work is part of the Stronger Families, Stronger Communities work described elsewhere.

We need ensure that the quality of services provided in the independent sector is maintained both through ensuring adequate funding and through tight quality control and monitoring by the council.

In the coming two years we will see proposed changes in legislation coming into force. The draft care and support bill will likely put the safeguarding of vulnerable adults into a legal framework. There are other aspects of the draft bill including well being, advice and information, support needs of broader communities and legal entitlement for carers.

Until the bill is enacted we will not know the details of the new duties and functions we will need to provide.

Tackling Inequalities

Adult Social Care services remain focused on supporting the most vulnerable people in the city, promoting independence to enable people to fulfil their potential. Working with colleagues in mental health services under formal S75 arrangements, we work and support the most complex people in the city through a range of interventions from a clinical nature through to helping people get back to work.

Low level preventative services focus on people accessing mainstream services and support around financial inclusion and isolation.

Creating a more sustainable city.

Recent commissioning, such as homecare is based on geographical data and reduce travel across the city and future developments are based on efficient and sustainable options. Developments such as Extra Care Housing will include sustainable specifications to reduce future energy costs and carbon emissions.

Engage People with live and work in the city.

Through our commissioning activity, significant contributions have been made by users of services, third sector, providers and representatives eg health watch.

The ‘local account’ on performance and priorities published for the first time on adult social care via the web provided some responses tor future development of the local account and a wider stakeholder event is planned for early in the new year. The Local Account summarises what Adult Social Services have done in the past year, how successful they have been and what their future priorities are and is used, in part, by the Care Quality Commission to judger and rate services.

There are also partnership boards and other groups for services or client group issues.

Responsible and empowering employer

Adult Social care staff are both employed in the council and mental health trust. These staff provide high level specialist input and front line care and support staff to care and deliver its key objectives for social care as well as consider how best to shape services to meet with needs of local residents in a cohesive way.

A council the city deserves

As with Children's Services, the Adult Social Care value for money programme has brought clear benefits which we have been able to extend across a wide range of services as we look to redesign the ways in which we engage with people in need. Our teams are engaging with and have embraced the Workstyles initiative in relevant locations and are developing new efficient working methods to take advantage of ICT investment, new telephony opportunities and customer access changes.

People-Adult Social Care- Summary Budget
Savings Proposals 2013/14

	Net Budget £'000	Commissioning £'000	VFM Programme £'000	Other Efficiency Gains £'000	Fees & Charges £'000	Investments / Service pressures £'000	Net Change £'000	Net Change %
2013/14 Savings Proposals	**79,857**	**-3,525**	**-1,784**	**-390**	**0**	**1,000**	**-4,699**	**-6**
2013/14 Full year Effect		-4,275	-1,884	-390	0	1,000	-5,549	-7

2013/14 Proposals	**Net Budget £'000**	**Commissioning £'000**	**VFM Programme £'000**	**Other Efficiency Gains £'000**	**Fees & Charges £'000**	**Investments / Service pressures £'000**	**Net Change £'000**	**Net Change %**
Commissioner - People	1,865	-200	0	-50	0	0	-250	-13
Delivery Unit - Adults Assessment	64,661	-2,460	-1,784	-340	0	942	-3,642	-6
Delivery Unit - Adults Provider	13,331	-865	0	0	0	58	-807	-6
Total Adult Social Care	**79,857**	**-3,525**	**-1,784**	**-390**	**0**	**1,000**	**-4,699**	**-6**

PEOPLE-ADULT SOCIAL CARE-2013/14
SAVINGS PROPOSALS

COMMISSIONER - PEOPLE							
Service (including brief description)	**Net Budget £'000**	**Description of Saving Opportunity**	**Saving Type**	**Impact on Outcomes / Priorities**	**Equalities Impact**	**Savings identified 2013/14 £'000**	**Full Year effect of 2013/14 savings £'000**
Commissioning support to Director of Adult Social Care statutory role including contracts	950	Review of support services to include commissioning, performance and development and contract management	Other Efficiency Gains	Costed options to be developed. Will reduce commissioning and contract management capability commensurate with need	Equalities issues to be addressed once plans are developed	-50	-50
Commissioned services to meet statutory obligations	590	Review of all contracts for services as part of commissioning plans and where appropriate re-specify contracts to meet changing needs. Focus on prevention/early intervention.	Commissioning	Contracts are being reviewed and discussions with providers taking place, including tapering and re-specifying contracts/contract sums.	EIA 8	-150	-150
Commissioned Community Meals service providing 85,000 meals pa	243	Review and Respecify Community Meals in the context of personalisation and the range of options that are currently available. The design process has included the Adult Social Care & Health Overview & Scrutiny Committee which held a workshop in January	Commissioning	A phased reduction of subsidy will provide time for the use of personal budgets to change and for meals to be targeted to the most vulnerable.	EIA9	-50	-50

		2012.					
						-250	**-250**

DELIVERY UNIT - ADULTS ASSESSMENT							
Service (including brief description)	**Net Budget £'000**	**Description of Saving Opportunity**	**Saving Type**	**Impact on Outcomes / Priorities**	**Equalities Impact**	**Savings identified 2013/14 £'000**	**Full Year effect of 2013/14 savings £'000**
Meeting assessed needs through Extra Care Housing within the overall housing commissioning plans	incl below	Jointly commissioned with housing to deliver extra care capacity to meet the need identified in the city. Plan to reduce number of people placed in residential care- options to include the use of Sheltered Accommodation/ Extra Care Housing, Shared Lives and other accommodation. Proposal includes an additional £500k stretch target, which will require accelerated approach.	Commissioning	Allows vulnerable adults to live healthy independent lives and achieves individual outcomes. Achieves better Value for money through increase in prevention services and reduce overall intervention costs	EIA 10	-2,140	-2,140
The service has a duty to meet assessed needs of people with Learning Disabilities within the Fair Access to Care (FACS) criteria	incl below	Develop proposals to implement the Learning Disabilities accommodation and support strategy and consult on the options. Look to utilise the capacity in the city and operate a robust and appropriate service	Commissioning	Based on proposals agreed at Adult Care & Health Committee in September 2012. Detailed implementation plans will need to be in place based on assessed needs of	EIA 11	-150	-150

		Key areas:- - Supporting move on to greater independence by increasing low level supported living options and modernising 'shared lives'. - Remodel services to provide short term crisis support and for those with the most complex needs to reduce out of area respite and emergency placements.		individuals.			
These services provide the statutory duty under the NHS and Community Care Act (1990) to assess needs and to provide services to meet those assessed needs.	52,601	Community Care. Scope potential to increase move on by: - further focus on reablement activities - short term interventions - prevention activities - better use of Telecare - better use of in-house residential services - improved short term services - continue to maximise sources of funding/income	VFM Programme	- Value for Money target /Benefits Realisation Enhanced reablement and better use of assisted technology to reduce numbers into residential/ nursing homes. Dependent on reviews and provider services. Further savings to include Supported Living Strategy(under development) which will require new services to be	EIA 12 & 13	-1,784	-1,884

				developed. May require further spend to save funding to develop Telecare solutions.			
Joint commissioning provider arrangements	3,738	Look at options for re-modelling staffing arrangements in Assessment Services	Other Efficiency Gains	Efficiency review of integrated staffing and management arrangements	Equalities issues to be addressed once plans are developed	-340	-340
Meeting assessed needs through Home Care	Incl within Community care	Home Care recommissioned to a new specification and contract let from 1 June 2012. Ongoing impact following introduction of the Electronic Care Monitoring System.	Commissioning	New contract gives the opportunity to revise rates structure and ensure the correct incentives .	EIA 14	-170	-170
						-4,584	**-4,684**

DELIVERY UNIT - ADULTS PROVIDER							
Service (including brief description)	**Net Budget £'000**	**Description of Saving Opportunity**	**Saving Type**	**Impact on Outcomes / Priorities**	**Equalities Impact**	**Savings identified 2013/14 £'000**	**Full Year effect of 2013/14 savings £'000**
Small registered residential homes and supported living, includes Respite Services and Shared Lives scheme	4,509	Develop proposals for the in house service to implement the Learning Disabilities accommodation and support strategy and consult on the options. In house service to refocus on short term crisis intervention and those with the most complex needs. Potential capital receipts for the Council when properties become vacant which may need to be reinvested in alternative service provision. -reduce unit costs - In-house service to focus on those with the most complex needs	Commissioning	Delivers improved vfm. Tackling inequality by providing more homes and enhanced independence for people with learning disabilities who have highest level of needs. Focuses the accommodation service on a smaller number of houses to improve sustainability. Detailed implementation plans will need to be in place.	EIA 11	-465	-465

Services provided during the day for older people and older people with mental health needs to enable them to continue living independently and to provide carer relief	2,305	Day Activities. Option appraisal in development with focus on in -house building based day activities and contract for services provided in the independent sector. Proposal to be developed for consultation	Commissioning	Commissioning plan being developed. Tiering activity, providing building based services for people with highly complex needs and carer support and a 'hub and spoke' model for other people assessed as needing support. The Embrace model to provide universal support to communities. (NB Excludes mental health services which are subject to a separate joint commissioning plan with the NHS)	EIA 15	-150	-150
All current in house provider services including residential accommodation, community based services and day provision		Explore future models for delivery of services that deliver statutory services in the most cost effective way, and explore models of provision for non statutory services for vulnerable people. The savings associated with this could be across both the provider and assessment service.	Commissioning	Improves vfm by exploring different ways in which statutory services could be delivered.	EIA 16	-250	-1,000
						-865	**-1,615**
TOTAL SAVINGS - ADULT SOCIAL CARE						**-5,699**	**-6,549**

Delivery Unit - Adults Provider

Service (including brief description)	Total Net budget £'000	Description of saving	Service impact and risks	Savings identified 2013/14 £'000	Full Year effect of 2013/14 savings £'000
Small registered residential homes and supported living, includes Respite Services and Shared Lives scheme	4,509	Develop proposals for the in house service to implement the Learning Disabilities accommodation and support strategy and consult on the options. In house service to refocus on short term crisis intervention and those with the most complex needs. Potential capital receipts when properties become vacant which may need to be reinvested in alternative service provision. - In-house service to focus on those with the most complex needs	Detailed implementation plans will need to be in place.	415	415
Services provided to vulnerable people through in house service- includes reabling homecare and day care	3,111	Identify scope/options to reduce in house unit costs .	Costed options to be developed to include reduction in use of agency and to promote flexible working of staff to support units when users are attending day activities	50	50
Services provided during the day for older people and older people with mental health needs to enable them to continue living independently and to provide carer relief	2,305	Day Activities. Option appraisal in development with focus on in -house building based day activities and contract for services provided in the independent sector. Proposal to be developed for consultation	Commissioning plan being developed. Tiering activity, providing building based services for people with highly complex needs and carer support and a 'hub and spoke' model for other people assessed as needing support. The Embrace model to provide universal support to communities. (NB Excludes mental health services which are subject to a separate joint commissioning plan with the NHS)	150	150
All current in house provider services including residential accommodation, community based services and day provision		Continue to explore future models for delivery of services. The savings associated with this could be across both the provider and assessment service	Continue to prioritise the role of in house provision to meet high level need and gaps in provision.	500	1,000
Totals				**1,115**	**1,615**

Overall Total 2013/14 **5,449** **6,049**

Joint Commissioning Board	Agenda Item 24 Brighton & Hove City Council

Subject:		**Short Term Services Review – implementation update**		
Date of Meeting:		**28 January 2013**		
Report of:		**Chief Operating Officer, Brighton and Hove Clinical Commissioning Group**		
Contact Officer:	**Name:**	**Anna McDevitt**	**Tel:**	**574841**
	Email:	**annamcdevitt@nhs.net**		
Key Decision:	**No**			
Ward(s) affected:		**All**		

FOR GENERAL RELEASE.

1. SUMMARY AND POLICY CONTEXT:

1.1 In November 2011, the JCB endorsed the new service model for community short term services. The new service model included:

- a more equitable system where people with both social care and health needs can have easier access to multi disciplinary short term services
- making the system less fragmented by reducing the number of venues from which bed based short term care is provided
- bringing the provision of all short term care back within the city boundaries
- reduced bed based provision of short term care in favour of more home based provision
- more closely integrated rapid response services including the Roving GP service, Community Rapid Response Service, Out of Hours District Nursing Service and Age UK Crisis service
- reducing overall spend on short term care by £2m

1.2 This report provides a further update on progress.

2. RECOMMENDATIONS:

2.1 The JCB is asked to note this general update on the Community Short Term Service.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Service update and performance

Bed based community short term services

The reprovision of the final 16 beds at Newhaven Rehabilitation Centre was completed as planned on the 15th July 2012. The total Short Term Service bed stock reduced to 65 and community short term services increased by 25 units. All short term care is now provided within the city boundaries and the 65 beds are delivered from 3 sites. The distinction between transitional and intermediate care services no longer exists and the service now uses a single set of criteria for the beds encompassing the needs of patients that would previously have accessed transitional care

The final stages of the reprovision went very smoothly and in the period immediately afterwards, the new integrated service was able to cope very well with demand and delayed transfers of care across the city were at record lows.

Since October, there have been significant pressures across the whole health economy which were compounded by the closure of 6 beds at Knoll House bed (see below). Commissioners have responded to this by spot purchasing an additional 13 beds for the winter period and increasing in reach and medical cover. After the winter period is over, we will undertake a further review to ensure the number of beds in the system is appropriate. The 2012 National Audit of Intermediate Care concluded that the average number of community beds per weighted population of 100,000 was 22.5 which would equate to 63 beds in Brighton. We currently have 65 beds and therefore have slightly more than the above average number of beds according to the audit. However working with fewer beds in the city has reduced flexibility and there is a greater impact on the system as a whole when beds are closed to admission It is therefore likely that we will need to maintain the ability to spot purchase additional beds as and when the need arises on an ongoing basis.

The needs assessment of patients in short term beds undertaken in January 2011, indicated that 50% of patients could be more appropriately cared for at home with community support and that their actual medical needs were relatively low. With the reduction in bed numbers, only those requiring bed based care are now admitted to bed based services. As a consequence the overall dependency level of patients has increased and additional resources have been put into all three sites including 2 WTE overnight roving nurses and additional care staff. Dependency levels will be kept under review and a further needs assessment audit will be undertaken in the new year.

Since the changes have been implemented there has also been an increasing number of patients with dementia requiring one to one care. Appropriate arrangements are put in place for individuals as required in order to facilitate discharge from acute hospital care. Further work is required to understand whether this is a change in casemix for short term services, whether these patients needs were met differently before the changes and how appropriate they are for a short term rehabilitation service.

Despite these challenges the service has responded well to what have been significant changes and there has been good partnership working across Sussex Community Trust, the Victorias Nursing Homes , South East Health and BHCC.

At the end of October for the year there was

- an average of 60 referrals per month to a bed
- an average length of stay in a bed of 24 days
- an average of 137 referrals to a community place
- an average length of stay in a community place of 16 days

3.2 Knoll House

During summer 2012 it was noted that there had been an increase in the number of Safeguarding Adults Alerts at Knoll House. Adult Social Care management began the process of investigating and following up on a number of safeguarding cases under the Pan-Sussex Multi Agency Procedures. BHCC worked closely with Sussex Community NHS Trust (SCT) who were then managing the service to ensure plans were in place to address concerns and a protection plan was put in place. Key issues being addressed were:

- the quality of care being provided at the service including record keeping and care planning
- medication errors and ability of the non clinical staff to carry out their functions in relation to management of medication
- management and leadership within the service and continuing issues with absence management and high use of agency staff

The Care Quality Commission subsequently inspected Knoll House on the 5th September 2012 and deemed that the service was non compliant in Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential. Following on from this it was mutually agreed between BHCC and SCT that responsibility for managing the service would be transferred from SCT to BHCC on 8th October. An action plan to improve the service was developed and submitted to the CQC on 9th October. A key benefit of the transfer is that the Council already operates three other residential care homes including Craven Vale which is also within the range of Community Short Term Services in the city. This significantly increases the level of support and resilience for Knoll House as a service.

In order to further facilitate the improvement plan at Knoll House, 6 of the 20 beds were closed from 31st October, to allow the home the time, space and capacity to take action to manage the risks and the change management issues. The closure of beds allowed for some of the essential development work and support to be delivered during this transition and for safeguards to be put in place. The service reopened the beds on 12th December and are now in the process of managing admissions back up to full capacity with the intention of this being complete by Christmas. BHCC continues to liaise with the CQC to ensure the improvement action plan is delivered and the Safeguarding process is scheduled for a review in mid January 2013.

The CCG and BHCC responded to these issues by spot purchasing additional beds and putting in additional nurse capacity to support medicines management. Discharge planning has also been tightly managed across the short term services with additional conference calls and multi disciplinary meetings being held in order to expedite earlier discharges from residential services into the community as long as this has been safe to undertake.

The Council will continue to support service improvements within Knoll House and progress the action plan in place to meet CQC compliance standards. While improvements have been made to date, there is ongoing work needed to create a sustainable environment in which the service can excel. The key focus of this work is in supporting and developing the core Council staff team within Knoll House and improving the culture and practice of staff within the service. In order to support staff in this endeavour the review of a significant number of management systems currently in place is required. This will involve aligning Knoll House with the Council's other Community Short Term Service at Craven Vale in terms of some of the processes, procedures and governance required to operate effectively within a local authority context.

3.3 Integration of the rapid response services

The Provider Management Board is working towards integrating the CRRS, Age UK Crisis service, OOH district nursing service and the roving GP service by April 2013. This virtual rapid response service will then be responsible for delivery of the rapid element of the Community Short Term Service A detailed plan describing the route map for implementation was presented to commissioners on 19 December.

In addition, extra capacity has been commissioned in these services over the winter period including:

- day sitting capacity provided by Age UK to support patients in CRRS with dementia
- additional night sitting capacity provided by South East Health.

3.4 Ongoing clinical governance and quality assurance for community short term service

Commissioners are working together with Quality Governance in the CCG and the Adult Social Care Contracts Unit to put in place more robust arrangements for providing assurance of the quality of all aspects of the community short term service. The aim is to produce a single report quarterly that brings together the information in one place. We are seeking to extend the role of the Quality Review Nurse for nursing homes to include all aspects of community short term services. The quality assurance system would identify any issues at an earlier stage and help support providers to improve practice where required. The function of the Short Term Services Project Board will also change with half of the meeting operating as a Performance and Quality Board with the commissioners looking at all aspects of quality and performance in the services and holding all providers to account.

3.5 Arrangements for home care

We will be considering the options for the home care element within the Community Short Term Services. Currently staff from Brighton & Hove City Council are seconded to SCT to provide the home care elements of the short term service. In addition SCT provides rehabilitation assistants who provide a very similar function. The JCB will be consulted once the options have been worked up.

3.6 Update from the Provider Management Board

In April 2012 the Provider Management Board was formed by the Community Short Term Services partners; South East Health, Brighton & Hove City Council, Sussex Community Trust, Age UK Brighton & Hove, and Victoria Nursing Homes. The Board has worked very well together with the intention of improving and streamlining the way that they deliver short term services.

The PMB have:

- agreed the parameters of their work and how they will work together (producing a Partnership Agreement and common performance and quality measures),
- developed proposals, including an implementation plan, to create a single referral and assessment team by April 2013
- developed plans to provide a joined-up multi disciplinary approach which makes best use of all the services and resources available within the partnership and which will improve the cross-working and information sharing across the partnership.

This work has been informed by the views of current service users gathered via a short piece of research by Age UK, stakeholders through a workshop event attended by 50 health and social care representatives

3.7 Next steps for Short Term Services

Priority areas for now onwards include:

- ensuring the robustness of the current bed and community based models including the balance between bed and community based services, ensuring the right skill mix to meet levels of need and identifying options for supporting patients with dementia
- developing a formal framework for clinical responsibility for patients in the service
- implementing a more robust process for assuring commissioners of clinical governance and quality in the services
- the integration of the community rapid response elements of the service with a view to creating a single service by April 2013
- implementing the single point of access to the service to enable the delivery of ‘one referral one assessment’
- working up options for the most effective way of providing the home care element of Community Short Term Services
- and evaluating both the service and the delivery mechanism and making recommendations to the JCB about next steps

4. COMMUNITY ENGAGEMENT AND CONSULTATION

Extensive patient, public and wider stakeholder feedback informed the final recommendations of the review. A well attended stakeholder event was held by the Provider Management Board in October. And Age UK is in the process of doing further work with users to inform the development of the rapid response element of the Community Short Term Service.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 Financial Implications:

The original service model sought to deliver savings of £2m which was based on 15% of the estimated cost of the service i.e approximately £13m. It is expected that a total of £1.3m savings will have been achieved by the end of 2013/14 with a further £259k in 2014/15 reflecting the fact that some of the changes only occurred part way through this year.

However there a number of risks to this including:

- The need to fund additional staffing to manage increased dependency levels
- The cost of spot purchased beds over the winter period
- Ad hoc arrangements to provide one to one care for patients with dementia and high level needs
- Additional homecare capacity for Community Short Term Services

All of these additional costs have been funded this year via joint health and social care non recurrent reablement allocations.

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Finance Officer Consulted: Michelle Herrington 17/01/2013

5.2 Legal Implications:

This Report is for noting only so that no specific legal or Human Rights Act 1998 implications arise. However both Health and Social Care partners need to ensure that their relative statutory health and community care duties are continued to me with regard for individuals Human Rights through the commissioning and delivery of this service.

Lawyer Consulted: Sandra O'Brien Date: 09/01/13

5.2 Equalities Implications:
The reconfiguration of short term services is a key element of the Urgent Care Commissioning Plan which has been subject to a full equalities impact assessment. The new model for short term services will improve equity, creating a new more streamlined, efficient, tailored and effective service which improves patient outcome and experience.

5.3 Sustainability Implications:
The reconfiguration of short term services will develop a new sustainable model of care which will make a positive ongoing contribution to preventing inappropriate admissions and facilitating effective discharge. The development of existing estate

within the city will take due account of sustainability implications in line with the LA sustainability principles and duties.

5.4 Crime & Disorder Implications:
There are no crime and disorder implications arising from this work.

5.5 Risk and Opportunity Management Implications:
A high level risk register is maintained by the CCG as part of its secretariat function for the Short Term Services Project Board. Risks and mitigating actions are reviewed at the STS Project Board meetings*].*

5.6 Public Health Implications:
The new service will have an increased focused on prevention and therefore will aim to avoid and reduce the severity of patient illness, improving both patient outcomes in addition to being more efficient. The inclusion of the development of a new integrated rapid response service ensures that patients who do require a more urgent intervention receive this in a timely and more effective way, improving outcomes and reducing the need for long term care

5.7 Corporate / Citywide Implications:
The reconfiguration of short term services will have a positive impact on all wards of the city, reducing inequalities and improving patient outcomes and experience.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 During the Short Term Services Review a range of options were considered, including maintaining the current split between means tested adult social care and free NHS services and in taking different approaches to the tendering of one element of the future service. However it was felt that these approaches would have maintained inequities in the system and failed to resolve the complexity for staff and patients.

6.2 And in terms of delivery the JCB considered and discounted the option of tendering for the whole of the short term service model at the November 2011 meeting. In part this was decision was informed by market testing that had been undertaken which suggested that there was not a suitable provider for the service.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 No recommendations are being made as part of this report

JOINT COMMISSIONING BOARD	Agenda Item 25 Brighton & Hove City Council

Subject:		Developments at Craven Vale
Date of Meeting:		28 January 2013 24 January 2013 – Policy & Resources Committee 21 January 2013 – Adult Care & Health Committee
Report of:		Director of Adult Social Services/Lead Commissioner Adult Social Care and Health
Contact Officer:	name:	Jane MacDonald
	email:	Jane.macdonald@brighton-hove.gov.uk
Ward(s) affected:		All

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 Craven Vale a Brighton and Hove City Council owned Resource Centre, currently (winter 2012) has 24 community short term service beds, 7 crisis care/planned breaks beds; a current total of 31 beds. This report outlines the proposal and recommendation for an additional 20 bedrooms to give a total of 51 bedrooms at Craven Vale, 44 of these would be Community Short Term beds.

1.2 Proposals outlined in this report are consistent with recommendations in the Short Term Services Strategic review. This is for fewer sites to provide short term service beds across the city.

1.3 The Clinical Commissioning Group Board support the recommendations to develop Craven Vale

2. RECOMMENDATIONS:

2.1 The recommendations are that the Joint Commissioning Board notes the following:

That the Adult Care and Health Committee on 21 January 2013 was recommended to:

2.1 Agree to the development of Craven Vale to create an additional 20 bedrooms and to a formal collaboration agreement between the Council and Brighton and Hove Clinical Commissioning Group in relation to the development to enable both parties to fulfil their statutory functions;

2.2 Agree to delegate power to the Director of Adult Social Services/Lead Commissioner Adult Social Care and Health to sign the collaboration agreement on behalf of the Council; subject to satisfactory terms being agreed;

That the Policy & Resources Committee on 24 January 2013 was recommended to:

2.3 Note that the development will be delivered by Property and Design using the Council's existing Strategic Construction Partnership;

2.4 Agree that delegated power is given to the Director of Adult Social Services/Lead Commissioner Adult Social Care and Health and Director of Finance and to enter into a building contract with an estimated value of £2.2million.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Current Service

3.1.1 The community short term service is a joint funded integrated care and health service. Craven Vale currently has 24 community short term service beds, 7 crisis care/ 7 planned breaks beds. This is a current total of 31 beds.

3.1.2 It is proposed that an additional twenty bedrooms are constructed with ancillary areas which would require building another floor. This would make a total of 51 beds. 44 of these beds would be Community Short Term beds.

3.1.3 The development will be managed and contract administered by the Council's Property and Design Team and will be delivered using the existing Strategic Construction Partnership. The Partnership has already been procured through OJEU and has an established track record of delivering projects on time and on budget. The partnering process uses an 'open book' approach which ensures Best Value and will deliver the project in a timely manner as there is no need to go through a traditional tendering process. Use of the Partnership also ties in with the roles and responsibilities associated with Corporate Landlord.

3.1.4 The project includes re-providing Craven Vale day centre. This was reported to Adult Social Care Committee in September 2012 as part of the Day Services Review. Following a decline in numbers over a few years and consultation with existing members it is anticipated that the centre will close at the end of January 2013. The last few members will be moving to Tower House in January 2013.

