Brighton & Hove City Council

HEALTH & WELLBEING BOARD

4.00PM 10 JUNE 2014

COUNCIL CHAMBER, HOVE TOWN HALL

AGENDA

Brighton & Hove City Council

Health & Wellbeing Board

Title:	**Health & Wellbeing Board**
Date:	**10 June 2014**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
BHCC Members:	J Kitcat (Chair),K Norman (Opposition Spokesperson), Jarrett, Morgan and G Theobald
Health Members:	Dr Xavier Nalletamby (Brighton and Hove Clinical Commissioning Group), Geraldine Hoban (Brighton and Hove Clinical Commissioning Group), Dr Christa Beesley (Brighton and Hove Clinical Commissioning Group), Dr Jonny Coxon (Brighton and Hove Clinical Commissioning Group) and Dr George Mack (Brighton and Hove Clinical Commissioning Group)
Non-voting co-optees:	Denise D'Souza (Statutory Director of Adult Services), Dr Tom Scanlon (Director of Public Health), Pinaki Ghoshal (Statutory Director of Children's Services), Frances McCabe (Healthwatch), Graham Bartlett (Brighton & Hove Local Safeguarding Children's Board) and Sarah Creamer (NHS England)
Contact:	**Caroline De Marco** Democratic Services Officer 01273 291063 caroline.demarco@brighton-hove.gcsx.gov.uk

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AGENDA

Part One **Page**

1. 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 – Statements by all Members present of any personal interests in matters on the agenda, outlining the nature of any interest and whether the Members regard the interest as prejudicial under the terms of the Code of Conduct.

(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 Two of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.*

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

2. MINUTES 1 - 22

a) To consider the minutes of the Health & Wellbeing Board meeting held on the 5 February 2014 (copy attached).

b) To consider the minutes of the Adult Care & Health Committee held on 17 March 2014 (copy attached).

3. CHAIR'S COMMUNICATIONS

4. PUBLIC INVOLVEMENT

5. BRIGHTON & HOVE HEALTH & WELLBEING BOARD (HWB): NEW TERMS OF REFERENCE 23 - 44

Report of Director of Public Health (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 291038*
Ward Affected: *All Wards*

6. BETTER CARE FUND PLAN UPDATE 45 - 50

Report of Executive Director, Adult Services & Chief Operating Officer, CCG (copy attached).

Contact Officer: *Gill Brooks* *Tel: 01273 574635*
Ward Affected: *All Wards*

7. BRIGHTON AND HOVE CCG 5 YEAR STRATEGIC PLAN 2014-2019 AND 2 YEAR OPERATING PLAN 2014-2016 **51 - 60**

Report of Chief Operating Officer, CCG (copy attached).

Contact Officer: *Geraldine Hoban* *Tel: 01273 574863*

8. UPDATE ON PROGRESS WITH THE INDEPENDENT DRUGS COMMISSION REPORT **61 - 90**

Report of the Director of Public Health (copy attached).

Contact Officer: *Peter Wilkinson* *Tel: 01273 296562*
Ward Affected: *All Wards*

9. DISABILITY AND SPECIAL EDUCATIONAL NEEDS REVIEW **91 - 98**

Report of Executive Director, Children's Services (copy attached).

Contact Officer: *Regan Delf* *Tel: 01273 293504*
Ward Affected: *All Wards*

10. PROVIDING HOMES FOR PEOPLE WITH LEARNING DISABILITIES - DEFERRED TO A FUTURE MEETING **99 - 106**

Report of the Executive Director of Adult Services (This item has been deferred to a future meeting).

Contact Officer: *Karin Divall* *Tel: 29-4478*
Ward Affected: *All Wards*

HEALTH & WELLBEING BOARD

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Date of Publication - Monday, 2 June 2014

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING BOARD

4.00pm 5 FEBRUARY 2014

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Jarrett (Chair) Councillors K Norman (Opposition Spokesperson), Meadows (Opposition Spokesperson), Bennett, Bowden, Pissaridou and Shanks

Other Members present: Pinaki Ghoshal, Statutory Director of Children's Services, Denise D'Souza, Statutory Director of Adult Social Care, Peter Wilkinson, Deputy Director of Public Health, Geraldine Hoban, Clinical Commissioning Group, Zaid Khayal, Youth Council, and Jane Viner, HealthWatch.

Apologies for absence: Dr. Xavier Nalletamby, Clinical Commissioning Group

PART ONE

37. PROCEDURAL BUSINESS

37A Declarations of Substitute Members

37.1 Peter Wilkinson, Deputy Director of Public Health, declared that he was attending as a substitute for Tom Scanlon.

37B Declarations of Interests

37.2 There were none.

37C Exclusion of the Press and Public

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

37.4 **RESOLVED** - That the press and public be not excluded from the meeting.