3.2 Short Term Services Review

3.2.1 The joint Adult Social Care and Health Short Term Services Review has been underway for the last two years. It has made recommendations for current and future service commissioning and a number of reports have been presented to both Adult Social Care Cabinet Member and the Joint Commissioning Board. Many of the proposed changes to the service model have already taken place. These are delivered under the new service name which is the Community Short Term Service, these developments include:

- A joint 'short term' service with an integrated intermediate care and transitional care service working together
- A non means tested service
- An improved prevention of avoidable admissions to hospital and long term residential/nursing care homes
- A more timely discharge from hospital and prevention of avoidable admission

- Streamlined pathways
- Improved user experiences and outcomes

3.2.2 Key to the success of Community Short Term Service is the on going savings to both the Council and Health. A recent National Audit provided evidence that following intermediate care there was a 77% reduction in admissions to long term care, 62% reduction in hospital repeat admissions and 62% reduction in length of stay for certain conditions. *National Audit of Intermediate Care Report 2012*

3.3 Community Short Term beds

3.3.1 The Short Term Services Review recommended that the total number of community short term service beds is reduced in favour of more provision in the community within service user's own homes. The Review also proposed a reduction in the number of sites from which bed based services are delivered, ideally to one site but with a maximum of three. Beds are currently provided in 3 venues, Craven Vale, Knoll House and Highgrove Nursing Home. Following the closure of Newhaven Rehabilitation Centre the number of beds was reduced from 92 to 65. Currently there are an additional 13 extra capacity beds in the system, partly to mitigate the impact of the bed closures and partly to provide additional flexibility in winter.

3.3.2 The Community Short term Beds at Craven Vale and Knoll House are funded jointly by the Clinical Commissioning Group (CCG) and Council. The services are jointly provided by Sussex Community Trust (SCT) and the Council under a section 75 agreement. The CCG also has a separate contract with the Victoria Nursing Home Group for 21 beds at Victoria Highgrove Nursing Home. SCT provide the in reach service to all these bed based services.

3.3.3 The development of the Craven Vale site to provide an additional 20 beds gives the opportunity to reduce the number of sites to two Council owned resource centres. A decrease in sites reduces the length of time spent on travel and thus increases the amount of time staff can spend on service user care.

3.4 Rationale for Developing Craven Vale

3.4.1 The rationale for developing Craven Vale is:

- Craven Vale is a Council owned building that is underdeveloped. Community care analysts Laing & Buisson have developed an 'efficient' care home for older people model. They argue that size is key to efficiency and those homes with fewer that 50 beds are likely to be inefficient http://www.jrf.org.uk/sites/files/jrf/2252-care-financial-costs.pdf
- Public services in the city have a track record of providing quality short term services. Craven Vale has a proven history of delivering a high quality complex service.
- There is a long history of close partnership working between the Council and health colleagues. The White Paper, Caring for our future published in July 2012 alongside the draft Care and Support Bill emphasize the importance of joint working. Developments at Craven Vale will build on this integrated model of care.

3.5 Advice on Developing Craven Vale

3.5.1 Legal advice has confirmed that it is possible for public bodies to enter into joint arrangements including the provision of services in order to achieve a goal which they mutually have to perform, and which is not commercial in nature, without having to go out to tender, provided that certain conditions are fulfilled. This would apply to the integrated developments at Craven Vale.

3.5.2 The proposed mechanism is for the parties to enter into a collaboration agreement in which the Council will agree to fund the development subject to the CCG agreeing to continue to purchase the Council's services for a fixed period. The final terms of the agreement are yet to be confirmed (e.g. Length of the agreement, service levels and occupancy levels).

3.5.3 On 15th January 2013 the Clinical Commissioning Group Board supported the recommendations to develop Craven Vale.

3.6 Finances

3.6.1 The Council's gross direct expenditure revenue budget for the existing 31 residential beds at Craven Vale is £1.356m which with overheads increases to £1.540m. Approximately £1.050m (£1.192m including overheads) relates to the 24 Short Term Service beds. An outline business model has been developed for the 20 additional beds which demonstrates that costs for these beds are likely to be £111 per bed per day. The contribution from the CCG as described in paragraph 3.6.2 below is expected to cover these costs. Any additional risks on revenue costs are expected to be managed within the Craven Vale budget.

3.6.2 The CCG state that the expectation is broadly that current financial levels would be maintained and transferred, but ultimately that there would be some economies of scale in terms of locating the majority of the resource on one site.

		Resources for 24 plus 20 beds at developed site
	£K	**£K**
Craven Vale - Current 24 beds		
NHS contribution to be costs	671	671
In reach provided by SCT	521	521
Medical cover	55	55
Highgrove - current 21 beds		
NHS bed costs	843	803
In reach provided by SCT	512	512
Medical Cover	46	46
Revenue that would transfer to ASC		**803**

3.7 Capital project

3.7.1 The construction period is likely to be 15 months with approximately six months lead in for detailed design, consultations, planning and other approvals. It is

proposed that the project will be designed and Contract Administered by Property and Design and procured through the existing Strategic Partnership, which is also managed by Property and Design.

3.7.2 If funding is secured in January, design work can commence in March 2013 with a target completion in late autumn of 2014.

3.7.3. It is proposed that the Council fund all the capital costs.

Estimated Capital Costs (Over Project Life)

	£K	
Build (inc. professional fees)	2,448	*Figures include a 5% construction contingency*
Fixtures and Fittings	342	*Figures include a 10% contingency*
Project manager	93	*Figures include on costs*
Total	**2,883**	

The Capital Costs include details of a Project Manager and the professional fees associated with build costs.

3.7.4 The project will need support from other Council teams as it develops eg Communications, Finance, Legal, Procurement, Human Resources. The amount of input needed will depend on how the project develops.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 There has been a range of consultation undertaken as part of the Short Term Services Review. This has included cross organisation and lay engagement.

4.2 An Equalities Impact Assessment has been started for the project. This includes the re-provision of the day service currently based at Craven Vale. If recommendations are agreed this will be kept live throughout the project, with full consultation and engagement.

4.3 A number of discrete processes eg Planning will have engagement attached to them.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The estimated capital costs of the development at Craven Vale is £2.883m as detailed above and the options for the Council funding this development are currently being explored. Should this proposal be agreed in principle and a formal agreement developed, a report will be taken to a future Policy and Resources Committee to seek formal approval of the scheme. This would be dependent on an agreement being met with the CCG regarding the ongoing revenue costs of the additional beds.

5.2 The Council's gross direct expenditure revenue budget for the existing 31 residential beds at Craven Vale is £1.356m which with overheads increases to £1.540m. Approximately £1.050m (£1.192m including overheads) relates to the 24 Short Term Service beds. The CCG currently contribute £0.671m p.a. towards the 24 CSTS beds which is based on a combination of calculations towards costs. Using the latest bed per day contribution agreed with the CCG, an additional 20 beds would equate to £0.814k p.a. and it is understood that the CCG would divert funding from CSTS beds currently provided for elsewhere in the city to support the new beds at Craven Vale.

5.3 It is anticipated that efficiencies will be achieved as a result of delivering the service from one site although costings are still being quantified. It is intended to rationalise the funding contributions from the CCG and Council as part of the ongoing development of the scheme for mutual benefit. Agreement is being sought from the CCG for their commitment to the ongoing revenue costs and it is expected that a verbal update will be given at Committee. There is a risk that the CCG may choose to withdraw from this joint working in future and it is intended that the contractual arrangements will mitigate this. However, should this happen, the asset would remain under the Council's control and it would present an opportunity to review service delivery across all client groups.

Finance Officer Consulted: Michelle Herrington Date: 02/ 01/13

Legal Implications:

5.4 The power for the parties to enter into this type of partnership agreement is set out in section 75 of the National Health Service Act 2006. The legal advice confirming the ability of the Council to enter into this type of arrangement is set out above. Given the value of the proposed building contract, the process followed in letting that contract must comply with the Procurement Rules. The Strategic Partnership Agreement is EU compliant, having been the subject of an OJEU when the Agreement was entered into.

Lawyer Consulted: Jill Whittaker Date: 21/12/12

Equalities Implications:

5.5 Development of Craven Vale is an investment in short term services that people say they want and need. An EIA has been completed. Unions have been advised of the proposed developments and staff have received a briefing paper which outlines the proposed developments at Craven Vale contained within this report. If the recommendations are agreed, management will work within the Council's Change Management Framework in order to consult with staff who may be affected by any proposed changes.

Sustainability Implications:

5.6 Development of the Craven Vale site will mean that fewer sites across the city are delivering short term services. This will result in significant economies of scale and rationalisation of resources. Less time will be spent on travel.

5.7 At the same time there will be improvements made to the existing Craven Vale building. The Council's Asset management will oversee the project and they are compliant with Council strategy and directives.

5.8 Craven Vale is in the east of the city and the developments will have a positive impact on the very local area.

Crime & Disorder Implications:

5.9 There are no specific crime and disorder implications.

Risk and Opportunity Management Implications:

5.10 An on going risk log for the project will be maintained. Each risk will have mitigating action listed against it.

Public Health Implications:

5.11 Short term beds are in high demand and many are used to help people move out of hospital. It is essential that there is the right number of beds in the system and they are managed well. Having the beds on fewer sites will lead to efficiencies.

Corporate / Citywide Implications

5.12 Care will be taken through out the project to adhere to Council's policies. The new service will generate new opportunities for people to receive a joined up service delivered by Health and Adult Social Care at Craven Vale.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Below are two options that were considered and not taken forward

Tender for new provider

- Craven Vale have a history of providing a high quality service (currently 31 beds is less than an 'efficient' size)
- The current undersupply of older people care home could if impacted if the process if the tender was awarded to a current provider – ie beds already used in the system would be changed and thus not available for other use

Do nothing

- The current 'short term' service is spread across the city (efficiency savings are possible)
- Craven Vale is not an 'efficient' size

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The recommendations are consistent with recommendations in the Short term Services Review.

SUPPORTING DOCUMENTATION

Appendices:
None

Documents in Members' Rooms
None

Background Documents
None

JOINT COMMISSIONING BOARD	Agenda Item 26 Brighton & Hove City Council

Subject:		**Update on the implementation of the Joint Dementia Plan**	
Date of Meeting:		**28 January 2013**	
Report of:		**Geraldine Hoban, Chief Operating Officer CCG**	
Contact Officer:	**Name:**	**Jo Matthews**	**Tel: 01273 574685**
	Email:	**Joanne.matthews1@nhs.net**	
Key Decision:	**No**		
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The 2011-12 NHS National Operating Framework set out a requirement for each local area to make improvements and changes to services against the four priority areas identified in the National Dementia Strategy. The 2012/13 NHS National Operating Framework required Health and Social care commissioners in each area to publish a Joint Dementia Plan setting out local progress in terms of implementation of the NDS. For Brighton and Hove this plan was published in February 2012 and the purpose of this paper is to the JCB on progress implementing the plan.

2. RECOMMENDATIONS:

2.1 That the JCB note the contents of the report

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 There are about 750,000 people in the United Kingdom with dementia and this number is expected to double over the next 30 years. The prevalence of dementia increases with age so this increase in numbers is expected as a result of an aging population. As the number of people with dementia increase there is a knock on effect in terms of health and social care costs. The estimated costs of dementia care in England will rise from £14.8 billion in 2007 to £34.8 billion by 2026, a rise of 135% (Kings Fund, 2008)[1].

[1] Kings Fund (2008) Paying the Price: the cost of mental Health I England to 2026 London: Kings Fund.

3.2 A *National Dementia Strategy* (NDS) was published in 2009 and updated in September 2010. **The NDS aims to increase awareness of the condition, ensuring early diagnosis and intervention as well as improving the quality of care for people with dementia and their carers.**

3.3 The *National Operating Framework 2011-12* identified four priority areas from the NDS as likely to have the biggest impact on improving the quality of care outcomes for people with dementia and their carers. These are:

- Good quality early diagnosis and intervention for all
- Improved quality of care in general hospitals
- Living well with dementia in care homes
- Reduced use of antipsychotic medication

3.4 The *National Operating Framework 2012/13* built on this by prioritising action on dementia within a system approach to improve basic standards of care for elderly and vulnerable patients in areas such as nutrition, continence and communication. There is also a requirement for PCTs to:

- reduce inappropriate antipsychotic prescribing for people with dementia by two-thirds;
- improve dementia diagnosis rates;
- introduce a CQUIN[2] on improving diagnosis of dementia in hospitals; and
- work with local authorities to publish dementia plans setting out local progress against delivery of the NDS.

3.5 **Local Context**

A Joint Dementia Plan was approved at the Joint Commissioning Board in February 2012 setting out local implementation of the NDS in an integrated 'long-term conditions' approach aligning many dementia services with physical health services so an holistic approach is taken to the care of people with dementia. The Plan sets out how priority areas for service development will be delivered within a revised financial envelope and to a revised timetable. The Plan with updates is attached as Appendix 1.

The shadow Health and Wellbeing Board has identified dementia as a priority for the city and a Joint Health and Wellbeing Strategy has been prepared including a section on dementia, along with the other priorities, which will be ratified once the board is formally constituted in April 2013. The suggestion from this strategy is that a joint commissioning Dementia Board be established to give formal governance to future dementia developments.

3.6 Progress against the four priority areas identified in the NDS

3.6.1 Good quality early diagnosis and intervention for all
Memory Assessment Service

[2] The Commissioning for Quality and Innovation (CQUIN) payment is a tool to enable commissioners to reward excellence by linking a proportion of providers' income to the achievement of quality improvement goals.

In Brighton and Hove at current rates of diagnosis prevalence of dementia is expected to remain broadly constant over the next ten years. However only 36% of people (around 1,132) in Brighton and Hove with dementia are identified as being diagnosed on GP QOF registers.

The first of the four objectives of the National Dementia Strategy is to achieve "good-quality early diagnosis and intervention for all". In 2007 the National Audit Office concluded that “early diagnosis and intervention in dementia is cost-effective” However in Brighton and Hove we only diagnose around one third of dementias. *The Prime Minister’s Challenge on Dementia* states that “From April 2013 there will be a quantified ambition for diagnosis rates…. underpinned by robust and affordable local plans.”

In summer 2012 we invited bids an integrated memory assessment service, which will provide diagnosis to around 80% of people with dementia. Around 20% of people will still need secondary care referral for diagnosis due to complex needs or complex presentations.

This service will be operational by 1 June 2013 and at commissioned activity rates will increase the number of people diagnosed with dementia by 10% per annum, meeting and exceeding national targets for dementia diagnosis. People will also receive a diagnosis within 10 weeks of referral from their GP, significantly speeding up the diagnostic process. The service will also offer people with dementia and their carers information support and advice for up to one year after diagnosis.

Also through routine NHS Health Checks, GPs will be expected to identify risk factors for dementia - such as hypertension, alcohol and obesity – provide information on memory clinics and refer those in need of assessment. Additional Quality Outcomes Framework points are also likely to be introduced for ongoing support to people with dementia.

3.6.2 Improved quality of care in general hospitals

A one year dementia champion post was established at the Royal Sussex County Hospital. This post was filled earlier this year and is driving improved services for people with dementia across the trust. A dementia pathway has been developed in the hospital and is being trialled on care of the elderly wards. The trust launched the national dementia CQUIN which requires a memory screen for anyone over the age of 75 who is in hospital for 72 hours or more. This was launched under the banner of “Dementia – everyone’s business”.

The hospital has agreed to adopt the Butterfly scheme, planned for launch in March 2013. The butterfly scheme currently operates in 50 hospitals across the UK and provides a framework for rolling out education and an approach to caring for patients with dementia trust wide. The trust has a dementia steering group leading on developments in dementia care.

A Sussex wide **audit of people with dementia in the acute hospitals** was carried out and key findings showed that on aggregate people with dementia are twice as likely to be admitted to hospital as people with the same condition without dementia and to stay in hospital four days longer. People with dementia

also go into hospital for the same reasons as people without, e.g. UTI, respiratory infections and falls, however their illnesses are often at a later stage of severity or complexity which means that admission is harder to avoid. The learning from the audit is that work at a primary care level is key to admission avoidance in people with dementia. This relates to a need for education in the workforce and families and carers of people with dementia so that illness or infection is picked up at an earlier stage. This ties in well with the future plans to align community mental health teams with the integrated primary care teams to enable them to better support people with dementia.

3.6.3 Living well with dementia in care homes

The Sussex-wide Care home in-reach team has been operating just over one year. The service provides support to care homes to improve their ability to care for and support their residents who have dementia.

The service can either work with specific patients or with the home to make systemic changes and offer training and advice to the workforce. The team has conducted around 80 individual medication reviews, with around 45 having their anti-psychotic medications either reduced or ceased. The team has worked with a number of care homes in the city influencing the care of more than 500 residents. We have included the ongoing funding of this service in our plans for funding next year.

The Local Authority and PCT have worked together on the development of a set of nursing competencies for nursing homes which includes care of people with dementia.

3.6.4 Reduced use of antipsychotic medication

In 2008, The All Party Parliamentary Group (APPG) produced a report *Always a Last Resort* which highlighted the problem of over-prescribing anti-psychotics in care homes. At that time it was estimated up to 105,000 people with dementia were given anti-psychotics inappropriately - either for inappropriate reasons or for initially justifiable reasons, but inappropriately continued. The report also estimated that 1800 people with dementia died each year due to the adverse effects of low-dose anti-psychotics.

As part of the Department of Health's National Dementia Strategy, a pledge was made to reduce anti-psychotic prescribing by two thirds by November 2011. Whilst there has been a lot of work to reduce antipsychotic prescribing in people with dementia, both locally and nationally, as there is no accepted baseline data, it is not possible to measure the extent of the reduction.

There have however, been a number of initiatives locally to address the prescribing of antipsychotics to people with dementia including:

- A prescribing audit in primary care carried out over two separate years which shows a decrease in prescribing and an increase in medication reviews. It also showed that people are as likely to be prescribed antipsychotics if they live in their own home as if they live in a care home.

- A GP resource pack has been launched across Sussex to support GPs to better manage patients with dementia, and support reducing/ceasing of antipsychotics.
- The care home in reach team has a specific remit on antipsychotics, as mentioned above
- Enhancing Quality measure for acute and mental health trusts on best practice prescribing of antipsychotics and benzodiazepines
- A Sussex Reducing Antipsychotics Sub-group of Dementia Commissioners and Heads of Medicines Management has been convened to look at audits required in Sussex.

3.7 Additional work carried out on dementia includes:

3.7.1 Engagement work carried out on day services for people with **young onset dementia** and we are reviewing day services as a result. This will be aligned with the review Adult Social Care is completing on Day Services in the city.

3.7.2 Additional resource put into the **Community Rapid Response Service** (CRRS), which is a hospital avoidance service for people with an urgent physical need. The majority of people with dementia also have a physical health need so it makes sense to adopt an integrated long-term conditions approach to dementia care. The additional resource is to enable the CRRS to support more people with dementia. The service has also employed a mental health liaison nurse. We are also reviewing the current crisis pathway for people whose predominant need is their dementia.

3.7.3 Additional resource has been allocated to the older people **mental health liaison** service at the acute hospital to help reduce length of stay. This is currently being evaluated.

3.7.4 Commissioners are working with SPFT on the **dementia pathway** for people with complex needs to ensure there is a clear pathway into specialist dementia services from the new memory assessment service, to ensure a seven day a week crisis response and to further align dementia services with services supporting people with long term physical health needs. The proposal is to align the resource in the ICAST service with the resource in the Assessment and Treatment Service to create a specialist dementia service available 7 day a week. This will come into effect on 1 June 2013 to coincide with the launch of the memory assessment service

3.7.5 Regional innovation fund monies have been used to initiate a project to develop a care pathway for people with dementia at the **end of life**. This project has developed an action plan to identify and address workforce development needs and education and information, shared protocols.

3.7.6 Carers of people with dementia –.
The CCG funds Alzheimers Society to provide 'Singing for the Brain' sessions and fortnightly dementia cafes. This will continue for 2013/14. The CCG and Brighton and Hove City Council have a joint Multi-Agency Commissioning and Development Strategy for Carers, which identifies our commitment to all carers across the City. There are a range of services available to all carers, from intensive respite services to leisure opportunities (via the Carers Card). Carers

have a right to request an assessment of their needs, either via a joint assessment or a separate carers assessment, and this assists in the process of identifying desired outcomes and potential support.
The specialist services commissioned to support carers of people with dementia are predominately provided by the Alzheimer's Society. These include an Advice and Information Service, Carer Support Groups, and Home Based Respite services. Additionally the Carers Centre has had funding for the past two years to provider specialist case work support for carers of people with dementia.

3.8 The Prime Minister's Challenge on Dementia

3.8.1 The Prime Minister's Challenge on Dementia is an ambitious programme of work designed to make a real difference to the lives of people with dementia. The Challenge, launched in March 2012, builds on the achievements of the National Dementia Strategy to secure greater improvements in dementia care and research so that people with dementia, their carers and families get the services and support they need.

3.8.2 One strand of the Challenge is a programme to encourage communities to become more dementia friendly. **Dementia Friendly Communities** are defined by the Alzheimers' Society as communities which show a high level of public awareness and understanding so that people with dementia and their carers are encouraged to seek help and are supported by their community. Such communities are more inclusive of people with dementia, and improve their ability to remain independent and have choice and control over their lives.

3.8.3 Brighton and Hove is working toward becoming an Age Friendly City (World Health Organisation status) and this dovetails with being a dementia friendly community. We are currently bidding for funding to support a community development worker to drive this work.

3.8.4 Part of the Dementia Friendly Communities work includes Alzheimers Society's Dementia Friends which aims to make everyday life better for people with dementia by changing the way the nation thinks, talks and acts. By 2015, the aim is to have a million people with the know-how to help people with dementia feel understood and included in their community.

3.8.5 Dementia friendly environments is another strand of this work. A £50m fund has been announced to support the NHS and social care to create dementia-friendly environments. This investment will deliver physical improvements and knowledge-based evidence in NHS and social care environments that provide care for people with dementia through a range of national pilot projects. It will build on work already undertaken by The King's Fund to improve knowledge and evidence about the aspects of the physical care environment which can be used to improve the care of people with dementia. There is keen interest in Brighton and Hove to submit bids for this fund.

3.8.6 There is a shortage of specialist EMI (**Elderly Mentally Ill**) beds in Brighton and Hove and people are regularly placed out of area as a result. Meetings have taken place with new prospective providers and we anticipate more capacity will come available during 2013. There are also an increasing number of people with dementia being referred into Community Short Term Services. The CCG and

Adult Social Care commissioners are currently assessing the best way to meet the needs of people with more complex needs in these services.

4. CONSULTATION

COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 In 2010 Brighton and Hove PCT worked with the Department of Health's Care Services Efficiency Delivery Unit (CSED) to undertake a comprehensive stakeholder analysis of dementia services. This included extensive work with stakeholders to better understand existing services, to develop an 'ideal' care pathway and to recognise services deemed to be priorities. The outcome is a set of identified prioritised services, which could be developed to improve local services for people with dementia and the people who care for them. This consultation has been used to inform pathway development and the Joint Dementia Plan. The following organisations were involved in the consultation.

- Sussex Partnership Foundation Trust
- Brighton and Hove City Council
- Sussex Community NHS Trust
- Brighton and Sussex University Hospital Trust
- Alzheimer's Society
- Age Concern
- MIND
- The Martlets Hospice
- People with dementia and carers via the Alzheimer's Society.

4.2 Due to the decision by Alzheimer's Society to close of the Towner Club for people with young onset dementia, the CCG asked MIND to carry out a consultation with younger people with dementia. This was conducted in the summer and as a result we are reviewing day services for people with young onset dementia.

4.3 CVSF Networks are hosting two events in early 2013 that will focus on chapters of the Joint Health and WellBeing strategy. This includes the chapter in the strategy concerning dementia. Results from these events will feed into the final draft of the Joint Health and Well-Being Strategy and aim to influence future commissioning decisions.

5. FINANCIAL & OTHER IMPLICATIONS:

Area for Development	Investment 2012/13	Investment 2013-14	Comments on Funding Source	Notes on Whole System Cost Avoidance
Memory Assessment Service		£450,000	Funded through redesign of resources within Sussex Partnership Foundation Trust	• Reduce/delay need for stepped up services
Support for carers/peer support	£48,000	£25,000	In 2012/13 this was national funding via health for LA to spend on dementia carers. In 2013/14 £25,000 has been confirmed from CCG awaiting decision on LA match funding	• Reduce/delay need for stepped up services
Mental Health Hospital Liaison	£100,000	To be confirmed if funding demonstrates impact	Health Funding	• Reduction in re-admission & length of stay
Crisis Support	£100,000	To be confirmed if funding demonstrates impact	Redesign within existing resources	• Reduction in bed usage – general and dementia hospitals
Care Home in Reach	£180,000	£180,000	Health Funding	• Reduction in admissions • Delayed admission to EMI care homes
Day services for people with young onset dementia		£30,000	Additional to SPFT resource	• Respite • Reduction in admissions • Delayed admission to care homes
Total	**£428,000**	**£685,000**		

The above table represents service investment plans as reflected in the commissioning intentions in the CCGs Annual Operating Plan.

5.1 The Adult Social Care budget 2013-14 planning assumption is growth of 10 clients with long term conditions (dementia) and an additional investment of £138,000 has been identified. The net 2012-13 budget for Social Care in respect of Older People Mental Health (including those with Dementia) is £5.737 million covering S75 arrangements and a further net budget of £1.432 million for services at Wayfield Avenue and Ireland Lodge. It is not currently possible to separate out the resources allocated specifically for dementia, although the overall budget is prioritised to help support the Dementia Action Plan.

Finance Officer Consulted: *Anne Silley/Debra Crisp* *Date: 03/01/13*

Legal Implications:

5.2 This Report, which is for noting only, describes the National Operating Framework and National Dementia Strategy to prepare for and meet the needs of dementia sufferers. Both the Local and Health Authorities have statutory health and community care duties in respect of this group of the local community and JCB is the responsible body for overseeing the commissioning and delivery of appropriate services to ensure those duties are met. In considering the commissioning and delivery of services JCB and the service providers must have regard to Human Rights Act 1998 implications for the individuals affected in particular but not exclusively the Right to Privacy and Family Life.

Lawyer Consulted: *Sandra O'Brien* *Date:9/1/13*

Equalities Implications:

5.3 A full Equalities Impact Assessment has been carried out on the Joint Dementia Plan and is published along with the plan.

As part of the scoping work a number of equalities issues have been identified which the Joint Dementia Plan seek to address:

- Increasing number of people accessing service provision compared with current numbers as a result of increased diagnosis.
- People with Downs Syndrome are up 50% more likely to suffer early-onset dementia. The new memory assessment service will be able to provide diagnosis and support for this client group.

Sustainability Implications:

5.4 Discussed in the main report

Crime & Disorder Implications:

5.5 Nil

Risk and Opportunity Management Implications:

5.6 The drive to increase dementia diagnosis rates and raise awareness of dementia may create pressures in other services and increase demand.

Public Health Implications:

5.7 Brighton and Hove currently under-diagnoses people with dementia. Evidence suggests not having a diagnosis leads to increased reliance on higher levels of care and early admission to residential care.

Corporate / Citywide Implications:

5.8 Not applicable

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 During the consultation process alternative service options have been considered. Brighton and Hove is implementing a NDS at a local level. The exact configuration of services reflects local need and consultation while retaining general alignment with the national strategy.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 It is a Department of Health requirement that the Health and Social Care commissioners develops and publishes a Joint Dementia Plan. The JCB requested an update on progress on implementation.

SUPPORTING DOCUMENTATION

Appendices:

1. Joint Dementia Plan – updated December 2012

Documents in Members' Rooms

1. None.

Background Documents

1. Prime Minister's Challenge on Dementia
2. Brighton and Hove Shadow Health and Wellbeing Board Draft Strategy
3. JCB Paper February 2012

Brighton and Hove
Joint Dementia Plan
Update December 2012

No.	AREA FOR DEVELOPMENT/NDS OBJECTIVE	KEY ACTIONS	COMPLETION DATE	RAG	
1	Good quality early diagnosis and intervention for all	**Integrated memory assessment and diagnosis service (MAS)**			
		Give notice of intention to redesign resources at Aldrington House	December 2011	Complete	
		Final MAS model approved to include support and information service and awareness campaign	May 2012	Complete	
		MAS contract tendered	June 2012	Complete	
		Award MAS	October 2012	Completed December 2012	Delayed due to procurement process
		MAS service commencement	April 2013	Delayed	Likely to be June 2013
2	Improved quality of care in general hospitals	**(i) Older People's Mental Health Liaison Service at Royal Sussex County Hospital**			
		Short term resourcing increased to April 2012	Immediate	Complete	
		Medium term resourcing scoped identified and recruited to April 2013	April 2012		
		Analysis of impact of additional resourcing	March 2013		Awaiting information from the provider

No.	AREA FOR DEVELOPMENT/NDS OBJECTIVE	KEY ACTIONS	COMPLETION DATE	RAG	
		Identify sustainable plan from within current resource for April 2013 onwards	April 2013	SPFT lead	Discussion ongoing on reconfiguration of SPFT services including Complex MAS ICAST Sustainability of Liaison
		(ii) **Dementia Champion Post**: Recruited to post	April 2012	Complete	
		Reviewed and sustainable funding identified	September 2012		BSUH to take this forward
		Dementia implementation plan in place	June 2013		Work progressing
		(iii) Improved Diagnosis in acute hospitals: CQUIN signed off and agreed	March 2013		Launched October 2012 including awareness days and training for those completing the screening
3	Dementia Crisis & Short Term Support	Review current crisis service	May 2012		Additional funding has been put into Community Rapid Response Service for one year. Discussion ongoing on reconfiguration of SPFT services including Complex MAS

No.	AREA FOR DEVELOPMENT/NDS OBJECTIVE	KEY ACTIONS	COMPLETION DATE	RAG	
					ICAST Sustainability of Liaison
		Agree model for future crisis support	June 2013	On track	This will be agreed ahead of schedule
		Agreed model for short term community support	June 2013	On track	
4	Living well with dementia in care homes	**Care home in reach** Team established	December 2011	Complete	
		Review current service	November 2012	On track	Work progressing to review the team
		Agree options for ongoing service delivery based on outcome of review	December 2012	On track	Have included a bid for this in next year's annual operating plan
		Care home provision Improve availability of care home places and sustain/increase the current market	Ongoing	On track	
		Improve quality in care homes via contract minimum standards	Contract in place by April 2013	On track	

No.	AREA FOR DEVELOPMENT/NDS OBJECTIVE	KEY ACTIONS	COMPLETION DATE	RAG	
		Develop role of Ireland Lodge to improve length of stay in transitional beds and reduce delayed transfers of care	April 2013	On track	
5	Reduced use of antipsychotic medication	Initiation and review of AP to best practice standards across acute and MH trusts as per EQ/CQUIN initiative	2012/13	Ongoing	
		Action plan implemented to respond to findings of Prescribing Observatory for Mental Health (POMH) UK audit	Completed	Complete	
		Review findings and next steps following completion of Prescribing incentive scheme in primary care	May 2012	Complete	
		Audit of care homes AP via CH in Reach team	March 2012	Complete	
		Education to GPs via PLS on APM including identifying ongoing needs	February 2012	Complete	
		Update Whole System Partnership dementia modelling work to include localised data from audit Project to review acute admissions and LOS	Complete	Complete	

No.	AREA FOR DEVELOPMENT/NDS OBJECTIVE	KEY ACTIONS	COMPLETION DATE	RAG	
6	A clear picture of research evidence and needs	Input above into WSP model	March 2012	Complete	
		RSCH to complete Audit	January 2012	Not completed	Due to hospital being on code purple on the day of the audit
		RSCH data collection and analysis complete and adjustment factor identified	April 2012	Not completed	As above
		'All of Us' events finish	March 2012	Complete	
7	Development of structured peer support and learning networks	National funding used for peer support	March 2012	Complete	
		Review peer/carer support	April 2012	Complete	Additional resource was put into singing for the brain, dementia cafes and a dementia support worker at the carers centre
		Support implemented via MAS	April 2013	On track	
		Local Authority workforce/ independent sector training	Ongoing	Ongoing	

No.	AREA FOR DEVELOPMENT/NDS OBJECTIVE	KEY ACTIONS	COMPLETION DATE	RAG	
8	An informed and effective workforce for people with dementia	Dementia Champion in post	April 2012	Complete	
		Increase knowledge and skills of primary care via Protected Learning Session (PLS) and other mechanisms	Ongoing	On track	PLS event on antipsychotics in Feb 2012.
		Regional Innovation fund training programme initiated	2012/13	On track	
9	Improved end of life care for people with dementia	Work on end of life pathway for people with dementia	2012/13	On track	Pathway almost complete. “Products” being developed
		Develop an end of life in dementia learning network	2012/13	On track	
		Develop specialist resource for EoL and dementia	2012/13	On track	
10	Improved dementia services for people with specific needs including, young onset, learning disability, dual diagnosis, Korsakoffs	Review Towner Club	June 2012	Complete	
		Identify local need and service gaps for younger people with dementia	June 2012	On track	Consultation with younger pw dementia completed. Meeting SPFT to look at day service provision at Allen centre. Bidding for additional funding

No.	AREA FOR DEVELOPMENT/NDS OBJECTIVE	KEY ACTIONS	COMPLETION DATE	RAG	
					next year.
		CHiR team to support residential homes for people with learning disability and dementia	Ongoing		Bidding for ongoing funding for next year. Looking at skills mix.
		Ensure pathway for people with dual diagnosis is as integrated as possible in the general pathway	Ongoing		

JOINT COMMISSIONING BOARD

Agenda Item 27

Brighton & Hove City Council

Subject:		Learning Disabilities Health Self-Assessment Framework Year 4: 2012
Date of Meeting:		Monday 28th January 2013
Report of:		Director Adult Social Services/Lead Commissioner for People & Chief Operating Officer NHS Brighton and Hove
Contact Officer:	**Name:**	Mark Hendriks **Tel: 29-3071**
	Email:	mark.hendriks@brighton-hove.gov.uk
Ward(s) affected:		All

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 NHS South of England East Learning Disabilities Programme has completed its fourth year, which includes an annual Health Self-Assessment.

1.2 The objectives of the Programme are:

- To ensure that national learning disability targets are met across NHS South of England East
- To identify and address any health inequalities experienced by people with learning disabilities (in particular relating to access to mainstream primary and secondary care services);
- To ensure the safety and quality of NHS-commissioned bed-based services provided to people with learning disabilities within the region;
- To ensure the safety and Quality of NHS Commissioned services where people are placed outside their local area;
- To ensure that demonstrable progress is made in meeting the objectives in Valuing People Now.

1.3 A central component of delivering the above objectives has been the completion in each local health economy of a "Learning Disabilities Health Self-Assessment Framework". The fundamental purpose of the self-assessment is to provide commissioners, providers, and other stakeholders with an understanding of the strengths and weaknesses of health care services for people with learning disabilities.

2. RECOMMENDATIONS:

2.1 That the Joint Commissioning Board notes the validated outcomes of the Learning Disabilities Health Self-Assessment Framework for Brighton & Hove

2.2 That the Joint Commissioning Board notes and approves the recommendations for action set out in 3.11 of this report and in Appendix 2.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 In the south east region there has been much progress evidenced in successive Self-Assessment Framework outcomes over three years 2008-2011.

3.2 However, following the events of May 2011 and the abuse at Winterbourne View, the Government announced a review of Learning Disability Services.

3.3 Following the review an enhanced assurance exercise led to a number of outcomes, including the Self-Assessment process focussing more on safeguarding and ensuring that people were in appropriate placements that are reviewed regularly and robustly.

3.4 Due to these changes, it is not accurate to draw comparisons with the red-amber-green scoring of the past three years, as the validation of evidence has become more specific and robust.

3.5 The assessment this year looked at three key standards:-

1. **Access to Health**. Including numbers of people on learning disability registers, access to screening programmes, take up of the 'Directly Enhanced Services', Annual Health Checks and Health Action planning.

2. **People with complex needs**. Ensuring the Joint Strategic Needs Assessment (JSNA) reflects this population, young people in transition and people in the criminal justice system.

3. **Safeguarding**. To ensure that the PCT and Partnership Boards could assure themselves across all their commissioners and providers that people were safe and in placements that were appropriate and regularly reviewed.

3.6 There are a total of 30 elements across the 3 standards, and evidence submitted to each element is validated at RED, AMBER or GREEN.

3.7 NHS South of England East as a region continues to score AMBER.

3.8 NHS Brighton & Hove scored GREEN in Standard 1 and AMBER in Standards 2 & 3. (Appendix 1)

3.9 NHS Brighton & Hove scored at least AMBER in every element of each standard and is the only locality in the region to with no RED scores.

3.10 Of 30 elements across three standards, NHS Brighton & Hove scored 11 GREEN and 19 AMBER

3.11 The SHA outlines future priorities for NHS Brighton & Hove Health Strategy, (Appendix 2) as follows:

Standard 1: Access to Health

- Stratify GP register data to sub-divide learning disability into categories including Profound & Multiple Learning Disabilities (PMLD), ethnicity groupings & autism spectrum conditions.
- Develop referral documents in secondary care and other healthcare providers to identify people who have a learning disability and evidence making reasonable adjustments as required.
- Increase Annual Health Checks by 10% 2012/13
- Carry out a cost benefit analysis to improve informatics and data collection for people with learning disabilities across the healthcare system
- Audit cervical screening data and use as comparative data against non-learning disabled population in each national screening programme.
- Take acute peer review action plan forward & continue hospital champions in training and developing hospital services.

Standard 2: People with Complex Needs

- Complete the update of JSNA to enable Health and Wellbeing board to establish priorities when it commences in April 2013
- Continue work on Health Action Plans from age 17 ready for transition at 18 years old

Standard 3: Safeguarding Governance Assurance and Quality

- Continue to monitor commissioning and contracting through central monitoring team. Evidence contractual levers for safety and quality that can be applied equally to people with learning disabilities. Evidence positive examples of outcomes and involvement of people with learning disabilities and families
- Operate new specialist reviewing role for clients placed in specialist services under the Mental Health Act
- Monitor changes re process of complaints and whistle blowing policy affecting people with learning disabilities leading to improved practice

3.12 These priorities have been developed into an action plan which will inform work plans for the Learning Disability Partnership Board, the Healthy Lives sub-group and the work of our Health Facilitator, in partnership with colleagues in the Clinical Commissioning Group.

3.13 For 2013, a working party consisting of the Strategic Health Authorities and ADASS was set up to bring together the Health Self-Assessment framework and the Partnership Board Annual report, so that local areas only have one submission to do across health and social care. The proposed new framework is now out for consultation and Brighton & Hove will be coordinating a response to

ensure we are well placed to continue to deliver evidence of improvement in local services.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 The self assessment has been completed in conjunction with the Learning Disability Partnership Board, with a specially organised Big Health Service Check meeting in July 2012. Meetings have also been held with family carers and people with learning disabilities and feedback regarding health services has been obtained via questionnaire, including accessible versions for people with learning disabilities.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 Financial Implications:

The majority of the recommended actions can be accommodated within the resources included in the draft 2013/14 budget strategy. However there may be resource implications for some of the priorities which will need to be identified and addressed in future reports, as appropriate.

Finance Officer Consulted: Name Michelle Herrington Date: 20/12/12

5.2 Legal Implications:

The Local and National context to the Self Assessment Process is set out in the body of this report including the change in approach arising from the Government Review following the Winterbourne View abuse. JCB is responsible for oversight and monitoring of Learning Disability service commissioning and provision and is therefore asked to note the content of this annual report and approve the standards set out in paragraph 3.11. Particular attention is drawn to the focus on Safeguarding in light of Winterbourne. The Local Authority has specific duties to vulnerable adults and regard must be have to its statutory community care obligations; both public authorities must have regard to individuals' rights under the Human Rights Act 1998 specifically Articles 8,2,5 and 3 Right to Privacy and Family Life, Right to Life, Right to Liberty and Right to be free from inhumane treatment.

Lawyer Consulted: Sandra O'Brien 19.12.2012:

5.3 Equalities Implications:

As this is an update, rather than policy changes, an Equality Impact Assessment has not been carried out. Nevertheless, the aim of the self assessment framework is to reduce health inequalities for people with learning disabilities

5.4 Sustainability Implications:

There are no specific Sustainability Implications of this report.

5.5 Crime & Disorder Implications:

There are no specific Crime & Disorder Implications of this report.

5.6 Risk and Opportunity Management Implications:

There are no direct implications from this report. If the action plan is not implemented, there is a risk that the benefits to people with learning disabilities of improved health will not be achieved.

5.7 Public Health Implications:

The aim of the self-assessment is to assess how far local health services are making reasonable adjustments for people with learning disabilities and autism

The types of reasonable adjustments expected are those required under the Equalities Act 2010 which requires the NHS along with all other public bodies to make reasonable adjustments to reduce or remove physical or other barriers and to provide additional support if necessary.

5.8 Corporate / Citywide Implications:

Implications are positive as this work contributes to people's general health and well being and aims to reduce health inequalities.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 The submission of the Health Self-Assessment Framework is a performance requirement of the National Operating Framework therefore no alternatives options have been explored

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 For Joint Commissioning Board Members to note the self assessment of current performance and progress made.

7.2 For Joint Commissioning Board Members to agree the actions in 3.11 of this report for NHS Brighton and Hove over the coming year.

SUPPORTING DOCUMENTATION

Appendices:

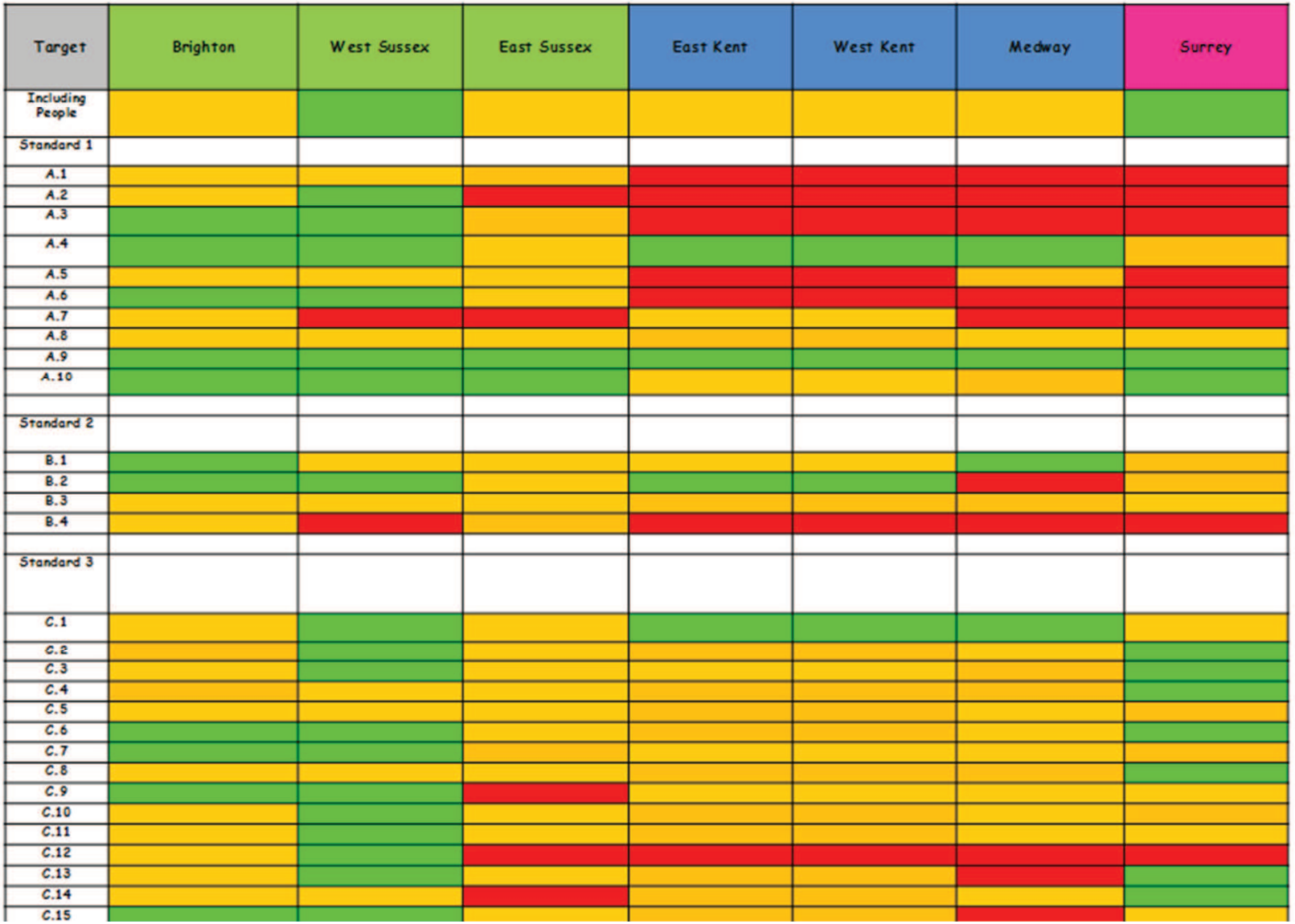
1. The Results from PCTs

2. NHS South of England East Priority Table NHS Brighton and Hove

Background Documents

1. Brighton & Hove Learning Disabilities self assessment report- September 2012

The Results from PCTs: Year 4 - 2012



Target	Brighton	West Sussex	East Sussex	East Kent	West Kent	Medway	Surrey
Including People							
Standard 1							
A.1							
A.2							
A.3							
A.4							
A.5							
A.6							
A.7							
A.8							
A.9							
A.10							
Standard 2							
B.1							
B.2							
B.3							
B.4							
Standard 3							
C.1							
C.2							
C.3							
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C.5							
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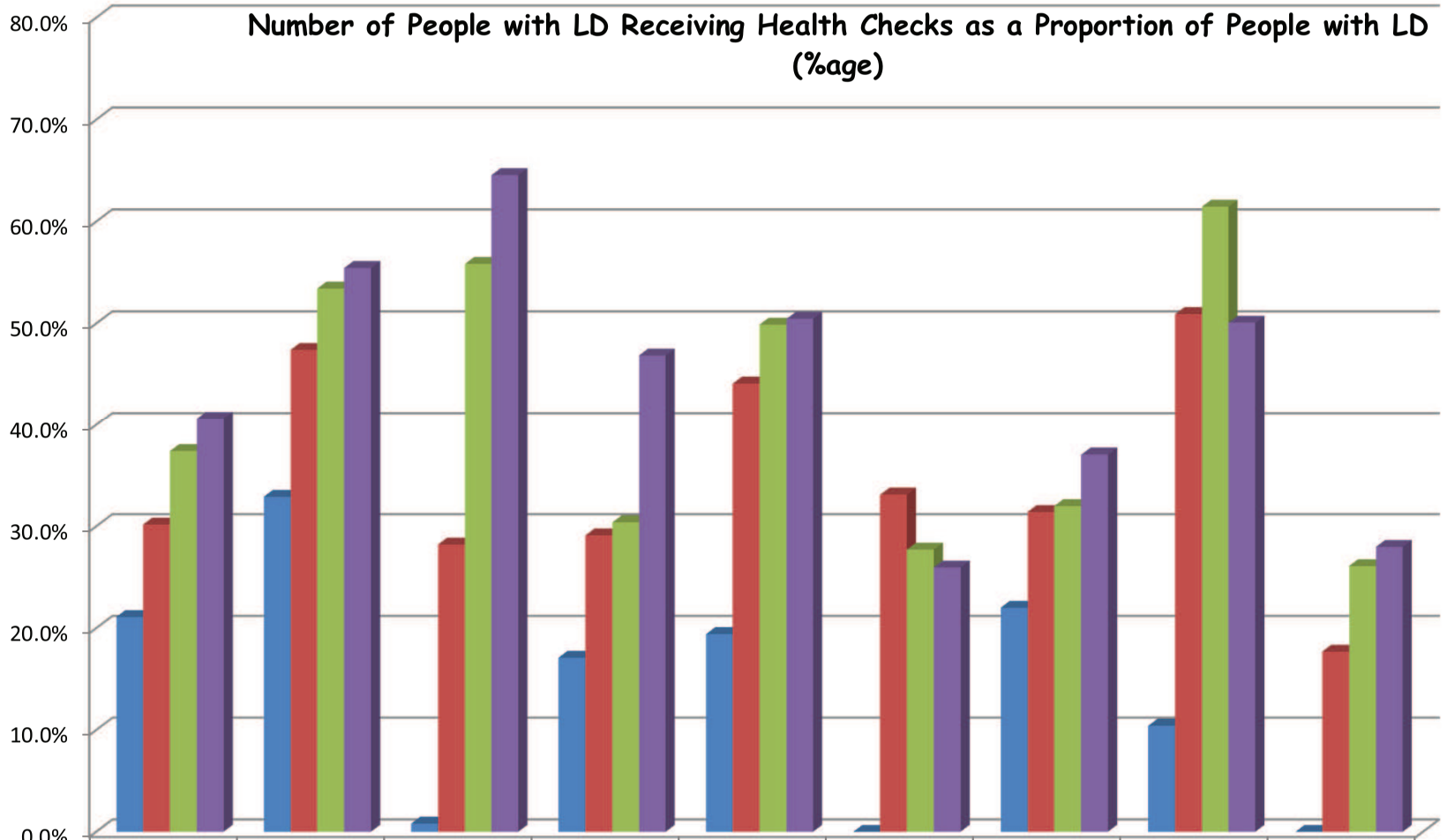


	South East Coast SHA	Brighton And Hove City PCT	West Sussex PCT	East Sussex Downs And Weald PCT	Hastings And Rother PCT	West Kent PCT	Eastern And Coastal Kent PCT	Medway PCT	Surrey PCT
2008-2009	21.1%	32.9%	0.8%	17.1%	19.4%	0.0%	22.0%	10.4%	0.0%
2009-2010	30.2%	47.4%	28.2%	29.1%	44.1%	33.1%	31.4%	50.9%	17.7%
2010-2011	37.4%	53.4%	55.8%	30.4%	49.9%	27.7%	32.0%	61.4%	26.1%
2011-2012	40.6%	55.4%	64.6%	46.9%	50.4%	26.0%	37.0%	50.1%	28.0%

NHS South of England East(Appendix 2) **Priorities to be included in NHS Brighton and Hove City Health Strategy for People with learning disabilities**	
Standard Description	Standard 1: Access to Health
A1	Requires further data collection and stratification with other registers i.e. Downs syndrome (To included data collection and informatics consultation (Richards Eccles) action points)
A2	Primary care to use data collection event with Richard Eccles to identify and make necessary adjustments to communicate the learning disabilities status to other health care providers.
A5	Increase Annual Health Checks by 10% 2012/13
A6	To carry out a cost benefit analysis following informatics consultation Oct 2012 (Data collection consultation will inform action points)
A7 (High amber)	To audit cervical screening data and use as comparative data against non-learning disabled population in each national screening programme. (Data collection and informatics consultation will inform action points Oct12)
A10	Take acute peer review action plan forward. To continue hospital champions in training and developing hospital services.
	Standard 2: People with Complex
B2	Complete the update of JSNA to enable Health and Wellbeing board to establish priorities when it commences in September 2012
B3	Continue work on Health Action Plans from age 17 ready for transition at 18 years old
	Standard 3: Safeguarding Governance Assurance and Quality
C1	Continue to monitor commissioning and contracting through central monitoring team.
C9	Operate recently reviewed assessment process with additional capacity (new post)
C14	Monitor changes re process of complaints and whistle blowing policy affecting people with learning disabilities leading to improved practice.

JOINT COMMISSIONING BOARD	Agenda Item 28 Brighton & Hove City Council NHS Brighton & Hove

Subject:		**Day Activities Commissioning Plan**
Date of Meeting:		**28th January 2013**
Report of:		**Director of Adult Social Services**
Contact Officer:	**Name:**	**Anne Richardson-Locke Tel: 29-0379**
	Email:	**anne.richardson-locke@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 Adult Social Care is continuing to change the way in which services are provided to enable people to have choice and control of the services they receive. Day services in Brighton & Hove provide a vital role in maximising independence and supporting carers and there is an ongoing commitment to provide day services to all people assessed as needing them.

1.2 The Government's White Paper '*Caring for our future: reforming care and support'* continues to promote independence, wellbeing and focuses on giving individuals greater control over their care and support. Brighton & Hove City Council is committed to continuing the organisational shift towards more personalised, community based support.

1.3 This report summarises the feedback on the current provision of day services in Brighton & Hove, makes recommendations about a future Vision for day services and outlines the next steps.

2. RECOMMENDATIONS:

2.1 That the Joint Commissioning Board note that the Adult Care and Health Committee approved the proposed Vision for day activities set out in Section 7 below.

2.2 That the Board note that the Adult Care & Health Committee agreed the next steps set out in Section 8, that is to work with service users, advocates, carers and providers in the co-design and modelling of services to realise the Vision for day activities.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 This report builds on the June Committee report that set out proposals for consultation on a Day Services Commissioning Plan.

3.2 As the Day Services Commissioning Plan concerns all client groups, a considerable amount of information gathering and feedback was required from services users, carers and providers.

3.3 This report summarises the feedback from the information gathering exercise and makes recommendations for the Vision for day activities in the city.

3.4 This report also outlines the proposed next steps, which have been agreed by the Adult Care and Health Committee.

3.5 This information has also helped to identify gaps in provision. This has been used to populate the Day Activities Needs Assessment.

3.6 The Needs Assessment highlights different issues for different client groups and the actions required are different as a result.

3.7 Day services for older people and older people with mental health needs have been reviewed within the last two years. Services for people with a physical disability provided by the council were reviewed in 2010 when Montague House services users were relocated to Tower House.

3.8 Although all services continually make improvements to meet the needs of service users, there has not been a formal review of all day services for people with a learning disability.

3.9 As a result, while this report updates members on developments on day services across all client groups, the main focus of this report has been on day services for people with a learning disability.

3.10 The Board should also note that the June Committee also agreed to a period of engagement around the reprovision of day services at Craven Vale day centre and progress is set out below in section 5.1.3.

3.11 As service users needs change and the Vision is implemented and new choices become available to service users, social care assessments will take place for individuals and their support plans will be updated accordingly. As part of the ongoing programme of social care reviews, care managers will also discuss self-directed support options with service users, such as personal budgets or direct payments.