38. MINUTES

38.1 Councillor Pissaridou asked for an amendment to paragraph 35.5. The first sentence should read 'Tom Scanlon reported that there had been an *increased* uptake in flu vaccinations.'

38.2 **RESOLVED -** That the minutes of the meeting held on the 27 November 2013 be approved as a correct record of the proceedings and signed by the Chair subject to the above amendment.

39. CHAIR'S COMMUNICATIONS

Youth Council Representative

39.1 The Chair welcome Zaid Khayal as the new representative of the Youth Council. The Chair hoped Zaid would find the Board a useful forum for discussion.

40. PUBLIC INVOLVEMENT

(a) Petitions

40.1 The Chair noted that there were no petitions from members of the public.

(b) Written Questions

40.2 Mr Ken Kirk asked the following question:

"Should the Health and Wellbeing Board, in its function of identifying the health service needs of Brighton and Hove, scrutinise the proposed tendering of services by the CCG to –

a. minimise the fragmentation of the local NHS
b. ensure the financial security of local health services so that trusts are not denuded of profitable services
c. maintain the skill-base of local medical staff since the redundancy of well-trained medics is likely to follow outsourcing to a for-profit provider?

Does the H&WB in its role in overseeing the CCG actively challenge its decisions in the interests of the people of Brighton and Hove?"

40.3 The Chair gave the following response:

"The HWB provides citywide strategic leadership to local health and social care commissioning with the ultimate aim of improving the health and wellbeing of local people.

As such the HWB has an interest in ensuring that CCG and city council commissioning policies do not result in negative impacts on local services.

However, NHS and local authority commissioners have limited freedoms with regard to commercial procurement, which is largely determined by national and European legislation. Although any procurement exercise inevitably involves some risks, such as those outlined in the question, it also presents a significant opportunity to improve the quality, social value and the value for money of services.

For this reason it would not make sense to simply adopt a policy of opposing going out to tender where this might be legally possible.

Given this, it is unlikely that the HWB would seek to 'scrutinise' any particular CCG decision to go to tender. However, the HWB will seek to hold the CCG (and the city council) to account for the general impact of its commissioning decisions, particularly in terms of the Joint Health & Wellbeing Strategy commitments."

40.4 Mr Kirk stated that the financial security of the NHS Trust would be placed in jeopardy if profitable services were contracted out. He stressed that commercial companies would want to cherry pick profitable services. He asked if the Health & Wellbeing Board saw its role as overseeing that process.

40.5 The Chair replied that the Health & Wellbeing Board needed to work in the best interests of the City. It would not be in the best interests of the City if the NHS became non-viable. However, the Board needed to act within the law. The Board would need to think about the financial implications of the decisions it took and it could be consulted on whether they wanted to agree a position on this matter.

40.6 **RESOLVED-** That the written question be noted.

40.7 Ms Madeleine Dickins asked the following question on behalf of Ms Jozette Power:

"In view of the City Council's referendum on a possible council tax rise, does the Health and Wellbeing Board share my concern that the people of Brighton and Hove are generally unaware of what is happening to their health services and that their views should be sought on the subject of are they –

1. concerned by the take over of their health services by alternative providers;

2. supportive of the fragmentation of the unified NHS into pieces to offer to the private sector;

3. aware that the publicly-run NHS will be left with the rump of unprofitable services that the private sector have decided it can't make money from?"

40.8 The Chair gave the following response:

"Proposals to hold a referendum on Council Tax, if they go ahead, will present local people with a clear choice of accepting or rejecting a planned CT increase.

It is hard to see, however, how local people could be presented with similar clear choices on the future of NHS services, since many of the key decisions here have been

taken at a national level and local bodies are essentially implementing these nationally-determined policies.

To the degree that there is scope for local determination, commissioners are committed to maintaining a cohesive and effective healthcare system with delivers the best possible care for local people.

NHS services are, and will continue to be, a key part of this offer; but it is the case now and will be the case going forward that NHS healthcare benefits from a plurality of providers. "

40.9 The Chair added that the CCG did have public meetings and that the public could make representations at those meetings.

40.10 Ms Dickins asked what mechanisms were in place in Brighton and Hove for meaningful public consultation on decisions being taken.

40.11 The Chair explained that a number of council decisions were made after a public consultation process. Geraldine Hoban explained that the CCG had a range of public consultation in relation to its service plans. With regard to procurement, the CCG was legally obliged to follow legislation. Legal advice would have to be sought as to whether it would be possible to have a consultation process.

40.12 Ms Dickins stated that many residents were concerned about the tendering process already taking place. She accepted the point about the legal implications but stressed that there was often room for manoeuvre.

40.13 The Chair replied that he would investigate if there was a way members of the public could have an input in how services are delivered. Geraldine Hoban stated that the CCG did have public questions at its public bodies. The CCG were keen to hear what people had to say.