4 OVERARCHING FEEDBACK ON DAY ACTIVITIES

4.1 The feedback is that day services are highly valued and very important to services users and carers and it is evident that people are anxious about changes to day services.

4.2 Day services across all client groups and both council run and run by the independent sector are supporting people with a variety of needs. Some services are specialists in that they particularly support those with complex needs whilst some services support people who are more able. There are individuals who require a day service placement over the course of the typical five day working week whilst others are able to access community facilities with support.

4.3 The provision of day services is vital for carer respite. There are challenges in balancing the needs of service users with the needs of carers. Equally there is a difference between what current users and carers who are used to the existing model want compared with what future users and carers might expect of day options.

4.4 Friendship groups are critically important for people attending day services. Where different day services and options have been combined, this has had a positive effect in that service users have more opportunities to meet different people.

4.5 With the exception of a very small number of carers, the vast majority of people did not know about direct payments or personal budgets. Some carers receive a direct payment for respite and expressed an interest in paying for day services with a direct payment as it would give their family member more flexibility in how and when then access activities. Many people expressed concerns about how they would manage a budget and thought that it would be too complicated. There was very little knowledge of self directed support mechanisms, for example a council managed personal budget.

4.6 Transport arrangements are complex and are not always person-centred or flexible to support carers' work opportunities.

4.7 Council provided services are working to develop capacity to support and focus provision more on those with complex behavioural and physical health needs. Services provided by the council are under intense scrutiny to demonstrate value for money and excellence. Other council provided services in Adult Social Care (home care and residential care for older people, for instance) have become more specialised.

4.8 There is a lack of awareness of alternative specialist or universal services available to people and how to access them.

4.9 Some buildings are under utilised and they have potential to be used in different ways by others thereby ensuring the best use of resources.

4.10 There are activities that could take place within the community rather than within dedicated day centre buildings.

4.11 Day service providers across the board are of good quality and are responsive to needs. It is also recognised that a great deal of community support work is undertaken by some services in addition to purely building-based activities.

5 FEEDBACK AND DEVELOPMENTS BY CLIENT GROUP

5.1 Older people

5.1.1 Table of services and approximate number of older people supported in a day centre building:

Service:	No of people supported:
Council provided:	
Craven Vale	29
Tower House	61
Independent sector:	
St John's	47
Somerset House	42

5.1.2 Council provided day services for older people have been subject to review in 2010/ 2011. Service users, carers and staff have been actively involved in service development.

5.1.3 Tower House is the central day service for older people and people with disabilities. In addition, Craven Vale day centre currently operate three days per week and numbers have been reducing for some time. Committee agreed to a period of engagement with service users with a view to offering them alternative services.

5.1.4 All day centre members at Craven Vale have been reviewed and their needs and the needs of their carers have been carefully considered. Of the twenty nine people attending, twenty six will be going to Tower House, one will be going to Somerset Day Centre, one will be going to Ireland Lodge and one will be going to Patching Lodge activities. All members have been attending Tower House on a Friday since Easter 2012 to assist with the transition and as of the first week in November, a second day is being introduced. The full reprovision will be complete by the middle of January 2013 at the latest. See Appendix 1 for the Equalities Impact Assessment.

5.1.5 The day centre facility at Craven Vale will be unoccupied from approximately middle of January 2013, and managers will be considering how best to use this facility in the future.

5.1.6 The voluntary sector runs two day services for older people. In addition, there are community activities available across the city being used by older people.

5.1.7 To date there has been engagement with services that are provided and used predominantly by older people. Over many years, older people and carers have contributed to service development and there have been discussions about a 'hub and spoke' model of care. However, there is some duplication of activity across provision and a lack of knowledge about what else is available and how to access different types of service.

5.1.8 Engagement with local older people by Age UK and the University of Brighton identified isolation and loneliness as major issues for those accessing care and

rehabilitation services. Lack of social contact can be as a result of loss of mobility and/or confidence to go out. Bereavement and the gradual loss of friends and family can result in an increasing sense of isolation and feeling cut off from the world and having regular social contact makes a big difference to well-being.

5.1.9 There is a lack of information on alternative community based activities in order to meet needs around social isolation, which can impact on health/mental health and general well-being. Transport is an additional element in enabling people to access community.

5.2 Older People with Mental Health needs:

5.2.1 Table of services and approximate number of adults with mental health needs supported in a day centre building:

Service:	**No of people supported:**
Council provided:	
Wayfield Avenue	62
Ireland Lodge	60

5.2.2 Discussions are being held with commissioners in the Clinical Commissioning Group in relation to how the developments in day services could link with the plans outlined in the Dementia Strategy.

5.2.3 These discussions include ongoing support for carers and a drive to develop a strategy to support people with learning disabilities and dementia, younger people with dementia and carers.

5.2.4 Service users, carers and other stakeholders were involved in the consultation with regard to the Dementia Strategy and this work could also help inform developments in day services.

5.2.5 There is an increase in the number of people attending day services with dementia who also need support with physical health needs.

5.2.6 Services provide a very valuable respite function and are looking to provide more person centred activities with the possibility of more reablement opportunities and some therapeutic input.

5.2.7 Of the nineteen service users who were supported to respond to questions about outcomes, the majority overwhelmingly stated that the reason for attending was to address needs around social isolation. Few people were aware of self-directed support options.

5.3 Physical Disabilities and Acquired Brain Injuries

5.3.1 Table of services and approximate number of people with physical disabilities and acquired brain injuries supported in a day centre building:

Service:	No of people supported:
Council provided (Physical Disability):	
Tower House	44
Independent sector (Acquired Brain Injury):	
Swanborough Services	3
Headway (Montague House site)	6

5.3.2 There are services for people with high levels of need such as those for people with Acquired Brain Injury and these services in particular are rehabilitative in nature and can provide both short-term and ongoing specialist support.

5.3.3 There has been a great deal of consultation, review and remodelling of council provided day services to meet the needs of people with physical disabilities. This has resulted in the move from Montague House to the amalgamated service at Tower House, which also supports older people. There is a particular focus on employment and volunteering opportunities and better use of community resources although there is a need to further develop day activity options for those with a physical disability.

5.3. 4 Since the service has amalgamated, reviews have indicated that people are very happy to be attending Tower House. It has also highlighted that for some the transition was much easier than for others. Service users have been very positive about staff although the majority did miss some of the ex-Montague House staff due to attending there for many years and staff having a greater understanding of their disabilities as a result.

5.3.5 Service users felt that initially the mix of client groups did not work due to various issues and needs, but on the whole it is now felt that this has much improved and there are now only a small group of ex-Montague House service users that believed this still to be the case. Most service users say that they enjoy the mix and that it is good to learn from each other. In the main, service users feel that staff listen to them and that they are very helpful and caring. All of Tower House service users are empowered to continue to meaningfully contribute to the ongoing review of their day centre in order to shape their service.

5.4 Learning disabilities and Autism

5.4.1 Table of services and approximate number of adults with a learning disability supported by a day centre(s):

Service:	No of people supported:
Council provided:	
Day Options Service	132
Independent sector:	

Grace Eyre Foundation	128
Scope	35
Care Co-ops	20
Aspirations Active	20
Autism Sussex	13

5.4.2 There are a wide variety of activities available in learning disability services. Service users and carers provided positive feedback on the quality and range of activities.

5.4.3 A variety of providers support people with complex physical health needs and challenging behaviour; this includes the voluntary sector, private providers and council provided services.

5.4.4 There is however a lot of duplication of activities across different provision and a general lack of knowledge about other available activities and how to access them. There are very few examples of people using a variety of providers to access the activities they need.

5.4.5 There has been a move toward providing activities in the community rather than a reliance on building bases within all learning disability day services. This has proved popular with both service users and carers. There are however a core group of people with particularly complex needs who need a building base. There are also examples of people who are using day services whose needs may be better met elsewhere.

5.4.6 Feedback from carers was largely very positive but some expressed frustration at the length of a 'day' at some day services, with some service users not leaving the house until 10am and then arriving home by 3.30pm. For carers to be able to work 'typical' hours they need a more flexible service.

5.4.7 There are a few examples of service users who have flexible, personalised day options with a combination of council provided and independent day activities combined with work, education or leisure activities but these are the exception rather than the rule.

5.4.8 There is some evidence of very good person centred practice, for example staff working flexibly across day services and accommodation or community services so that service users receive continuity.

5.4.9 There is a lack of post-19 education options for people in the city who have profound and multiple learning disabilities. In addition, the right communication aids and other specialist equipment to meet sensory needs are not always available and there are issues with the continuation of skills-building once a person leaves full time education.

5.4.10 As more people with complex behavioural and physical health needs require services, it is essential that the resources are available to sensory meet needs.

5.4.11 Many people with learning disabilities expressed a desire to work. This could be paid or voluntary work; people want to make a contribution. The vocational activities such as catering and recycling were very popular.

5.4.12 Many people with learning disabilities expressed a desire to develop their life skills in areas such as money handling or cooking, for instance, which would enable them to maximise independence.

5.4.13 There are some good examples of residential care and supported living providers facilitating person centred activities for people during the day. This is something that will be explored further with service users and providers - some of whom have already expressed interest in developing in this area - as part of a range of options and based on individual need.

5.4.14 In order to make the best use of buildings and resources there have been some developments regarding council owned day centre premises that are entirely separate from this review. Property and Design are undertaking a review of buildings that includes Buckingham Road. In addition, Children's Services are exploring the possibility of expanding the West Hove Infant School Annexe and are keen to acquire the Connaught Day Options Base for adults with learning disabilities and complex needs which is sited at the rear of the school. This will have implications for the Connaught Day Options Base for adults with learning disabilities and complex needs which is sited at the rear of the school. Discussions are ongoing around both of these developments.

5.4.15 It is important to note that discussions about the use of Connaught Road and Buckingham Road Day Options bases are taking place outside of this review. Committee will be updated on any future plans.

6 OPPORTUNITIES

6.1 The **Embrace** initiative has been gathering information on grassroots activities across the city. This will shortly be available via a website and in a range of other formats. The initiative is beginning to identify where there are gaps in service and where there may be an oversupply or duplication of service. The Embrace Initiative will help drive and inform the commissioning direction. The Needs Assessment illustrates the geographical location of current day service users and the location of the day centres by client group, ward and deprivation quintile. This information will be used alongside the geographical data on the Embrace community activities to identify where there are gaps in the city.

6.2 The **Community & Voluntary Sector Forum** (CVSF) are keen to work with the Council on commissioning developments in the city and as day activity provision is represented well by partners in the community and voluntary sector, this is a good opportunity to work in partnership to help shape future services.

6.3 Corporately, **libraries** have been looking at how well their services cater for all people in the city. They have assessed gaps in their market and continue to develop their services positively to enable access to everyone. It is the intention of adult social care commissioners to build on the established community links

that libraries already have with a view to further enable capacity through exploring joint working opportunities in order to look at current and future building use, particularly in view of the potential developmental areas arising from the day activity review.

6.4 There is also a corporate review of service user **transport** and adult social care commissioners will contribute to this review to make best use of resources.

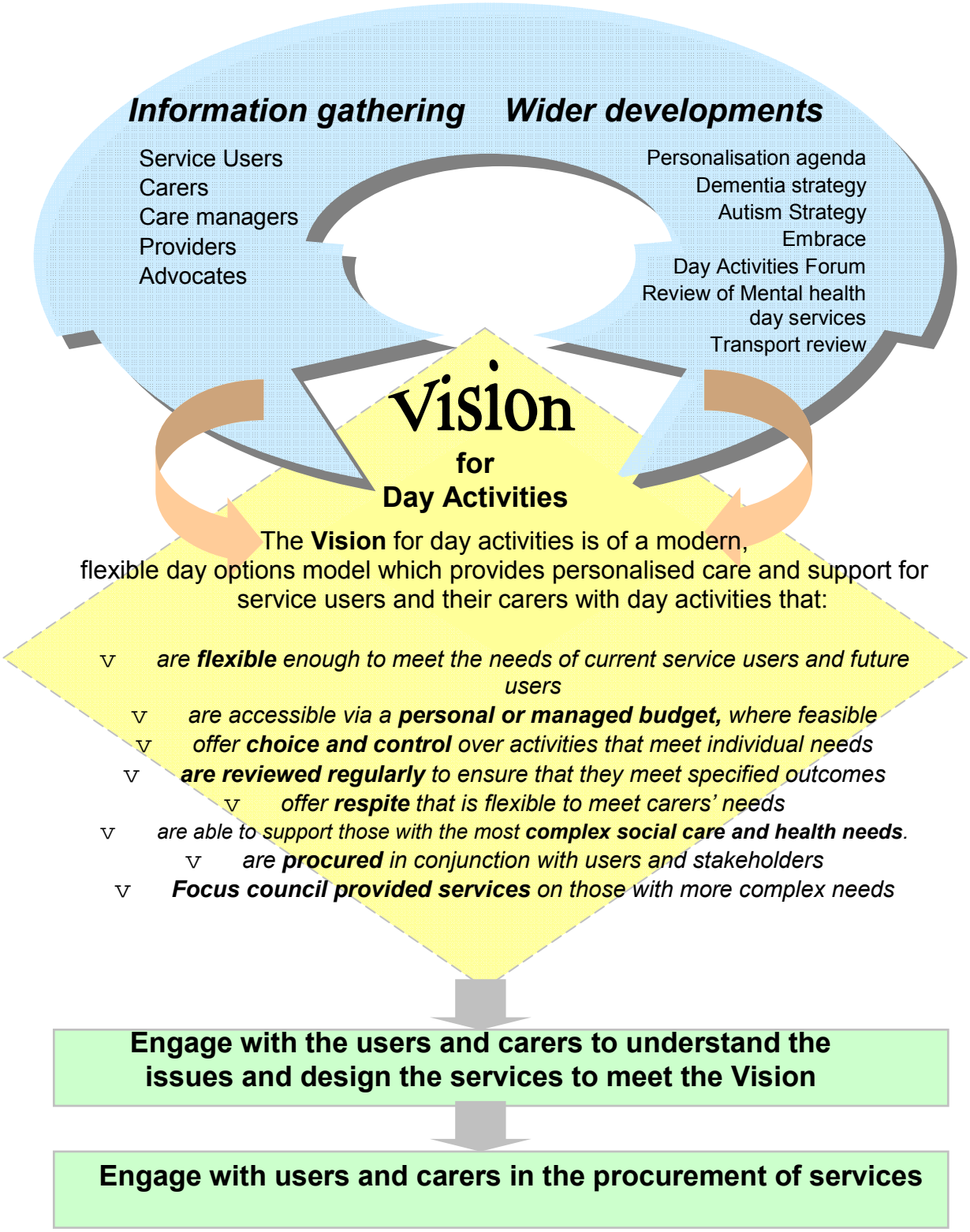
6.5 Discussions are taking place with commissioners in Supporting People to explore whether there are any opportunities for people to **access life skills and literacy courses** that were previously not open to them.

6.6 **Leisure and fitness** were highlighted as activities that people are very interested in and that are very beneficial for people's wellbeing. There are opportunities to make links with leisure providers to see what kind of adjustments need to be made to ensure access to services.

6.7 Links will be made with commissioners in children's services, the transitions team and **schools and colleges** to ensure that the needs of future service users are met.

6.8 The **Commissioning Prospectus,** a new method of procuring Adult Social Care Services in the voluntary sector, will offer opportunities for further consultation with providers on how the proposed outcomes for people using day services can be met.

7 A VISION FOR DAY ACTIVITIES IN THE FUTURE



7.1 Through talking to service users, carers, advocates, care managers and providers, the following Vision and outcomes have been identified for future day activities. The Vision has also been informed by wider developments such as:

- The Personalisation agenda
- The Autism Strategy
- The work of the Day Activity Forum (cross-sector providers)
- The Dementia Strategy.
- The Embrace Initiative developed by the Federation for Disabled People
- The review of mental health day services
- The transport review

7.2 The **Vision** for day activities is of a modern, flexible day options model which provides personalised care and support for service users and their carers with day activities that:

- are **flexible** enough to meet the needs of current service users and future users
- are, where feasible, accessible via a **personal or managed budget** and that opportunities to pool money to purchase services is enabled
- offer **choice and control** over activities that meet individual needs
- are **reviewed regularly** to ensure that they meet specified outcomes
- offer **respite** that is flexible to meet carers' needs
- are able to support those with the most **complex social care and health needs**.
- are **procured** in conjunction with users and stakeholders
- **focus council provided services** on those with more complex needs

7.3 The Vision is of day activities that meet the following outcomes:

Supporting people to be as independent as possible:

- Individuals have good quality information and advice available to them to enable choice and control.
- Individuals are supported to enable them to connect with the community
- Individuals are supported to enable them to contribute and to play an active role in their community.
- Flexible support is available to families and carers to enable people to remain in / return to their home.

Reducing social isolation:

- Barriers to social isolation are addressed e.g. transport, communication etc.
- There is robust signposting and awareness raising of opportunities in local communities.
- Individuals are supported to maximise their potential and real opportunities for supported employment and volunteering are capitalised and explored.

People remain healthy and well for as long as possible:

- Individuals have access to enablement / reablement support, where appropriate.
- Links are in place for allied health and social care systems e.g. GPs, Information Prescription etc.
- Individuals are supported to access preventative services e.g. smoking cessation clinics, bariatric care etc.

7.4 The above outcomes were developed with providers at the Day Activity Forum over two meetings. Speak Out advocacy service supported commissioners to simplify the three outcomes to a series of six easy read questions and these were used when meeting service users and carers.

8 PROPOSALS

8.1 There are opportunities to carry out detailed work with service users, carers, advocates and providers to realise the Vision and to work collaboratively to design and model day services in the city in conjunction with corporate communications.

8.2 The information obtained through the service mapping carried out with providers and the feedback from service users, carers and professionals will be used to inform this work. This may result in some changes to day services and a detailed Equalities Impact Assessment will be completed.

8.3 The extent of this work will vary, depending on the issues concerned for each service user group. It is proposed that further detailed work will be carried out in day services for people with a learning disability. It is also proposed that developments in older people's services continue to progress and that additional opportunities are explored for those with a physical disability; services for those with acquired brain injury will be reviewed in collaboration with health. It is proposed that day services for older people with mental health needs work with commissioners to link in with the Dementia Strategy. This work could be done through a series of focus groups with service users, carers, advocates and providers.

8.4 A progress report with a plan will be presented to Adult Care & Health Committee. If the recommendations are agreed, it is proposed to begin work immediately on how the Vision will be realised. A progress report with a plan will presented to Committee on 18th March 2013.

9. COMMUNITY ENGAGEMENT

9.1 Between August and October 2012 there have been opportunities for service users, providers, carers and professionals to feed into the Needs Assessment via meetings, forums and one to one meetings with commissioners as part of an information gathering exercise.

9.2 Providers were asked to complete a series of mapping questions which enabled and supported day service profiling and providers were asked to support those

service users with more complex needs to understand questions about their current and future outcomes from attendance.

Information gathering summary:

Information gathering activity:	***Specifics:***	***Sum:***
Numbers of day centres visited:	Independent and voluntary sector: Council provided:	8 7
		Total: 15
Numbers of people who provided feedback on outcomes as a result of seven information gathering sessions arranged (1:1 meetings):	Service users: Carers: Accommodation support staff: Volunteer staff member:	76 14 2 1
		Total: 93
Numbers of people supported by their day service provider to directly feedback in to information gathering exercise on outcomes outside of prearranged meetings:	Service users:	21
		Total: 21
Numbers at meetings where day activity information gathering was discussed:	Learning Disability Partnership Board: Big Meeting (and other advocacy groups): Carers Centre and Amaze Meeting: Carers of council provided day services: Learning Disability Provider Forum in September:	24 22 (+ 19) 15 27 14 (providers)
		Total: 121
Numbers of Care Managers who have provided feedback:	B&HCC assessment teams:	15
		Total: 15

See Needs Assessment for further detail

10. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

10.1 There is net budgetary provision in 2012/13 in excess of £4.5m across Older People, Physical Disabilities and Learning Disabilities of which approximately £1.8m is currently in respect of independent providers with the remainder being for in-house services. The financial implications will be quantified as the

proposals are developed and will take into account the current and emerging budget strategies.

Finance Officer Consulted: Michelle Herrington *Date: 26/10/2012*

Legal Implications:

10.2 The report sets out how Adult Social Care will restructure services in line with the national personalisation agenda and in accordance with value for money principles.

10.3 The proposals have taken account of the outcome of consultation with key stakeholders to ensure that the Council can make changes while still meeting assessed need.

Lawyer Consulted: Hilary Priestley *Date 26/10/12*

Equalities Implications:

10.4 An Equalities Impact Assessment has been undertaken for the changes to the Craven Vale service and is attached as Appendix 1.

10.5 Equalities issues relating to the Vision set out in this report are explored in the Needs Assessment. In summary the Vision will have a positive equalities impact by promoting access to activities that are relevant and appropriate to meet an individual's support needs

10.6 Should Committee agree to the recommendations made in this report, a detailed Equalities Impact Assessment will be undertaken which will further inform the next steps of the review.

Sustainability Implications:

10.7 The Vision highlights better use of resources including buildings and transport and advocates for the co-production of any future services with service users, carers and providers resulting in a more sustainable model of services.

Crime & Disorder Implications:

10.8 This proposal will promote social inclusion for people with disabilities and older people through supporting increased access to mainstream services and participation as equal citizens in the community.

Risk and Opportunity Management Implications:

10.9 The risk is that the proposed Vision does not reflect the needs of service users and carers. Commissioners will work collaboratively with service users and carers to ensure that people's needs are reflected in the design of services.

Public Health Implications:

10.10 Adult social care has clear interconnection with the wider public health agenda and the proposed next steps reinforce the aim to support equality, health and well-being in the city.

Corporate / Citywide Implications:

10.11 This proposal will increase access to mainstream and universal services available locally and so enable people to participate more fully in the city.

10.12 There is a council review of the use of buildings that may have an impact on service delivery at Connaught and Buckingham Road day centres. Discussions are ongoing around both of these developments.

11. EVALUATION OF ANY ALTERNATIVE OPTION(S):

11.1 The alternative option is to not develop a commissioning plan and make no changes to day services. The impact of this would be that day services remain the same and service users do not benefit from more flexible, personalised services.

12. REASONS FOR REPORT RECOMMENDATIONS

12.1 The report recommends that day activity provision in the city is developed to enhance services so that they are flexible enough to meet the needs of current service users and future users and are, where feasible, accessible via a personal or managed budget and that opportunities to pool money to purchase services is enabled. The report recommends that information be accessible on available activities to enable service users and their carers to have choice and control of how their needs are met.

12.2 The report recommends that work with service users, advocates, carers and providers is undertaken in order to co-design and model services to realise the Vision for day activities. This will ensure that services provided meet the needs of service users and carers.

SUPPORTING DOCUMENTATION

Appendices:

1. Craven Vale Equalities Impact Assessment

Documents in Members' Rooms

1. Day Activities Needs Assessment

ASC EIA Template

Title of EIA	**Craven Vale re provision at Tower House**	**Ref No.**	
Name of: **Delivery / Resource / Finance Unit or Intelligent Commissioning**	**Adult Social Care Provider Unit**	**Head of Service:** **Karin Divall**	
Aim of policy or scope of service (outlining proposed changes to service)	Adult Social Care Day Services – Day services provide support to Adults with a Physical Disability of working age, Older People / Older people with Mental Health needs from several establishments across the City. We have two stand alone day services (Tower House & Craven Vale), and also two day services for Older People Mental Health Needs, these are based at Ireland Lodge and Wayfield Avenue (Resource Centres). We also have a contract with 2 voluntary sector services (St. Johns & Somerset Day Centre). <u>This EIA is focusing on the re-provision of Craven Vale transferring into Tower House</u> A consultation has taken place looking at the future needs of the service. It has been agreed to combine Craven Vale and Tower House. Craven Vale will relocate to Tower House providing a service that works across the age spectrum resulting in increased opportunities, more choice, control, and independence for those using these services.		

	This will result in a central 'community hub', and work towards a centre of excellence. The service supports people from across the Equality Strands. The Equality Impact Assessment will look at the positive and negative impacts of the service. This EIA takes into consideration consultation that has already been undertaken within the City for people receiving day services, in line with developing the Older peoples Strategy and the Personalisation programme. A consultation with staff will identify issues for them as a team/ individuals.

Relevant Data/legislation and Evidence of Consultation related to the proposed change above:

Title (Data/Legislation or Consultation)	**Date** (and venue if engagement)	**Lead Officer** (where relevant)	**Key findings related to this Assessment of Impact**

Staff consultation Activity	**Team meetings** **19th June (unions present)** **11th October** **Meeting with staff & unions 19/6/12** **Staff Bulletin 18/6/12**	**Alison Sinclair**	**Staff have fully engaged with process, have supported members positively to access Tower House.** **During meetings have been kept updated with progress of consultation time table.**
Members/Carers Activity	**Members meeting Held through out August** **Members bulletin August 2012** **All members have attended `taster` days at Tower House** **Friday's at Craven Vale have already**	**Alison Sinclair** **Sharon Magee** **Sharon Magee**	**Members meeting** **All members have had 1 to 1 meetings with S C O. on how taster sessions have gone** **28 members reviewed**

	successfully merged with Tower House **All members have been reviewed looking at individual needs**		**25 will move to Tower House** **2 have been assessed to require a mental health day Centre** **1 will be linked to Somerset day Centre**

Assessment:

Different Groups to be included in Assessment	Potential Positive impact on a group	Potential Negative impact on a group	Agreed Action/s
Community Cohesion	Some members would be more suited to an alterative day service , this will address their individual needs, & offer the more choice, and may offer them links to facilities within	**Loss of contact with established friends, settling into new service**	**Staff to assess all Craven Vale members, looking at what needs they require from service, does service still meet their needs?, Is there a more appropriate resource within their community, assess for Direct Payments.**

	their local community		
Age	Potential opportunity to consider needs of older members would be helpful.	Some older members may have attended Craven Vale for many years , change may be difficult, • Additional travelling time	**Assessment of individual needs to be completed, looking at managing change, travel, resources available at Tower House, Quite areas?.** **Individual care plans to be completed.**
Disability	Change in service may result in more suitable placements for some members : Chance to match people to suitable environments.	Tower House is a larger resource, but with more members & more walking aids/Wheel chairs more of a risk of `incidents`/ falls etc…	**S C O / STAFF to risk assess every member, explain there are additional members to consider/ work shop with members / explaining different mobility needs/ tolerance**
Gender reassignment	No impacts identified as a result of the Consultation process.	No impacts identified as a result of the Consultation process.	**Gender needs of affected members will be considered as part of their social care review-any identified needs will be addressed as part of this process**.
Pregnancy and	No impacts identified as a	No impacts	**N/A**

maternity	result of the Consultation process.	identified as a result of the Consultation process.	
Race	No impacts identified as a result of the Consultation process.	No impacts identified as a result of the Consultation process.	**Cultural/ethnic needs of affected service users will be considered as part of their social care review-any identified needs will be addressed as part of this** process.
Religion or belief	No impacts identified as a result of the Consultation process.	No impacts identified as a result of the Consultation process.	**Religious needs of affected service users will be considered as part of their social care review-any identified needs will be addressed as part of this process.**
Sex	No impacts identified as a result of the Consultation process.	No impacts identified as a result of the Consultation process.	**We will consider service users needs based on gender where required.** **We will ensure we will have a balance of both male and female staff where required/appropriate.**
Sexual orientation	No impacts identified as a result of the Consultation process.	No impacts identified as a result of the Consultation process.	**Sexual Orientation needs of affected members will be considered as part of their social care review-any identified needs will be addressed as part of this process.**

Marriage and civil partnership	No impacts identified as a result of the Consultation process.	No impacts identified as a result of the Consultation process.	**N/A**
Staff	• Staff will learn new skills and exchange different ways of working, increase skills base. • Opportunities to have new experience and personal development, take on new roles (e.g. medication ordering etc). • Improves career development options. • Improves long term career potential –ability to stay with BHCC as main employer. • Some staff are looking forward to the opportunity to work somewhere new and feel that change is positive.	• Some staff are reluctant to work in more complex environments e.g. challenging behaviour. - Change in staff roles - New Job Descriptions: (driver/ attendants will become driver/care officers) Some staff may not feel confident to work within the new	**Craven Vale staff are already working at Tower House on Friday's, with additional support & training any anxieties will be kept at a minimum.** **Addition 1 to 1 support with line manager will be offered during transition.** **Staff will be able to access `excess travel policy ` for 3 years** **Staff training will be identified in 1 to 1 meetings, with additional support/ training offered to enable them to feel confident within their new role.** **Staff may request to go into redeployment pool.**

	• Staff development opportunities-ensure equal opportunities for staff working within or applying to work in services	criteria. Staff may feel anxious working with service users that they do not currently work with e.g. physical disabilities (high level needs) - Staff may not be engaged (low staff morale)	**Team days and individual staff training will be identified** **Mangers will work closely with staff to indentify areas of concern for staff.**

Lead Officer Responsible for ensuring agreed actions are transferred to service or Business Plan:

Name:	**Alison Sinclair**

Job Title:	**Operations Manager**
Contact details:	**296330/293705** **alison.sinclairbrighton-hove.gov.uk**
Agreed Date to Review Service /Business plan and/or this EIA:	**March 2013**

Signing of EIA:-

Lead Officer for this EIA:		**Date:**	
Head of Service Delivery Unit		**Date:**	
Lead Commissioner (if required):		**Date:**	
Communities and Equality Team	**Clair Hopkins**	**Date:**	**26.10.12**

You must also complete and submit a summary of the EIA in the Publication Template (see below)

JOINT COMMISSIONING BOARD	Agenda Item 29 Brighton & Hove City Council

Subject:		**Adults Section 75 Review**	
Date of Meeting:		**Joint Commissioning Board – 28/01/13 Adult Social Care and Health Committee – 18/03/13 Policy and Resources – 21/03/13**	
Report of:		**Denise D'Souza – Director of Adult Social Care**	
Contact Officer:	**Name:**	**Geraldine Hoban – Chief Operating Officer, CCG**	**Tel: 01273 574 863**
	Email:	**Geraldine.Hoban@nhs.net**	
Key Decision:	**No**		
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This paper outlines revisions to the Adults Section 75 Agreement between the Council and the Clinical Commissioning Group which will come into effect on 1st April 2013.

2. RECOMMENDATIONS:

2.1 The Committee is asked to note the revisions to the Section 75 Agreement and review the draft documentation.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Background

3.1.1 The CCG and Council are committed to maintaining both formal joint commissioning agreements, namely the Section 75 for Children's Services and the Section 75 for Adults' Services.

3.1.2 In preparation for the CCG becoming the accountable body for commissioning healthcare in the City on 1st April 2013, both agreements need to be updated to reflect the new commissioning landscape.

3.1.3 The Council is leading on the review of the Children's Section 75 and the CCG is updating the documentation for Adult Section 75 Agreement.

3.1.4 A working group comprising the Chief Operating Officer from the CCG, Director of Adult Social Care from the Council and various joint commissioning leads have reviewed and updated the document. Templates supplied by DAC Beachcroft (lawyers supporting a number of CCGs nationally in updating formal joint commissioning agreements) have been used as the basis for the revised Agreement.

3.1.5 Service areas and associated financial resources have been reviewed to ensure they are up to date but otherwise the vast majority of the ways of working and governance around the formal agreement remains the same.

3.1.6 All significant elements of the revised Agreement are summarised below and a full version of the draft document is attached as an appendix.

3.2 Duration of the Agreement

3.2.1 The revised agreement is for a three year period commencing 1st April 2013. The agreement can be amended, terminated or extended in accordance with clauses set out in the documentation.

3.3 Jointly Commissioned Service Areas

3.3.1 Given changes to commissioning responsibilities and funding flows the service areas to be jointly commissioned required updating as below:

Previous Section 75	New Section 75	Rationale for Change
HIV/AIDS Support Grant Funded Services	Not in	Now solely commissioned by the Council so no longer need for formal joint arrangements
Substance Misuse Services	Not in	Now solely commissioned by the Council so no longer need for formal joint arrangements
Older People's Mental Health Services	Not in	No longer separated as a discrete service area but incorporated into generalist mental health and dementia sections.
Intermediate Care Services	Remains in	
Learning Disability Services	Remains in	
Mental Health	Remains in	
Short Term Services	Remains in	
	Personalisation and Support	Describes areas of joint strategic commissioning and collaboration
	Dementia	
	Carers	Was not previously in S75 but is a significant area of collaborative commissioning and integrated funding.

3.4 Commissioning Resource

3.4.1 The CCG and Council will maintain the arrangements whereby commissioners will be hosted by the respective lead organisation but work on behalf of both the CCG and Council to commission an integrated service. Each organisation will contribute to the cost of the lead commissioning function as detailed in the Agreement. Posts will be held accountable through clear joint line management arrangements again, clearly set out in the Agreement.

3.5 Governance and Accountability

3.5.1 The revised Section 75 proposes maintaining the Joint Commissioning Board (JCB) with delegated authority from the Council and CCG for setting the strategic

direction and overseeing the planning, monitoring and review of jointly commissioned service areas.

3.5.2 Areas of joint commissioning will be reviewed annually in light of emerging national guidance, the Health and Wellbeing Strategy, Joint Strategic Needs Assessments etc and an annual Joint Commissioning Plan developed for sign off by the JCB.

3.5.3 Further discussions are being held about the governance and accountability arrangements for the Children's Section 75.

4. CONSULTATION

The original Section 75 was consulted on widely. Given this document updates rather than changes anything significantly it was not considered necessary for any further public consultation and engagement.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 The estimated financial contributions from each party will be specified within the agreement and monitored through the Joint Commissioning Board. The contribution from Adult Social Care for 2013/14 will be contained within the budget proposals. The revised Section 75 maintains the previous funding arrangement whereby respective financial contributions are not pooled, but instead are separately managed and reported on by the lead commissioner on behalf of both organisations.

Finance Officer Consulted: *Anne Silley* *Date: 17/01/13*

5.2 Legal Implications:

The rationale and legal changes leading to the requirement to amend the S75 Agreement are set out in the body of this Report. At this stage JCB is asked to note and comment only on the work leading to an amended S75 in April 2013 that is still progressing. There are no specific legal implications other than those referred to in the main body of the Report arising.

Lawyer Consulted: *Sandra O'Brien* *15.01.13*

Equalities Implications:

5.3 There are no equality implications arising from this report, as it just states the intention to commissioning collaboratively. Specific service related changes or strategy development would be subject to their own individual EQAs.

Sustainability Implications:

5.4 There are no sustainability implications.

Crime & Disorder Implications:

5.5 There are no implications arising out of the redrafted document for crime and disorder.

Risk and Opportunity Management Implications:

5.6 Collaborative commissioning arrangements will enable the city to benefit from more integrated and efficient services.

Public Health Implications:

5.7 The areas chosen for collaborative commissioning reflect the priorities contained within the Health and Wellbeing Strategy, namely dementia and mental health.

Corporate / Citywide Implications:

5.8 This revised agreement reflects the continued commitment to collaboration and partnership working between the CCG and Council.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Given the commitment to maintain collaborative commissioning arrangements, not alternative options were considered.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 In light of changes to commissioning responsibilities and a new commissioning architecture the Adults Section 75 Agreement has been reviewed and updated. Other than revisions reflecting national changes in the commissioning landscape, the vast majority of the agreement and ways of working are unchanged.

7.2 The Committee is therefore asked to note the changes to the jointly commissioned service areas and comments on an early draft of the revised documentation.

7.3 Following comments from the Committee, the draft Section 75 Document will continue to be worked on and updated and sent to the CCG Lawyers for review. A final version brought back to the Committee Board for formal approval in March.

SUPPORTING DOCUMENTATION

Appendices:

1. Draft Adult Section 75 Agreement

March 2013

BRIGHTON & HOVE CLINICAL COMMISSIONING GROUP

AND

BRIGHTON & HOVE CITY COUNCIL

Agreement under Section 75 of the National Health Service Act 2006 for the Joint Commissioning of Health & Social Care Services

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D R A F T

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Clause heading and number — Page number

THIS AGREEMENT is made the ..... day of 2013

BETWEEN:

(1) **BRIGHTON & HOVE CLINICAL COMMISSIONING GROUP** of Lanchester House, Trafalgar Place, Brighton BN1 4FU (the **"CCG"**); and

(2) **BRIGHTON & HOVE CITY COUNCIL** of Kings House, Grand Avenue, Hove BN3 2LS (the **"Council"**),

together, the **"Parties"**.

INTRODUCTION:

(A) The CCG and the Council have agreed to enter into a partnership arrangement pursuant to section 75 of the National Health Service Act 2006 and Regulation [8(1)]/ [9(1)] of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (SI 617), in respect of a range of health and social care services for vulnerable people as further described in this Agreement.

(B) As part of the partnership arrangement referred to at Recital (A) above, the Parties have agreed that the CCG shall delegate certain of its functions to the Council under a lead commissioning arrangement. For these purposes, the Parties shall establish and maintain a non-pooled fund which is made up of contributions from the CCG and the Council (described in Schedule 6 (Resources)), out of which payments may be made towards expenditure incurred in the exercise of any CCG Functions or Council Functions in connection with this Agreement.

NOW IT IS HEREBY AGREED as follows:

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement unless the context otherwise requires the following words and expressions shall have the following meanings:

"Act"	the National Health Service Act 2006;
"Agreement"	this agreement between the CCG and the Council comprising these terms and conditions, together with all Schedules attached hereto;
"Arrangements"	has the meaning ascribed to it in Clause 0;
"CCG Functions"	those of the functions of the CCG set out in Regulation 5 of the Regulations (and further described in Schedule 2 (CCG Functions) of this Agreement) in relation to these Arrangements and as are exercised in making arrangements for the provision of the Services, excluding the Excluded Functions;
"CCG Staff"	any employee or employees of or persons engaged by the CCG carrying out the Functions;

"Client Group"	the collection of Service Users either receiving or eligible to receive the Services and living within the administrative area of Brighton & Hove and registered with a Brighton & Hove CCG GP or as otherwise agreed between the Parties;
"Commencement Date"	1st April 2013
"Contributions"	the respective financial contributions of the Parties (as set out in Schedule 6 (Resources)), for use by the Lead in connection with the Lead Commissioning of the Services in fulfilment of the Functions and in accordance with the terms of this Agreement;
"Contributions Manager"	Financial Lead within the respective organisation;
"Council Functions"	the health related functions of the Council listed in Regulation 6 of the Regulations (and further described in Schedule 3 (Council Functions) of this Agreement) in relation to these Arrangements and making arrangements for the provision of the Services, but excluding the Excluded Functions;
"Council Staff"	any employee or employees of or persons engaged by the Council carrying out the Functions;
"Department"	the Department of Health;
"DPA"	the Data Protection Act 1998, as amended from time to time;
"Event of Force Majeure"	an event or circumstance which is beyond the reasonable control of the Party claiming relief under Clause 22 (Force Majeure), including without limitation war, civil war, armed conflict or terrorism, strikes or lock outs, riot, fire, flood or earthquake, and which directly causes that Party to be unable to comply with all or a material part of its obligations under this Agreement;
"Excluded Functions"	such Functions contained in Schedule 4 (Excluded Functions) of this Agreement and/or such Functions as the Parties may agree from time to time are excluded from the Arrangements, together with any exclusions set out in the Regulations;
"Financial Year"	the financial year running from 1 April of one year to 31 March in the next year;
"FOIA"	the Freedom of Information Act 2000, as amended from time to time;

"Functions"	the CCG Functions and the Council Functions in relation to the making of arrangements for the provision of the Services to meet the needs of the Client Group, but excluding the Excluded Functions as set out in Schedule 4 (Excluded Functions);
"Community Care Budget"	the budget allocated for the provision of services to individuals who receive an assessment under Section 47 of the NHS and Community Care Act 1990 and whose care is purchased in the independent or voluntary sector;
"HMRC"	Her Majesty's Revenue and Customs;
"Lead"	the Council or CCG being the Party nominated by the Parties to perform the Lead Commissioning and to be responsible for the management of the associated fund;
["Lead Commissioning"	the commissioning of the Services by the Lead for either the Council and the CCG as further detailed in Clause 0 (Services) of this Agreement;
"Joint Commissioning Board"	the Joint Commissioning Board is made up of representatives from both the CCG and the Council (as further described at Clause 8 (Governance and Monitoring Arrangements) and Schedule 7 (Joint Commissioning Board));
"NHS"	National Health Service;
"NHS Body"	has the meaning given to it at section 275(1) of the Act, and "**NHS Bodies**" shall be construed accordingly;
"Quarter"	each of the following periods in the Financial Year: (i) 1 April to 30 June; (ii) 1 July to 30 September; (iii) 1 October to 31 December; (iv) 1 January to 31 March, and **"Quarterly"** shall be construed accordingly;
"Regulations"	the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (SI 617) as amended from time to time;

"Section 75 Flexibility"	any of the powers set out in section 75 of the Act, developed to give NHS Bodies and local authorities the flexibility to be able to respond effectively to improve services, either by joining up existing services, or developing new, co-ordinated services, and to work with other organisations to fulfil this, which may include: (i) a pooled fund arrangement; (ii) a lead commissioning arrangement; and (iii) an integrated provision arrangement;
"Services"	the Services described in Clause 0 (Services) and Schedule 5 (The Services) and which the Parties have agreed will come within the Arrangements and which will (unless specified otherwise in this Agreement) be procured by the Lead from third party providers;
"Service Users"	any individual for whose benefit the Services are provided, as further described at Schedule 5 (The Services);
"Staff"	the staff of the Council and/ or the CCG who are carrying out the Arrangements under this Agreement;
"Variation"	an addition, deletion or amendment in the Clauses of or Schedules to this Agreement, agreed to be made by the Parties in accordance with Clause 15 (Review and Variation) or Clause 16 (Change of Law);
"VAT Guidance"	the guidance published by the Department entitled "VAT Arrangements for Joint NHS/Local Authority Initiatives including Disability Equipment Stores and Welfare - Section 31 Health Act 1999"; and
"Working Day"	any day other than Saturday, Sunday, a public or bank holiday in England and Wales.

1.2 References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.

1.3 The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are clauses in this Agreement.

1.4 References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.

1.5 References to a person or body shall not be restricted to natural persons and shall include a company, corporation or organisation.

1.6 Words importing the one gender shall include the other genders and words importing the singular number only shall include the plural.

1.7 Where anything in this Agreement requires the mutual agreement of the Parties, then unless the context otherwise provides, such agreement must be in writing.

2. BACKGROUND

2.1 The CCG is a clinical commissioning group established under section 14C of the Act. The CCG commissions services for the Client Group in Brighton & Hove.

2.2 The Council is a local authority established under the Local Government Act 1972 (as amended) and has a health and social care department responsible for **[enter relevant services commissioned by the Council e.g. the protection and support of vulnerable adults and children]**. The Council commissions relevant services for the Client Group in Brighton & Hove.

2.3 The CCG and the Council have duties and powers to provide care to the Client Group and section 82 of the Act requires both local authorities and NHS Bodies when exercising their respective functions to co-operate to secure and advance the health and welfare of the people of England and Wales. Furthermore, under relevant guidance, local authorities and NHS Bodies are encouraged to consider partnership working, including Lead Commissioning under the Act. Section 75 of the Act and the Regulations have introduced powers for local authorities and NHS Bodies to set up joint working arrangements.

2.4 The Parties are entering into this Agreement (which includes Lead Commissioning) in exercise of the powers under section 75 of the Act and pursuant to the Regulations.

The CCG and the Council have, in accordance with Regulation 4(2) of the Regulations, jointly consulted with a wide range of stakeholder organisations as described in Schedule 1 (Aims and Outcomes) on the proposals for this Agreement and with those who are affected by the Arrangements.

2.5 [The CCG is satisfied that the Arrangements are consistent with the commissioning plan prepared by it under section 14Z11 of the Act.]

2.6 The Parties are satisfied that the arrangements contemplated by this Agreement are likely to lead to an improvement in the way that their functions are exercised.

2.7 The CCG and the Council have approved the terms of this Agreement and agree to work together in accordance with the terms of the Agreement.

3. DURATION OF THE AGREEMENT

3.1 This Agreement shall take effect on the Commencement Date and shall continue for a period of 3 years, subject to earlier termination in accordance with the provisions of Clause 17 (Termination) and any extension agreed in accordance with Clause 3.2 below.

3.2 This agreement may be extended on 31st March 2016 for a further defined period.

4. SUMMARY OF THE ARRANGEMENTS

4.1 The Parties have agreed that, with effect from the Commencement Date, the partnership arrangements are to comprise:

4.1.1 the Lead Commissioning arrangements set out in this Agreement (and more particularly described at Clause 0 (The Services));

4.1.2 the management of a non-pooled fund (as further described in Clause 10 (Financial Arrangements) and Schedule 6 (Resources)) for the revenue expenditure on the Services;

4.1.3 provision of the Contributions by each Party, insofar as is required for the exercise of the Functions (as set out in Schedule 6 (Resources));

4.1.4 performance of the Functions specified in Schedule 2 (CCG Functions) and Schedule 3 (Council Functions) in accordance with this Agreement; and

4.1.5 full engagement in the Joint Commissioning Board established for the monitoring of the Functions and the Services (as set out and described in Clause 0 (Governance and Monitoring Arrangements) and Schedule 7 (Joint Commissioning Board);

the **"Arrangements"**.

42. Without prejudice to the other provisions of this Agreement, the primary objective of the Parties in entering into this Agreement is to improve the commissioning of the Services in accordance with the aims and outcomes outlined in Schedule 1 (Aims and Outcomes).

4.3 The Parties hereby represent that they have obtained all necessary consents sufficient to ensure the delegation of Functions provided for by this Agreement.

4.4 It is the Parties' intention that the Arrangements shall be the mechanism through which the Functions shall be fulfilled.

4.5 The Parties wish to use this Agreement to enable the Council and CCG to act as the Lead Commissioner for designated service areas.

4.6 The Lead Commissioner shall (without limitation):

4.6.1 act as the Lead Commissioner and exercise both the Council and CCG functions concurrently;

4.6.2 administer the Parties' Contributions in accordance with the provisions of this Agreement; and

4.6.3 be responsible for all Staff carrying out the Functions.

5. SERVICES

The services areas covered under this Agreement are as follows:

Council Lead	CCG Lead
Integrated communication equipment	Mental Health
Carers	Dementia
Older People and people with a Physical Disability	Community Short Term Services
Learning Disability	

The Lead Commissioner shall commission the free services set out in Schedule 5 (The Services), in order to satisfy the Functions and its other obligations set out in this Agreement and in accordance with the procedure set out in Schedule 8 (Standards of Conduct).

6. SERVICE STANDARDS AND PERFORMANCE MANAGEMENT

6.1 The Lead Commissioner shall use all reasonable endeavours to procure that the Services under this Agreement are carried out in accordance with national and local standards:

6.1.1 the agreed set of standards that apply to the Services and specific aspects of the Services, as set out in Schedule 8 (Standards of Conduct); and

6.1.2 each Party's respective standing orders and standing financial instructions,

and will be monitored by applicable bodies / regulators, e.g. the Care Quality Commission, Monitor.

6.2 Without prejudice to Clause 6.1 above, the Lead Commissioner shall exercise its duties, obligations and functions arising out of or in relation to this Agreement effectively, efficiently, fairly and in good faith.

6.3 The Lead Commissioner shall report to the Joint Commissioning Board as required on the operation of the Arrangements (which, to avoid doubt, shall include but not be limited to, the operation of the Services and performance levels against agreed performance measures, targets and priorities) and the exercise of the Functions by the Lead.

6.4 The Parties shall agree the format of, and the content to be included in, the reports to the Joint Commissioning Board referred to at Clause 6.3 above. Any disagreement as to the format of the content to be included in the reports may be referred to the Joint Commissioning Board for its determination and/or instruction.

6.5 The Joint Commissioning Board shall ensure that Service Users and their families fully participate at all levels of the Lead's work under these Arrangements and that an annual evaluation of the Lead takes place and includes outcomes which are qualitative as well as quantitative.

7. LEAD COMMISSIONING STRUCTURE

7.1 The CCG's Chief Operating Officer shall have overall responsibility for the carrying out of the functions for the CCG client groups.

7.2 The Council's Director of Adult Social Care shall have overall responsibility for the carrying out of the functions for the Council commissioned client groups.

7.3 The management structure for lead commissioning is out in Schedule 10

7.4 The parties may agree changes in the lead commissioning structure in writing in accordance with clause 15. Such changes shall only be made in accordance with all applicable low and guidance after such consultation as shall be required by law and guidance.

8. GOVERNANCE AND MONITORING ARRANGEMENTS

8.1 The Parties shall jointly monitor the effectiveness of the Arrangements.

8.2 The Parties agree that they shall establish and maintain the Joint Commissioning Board, whose role and function shall be as described at Schedule 7 (the Joint Commissioning Board). The Joint Commissioning Board 's terms of reference shall be reviewed by the Parties on an annual basis and, if necessary, amended to ensure that the Joint Commissioning Board continues to assist the Parties to meet the aims and objectives of the Arrangements.

8.3 The role of the Joint Commissioning Board is to manage and monitor the Council's/ CCG's role as Lead Commissioner, the exercise of the Functions and the application of the Contributions, the management and administration of the contributions, together with supporting the implementation of any strategic plan or variation to the Services as provided for in Clause 0 (Services).

Clinical and Corporate Governance

8.4 The CCG is subject to a duty of clinical governance, which (for the purposes of this Agreement) shall be defined as "*a framework through which it is accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish*".

8.5 The Council acknowledges that clinical governance (as described at Clause 0 above) applies to the treatment of NHS patients. Such patients are entitled to expect to receive services which are part of a clinical governance system irrespective of where they are treated.

8.6 The Arrangements will therefore themselves be subject to clinical governance obligations to the extent they are relevant to the process of commissioning the Services and the Lead will require that all Services are subject to clinical governance obligations relevant to the Services (as set out in Schedule 10 (Standards of Conduct)) and the Council shall use reasonable endeavours to co-operate with all reasonable requests from the CCG, which the CCG considers necessary in order to fulfil its obligations.

8.7 The Lead Commissioner shall comply with the principles and standards of corporate governance relevant to NHS Bodies and local authorities.

9. INSPECTION

The Parties shall co-operate with any investigation undertaken by the Care Quality Commission and/or the Audit Commission and/ or any regulatory authority/ body.

10. FINANCIAL ARRANGEMENTS

10.1 The Parties acknowledge that they are not entering into a Pooled Fund arrangement pursuant to section 75(2)(a) of the Act and Regulation 7 of the Regulations.

10.2 The Parties agree to adhere to the financial arrangements more fully set out in Schedule 6 (Resources) Part 1 (Financial Resources) of this Agreement.

10.3 The Lead Commissioner will be responsible for the proper management and auditing of the accounts and shall appoint an officer ("**the Contributions Manager**") to be responsible for managing and administering the Parties' Contributions to the extent required in Schedule 6 (Resources) Part 1 (Financial resources).

10.4 Any overspends or underspends that may occur throughout the term of this Agreement shall be dealt with according to the provisions of Part 2 (Overspends and Underspends) of Schedule 6 (Resources).

11. TREATMENT OF VAT

The Parties shall agree that their respective Contributions shall be treated, for VAT purposes, in accordance with the provisions set out in Schedule 6 (Resources) Part 3 (VAT Regime).

12. STAFFING ROLES

12.1 The Parties have agreed that the Arrangements shall be facilitated by the Staff covered by the joint resource set out in Schedule 9

12.2 The CCG / Council shall make available the level of staff resources required to carry out the CCG / Council functions in relation to the Lead Commissioner responsibilities.

12.3 Any mention needed to TUPE?

13. CONFLICTS OF INTEREST

13.1 No member of staff or representative of the commissioning organisation shall put themselves in a position whereby duty and private interest conflict. The parties' policies for identifying and managing conflicts of interest should be adhered to.

14. INDEMNITIES, LIABILITY AND INSURANCE

14.1 Nothing in this Agreement shall affect:

14.1.1 the liability of the CCG to the Service Users in respect of the CCG Functions; or

14.1.2 the liability of the Council to the Service Users in respect of the Council Functions.

14.2 Each Party (the "First Party") shall indemnify and keep indemnified the other Party (the "Second Party") and its officers, employees and agents against any damages, costs, liabilities, losses, claims or proceedings whatsoever, arising in respect of:

14.2.1 any damage to property (real or personal) including, but not limited to, any infringement of third party intellectual property, including patents, copyrights and registered designs;

14.2.2 any death or personal injury;

14.2.3 any fraudulent or dishonest act of employees;

14.2.4 any Service User complaint or investigation by the Parliamentary and Health Service Ombudsman or the Local Government Ombudsman or any similar entity,

arising out of or in connection with the Agreement, to the extent that such damages, costs, liabilities, losses, claims or proceedings shall be due directly or indirectly to any negligent act or omission, any breach of this Agreement or any breach of statutory duty by the First Party, its officers employees or

agents. Where the Parties are unable to agree any such apportionment of liability and consequential indemnity under this Clause 14 the disputes procedure in Clause 23 (Dispute Resolution) shall apply.

14.3 For the avoidance of doubt, the Second Party shall be under a duty to mitigate its losses in accordance with general principles of common law and the indemnity on the part of the First Party shall not extend to damage, cost, liability, loss, claim or proceedings incurred by reason of or in consequence of any negligent act or omission, misconduct or breach of this Agreement by the Second Party.

14.4 Each Party shall ensure that it maintains appropriate insurance arrangements in respect of employer's liability, liability to third parties and all other potential liability under this Agreement.