40.14 The Chair mentioned that the Health & Wellbeing Overview & Scrutiny Committee might be an appropriate place to raise this issue.

40.15 **RESOLVED-** That the written question be noted.

40.16 Ms Katrina Miller asked the following question on behalf of Mr Dave Baker:

"The presidents of British Association for Sexual Health and HIV and the Royal College of Physicians have written to all local councils:

"Tendering has negatively impacted on the provision of sexual health services, destabilising, disintegrating and fragmenting services, causing significant uncertainty amongst patients and staff, and reducing overall levels of patient care."

They are warning against tendering, saying it's not in the interests of patient care. Monitor's guidance for commissioning say the interests of patients determine whether tendering should occur.

Therefore, on the basis of what evidence would this Board offer B&H's sexual health services to tender outside the NHS?"

40.17 The Chair gave the following response:

"Brighton & Hove City Council is currently considering all the options available, which may not necessarily require procurement by competitive tender, to achieve the most clinically and cost effective service.

This issue will be considered at the March 2014 Policy & Resources (P&R) Committee. As this is a decision for P&R rather than the HWB, and because the report for P&R is still at a draft stage, we are not in a position to provide any more details at this point."

40.18 The Chair explained that when public health became a council responsibility, the council were under the impression that it would be necessary to tender the service. Over the Christmas period new guidance emerged that suggested this might not be the case. Legal advice was being sought on this issue.

40.19 Ms Miller asked about the role of the Health and Wellbeing Board in relation to tendering. She asked when the original decision to tender was taken. She asked what the resolution stated and whether it was minuted.

40.20 The Chair explained that not all the work of the Public Health directorate was taken to the Board. Decisions could be taken under delegated powers and some decisions were taken to the Policy & Resources Committee.

40.21 Councillor Shanks explained that she was a member of Policy and Resources Committee. She confirmed that the Policy and Resources Committee had considered this matter due to the financial implications involved. The Committee had decided that this service should be tendered.

40.22 Ms Miller questioned how the public could be informed about these matters.

40.23 The Deputy Head of Law explained that all public committee papers were published on the Council's website a week before the meeting. The Council had to abide by the Access to Information Act with regard to making information public. The minutes of meetings were also published on the website. There were a number of reasons why reports were referred to the Policy & Resources Committee. It might be due to the budgetary implications or it might be because the issues affected several areas of work such as children & adults etc.

40.24 Councillor Meadows asked why the Children & Young People Committee and the Adult Care & Health Committee had not been informed about this issue.

40.25 The Deputy Director of Public Health informed members that the report was a general paper submitted to the Policy & Resources Committee and included other business such as substance misuse.

40.26 Councillor Pissaridou suggested that there should be a report back to the Board on what had happened with regard to the report. The Chair agreed that a brief report on this

matter be circulated to Health & Wellbeing Board members and potentially included as an item on the next committee meeting agenda.

40.27 **RESOLVED-** (1) That the written question be noted.

(2) That a report be circulated to members explaining which meeting had considered the original decision to tender and the date of that meeting. The report should explain why the matter was considered by that Committee and provide details of the resolution.

(c) Deputations

40.28 The Chair noted that there were no deputations from members of the public.

41. ISSUES RAISED BY COUNCILLORS AND MEMBERS OF THE BOARD

41.1 The Chair noted that there were no petitions, written questions, letters or Notices of Motion submitted by Councillors and members of the Board.

42. HAPPINESS: BRIGHTON & HOVE MENTAL WELLBEING STRATEGY

42.1 The Board considered a report of the Assistant Chief Executive which presented the draft Happiness: Brighton & Hove Mental Wellbeing Strategy. The strategy was developed to improve mental wellbeing in the city. The Board were updated on progress to date and the future direction of travel.

42.2 The report was presented by the Public Health Specialist who provided a presentation with slides. The Strategic Commissioner, CYPT was present to answer questions. Members were informed of progress to date and actions across the City. The key approaches within the strategy were 1) Development of an online resource based on the Five Ways. 2) Champions – a network across sectors, to include elected members. The Action plan would include 1. Engagement with partners. 2. Engagement with service users and vulnerable groups. 3. Engagement with the public. 4. Web pages.

42.3 The Public Health Specialist informed members that there would be a more detailed update at the next meeting of the Health & Wellbeing Board.

42.4 Councillor Meadows noted that the report talked about partners but expressed concern that there was no mention of the Sussex Partnership NHS Foundation Trust. Councillor Meadows was pleased to note that 73% of people in Moulsecoomb & Bevendean were happy.

42.5 The Public Health Specialist replied that officers did want to engage with service users and people with mental health problems. This would form part of the consultation process.

42.6 The Strategic Commissioner, CYPT referred members to the triangle diagram on page 26 of the agenda. This showed how the prevention and wellbeing agenda was fully

mindful of the whole range of people in the City. Officers wanted to engage with the wider community.