15. REVIEW AND VARIATION

15.1 If at any time during the term of this Agreement the Council or the CCG requests in writing any change to the Services described or the manner in which the Services are commissioned, then the provisions outlined in this Clause 15 shall apply.

15.2 The Party proposing the Variation ("the Proposer") shall provide a report in writing to the other Party (the "Report") setting out:

15.2.1 the Variation proposed;

15.2.2 the date upon which the Proposer requires it to take effect;

15.2.3 a statement of whether the Variation will result in an increase or decrease in Contributions by reference to the relevant component elements of the Service or Services the subject of change;

15.2.4 a statement on the individual responsibilities of the CCG and the Council for any implementation of the Variation;

15.2.5 a timetable for implementation of the Variation;

15.2.6 a statement of any impact on, and any changes required to the Services;

15.2.7 details of any proposed staff and employment implications; and

15.2.8 the date for expiry of the Report.

15.3 Following receipt by the receiving Party ("the Recipient") of the Report and allowing the Recipient 10 working days from receipt in which to consider the Report, the Parties shall meet to discuss the proposed Variation and acting reasonably and in good faith shall use reasonable endeavours to agree the Variation.

15.4 Where the Parties are unable to agree on the terms of the Variation then the Agreement may terminate in accordance with Clause 17.3.3

15.5 If agreement in principle is reached then the Parties shall confirm in writing their decision to proceed with the proposed Variation and shall agree a formal Variation to this Agreement.

15.6 All Variations made to this Agreement pursuant to this Clause 15 or otherwise shall be agreed between the Parties and made in writing.

16. CHANGE OF LAW

16.1 If at any time during the term of this Agreement a change to the manner in which a Service or the Services are commissioned is required by operation of NHS or Local Government law through statutes, orders, regulations, instruments and directions made by the Secretaries of State for Health and Local Government respectively or others duly authorised pursuant to statute or other changes in the law which relate to the powers, duties and responsibilities of the Parties and which have to be complied with, implemented or otherwise observed by the Parties in connection with the Functions for the time being, then the provisions outlined in this Clause 16 shall apply.

16.2 The Parties shall jointly investigate the likely impact of the required change on the Services and any other aspect of the Agreement and shall prepare a Report in writing, setting out:

16.2.1 the Variation proposed;

16.2.2 the date upon which it should take effect;

16.2.3 a statement of whether the Variation will result in an increase or decrease in Contributions by reference to the relevant component elements of the Service or Services the subject of change;

16.2.4 a statement on the individual responsibilities of the CCG and the Council for any implementation of the Variation;

16.2.5 a timetable for implementation of the Variation;

16.2.6 a statement of any impact on, and any changes required to the Services;

16.2.7 details of any proposed staff and employment implications; and

16.2.8 the date for expiry of the Report.

16.3 Where the Parties are unable to agree on the terms of the Variation then the Agreement may be terminated in accordance with Clause 17.3.3.

16.4 The Parties shall confirm in writing their decision to proceed with the proposed Variation and shall agree a formal Variation, in writing, to this Agreement.

17. TERMINATION

17.1 Either Party ("**the First Party**") may, at any time by notice in writing to the other Party, terminate this Agreement if the other Party is in default of its obligations under this Agreement (the **"Defaulting Party"**) and:

17.1.1 if such default is capable of remedy, fails to comply with a written notice from the First Party to remedy such default within a reasonable period (which shall be

specified in such written notice), such termination notice to take effect two (2) weeks from its date of receipt; or

17.1.2 if such default is not capable of remedy, such termination notice shall take effect upon receipt.

17.2 Either Party may terminate this Agreement:

17.2.1 for convenience, by giving no less than twelve (12) months' notice in writing to the other Party; or

17.2.2 immediately on written notice, if the other Party suffers an Event of Force Majeure and such event persists for more than twenty (20) Working Days following the service of the notice referred to at Clause 22.4.2;

17.3 Either Party ("**the First Party**") may terminate this Agreement by giving the other Party not less than 6 months' notice in writing if:

17.3.1 the First Party's fulfilment of its obligations hereunder would be in contravention of any guidance from any Secretary of State issued after the date hereof;

17.3.2 the fulfilment of the Arrangements would be ultra vires; or

17.3.3 the Parties are unable to agree a Variation to this Agreement in accordance with Clause 15 (Review and Variation) and/ or Clause 16 (Change of Law) so as to enable either/ both Parties to fulfil its/ their obligations in accordance with law and guidance.

18. EFFECTS OF TERMINATION

18.1 Upon termination of this Agreement for any reason whatsoever, the following shall apply:

18.1.1 termination of this Agreement shall have no effect on the liability of either Party to make payment of any sums due under this Agreement, nor any rights or remedies of either Party already accrued, prior to the date upon which such termination takes effect;

18.1.2 upon termination of this Agreement, the Parties agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities is carried out smoothly and with as little disruption as possible to individual Service Users, the Client Group as a whole, Staff, the Parties and third parties, in accordance with Schedule 12 (Winding Down Protocol); and

18.1.3 the Parties shall ensure that payment of the Contributions, including the handling of any potential remaining overspend or underspend, is carried out in accordance with the procedures set out in Schedule 12 (Winding Down Protocol).

18.2 Upon termination, but subject to the provisions of Schedule 12 (Winding Down Protocol), the Contributions shall continue to be used by the Lead Commissioner only to pay for any of the Services delivered by third parties under contracts approved by the Joint Commissioning Board until the earliest date at which such contracts can also be validly terminated.

19. CONFIDENTIALITY

19.1 Except as required by law and specifically pursuant to Clause 21 (Freedom of Information), each Party agrees at all times during the continuance of this Agreement and after its termination or expiry to keep confidential any and all information, data and material of any nature which either Party may receive or obtain in connection with the operation of this Agreement or otherwise relating in any way to the business, operations and activities of the other Party, its employees, agents and/or any other person with whom it has dealings including any Service User of either Party. For the avoidance of doubt this Clause shall not affect the rights of any workers under section 43 A-L of the Employment Rights Act 1996.

19.2 The Parties agree to provide or make available to each other sufficient information concerning their own operations and actions and concerning Service User information (including material affected by the DPA in force at the relevant time) to enable efficient operation of the Arrangements (which to avoid doubt shall include the Services).

20. DATA PROTECTION

20.1 The Parties acknowledge their respective duties under the DPA and shall give all reasonable assistance to each other where appropriate or necessary to comply with such duties.

20.2 To the extent that the Lead is acting as a Data Processor (as such term is defined in the DPA) on behalf of the CCG / Council, the Lead shall, in particular, but without limitation:

20.2.1 only process such Personal Data as is necessary to perform its obligations under this Agreement, and only in accordance with any instruction given by the CCG / Council under this Agreement;

20.2.2 put in place appropriate technical and organisational measures against any unauthorised or unlawful processing of such Personal Data, and against the

accidental loss or destruction of or damage to such Personal Data having regard to the specific requirements in Clause 0 below, the state of technical development and the level of damages that may be suffered by a Data Subject (as such term is defined in the DPA) whose Personal Data is affected by such unauthorised or unlawful processing or by its loss, damage or destruction;

20.2.3 take reasonable steps to ensure the reliability of employees who will have access to such Personal Data, and ensure that such employees are aware of and trained in the policies and procedures identified in Clauses 0, 0 and 0 below; and

20.2.4 not cause or allow such Personal Data to be transferred outside the European Economic Area without the prior consent of the CCG / Council.

20.3 The Lead shall ensure that Personal Data is safeguarded at all times in accordance with the DPA and other relevant data protection legislation, which shall include without limitation the obligation to:

20.3.1 perform an annual information governance self-assessment;

20.3.2 have an information guardian able to communicate with the Joint Commissioning Board, who will take the lead for information governance and from whom the Joint Commissioning Board shall receive regular reports on information governance matters including details of all data loss and confidentiality breaches;

20.3.3 (where transferred electronically) only transfer essential data that is (i) necessary for direct Service User care; and (ii) encrypted to the higher of the international data encryption standards for healthcare and the National Standards (this includes, but is not limited to, data transferred over wireless or wired networks, held on laptops, CDs, memory sticks and tapes);

20.3.4 have policies which are rigorously applied that describe individual personal responsibilities for handling Personal Data;

20.3.5have agreed protocols for sharing Personal Data with other NHS organisations and non-NHS organisations; and

20.3.6 have a system in place and a policy for the recording of any telephone calls, where appropriate, in relation to the Services, including the retention and disposal of such recordings.

21. FREEDOM OF INFORMATION

21.1 Each Party acknowledges that the other Party is subject to the requirements of the FOIA and each Party shall assist and co-operate with the other (at their own expense) to enable the other Party to comply with its information disclosure obligations.

21.2 Where a Party receives a "request for information" (as defined in the FOIA) in relation to information which it is holding on behalf of the other Party, it shall (and shall procure that its sub-contractors shall):

21.2.1 transfer the request for information to the other Party as soon as practicable after receipt and in any event within two (2) Working Days of receiving the request for information;

21.2.2 provide the other Party with a copy of all information in its possession or power in the form that the other Party requires within five (5) Working Days (or such other period as may be agreed) of the other Party requesting that information; and

21.2.3 provide all necessary assistance as reasonably requested to enable the other Party to respond to the request for information within the time for compliance set out in section 10 of the FOIA.

21.3 Where a Party receives a request for information which relates to the Agreement, it shall inform the other Party of the request for information as soon as practicable after receipt and in any event within two (2) Working Days of receiving the request for information.

21.4 If either Party determines that information must be disclosed pursuant to Clause 21.3, it shall notify the other Party of that decision at least two (2) Working Days before disclosure.

21.5 Each Party shall be responsible for determining at its absolute discretion whether the relevant information is exempt from disclosure or is to be disclosed in response to a request for information.

21.6 Each Party acknowledges that the other Party may be obliged under the FOIA to disclose information:

21.6.1 without consulting with the other Party; or

21.6.2 following consultation with the other Party and having taken its views into account.

22. FORCE MAJEURE

22.1 Where a Party is (or claims to be) affected by an Event of Force Majeure, it shall take all reasonable steps to mitigate the consequences of it, resume performance of its obligations as soon as practicable and use all reasonable efforts to remedy its failure to perform.

22.2 Subject to Clause 22.1, the Party claiming relief shall be relieved from liability under this Agreement to the extent that because of the Event of Force Majeure it is not able to perform its obligations under this Agreement.

22.3 The Party claiming relief shall serve initial written notice on the other Party immediately it becomes aware of the Event of Force Majeure. This initial notice shall give sufficient details to identify the particular event.

22.4 The Party claiming relief shall then either:

22.4.1 serve a detailed written notice within a further five (5) Working Days. This detailed notice shall contain all relevant available information relating to the failure to perform as is available, including the effect of the Event of Force Majeure, the mitigating action being taken and an estimate of the period of time required to overcome it; or

22.4.2 in the event it reasonably believes that the effects of the Event of Force Majeure will make it impossible for the Arrangements to continue, serve notice of this to the other Party and the Agreement will terminate in accordance with Clause 17.2.2 of this Agreement.

23. DISPUTE RESOLUTION

23.1 The Parties shall use their best efforts to negotiate in good faith and settle any dispute that may arise out of or relate to this Agreement. If any dispute cannot be settled amicably through ordinary negotiations, then it shall be referred to the Chief Executive of the Council and the Chief Executive of the CCG for discussion and resolution.

23.2 Each Party shall use all reasonable endeavours to reach a negotiated resolution to the dispute through the above dispute resolution procedure. If the dispute is not resolved, the Parties will use reasonable endeavours to settle it by mediation in accordance with the Centre for Effective Dispute Resolution (**"CEDR"**) Model Mediation Procedure (**"the Model Procedure"**).

23.3 To initiate the mediation, a Party must give notice in writing (**"ADR notice"**) to the other Party requesting a mediation in accordance with Clause 223.2.

23.4 The procedure in the Model Procedure will be amended to take account of:

23.4.1 any relevant provisions in this Agreement;

23.4.2 any other agreement which the Parties may enter into in relation to the conduct of the mediation (**"Mediation Agreement"**).

23.5 The costs of the mediation shall be met in equal shares by the Parties and will not be paid from the Contributions.

24. NOTICES

24.1 Any notice or communication in relation to this Agreement shall be in writing.

24.2 Any notice or communication to the Council shall be deemed effectively served if sent by registered post or delivered by hand to the Council at the address set out above and marked for the Chief Executive or to such other addressee and address notified from time to time to the Joint Commissioning Board for service on the Council.

24.3 Any notice or communication to the CCG shall be deemed effectively served if sent by registered post or delivered by hand to the address set out above and marked for the attention of the Chief Executive or to such other addressee and address notified from time to time to the Joint Commissioning Board for service on the CCG.

24.4 Any notice served by hand delivery shall be deemed to have been served on the date it is delivered to the addressee. Where notice is posted, it shall be sufficient to prove that the notice was properly addressed and posted and the addressee shall be deemed to have been served with the notice forty-eight (48) hours after the time it was posted.

25. EXCLUSION OF PARTNERSHIP AND AGENCY

25.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Parties or render either Party directly liable to any third party for the debts, liabilities or obligations of the other Party.

25.2 Save as specifically authorised under the terms of this Agreement, neither Party shall hold itself out as the agent of the other Party.

26. ASSIGNMENT AND SUB-CONTRACTING

This Agreement, and any right and conditions contained in it, may not be assigned or transferred by either Party without the prior written consent of the other Party, except to any statutory successor to the relevant function.

27. THIRD PARTY RIGHTS

The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Parties to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that act.

28. COMPLAINTS

28.1 Any complaints relating to Council Functions shall be dealt with in accordance with the statutory complaints procedure of the Council.

28.2 Any complaints relating to the CCG Functions shall be dealt with in accordance with the statutory complaints procedure of the CCG.

28.3 Insofar as any complaint may relate to the content of this Agreement or to the operation of the Arrangements, such complaints shall be referred to the Joint Commissioning Board or such Joint Commissioning Board member or sub-committee made up of Joint Commissioning Board members as it nominates for the procedure adopted by it for the handling of complaints to be carried through.

28.4 All complaints shall be reported by the Parties to the Joint Commissioning Board.

29. ENTIRE AGREEMENT

This Agreement constitutes the entire agreement and understanding of the Parties and supersedes any previous agreement between the Parties relating to the subject matter of this Agreement.

30. SEVERABILITY

If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

31. WAIVER

31.1 The failure of any Party to enforce at any time or for any period of time any of the provisions of this Agreement shall not be construed to be a waiver of any such provision and shall in no matter affect the right of that Party thereafter to enforce such provision.

31.2 No waiver in any one or more instances of a breach of any provision hereof shall be deemed to be a further or continuing waiver of such provision in other instances.

32. COSTS AND EXPENSES

Each Party shall be responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

33. GOVERNING LAW AND JURISDICTION

Subject to the provisions of Clause 23 (Dispute Resolution) this Agreement shall be governed by and construed in accordance with English Law, and the Parties irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

34. FAIR DEALINGS

The parties recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that if in the course of the performance of this Agreement, unfairness to either of them does or may result then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

SIGNATURE PAGE

SIGNED by: **DR CHRISTA BEESLEY** .....

for and on behalf of **BRIGHTON & HOVE** (Signature)

CLINICAL COMMISSIONING GROUP .....

(Date)

WITNESS:

Signature .....

Name .....

Address:
LANCHESTER HOUSE
TRAFALGAR PLACE
BRIGHTON
BN1 4FU

Occupation: **CLINICAL ACCOUNTABLE OFFICER**

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

for and on behalf of **BRIGHTON & HOVE CITY** (Signature)

COUNCIL .....

(Date)

WITNESS:

Signature .....

Name .....

Address .....

.....

.....

.....

(PLEASE COMPLETE IN CAPITALS)

SCHEDULE 1

AIMS AND OUTCOMES

1. The Parties wish to use this Agreement to enable the Lead Commissioning arrangements for 7 designated service areas.

2. Without prejudice to the other provisions of this Agreement, the primary objective of the Parties in entering into this Agreement is to improve the commissioning of the services by:-

   2.1 analysing local needs, gaps in current service provision and capacity and demand issues, so as to ensure investment is targeted and cost effective;

   2.2 commissioning integrated services and seamless care pathways, which will improve outcomes and service user / carer experience of the services; and

   which shall be achieved by (without limitation)

   2.3 synergising business planning, reporting procedures and other bureaucratic requirements between the Parties;

   2.4 aligning budgets to improve the efficiency and cost-effectiveness of service provision/ commissioning;

   2.5 improved team working and priority setting;

   2.6 a higher level of accountability via the Joint Commissioning Board.

SCHEDULE 2

CCG FUNCTIONS

1. For the purposes of this Schedule 2 (CCG Functions), Schedule 3 (Council Functions) and Schedule 4 (Excluded Functions), reference to legislation and provisions within such legislation mirrors the references contained in the Regulations as at the Commencement Date, and shall be deemed to include any and all replacement and amending legislation and provisions as may come into force from time to time whether prior to or following the Commencement Date.

2. The NHS functions are:

   2.1 The function of providing, or making arrangements for the provision of, services:

      2.1.1 under sections 2 and 3(1) of the National Health Service Act 1977, including rehabilitation services and services intended to avoid admission to hospital; and

      2.1.2 under section 5(1), (1A), and (1B) of, and Schedule 1 to, the National Health Service Act 1977;

   2.2 The functions under sections 117 and 130A of the Mental Health Act 1983;

   2.3 The functions of making direct payments under:

      2.3.1 section 12A(1) of the National Health Service Act 2006 (direct payments for health care); and

      2.3.2 regulation 2(7) of the National Health Service (Direct Payments) Regulations 2010; and

      2.3.3 the functions under Schedule A1 of the Mental Capacity Act 2005.

SCHEDULE 3

COUNCIL FUNCTIONS

The health-related functions are–

1. The functions specified in Schedule 1 to the Local Authorities Social Services Act 1970 except for those Functions listed at Schedule 4 (Excluded Functions);

2. The functions under sections 7 or 8 of the Disabled Persons (Services, Consultation and Representation) Act 1986;

3. The functions of providing, or securing the provision of recreational facilities under section 19 of the Local Government (Miscellaneous Provisions) Act 1976;

4. The functions of local authorities under the Education Acts as defined in section 57 of the Education Act 1996;

5. The functions of local housing authorities under Part I of the Housing Grants, Construction and Regeneration Act 1996 and under Parts VI and VII of the Housing Act 1996;

6. The functions of local authorities under section 126 of the Housing Grants, Construction and Regeneration Act 1996;

7. The functions of waste collection or waste disposal under the Environmental Protection Act 1990;

8. The functions of providing environmental health services under sections 180 and 181 of the Local Government Act 1972;

9. The functions of local highway authorities under the Highways Act 1980 and section 39 of the Road Traffic Act 1988;

10. The functions under section 63 (passenger transport) and section 93 (travel concession schemes) of the Transport Act 1985;

11. Where the Parties enter into arrangements under regulation 7(1) or 8(1) in respect of the provision of accommodation under sections 21 or 26 of the National Assistance Act 1948, the function of charging for that accommodation under section 22, 23(2) or 26 of that Act, or

12. Where the Parties enter into arrangements under regulation 7(1) or 8(1) in respect of the provision of a service under any enactment mentioned in section 17(2)(a) to (c) of the Health and Social Services and Social Security Adjudications Act 1983, the function of charging for that service under that section.

SCHEDULE 4

EXCLUDED FUNCTIONS[10]

1.1 CCG Functions shall not include the following:

1.1.1 surgery;

1.1.2 radiotherapy;

1.1.3 termination of pregnancies;

1.1.4 endoscopy;

1.1.5 the use of Class 4 laser treatments and other invasive treatments; and

1.1.6 emergency ambulance services; and

1.2 The Council Functions shall not include any functions pursuant to the following:

1.2.1 subject to Regulation 6(k) of the Regulations, sections 22, 23(3), 26(2) to (4), 43, 45 and 49 of the National Assistance Act 1948;

1.2.2 sections 6 and 7B of the Local Authorities Social Services Act 1970;

1.2.3 section 3 of the Adoption and Children Act 2002;

1.2.4 sections 114 and 115 of the Mental Health Act 1983;

1.2.5 section 17 of the Health and Social Services and Social Security Adjudications Act 1983;

1.2.6 the Registered Homes Act 1984; and

1.2.7 Parts VII to X and section 86 of the Children Act 1989,

Or any other functions that are specified in the Regulations as amended from time to time as being excluded from section 75 arrangements.

2.1 To avoid doubt:

2.1.1 All functions that are not specified as either Council Functions in Schedule 3 or CCG Functions in Schedule 4 of this Agreement shall be Excluded Functions; and

2.1.2 Any Functions of either Party that do not relate to or benefit any individual falling within the Client Group shall be Excluded Functions.

10

SCHEDULE 5

THE SERVICES

Part 1: The Services

5.1 Integrated Community Equipment Service

5.1.1. Scope of the Service

The provider is jointly commissioned and funded by NHS Brighton & Hove (Brighton & Hove Primary Care Trust) and Brighton & Hove City Council, with the City Council acting as lead commissioner. There is a section 75 provider to provider agreement which details provision of staff and buildings. There is a section 75 agreement between Brighton & Hove City Council and the PCT for the joint commissioning of the ICES service, which includes funding for equipment. The equipment budget is currently aligned, with separate accounting systems.

5.1.2. Service Provision

Aim

To provide Section 75 Integrated Community Equipment Store delivering daily living and community health equipment and minor adaptations to across all tenures to adults and children who meet the accessibility criteria for the service

Objectives

- To maximise independence, choice and control and maintain people within their own homes
- To reduce need for provision of care packages and where this is not possible, support appropriate reduction in level and duration by the timely provision of equipment and minor adaptations
- To prevent avoidable admission to hospital or residential care
- To support timely discharge from acute hospital settings, residential and community care settings
- To support and enhance the quality of care provided by formal and informal carers to service users.

5.1.3. Service Description

The provider is commissioned to provide:

Community health equipment: Pressure care and posture management, toileting items required for medical reasons specified in the ICES standard stock list

Daily living equipment for adults and children, including sensory items as specified in the ICES standard stock list or approved as a special or non stock item through the Exceptions Panel.

In addition, the provider is commissioned to provide advice and information regarding minor adaptations, community health equipment and daily living equipment to service users and prescribers.

The ICES provider is not responsible for any clinical aspects of decision making around provision of equipment beyond verifying that the requisition has been provided by an authorised prescriber and agreed by the Exceptions Panel where necessary.

The ICES provider is not responsible for budgetary decisions around the provision of equipment and minor adaptations beyond ensuring efficiency, best value for money procurement process and monthly reporting of relevant financial information to prescribing managers and commissioners.

5.1.4. Eligibility/ Geographic coverage/boundaries

Social care equipment: All service users must have a permanent and substantial disability and be ordinarily resident within the Brighton & Hove Local Authority boundary or the responsibility of Brighton & Hove if placed outside the boundary.

Adults must meet the Brighton and Hove City Council Fair Access to Care Services criteria for equipment.

Children must have a physical and /or learning disability that affects their independence as a result of a medical condition, syndrome or trauma, or there must be evidence that they are in receipt of a disability benefit indicating a severe loss of function and independence.

Health equipment: Service users must be registered with a GP practice within the NHS Brighton and Hove boundary.

5.1.5. Budgetary Details

Budget Contributions				
Basis of Contract	**Unit of Measurement**	**Price**	**Thresholds**	**Expected Annual Contract Value (for this service)**
ASC contribution	Staff Other Equipment	£210,892 £75,718 £349,604		**£ 636214**
PCT contribution	Staff Other Equipment	£366,659 £104,760 £392,849		**£ £872998**
Total				**£1,509,212**

5.1.6. Commissioning and Governance

The CCG and ASC has a lead commissioner responsibilities for jointly commissioning Integrated Community Equipment. Decisions regarding funding allocation have been delegated to Joint Commissioning Board.

5.2 Carers Support Services

5.2.1 Scope of the Service

5.2.1.1 In the 2001 Census 21,800 (9% of the total population) identified themselves as Carers. In Brighton and Hove over 4,000 people (19%) cared for more than 50 hours a week. More than half of the carers in the city are aged 50 years or over. Of people aged 85 years or over, 5% provided some form of unpaid care, 50% of whom provided 50 hours or more.

5.2.1.2 Under the Carers (equal opportunities) Act 2004, local authorities are required to inform carers that they are eligible for an assessment of their needs and support requirements and make provision to meet these needs. In 2011/12 Brighton & Hove City Council carried out 1,430 Carers Assessments (970 separate Carers Assessments and 460 Carers who were jointly assessed with the person they care for). Of these 1,136 (79%) received carers services as a result.

5.2.1.3 Brighton and Hove has a Multi-Agency Commissioning and Development Strategy for Carers, the strategy identifies the key priorities and outcomes for Brighton and Hove City Council; Brighton and Hove Clinical Commissioning Group; NHS Sussex; Sussex Community NHS Trust; and Sussex Partnership Foundation Trust. In Nov'11 the Joint Commissioning Board agreed the refreshed strategy. http://www.brighton-hove.gov.uk/index.cfm?request=c1152568.

5.2.1.4 The local strategy echoes the national Carers Strategy priorities – Identification and Recognition of carers; Realising and Releasing Potential; A Life Outside of Caring; Supporting Carers to Stay Healthy; and Young Carers. Additionally Brighton and Hove recently published a Carers Plan which pulls together information regarding the strategy; the recently completed Carers Needs Assessment; as well as the current funding commitments for the provision of support for carers locally.
http://www.brighton-hove.gov.uk/index.cfm?request=c1152568

5.2.1.5 Brighton and Hove provides a range of services, both within the statutory and voluntary sector to support the needs of carers locally, some are commissioned jointly and others are solely funded by either Health or Adult Social Care (City Council). These are summarised within section 2 and 3.

5.2.2 Service Details

The services listed here at section 2 and 3 are correct for 2012/13 and may be varied by written agreement between the Partners from time to time.

Voluntary Sector Services commissioned by Adult Social Care and Health

Service	Health (£)	Adult Social Care (£)	Total (£)	Notes

5.2.3. Statutory Services commissioned by ASC and Health

Service	Health (£)	Adult Social Care (£)	Total (£)	Notes

Service	Health (£)	Adult Social Care (£)	Total (£)	Notes

5.2.4. Commissioning and Governance

The PCT and ASC has a lead commissioner responsibilities for jointly commissioning services for carers. Decisions regarding funding allocation have been delegated to Joint Commissioning Board.

5.3 Older People/People with a Physical Disability

Scope of the Service

This section outlines all services for older people and people with a physical disability where

a) There are jointly commissioned services in place (NB Community Short Term Services are part of a separate Section75 agreement)
b) There are services funded by both CCG and BHCC
c) Services funded by the CCG only and which are monitored by BHCC contracts unit

5.3.1. Role of Council Adult Social Care with regard Section 75

Adult Social Care Contracts Unit: The Contracts Unit monitor contracts on behalf of the CCG. Funding for this is detailed in a separate Memorandum of Understanding.

Adult Social Care Commissioning & Partnerships Team: The team commission services jointly with a range of commissioners, including Health commissioners. Funding for Joint Commissioning is separately reported.

Details of Commissioning Manager below (as an example of joint commissioning activity).

Care Homes

- To co ordinate the commissioning of care homes, both residential and nursing in the city for older people.
- To lead, but work closely with the CCG commissioning manager (dementia) on the commissioning of care homes, both residential and nursing in the city for older people with mental health needs.

Activity includes:
Service specification (also includes working with Continuing Health Care)
Provider relations
Response to Planning
Fee reports
Lead on joint governance

Short Term Services

- To support CCG commissioning of joint service.
- To lead on activity that primarily involves the Council as provider.

Activity includes:
Active participation in discussions and attendance at a arrange of meetings
Contribution to governance

Shared Lives

- To lead on the commissioning of Shared Lives across the city for all client groups.
- With regard mental health to work closely with the CCG commissioning manager (mental health).

Activity includes:
Service specifications
Provider relations
Active participation in discussions and attendance at a arrange of meetings
Contribution to governance

Older People

- To co ordinate with a range of CCG commissioners services for older people, to ensure activity is joined up.

Activity includes: Service specifications Provider relations Active participation in discussions and attendance at a arrange of meetings Contribution to governance

Self Directed Support

- To co ordinate with a range of CCG commissioners services that support direct payments.
- To co ordinate with a range of CCG commissioners services that support a development of a market fit for personalisation.

Activity includes: Service specifications Provider relations Active participation in discussions and attendance at a arrange of meetings including those on Personal Health budgets Contribution to governance

Other

To contribute to positive joint working

Activity includes: Attendance at team meetings – approximately one in three

As well as Adult Social Care, other Council Directorate and teams commission services that support individual's health and wellbeing, most notable are probably Public Health and Community teams.

5.3.2 Adult Social Care Services

The aim of adult social care services is to enable residents who are eligible for social care funding to:

- gain maximum independence
- make choices about their care
- stay healthy and safe and
- increase their ability to participate in family and community life.

Adult social care fulfils the council's statutory duties in respect of vulnerable adults under the National Assistance Act 1948 and subsequent related legislation. Councils are required to complete a thorough assessment of an individual's needs and to meet these assessed needs in the most cost effective manner by providing community care services. The eligibility criteria are set by the Department of Health's Fair Access to Care Services (FACS). Councils have a duty to provide information and advice for residents who are not eligible for adult social care.

5.3.3 Service Details

The services listed below are correct at 12/13 and may be varied by written agreement between the partners from time to time. Services listed below are as follows:

- Assessment Team and Care Matching Team
- Care Homes
- Home Support, Community and Voluntary Services
- Physical Disability
- Information and Advice
- Advocacy
- Personalisation and Support – including telehealth/telecare
- Governance

5.3.4 Assessment Teams/Care Matching Team

- **BHCC Adult Social Care Assessment team**
  Role of teams - Assess individuals and arrange care in contracted services. Monitor individual service users. Lead on safeguarding. Lead on provision of Adult Social Care information and advice.

  Teams within the assessment function:
  Access Point
  Assess & Reablement team
  Independent Living
  Review
  Planned Intervention & Response
  Hospital Discharge Service
  Hospital Rapid Discharge Service
  Hospital Assessment Service
  Short Term Services

- **Care Matching Team**

  The Care Matching Team is managed as part of the Assessment teams.
  Role of team - the Care Matching Team is responsible for managing placements in continuing health care beds, nursing care beds, residential beds and homecare packages.
  CCG pays £22,280 (50% of manager).
  Continuing Health Care also contribute to Care Matching Team Support £24,240.

- **Funding: Assessment & Care Matching Team**

	Health (£)	Adult Social Care (£)	Total (£)	Notes

- The Community Care budget funds services to support people meet their individual needs. This includes nursing home placements, residential care placements, shared lives and other accommodation, personal budgets, home care and day services.

- In order to provide some services the Council may 'top slice' the Community care budget. This funding may be used to fund 'preventative' services via a range of contractual arrangements eg 'block contractual arrangement for a building based day service.

- Main stream Adult Social Care budget contributes to the cost of in-house services.

- CCG currently contribute a grant to Sycamore Court.

- All nursing homes receive the Registered Nursing Care Contribution (RNCC) and continence payments.

5.3.5 Care Homes

- Both in the city and outside the city, care is commissioned in a number of care homes. Out of city placements are funded by the Council, but the Health costs are paid by the local area.

- The Council's Commissioning Support Unit are responsible for monitoring quality in a range of homes, excluding community short term beds. The clinical quality review nurse is responsible for monitoring quality in nursing homes. The clinical quality review nurse is funded by the CCG.

- The Care Matching Team is responsible for managing placements in continuing health care beds, nursing care beds, residential beds and homecare packages.

- Some services e.g. Craven Vale and Knoll House will be included in the S75 for Community Short Term Service section. (some detail also below)

	Health	Council	Total	Comment

	Health	Council	Total	Comment

	Health	Council	Total	Comment

5.3.6 Home Support, Day, Community and Voluntary

- Home care in the main is commissioned by the Council who are also responsible for procurement and contract monitoring. Continuing Health Care commission some home care placements.

- CCG joint commission some home care to support short term services. The Council and CCG jointly procure these services and the Council contract monitors.

- Some services eg Age UK Crisis will be included in the Section 75 for Community Short Term Service

Provider	Name of service	Start date of original contract	Start date of current contract	End date	Council contract sum 12/13	Health funding 12/13	Total contract Sum 12/13	Lead commissioner	Procurement and contract	Contract monitoring

5.3.7 Physical Disability

- Overlap with Carers e.g. Headway

Provider	Name of service	Start date of original contract	Start date of current contract	End date	Council contract sum 12/13	Health funding 12/13	Total contract Sum 12/13	Lead commissioner	Procurement and contract	Contract monitoring

5.3.6 Information and Advice including Governance

- There are many information and Advice type contract that Health has with parts of the Council other that Adult Social Care.

Provider	Name of service	Start date of original contract	Start date of current contract	End date	Council contract sum 12/13	Health funding	Total contract Sum 12/13	Lead commissioner	Procurement and contract	Contract monitoring

5.3.7 Advocacy

Provider	Name of Service	Start date of original contract	Start date of current contract	End Date	Council Contract Sum 12/13	Health Contract Funding 12/13	Total Contract Sum 12/13	Lead commissioner	Procurement and Contract	Contract Monitoring

5.3.8 Telecare and Telehealth

There is scope for commissioners to work jointly on the developments in Telecare & Telehealth:

Over the next three years, the Council and CCG are keen to explore the opportunities for greater integration in the area of personalisation and support. With a growing focus on individualised care, personal health budgets etc. there are benefits in doing this in as joined up a way as possible to ensure greater efficiency and innovation. We will be developing shared plans around telecare/telehealth and exploring a joint approach to the management of personal budgets over the duration of this agreement and will update the service schedules accordingly as part of the routine annual review.

TELEHEALTH

Telehealth devices can empower patients to take more control of their health and be more independent. Telehealth systems can be used to support people with long-term health conditions, such as diabetes, heart failure and chronic obstructive pulmonary disease. Blood pressure, blood glucose, weight and other vital signs can be measured in the person's home and sent confidentially to a response centre or health professional. This enables health professionals to identify any changes or deterioration in a person's condition and take appropriate action to prevent the need for hospital admission. Telehealth has proven to reduce GP visits and hospital admissions.

A recent Telehealth study by Kent County Council reported significant benefits from Telehealth in supporting long term conditions - COPD, coronary heart disease and diabetes mellitus.

https://shareweb.kent.gov.uk/Documents/adult-Social-Services/professionals-and-projects/WSD/Telehealth%20Full%20Report%20FINAL_Layout%201.pdf

Other study examples include Stoke-on-Trent:

http://www2.hull.ac.uk/administration/pdf/NHS%20Stoke%20report%20(Final).pdf

BHCC Adult Social Care – Telecare Development Update

The city Council recognises the increasing role that Telecare technologies have in supporting service users with a broad range of needs to increase independence, manage risks in the home environment and avoiding or delaying the need for additional social care and health services. The Council has a well established in-house Telecare provider CareLink Plus with approximately 6,000 customers, comprising of 3,500 people living independently in the community and the remainder living in sheltered or supported accommodation.

The provision of Telecare reflects the national drive for more preventative, community-based care. Telecare can help prevent admission to hospital or support with hospital discharge. Telecare can also help minimize or delay the need for home care or care home provision.

The economic benefits of Telecare are evident. An external CSED evaluation of 69 Council Telecare users in receipt of a Telecare service during the period between October 2009 and January 2010 estimated that, for the sample group total savings were made in Social Care in the range of £640,117 to £711,241 and NHS provision in the range of £51,045 to £56,717. Of the sample using Telecare 50 users were avoiding the escalation of further support by using Telecare; 16% avoided an increase in home care, 44% avoided NHS provision, 32% avoided reablement and 32% avoided residential care.

A Telecare steering group was established in 2011 to raise the raise the profile and promote the use of Telecare. The group created Telecare champions across adult social care to imbed thinking and referrals for Telecare. The group also provided staff training events, produced demonstration and Telecare display kits and ensured that adult social care assessment funding panels consider the need for Telecare.

In October 2012 a dedicated project manager (Joel Caines) was appointed to further raise the profile of Telecare in Brighton & Hove and increase the number of users of Telecare. A project plan has been signed-off with the overall objectives:

- **Marketing** what we do to raise the profile of Telecare and increase engagement
- Establish an effective **infrastructure** and **performance regime** to ensure we have the right resources to facilitate Telecare growth and manage performance
- Conduct Market **Research** around Telecare to ensure we are using the right solutions to meet needs
- Work in **partnership** with colleagues across the Council and externally to maximise the potential of Telecare
- **Support and develop staff** skills, knowledge and experiences of Telecare

The project will seek to raise the profile of Telecare via a 2013 marketing campaign as well as working with the independent, voluntary and public sector partners to increase referrals for Telecare. New and emerging technologies such as devices which use GPS satellite technologies are being explored which can support people in the community and can be used to locate someone in times of distress. The project seeks to learn from national developments such as the *3 million lives campaign* and explore links with the telehealth agenda.

5.3.9 Governance

- Decisions taken by Adult Care & Health Committee: Joint commissioning decisions affecting services where the majority spend is Council's Adult Social Care e.g. care homes. The decision is then noted and ratified by the Joint Commissioning Board.

- Decisions taken by the Joint Commissioning Board:
  a) Where joint commissioning decisions and comparable joint funding arrangements exist.
  b) Where the majority of spend is CCG and where joint commissioning decisions affecting services exist.

- Commissioners share information and governance arrangements for some services (mechanism to be reviewed)

5.4 Learning Disability Services

5.4.1 Scope of the Service

Adult Social Care are the Lead Commissioner for Learning Disability Services. These services are not in the scope of the section 75 agreement. However, because of the close links between learning disability and mental health, and the need for reasonable adjustments across all health services for people with a learning disability, it is important to document joint working and funding arrangements.

The commissioning plan for learning disability services will be reviewed in the New Year and there is an intention to produce a market position statement which will outline how services will be developed in the future.

5.4.2 Service Details

The services listed here at section 2 and 3 are correct for 2012/13 and may be varied by written agreement between the Partners from time to time.

Assessment Services: (see Table below - 2.4.) The health staff in the Community Learning Disability Team (CLDT) are currently funded by SPFT through a block contract from the CCG.

The community care budget for the CLDT is managed in Adult Social Care. The Community Care budget funds the following:

- Residential placements
- Respite services
- Shared Lives placements
- Supported accommodation
- Home Care support
- Direct payments
- Day services

5.4.3 Table: Services Provided by the Council (Assessment Services)

Service	Health (£)	Adult Social Care (£)	Total (£)	Notes

5.4.4 Table: Services Provided Directly by the Council (Provider Services)

Service	Health (£)	Adult Social Care (£)	Total (£)	Notes

Continuing Health Care Funding: The CCG fund service users living in group homes managed by the council including Old Shoreham Road, Leicester Villas, Beach House, Hawkhurst Road, Windlesham Road and day options (Total £700,822)

5.4.5 Voluntary Sector Services Commissioned by Adult Social Care and Health

Service	Health (£)	Adult Social Care (£)	Total (£)	Notes

5.4.6 Commissioning and Governance

5.4.6.1 Relevant reports for people with a learning disability will continue to be presented at Joint Commissioning Board.

5.4.6.2 Joint commissioning and governance arrangements for the health element of Learning disability services need to be clarified. All generic services commissioned by health are required to make reasonable adjustments for people with learning disability.

5.4.6.3 The current Block contract between the CCG and SPFT for the Community Learning Disability Team has no KPIs or monitoring data on Learning Disabilities.

5.5 Adult Mental Health Services

5.5.1 Scope of the Service

Services will be commissioned to meet the mental health and well-being needs of adults aged 18 and over. Health and social care budgets are utilised to fund services from a range of providers through a range of different contractual arrangements. Some of the contracts are joint contracts (Health & Adult Social Care) and others are solely Health or solely Adult Social Care contracts.

The services are available to residents aged 18 or over registered with a Brighton and Hove GP and any Brighton and Hove resident not registered with a GP.

A Joint Commissioning Strategy for Mental Health for Adults outlines the strategic approach to the development of services in Brighton and Hove and provides a framework for service development. The document is available at the following link:
http://www.brightonandhovepct.nhs.uk/about/commissioning/documents/MentalHealthJointCommissioningStrategyforAdults2010-2013_2_.pdf

A summary of services commissioned under this agreement are detailed in section 2. Each service commissioned has a service specification which contains the detail of the service to be delivered, access criteria and performance management arrangements. Decisions in terms of significant change to services provision, for example through de-commissioning and re-commissioning processes will be approved by the Joint Commissioning Board.

5.5.2 Service Details

5.5.2.1 The services listed here at section 2 are correct at 1 April 2013 and may be varied by written agreement between the Partners from time to time.

5.5.2.2 **Services provided by Sussex Partnership Foundation Trust (SPFT) services (correct for 2012-13)**
Services are managed and delivered in an integrated way by SPFT.

Service	Health (£)	Adult Social Care (£)	Total (£)	Notes
Secure & Forensic				
Working Aged Services				

5.5.2.3 **Community Care Budget**

The Community Care budget is managed by SPFT under the terms of the Section 75 agreement between Brighton & Hove City Council and SPFT. The budget is sourced from Health and Adult Social Care funds. There is a 50:50 risk share between Brighton and Hove City Council & SPFT on any under/over-spends against this budget, and the details of this arrangement are described in the B&H City Council & SPFT Section 75 agreement.

	Health (£)	Adult Social Care (£)	Total (£)	Notes

The Community Care budget funds the following:

- Nursing home placements
- Residential care placements
- West Pier Hostel - joint contract with the Housing Department
- Wayfield Avenue – how is this funded?
- Shared Lives placements
- Home Care
- Day Care

5.5.2.4 **Services provided by the Mental Heath Partnership** (Brighton and Hove Integrated Care Service, SPFT, 7 GP practices in Brighton and Hove, MIND in Brighton and Hove and Turning Point)

	Health (£)	Adult Social Care (£)	Total (£)	Notes

Total				

5.5.2.5 **Community & Voluntary Sector Provision**

Community & Voluntary Sector Provision Organisation	Description	Health (£)	Adult Social Care (£)	Total (£)	Notes

Community & Voluntary Sector Provision Organisation	Description	Health (£)	Adult Social Care (£)	Total (£)	Notes

5.5.3 Specialist Placement Budget

5.5.3.1 specialist placements budgets is held by the CCG. The total budget is X and is operated... (To be agreed after discussions with other CCG's and LAT). The services include:

- Complex and/or Refractory Disorder Services
- Specialised Services for Asperger's Syndrome and Autism Spectrum Disorder (Need to check with Anne Hagan where this sits and approval process)

5.5.3.2 This budget exists in addition to the specialised commissioning budget for which is held by the National Commissioning Board and covers "Prescribed Services" which are:

- Specialised Services for Eating Disorder – inpatient services only
- Forensic & Secure Mental Health Services – high secure, medium secure, low secure inpatient services
- Specialised Mental Health Services for Deaf Adults – inpatient services
- Gender Identity Disorder Services – assessment, treatment & surgery
- Specialised Perinatal Services – pre-pregnancy assessment of women with severe mental illness and inpatient Mother and baby units.
- Tier 4 Severe Personality Disorder Services

5.5.4. Commissioning and Governance:

5.5.4.1 The CCG has lead commissioning responsibilities for Adult Social Care mental health services. Issue to be addressed – the CCG's block contract with SPFT does not cover Adult Social Care services and this needs to be addressed.

4.1 Decisions Regarding Funding Allocation have been delegated to the Joint Commissioning Board

Service	Health (£)	Adult Social Care (£)	Total (£)	Notes
Secure & Forensic				
Working Aged Services				
Older Adults				

Service	Health (£)	Adult Social Care (£)	Total (£)	Notes
Total				

5.5.3 Community Care Budget

The Community Care budget is managed by SPFT under the terms of the Section 75 agreement between Brighton & Hove City Council and SPFT. The budget is sourced from Health and Adult Social Care funds. There is a 50:50 risk share between Brighton and Hove City Council & SPFT on any under/over-spends against this budget, and the details of this arrangement are described in the B&H City Council & SPFT Section 75 agreement.

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Service	Health (£)	Adult Social Care (£)	Total (£)	Notes

The Community Care budget funds the following:

- Nursing home placements
- Residential care placements
- West Pier Hostel - joint contract with the Housing Department
- Wayfield Avenue – how is this funded?
- Shared Lives placements

- Home Care
- Day Care

5.5.4 Services provided by the Mental Heath Partnership (Brighton and Hove Integrated Care Service, SPFT, 7 GP practices in Brighton and Hove, MIND in Brighton and Hove and Turning Point)

Service	Health (£)	Adult Social Care (£)	Total (£)	Notes

5.5.5 Community & Voluntary Sector Provision

Community & Voluntary Sector Provision Organisation	Description	Health (£)	Adult Social Care (£)	Total (£)	Notes

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Community & Voluntary Sector Provision Organisation	Description	Health (£)	Adult Social Care (£)	Total (£)	Notes
Total					

5.5.6 Specialist Placement Budget

A specialist placements budgets is held by the CCG. The total budget is X and is operated... (To be agreed after discussions with other CCG's and LAT). The services include:

- Complex and/or Refractory Disorder Services
- Specialised Services for Asperger's Syndrome and Autism Spectrum Disorder (Need to check with Anne Hagan where this sits and approval process)

This budget exists in addition to the specialised commissioning budget for which is held by the National Commissioning Board and covers "Prescribed Services" which are:

- Specialised Services for Eating Disorder – inpatient services only
- Forensic & Secure Mental Health Services – high secure, medium secure, low secure inpatient services
- Specialised Mental Health Services for Deaf Adults – inpatient services
- Gender Identity Disorder Services – assessment, treatment & surgery
- Specialised Perinatal Services – pre-pregnancy assessment of women with severe mental illness and inpatient Mother and baby units.
- Tier 4 Severe Personality Disorder Services

5.5.7 Commissioning and Governance:

5.5.7.1 The CCG has lead commissioning responsibilities for Adult Social Care mental health services. Issue to be addressed – the CCG's block contract with SPFT does not cover Adult Social Care services and this needs to be addressed.

5.5.7.2 We also need to agree the governance for monitoring the Commissioner to Commissioner Section 75 Agreement

5.6 Dementia Services

5.6.1 Scope of the Service

5.6.1.1 Services will be commissioned to meet the mental health and well-being needs of adults with dementia aged 18 and over. Health and social care budgets are utilised to fund services from a range of providers through a range of different contractual agreements. Some of the contracts are joint contracts (Health & Adult Social Care) and others are solely Health or solely Adult Social Care contracts.

The services are available to residents aged 18 or over registered with a Brighton and Hove GP and any Brighton and Hove resident not registered with a GP.

5.6.1.2 A Joint Commissioning Plan for Dementia outlines the local approach to implementing the National Dementia Strategy and provides a framework for service development. The document is available at the following link:
http://www.brightonandhove.nhs.uk/about/improving/index.asp

A summary of services commissioned under this agreement are detailed in section 2. Each service commissioned has a service specification which contains the detail of the service to be delivered, access criteria and performance management arrangements. Decisions in terms of significant change to services provision, for example through de-commissioning and re-commissioning processes will be approved by the Joint Commissioning Board.

5.6.2 Service Details

5.6.2.1 The services listed here at section 2 are correct at 1 April 2013 and may be varied by written agreement between the Partners from time to time.

5.6.2.2 **Services provided by Sussex Partnership Foundation Trust (SPFT) services**

Services are managed and delivered in an integrated way by SPFT. The details of the dementia specific services provided by SPFT are detailed in the mental health schedule.

5.6.3 Local authority provided

	Description	Health (£)	Adult Social Care (£)	Total (£)	Notes

5.6.4 Community Care Budget

The Community Care budget is managed by SPFT. The budget is detailed in the mental health schedule.

The Community Care budget funds the following:
Nursing home placements
Residential care placements
Shared Lives placements
Home Care
Day Care

5.6.5 Community & Voluntary Sector Provision

Community & Voluntary Sector Provision Organisation	Description	Health (£)	Adult Social Care (£)	Total (£)	Notes

Note this does not include services commissioned with Age UK for carer crisis support – need to cross reference with Carers

5.6.6 Memory Assessment Service -

	Health (£)	Adult Social Care (£)	Total (£)	Notes

5.6.7 Commissioning and Governance:

The PCT has lead commissioning responsibilities for [specify which elements of] dementia services. Issue to be addressed – the PCT's block contract with SPFT does not cover Adult Social Care services and this needs to be addressed.

Decisions regarding funding aloocation have been delegated to the Joint Commissioning Board

5. 7 Service: Short Term Services

5.7.1 Scope of the Service

Brighton and Hove Clinical Commissioning Group (formerly Brighton and Hove Primary Care Trust) and Brighton & Hove City Council jointly commission Short Term Services (STS) via a section 75 agreement. STS includes the following elements:

- Bed based and community STS (formerly intermediate care)
- Integrated rapid response service (including Community Rapid Response, Roving GP, OOHs District Nursing and Age UK Crisis)

5.7.2 Service Provision – Bed Based and Community STS

Aim

The Community Short Term Service supports people either in their own homes or in a bedded facility following a spell of illness. The service provides multidisciplinary short term intensive rehabilitation/reablement programmes to promote independence and support recovery from illness, prevent unnecessary admission to hospital or residential care and support timely discharge from acute hospital settings.

5.7.2.1 Objectives

The objectives of the service are to

- § prevent unnecessary admission to hospital or care home
- § support timely transfer from acute settings
- § provide multidisciplinary care, assessment and discharge planning for people identified as having short term rehabilitation/reablement goals as part of a planned programme of care, within a persons own home, current residence or in a CSTS bed
- § promote seamless care from the point of referral to discharge from the service, working closely with health and social care professionals and the voluntary and community sector
- § map a person's need to appropriate place of care
- § work flexibly to accommodate changes to a person dependency/need and the demands on the service
- § deliver high quality care through improved person and carer experience and outcomes.

5.7.2.2 Service Description

The service provides multidisciplinary short term intensive rehabilitation/reablement programmes to promote independence, faster recovery from illness, prevent unnecessary admission to hospital or residential care and support timely discharge.

The service is delivered to people meeting agreed criteria within their usual place of residence or in dedicated beds for a maximum period of 6 weeks between the hours of 8am and 8pm.

There will be continuous monitoring of a person's outcome and experience to inform service improvement.

For those people in bed based services 24 hour care is provided. Highgrove provides 24 hour nursing. Nursing requirements for people in bedded facilities without overnight nursing will be monitored and a solution will be developed if a need is identified.

The service is multidisciplinary and comprises social workers registered nurses, physiotherapists, occupational therapists, care officers, home care, rehab assistants and administrative staff.

Medical cover via GPs is provided by contract with B&H CCG via South East Health (SEH), providing out or hours nurse's support. There is also input from elderly care consultants from BSUH. Sussex Community Trust provides pharmacist support.

The service is available between 8am and 8pm, 7 days a week including bank holidays.

Bed based services are 24 hour provision as per location specifications and operational policies.

5.7.2.3 Responsibility for delivery of the service

The service is jointly provided by Sussex Community Trust, Brighton and Hove City Council and the Victoria Nursing Home Group according to the specification for Bed and Community Short Term Services (current version attached). Detailed information about the individual organisations' responsibility for delivering the service are set out in the specification and the joint Partnership Agreement which describes both the roles and the accountability arrangements. In summary

- The Register Managers of each of the 3 bedded sites are responsible for ensuring the overall quality of care provided in each site for the purposes of CQC registration
- BHCC is responsible for the overall management of the beds at Craven Vale and Knoll House
- The Sussex Community Trust is responsible for the providing nursing care, physiotherapy, occupational therapy and health care worker support to patients in the beds at Knoll House and Craven Vale
- SCT is responsible for providing overnight nursing to Craven Vale and Knoll House
- BHCC is responsible for providing social worker, support worker and home care support to people whilst they are being supported by the CSTS
- The Victoria Nursing Home Group provides 21 beds with nursing to the Community Short Term Service. The Victoria Nursing Group is responsible for overall management of these beds and for providing the nursing care. SCT provides additional in reach nursing and therapy support to these beds.
- SCT is responsible for providing the screening service that manages the flow of people into the service
- South East Health is responsible for providing medical cover to patients in the beds.
- Patients own GPs are responsible for the ongoing medical provision to patients whilst they remain in their own homes
- Collectively providers are responsible for generating the information required for performance and activity reports

5.7.2.4 Eligibility and Geographic Boundaries

This service is available to residents of Brighton and Hove.

Referrals are accepted from all health and social care professionals, including GPs, community nurses, social workers, hospital consultants and nurses, Carelink and paramedics

and paramedic practitioners from SECAMB. It is also possible for the Community Short Term Service to receive referrals via HERMES

Exclusions to the service are

- A person who is under 18 years of age
- A person who requires acute hospital admission as they are medically unwell and cannot be safely cared for within the community
- A person who presents with symptoms of new onset stroke
- A person who is not able physically and/or willing to take an active role to achieve maximum independence.
- A person with significant mental health needs who requires the input of specialist mental health services (low level dementia alone is not a reason to exclude a person from the service)

Exceptions to these criteria will be considered on an individual basis.

5.7.3 Service Provision - Integrated Rapid Response Service

Aim

The 2 main aims of the integrated rapid response service

- to prevent avoidable admissions to hospital or residential care
- and to provide short term support to patients who are medically fit for discharge from AMU and A&E but require additional short term support at home to enable them to be discharged

Objectives

The service has the following objectives:

- rapid assessment and diagnosis service for patients
- rapid co-ordination and treatment service that responds to patients identified needs
- provision of whatever services a patient needs to prevent them from being admitted to hospital where admission is not essential.

Service Description

It is expected that the integrated rapid response service

- is a single multi-disciplinary service
- is free to patients
- is able to respond within 2 hours to referrals for urgent support
- provides a rapid response service for up to 72 hours
- provides appropriate levels of care to patients overnight where appropriate
- is accessible via a single point
- has clear referral criteria and accompanying pathways

Responsibility for delivery of the service

The Integrated Rapid Response Service (IRRS) comprises services currently provided by the Roving GP service, the Community Rapid Response Service , Age UK Crisis and the out of hours district nursing service. These providers work to the specification for IRRS (current draft attached – final draft to be agreed in January 2013). These services include:

- rapid assessment of patients
- development and implementation of care plans that will support patients in their own home or place of residence
- identification of ongoing support needs beyond the initial 72 hours and work with partner organisations/services to put in place those services.
- palliative care
- catheter care
- PEG feeding
- administration of medicines including: injections, infusions, intra-venous drugs, and administration
- mobile access to ECG, defibrillator, oxygen saturation monitor and out of hours formulary medications
- night sitting/ take home and settle/pop in service
- low level personal care – e.g. help with client's normal daily wash and dress
- light household tasks
- Other support as required including collecting pensions / prescriptions, shopping for essential items, paying bills, posting mail etc.

Eligibility and Geographic Boundaries

The IRRS will support patients who

- are over 18
- are resident of Brighton and Hove
- require support for up to 72 hours to enable them to avoid being admitted to hospital or residential care
- require support for up to 72 hours to enable them to be discharged from hospital
- require stop gap support until alternative services are available e.g. intermediate care, hospice at home and homecare
- require short term support at night to enable them to remain in their own homes

There are a number of exclusions to the service

- clients who require acute hospital admission that cannot be safely cared for within the community
- clients who present with symptoms of new onset stroke
- clients who are not able and/or willing to take an active role to achieve maximum independence.
- clients with significant mental health needs who require the input of specialist mental health services

- clients who require predominately social care services. These clients should instead be referred to the social care access point.
- clients under the age of 18

5.7.4 Budgetary Details

5.7.5. Commissioning and Governance

The commissioning of Short Term Services is undertaken jointly by lead commissioners within Brighton and Hove Clinical Commissioning Group and Brighton and Hove City Council.

All key services within the scope of Short Term Services are contracted for separately with individual providers as set out in the table below.

Service	Provider	Contract Holder
Roving GP and medical cover	South East Health	Brighton and Hove CCG
OOHs Nursing	South East Health	Brighton and Hove CCG
CRRS, in reach, community STS	Sussex Community NHS Trust	Brighton and Hove CCG/Brighton and Hove City Council
Crisis	Age UK	Brighton and Hove CCG
STS beds	Victoria Nursing Homes	Brighton and Hove CCG
COTE cover	Brighton and Sussex University Hospitals NHS Trust	Brighton and Hove CCG

For the elements directly provided by Brighton and Hove Adult Social Care, the CCG and BHCC will enter into a separate section 75 agreement which will set out the level of service required and include a risk sharing agreement between the parties to mitigate the impact of loss of capacity in the services.

Whilst the separate elements of the service are contracted for separately, it is a term of the providers' contracts that they collaborate with each other via a Provider Management Board. Whilst the providers are responsible for delivery distinct elements of each service (and these are set out in the specifications and PMB agreements) they are also collectively responsible for delivering a seamless and integrated service to patients.

The members of the Provider Management Board will be held to account in terms of service delivery by a quarterly Performance and Quality Board chaired by joint commissioners from CCG and BHCC.

The effectiveness of the Provider Management Board as a vehicle for delivering an integrated service according to the service specifications will be evaluated on an annual basis.

SCHEDULE 6

RESOURCES AND VAT TREATMENT

Part 1: Financial Resources

1. The Parties' Contributions shall be managed by the [Pooled Fund Manager] / [Contributions Manager], appointed by the Lead.

2. Each Party's Contributions for the first Financial Year shall be set out in Annex A to this Schedule 6 Part 1.

3. For each Financial Year subsequent to initial Financial Year, the Parties shall agree the Contributions no later than 3 months before the end of the preceding Financial Year.

4. In the event that the Contributions are not agreed by the start of the Financial Year to which they pertain, the Contributions shall be deemed to be the same as the Contributions of the immediately preceding Financial Year.

5. Each Party shall ensure that their respective financial officers attend such meetings (with relevant papers to be circulated at least five Working Days before such meetings) and have all support and resources necessary to negotiate and agree the budgets described in this Schedule 6 Part 1 within the timescales stated.

6. Once the Contributions for a Financial Year have been agreed, they may only be varied in accordance with the process laid out in Clauses 15 (Review and Variation) and/ or 16 (Change of Law).

7. [This Agreement does not create any pooling of funds and the funds of the Parties shall be kept and recorded separately at all times.]

8. The [Pooled Fund Manager] / [Contributions Manager] shall report to the Joint Commissioning Board on expenditure against Contributions at each meeting.

9. Any overspends and underspends shall be dealt with in accordance with the provisions of Schedule 6 Part 2.

10. [The Lead will provide the financial administrative systems for the pooled fund.

11. The Pooled Fund Manager will be responsible for: -

    11.1 managing the Contributions, which shall be placed in a separate bank account held in the Lead's name allocated exclusively for the Arrangements; and

    11.2 submitting to the Parties Quarterly reports on the pooled fund and an annual return and all other information required by the Parties in order to monitor the pooled fund;

12. The monies in the pooled fund:

12.1 may be expended on the Functions in such proportions as the Parties shall agree is necessary to undertake the Functions and to procure or otherwise provide the Services;

12.2 shall be spent in accordance with any restrictions agreed in writing between the Parties from time to time; and

12.3 are specific to the Arrangements and shall not be used for any other purpose.

]

Annex A:

Contributions for the Financial Year 2013

[Debra can you insert a summary table relating to the financial contributions]

Part 2: Overspends and Underspends

1. The Lead shall make the other Party aware of any potential overspend as soon as it becomes aware of this possibility. The Lead will highlight reasons for the overspend, both current and projected, and make recommendations for action to bring the relevant Contributions, as appropriate, back to balance. The [Council]/[CCG] will act in good faith and in a reasonable manner in agreeing the management of the overspend.

2. If the [Council]/[CCG] agrees with the recommendations made by the Lead in accordance with Paragraph 1 above, it will promptly carry out whatever actions are reasonably necessary to implement such recommendations. If the [Council]/[CCG] cannot agree, or if notwithstanding agreement, the [Council]/[CCG] fail to implement any such agreed actions, then the matter should be referred as soon as possible to the Chief Executive of the Council (or her nominee) or the Accountable Officer of the CCG (or her nominee) for resolution. If the Council's Chief Executive and the CCG's Accountable Officer or their nominees (as appropriate) are unable to resolve matters within a period of twenty-one (21) days (or such other period as they may agree) then the amount of overspend will be borne by the Party to whom such overspend relates save that where and to the extent that it is not possible to distinguish whether the overspend primarily relates to a NHS health care function or a Council health related care function, then the Parties shall, subject to Paragraph 3, be jointly responsible (in the proportion of their respective Contributions to the pooled fund for the relevant Financial Year) for any such overspend. The Parties shall make such payments to each other as shall be required to reflect this allocation.

3. For the avoidance of doubt, each Party shall be liable for any overspend relating to their contribution to the extent that such overspend is due directly or indirectly to that Party's liability arising pursuant to Clause 14.

4. The Lead shall make the [Council] / [CCG] aware of any potential underspend in relation to its Contributions, prior to the end of the Financial Year. The Lead shall highlight reasons for the underspend and identify any part of that underspend which is already contractually committed. The Lead shall either carry forward any such under spend to the following Financial Year, or refund the value of such underspend to the [Council] / [CCG], in accordance with the instructions of the [Council] / [CCG]'s financial officer.

5. In the event that agreement cannot be reached in respect of any matters referred to in Paragraphs 1 and 2 above, then either Party may terminate this Agreement in accordance with Clause 17.2.1, and the process in Clause 18.1.3 for handling any overspends and underspends shall apply.

Part 3: VAT Regime

[Debra can you advise which option is peferable]

1. [The Parties agree to adopt "Partnership Structure (a)" as described in the VAT Guidance through which the Parties agree that goods and services will be purchased in accordance with the Lead's VAT regime and reimbursed from the Parties' contributions.]

OR

1 [The Parties agree to adopt "Partnership Structure (b)" as described in the VAT Guidance through which the Lead agrees to purchase goods and services in its own name and then re-invoice the [Council] / [CCG] for their share of the VAT charge enabling the [Council] / [CCG] to recover any VAT which may be incurred under its VAT regime. Invoices shall be issued in the format given in Annex A to the VAT Guidance.

2 The Lead will provide sufficient and complete documentation to the [Council] / [CCG], to enable the [Council] / [CCG] to satisfy the requirements of HM Revenue and Customs with respect to reclaiming any VAT.

3 For the avoidance of doubt, sums invoiced pursuant to Paragraph 1 will be paid by the [Council] / [CCG] within [10 Working Days] of the [Council] / [CCG] receiving confirmation from HM Revenue and Customs that the VAT claim, with respect to expenditure by the Lead, is valid.]

OR

1 [The Parties agree to adopt "Partnership Structure (b)" as described in the VAT Guidance through which the Lead agrees to arrange for invoices for those goods and services listed at Paragraph 2 below to be invoiced directly to the [Council] / [CCG]

for their share of the VAT charge enabling the [Council] / [CCG] to recover any VAT which may be incurred under its VAT regime.

2 Those goods and services in respect of which the [Council] / [CCG] will be directly invoiced are as follows: [insert details].]

SCHEDULE 7

JOINT COMMISSIONING BOARD

1. The particular responsibilities of the Joint Commissioning Board are (without limitation) as follows:

    1.1 to receive feedback and reports from the Parties on the Services commissioned;

    1.2 to monitor, advise and agree resource allocation and highlight cost pressures to the Parties through reporting lines to be agreed between the Parties;

    1.3 to approve changes to the commissioning of the Services, within the terms of this Agreement;

    1.4 to ensure the Parties comply with this Agreement;

    1.5 to measure performance and quality of the commissioning of the Services against the standards of conduct outlined at Schedule 10 (Standards of Conduct);

    1.6 to pursue the intended aims and outcomes as specified in Schedule 1 (Aims and Outcomes); and

    1.7 [without prejudice to any complaints procedures under the Hospital Complaints Procedures Act 1985 or under section 7B of the Local Authorities Social Services Act 1970 or otherwise, to appoint [a sub-committee] / [a member of the Joint Commissioning Board] to consider complaints about the Arrangements if the complaints are made by or on behalf of Service Users]

2. The Parties may agree in writing from time to time to modify, extend or restrict the remit of the Joint Commissioning Board.

SCHEDULE 8

STANDARDS OF CONDUCT

1. The Partners Will:

   1.1 Comply and ensure their staff comply with all statutory requirements national and local and other guidance on conduct and probity and to ensure good corporate governance (including their respective SOs and SFIs); and

   1.2 will ensure that the Joint Commissioning Board, the CCG's Chief Operating Officer and the Council's Director of Adult Social Care carry out their respective responsibilities in such a manner as to ensure the fulfilment of the Functions.

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SCHEDULE 9

SHARED MANAGEMENT SUPPORT COSTS

Schedule 9 - Shared Management Support Costs

Jointly Commissioned Areas	WTE	Council %	Contribution £	CCC %	Contribution £	Total	
Mental Health	1 x AfC 8C	50%	£41,623	50%	£41,623	83,246	
Dementia	1 x AfC 8A	50%	£28,439	50%	£28,439	56,878	
Community Short-Term Services	1 x Afc 8C	25%	20,811	75%	62,434	83,246	
Older People's Residential and Home Care	1 x	50%	£24,540	50%	£24,540	£49,080	Check that this includes all oncosts
Carers	0.5 wte	50%	£21,650	50%	£21,650	£43,300	check that this includes all oncosts
Integrated community Equipment	0.5wte	50%		50%			
Learning Disability	1 wte	50%		50%			
Total Joint Commissioning			£137,063		£178,686	£315,750	
Other Areas							
contracts support team	contribution to overall				£46,702		(check whether this or £29k)

care matching team	cost contribution to overall cost		(check with Wendy)
third sector commissioning	1 wte AfC 8B	100%	68,812

SCHEDULE 10

MANAGEMENT ARRANGEMENTS FOR LEAD COMMISSIONERS

Director of Adult Social Care	Chief Operating Officer

Council Senior Commissioning Lead for Adults S75	CCG Senior Commissioning Lead for Adults S75
§ Commissioner for Older People Residential and Home Care § Commissioner for Carers § Commissioner for ICES § Commissioner for LD § Contract Support Team § Care Matching Team	§ Commissioner for Mental Health § Commissioner for Dementia § Commissioner for STS § Commissioner for Third Sector and Partnerships

The Council shall make the management resource listed in Schedule x and outlined above available in order to effectively discharge their lead commissioning responsibilities.

The CCG shall make the management resource listed in Schedule x and outlined above available in order to effectively discharge their lead commissioning responsibilities.

The Human Resource procedures operative in relation to staff shall be those of the respective employer.

Neither Party shall alter the management structure aligned to its joint commissioning responsibility without prior agreement by the other Party.

Where a decision is taken to amend the S75 agreement and change the scope of joint commissioning arrangements any associated costs should be agreed by both Parties and respective contributions amended accordingly.

The Council's Director of Adult Social Care will have overall responsibility for commissioning services for which the Council is lead commissioner.

The CCG's Chief Operating Office shall have overall responsibility for commissioning services for which the CCG is lead commissioner.

The Director of Adult Social Care and Chief Operating Officer shall meet together with the Senior Section 75 Commissioning Lead from each organisation at least 6 times a year to develop annual collaborative commissioning plans for services covered by the Section 75 agreement and oversee delivery and performance of the commissioned services.

A meeting of all joint commissioners shall take place at least once a year to inform the Annual Joint Commissioning Plan. This shall be presented to the Joint Commissioning Board for sign of prior to the beginning of the financial year.

Regular reports relating to the performance and delivery of individual jointly commissioned areas shall be presented to the Joint Commissioning Board for information/decision.

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SCHEDULE 11

WINDING DOWN PROTOCOL

In the event that this Agreement is terminated the Parties agree to co-operate to ensure an orderly wind down of their joint activities as set out in this Agreement and the following provisions shall (unless agreed otherwise by the Parties) have effect:

1. the Council shall ensure or procure the continued provision of the Services related to the Council Functions;

2. the CCG shall ensure or procure the continued provision of the Services related to the CCG Functions;

3. each Party shall use its reasonable endeavours to arrange and ensure the novation of the contracts which were novated by the other Party (or other contracts either substituted or entered into solely in connection with other Party's Functions) back to that other Party, who shall accept such novation;

4. any assets transferred from a Party to the other under these Arrangements shall transfer back to the originating Party subject to agreed terms;

5. [the Lead's] / [each Party's] rights of occupation of Premises owned or controlled by the other Party shall cease insofar as applicable to the commissioning of the Services related to the Functions of that other Party;

6. the Parties will not, following service or receipt of a valid notice to terminate this Agreement:

    6.1 increase or decrease the number of persons employed or engaged by in connection with the provision of the Functions by more than 10% without obtaining the consent of the other (such consent not to be unreasonably withheld); or

    6.2 significantly alter the terms and conditions of employment of persons employed or engaged in connection with the provision of the Functions without obtaining the consent of the other (such consent not to be unreasonably withheld).

7. [If TUPE is deemed to apply at the end of the Arrangements to the Staff employed in relation to the [Council] / [CCG] Functions, such Staff will transfer to the [Council] / [CCG] in accordance with TUPE.]

8. The CCG and the Council shall work together to ensure an orderly handover in relation to all aspects of the Functions and shall at all times act in such a manner as not to adversely affect the delivery of the Services and in particular the Parties shall, as soon as reasonably practicable provide to the other details of the terms and conditions of employment of all employees engaged in providing the Functions.

9. Both Parties agree that all such information as may be provided to the other may be passed on to any prospective or new service providers (in confidence) for the purposes of future provision of the Functions and obtaining advice only.

10. Both Parties shall transfer ownership, to the originating Party, the records and information relating to the Functions, including any relevant records that were transferred to the other at the Commencement Date.

11. Both Parties shall agree a just and equitable approach to the final reconciliation of any budgetary underspend or overspend which shall be in accordance with any relevant provisions contained in Schedule 6 Part 2.

Joint Commissioning Board	Agenda Item 30 Brighton & Hove City Council

Subject:	Fee Level for Adult Social Care Services 2013-14
Date of Meeting:	21 January 2013
Report of:	Director of Adult Social Services
Contact Officer:	Jane MacDonald jane.macdonald@brighton-hove.gov.uk
Ward(s) affected:	All

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report concerns fees paid to independent and voluntary sector providers that supply care services on behalf of Brighton and Hove City Council Adult Social Care and Brighton and Hove Clinical Commissioning Group. It covers fees paid to providers of services for older people, people with physical disabilities, adults with mental health needs including HIV and substance misuse and adults with a learning disability. Service providers include care homes, supported accommodation, home care and community support, community service and direct payments.

1.2 With regard to the fees paid to local care homes, work continues internally within the council and with a range of stakeholders including providers of care. Recommendations for fees to providers of home care have been influenced by the recent tender. The price for delivering a range of community based services has been agreed through the Commissioning Prospectus processes, and will be in place from April 2013. Further activity will be included in future prospectuses. The recommendations in this report are in line with those of Commissioners of other services in the council. It is expected that they are also broadly in similar with other local authorities in the region.

2. RECOMMENDATIONS:

2.1 The recommendations are that the Joint Commissioning Board notes that:

Subject to the budget set by Council in February 2013, the recommendations are for the Adult Care and Health Committee to agree the changes set out in Table Two Section 3.9, to come into place for the financial year 2013/14.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 <u>Brighton and Hove current financial position</u>

The 2013/14 budget strategy for Adult Social Care will be agreed by Budget Council in February 2013. This will set out the need to ensure that the quality of

services provided in the independent sector is maintained both through ensuring adequate funding and through tight quality control and monitoring by the council.

3.2 Terminology

In this report the term 'care home' includes both residential and nursing homes. The report refers to care homes in the city and those out of the city. Some people choose to live outside Brighton and Hove others may be placed outside the city if there is not provision that meets their needs within the city. 'Set rates' are for placements in care homes for older people and older people with mental health needs. Fees for adults under 65 generally are individually negotiated ie 'non set rates'. Work is currently being undertaken to address differences in approach to funding.

Supported living and supported accommodation refer to services where service users have a tenancy or licence agreement for their accommodation, with separate agreements for care and support.

The report refers to third party payments; these are 'top ups' paid by a third party, usually a family to secure a placement at a price that is greater than the council would fund.

The report refers to Service Contracts. These are contracts that are provided for services, such as advocacy and day services that are provided in the community generally by voluntary and community groups.

3.3 Care homes and supported Living out of city

It is recommended that Brighton and Hove match the applicable host authority set rates for new and existing care home placements out of the city; and that any adjustments in these rates be reflected in any third party payments which apply.

For those care home places that are not set rate, the owners will be advised to contact the council to discuss future fees if this is necessary eg if a client's needs have changed and a reassessment is needed or if the provider is in financial difficulty.

For supported living out of the city, owners will be requested to contact the council to discuss future rates, again if this is appropriate. This includes supported living and community support for people with learning disabilities and accommodation services for people with mental health needs.

3.4 Care homes set rates in the city

For the year 2012-13 it was agreed that set rates paid to residential and nursing homes for older people, people with a physical disability, older people with mental health needs were uplifted 5%. This rise was significantly more than most other national, regional and local authorities.

It was expected that providers used a proportion of the fees to increase the salary of the lowest paid staff towards the living wage. A recent survey showed that out of 25 care homes for older people and older people with mental health needs, 17 homes increased wages and 68% of respondents were paying their lowest paid workers over £7.00 per hour.

Table One – Set fees paid by the council 2012-13

Type of care home	Service users	Cost of single room
Nursing home	Older People	£565.70
Nursing home	Older People with Mental Health Needs	£611.70
Residential home	Older People (high need)	£460
Residential home	Older People with Mental Health Needs	£504

In the last year there has been much work both internally within the council, with Improvement and Efficiency Social Enterprise and with a range of local stakeholders. Stakeholders have included a range of local providers and assessment teams. Currently work is being undertaken on an audit of care home costs. Results from this will inform future fee setting.

The council is also working closely through the Association of Directors of Adult Social Services to inform and learn from other local authorities about how best to develop a local fee model.

The council continues to provide a range of support and quality training that is free to access and which is much appreciated by providers and is a cost saving to them.

Given that the work on how best to develop a local fee model is not complete; the recommendation is for 1% uplift on set rates and care home block contract rates for the financial year 2013 / 2014. This recognises that providers have increased outgoings in providing 24 hour building based care, particularly with fuel and food costs having risen in the last year. This approach is supported by NHS commissioners.

3.5 Care homes and Supported Living non set rates in the city

The recommendation is for residents who are on rates lower than set rates to be uplifted to the set rate.

For those care home places that are not set rate, the owners will be advised to contact the council to discuss future rates, if this is needed.

For supported living in the city, owners will be encouraged to contact the council to discuss future rates, if this is necessary. This includes supported living and community support for people with learning disabilities and accommodation services for people with mental health needs.

3.6 Home care

The review of the Home Care contract report details the home care market. Following this it is recommended that a 2% increase is applied to home care rates for the financial year 2013/14 in recognition of the impact that rising fuel rates has had on the home care market. It is also recommended that an enhanced rate of 50p per hour is added for all evening calls beyond 8pm. Monitoring has shown that it can take longer to arrange a care package where there is a need for evening calls; having an enhanced rate will enable care providers to recruit staff who are willing to work beyond 8pm.

3.7 Direct payments

Similar issues that affect home care costs also apply to direct payments as these are used in the main to purchase hours of personal assistant time. It is therefore recommended that a 2% increase is applied to the direct payment hourly rate.

3.8 Service Contracts

The Commissioning Prospectus introduced a new approach to funding organisations operating locally. In the first prospectus the Council and NHS sought applications from parties interested in working in the areas of mental health, disability, carer support and older people's community services. The price for delivering services was agreed through the Commissioning Prospectus processes with agreed rates in place from April 2013.

Both council and NHS commissioners are working with providers on an individual basis and discussions are being held regarding planned service activity. The overarching recommendation for those providers not in the Prospectus is for no change to fees for the 2013/14 financial year. Any provider that experiences financial difficulty is encouraged to make the council aware and they will be offered advice and support. If the council cannot assist directly, business support partners might be able to help www.brighton-hove.gov.uk/index.cfm?request=b1000040

3.9 Recommended Fee Rates 2013/14

The table below sets out recommended fee rates for the financial year 2013/14.

Table Two – Summary of recommendations

	Rate	Comment
In city care homes set rate	1% increase	5% paid last year
In city care homes/ Supported Living Non set rate	0% change	owners will be encouraged to contact the council to discuss future rates, if this is necessary
Out of city care home supported living set rate	To reflect the host authority rate	owners will be encouraged to contact the council to discuss future rates, if this is necessary
Out of city care home Non set rate	0% change	owners will be encouraged to contact the council to discuss future rates, if this is necessary
Home care	2% increase	
Direct payments	2% increase	
Service Contracts	0% change	

3.10 Other local authorities are working on their fee rates at present. Further to discussions at a regional level, it is expected that the proposals from Brighton and Hove will be in line with the broad spectrum of recommendations from other areas in the region.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 The council is continuing to take forward work on fees to care homes and working with providers on this activity. The Director of Adult Social Services/Lead Commissioner for Adult Social Care and Health has made presentations to a number of provider forums and advised them of the additional support provided by the council and the current financial position.

The council is continuing to take forward work on fees to care homes and working with providers on this activity. A copy of the draft and final report has been shared with the Registered Care Homes Association.

The Area Chairman highlighted the rise in pay, food and energy costs and the possible increases in Living Wage. He argued that a 2.5% gross increase was necessary to maintain good quality care and financial viability and that there had been no increase between 2009 and 2012. Evidence from the latest Laing and Buisson report was quoted.

If the recommendations in this report are agreed care homes in the city on set rates will have been awarded a 6% uplift over two years. This balances the need to protect services to vulnerable adults with the duty to mange public money.

Home care providers have had the opportunity to inform the council of their financial position in the recent review.

This report has been shared with commissioners in the NHS Clinical Commissioning Group and they support the recommendations. Public Health confirms that none of the locally set public health contracts include a financial uplift on their contract price for 2013/14. Commissioners for other community services said that they do not routinely uplift their grant funding to any community organisation. Some organisations may receive enhanced or additional funding but this would be as a result of applying for new grant funding or through new contracts.

This report has been shared with the Older Peoples Council where a presentation was given. The Link was asked to comment but none were received.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 Financial Implications:

Current annual spend on care services is approximately £70 million. The proposed fee uplifts set out in section 3.9 can be met from within the 2% inflation allowance included in the budget model for 2013/14. Those fees not being increased in line with inflation will help contribute to the delivery of the overall budget strategy for Adult Social Care which will be considered by Budget Council in February 2013.

As described in the report, levels have been benchmarked and assessed against current costs. It is anticipated that a new model for care home fees will be in place to calculate fee levels from April 2014.

Finance Officer Consulted: Michael Bentley 10 December 2012

5.2 Legal Implications

The Local Authority has dual duties to assess and provide services to eligible vulnerable adults in the City and to the public purse to ensure adherence to budget. This report describes how those duties are to continue to met, informed by consultation and work with the CCG and stakeholders. The variance in funding of some service is recognised and addressed by systems in place for individualised consideration of specific non-set rates and provision of advice and support to providers.

The approval sought can therefore only be on the basis of budget proposal agreement.

There are no specific Human Rights Act 1998 implications arising from this Report.

Lawyer consulted: Sandra O'Brien 8 January 2013

5.3 Equalities Implications:

A separate Equalities Impact Assessment has been completed.

5.4 Sustainability Implications:

Fee rates awarded are intended to keep business sustainable.

5.5 Crime & Disorder Implications:

There are no specific crime and disorder implications set out in this report.

5.6 Risk and Opportunity Management Implications:

The financial risks have been set out in the main body of the report.

5.7 Risk and Opportunity Management Implications:

Variations of the recommendations were considered. The proposals balance risk, ongoing quality and sustainability of services in the city with the budget pressures.

5.8 Public Health Implications:

Fees paid to services keep a range of providers in business. This includes a range of preventative services that help maintain service user's health and prevent deterioration and reliance on more intensive provision.

5.9 Corporate / Citywide Implications:

The fees paid to provider services will impact on all wards of the city, keeping businesses sustainable and able to provide ongoing quality services.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 A range of different uplifts were modelled. The recommendations included in this report fit within current budget proposals. They will provide those delivering services on behalf of the council with sufficient funds to remain robust.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 Given the position of public sector finances where there are uplifts these are targeted to where they are most needed.

SUPPORTING DOCUMENTATION

Appendices
None

Documents in Members' Rooms
None

Background Documents
None

Document is Restricted