42.7 Councillor Shanks referred to talking therapies and mindfulness. She expressed concern that the waiting times for access to talking therapies meant that people who would prefer to be treated via counselling rather than medication were effectively forced to opt for the latter treatment and asked how this could be avoided.

42.8 The Public Health Specialist replied that the plan was to have more wellbeing-focused commissioning and to aim to provide an evidence based service. There would be more rapid access to talking therapies than in the past.

42.9 Councillor Shanks referred to the 'Happy' diagram on page 23 of the agenda and stated that statistics did not bear out that the more affluent areas of the City are happier. She noted that Preston Park had a percentage of 68%, whereas Moulsecoomb had a quite high percentage. More research was required to see why some areas are happier.

42.10 The Public Health Specialist replied that neighbourhood groups will be included in the consultation currently underway. Their comments will help officers to understand the issues more clearly.

42.11 Councillor Pissaridou asked if the strategy was a first draft. She felt the role of the Champion for Mental Health seemed vague and she would welcome more detail.

42.12 The Specialist in Public Health confirmed that the paper was a first draft. In terms of the Champion, she suggested developing a briefing on what was required. Councillor Pissaridou confirmed that she would welcome a briefing on this matter.

42.13 Councillor Bowden thanked officers for the report. He commented that that external factors could militate against the aims of the strategy. Page 25 of the agenda referred to good quality housing, but large numbers of people were on the housing waiting list. The question of how to contend with government policies and how to include the police into debates were issues he had raised before. Councillor Bowden stated that he had known people with mental health problems who had not been treated with appropriate sensitivity by the police and he considered it necessary to bring the police on board as partners. The police were not mentioned in the strategy.

42.14 The Public Health Specialist replied that she would take back the comments about the police and thanked Councillor Bowden for his suggestion.

42.15 Geraldine Hoban stressed that access to talking therapies was a key part of the strategy. Currently service users were waiting longer than they should to access services. Plans are in place to reduce these waiting times which are due to a backlog built up under the previous service model. The service has now been re-designed and re-tendered and is functioning much better, although it will take a number of months to bring the waiting list down.

42.16 Ms Hoban stated that she would like to see public sector employers sign up to the charter, to help improve the health and wellbeing of public sector employees in the City. For example, employers could offer flexible policies and ways of working.

42.17 Zaid Khayal referred to page 18, paragraph 3.6, which referred to the SICK festival. He asked what happened at this event. The Public Health Specialist explained that this was an arts festival run by The Basement. She recommended that he looked at The Basement's website.

42.18 Zaid referred to the circle diagram on page 28. He noted that this only referred to girls.

42.19 The Strategic Commissioner, CYPT explained that the chart was trying to draw together those groups who were most likely to report behaviours.

42.20 Pinaki Ghoshal stated that the chart was not properly explained in the strategy and should be removed. He felt it was unhelpful and did not fit comfortably in the strategy. Mr Ghoshal welcomed the strategy but felt it was not clear how it would link up to developments in children's services. Early health was critical. Mr Ghoshal asked how officers were reaching out to young people regarding the happiness agenda. There was a need to ensure young people were safe and happy. He did not see that in the strategy at the moment. There was an agenda about interaction within schools which was very important. More work was required on these issues.

42.21 The Strategic Commissioner, CYPT said she would take these comments on board.

42.22 Councillor Bowden stated that the strategy rightly identified isolated older people. He sat on the Older People's Council and noted that older people often were the last to ask for help. He would like to see that issue raised in the strategy. Councillor Bowden raised the matter of carers where lack of respite care was an issue. He was pleased to see a new strategy in place with regard to talking therapies. A great deal depended on finances and Councillor Bowden asked how this work would be funded.

42.23 The Public Health Specialist explained that the CCG were asking Age UK and the Carers Centre to respond to the paper. Officers were hoping to get feedback on what they felt were priorities. The issue of respite was covered by the Carers Strategy rather than the Mental Wellbeing Strategy.

42.24 Geraldine Hoban made the point that demand would outstrip supply and there was a need to pick up problems at an earlier stage. Better housing and better work advice was needed. The best way forward was to keep people healthy in the first place. This was the only way to stem the tide of growing levels of anxiety.

42.25 Ms Hoban recognised that the integrated care of frail people would need to include consideration of carers. Carers were a key part of the model.

42.26 Denise D'Souza suggested that the final strategy should have a list of who had been consulted. With regard to the workforce, there was some work carried out two years ago on this issue. There was no need to duplicate this work.

42.27 The Strategic Commissioner, CYPT stated that consultation was live and ongoing. The strategy did not have shape as officers were asking people what they wanted. There would be a great deal of wide ranging consultation. The current report was an update and there was a great deal more work to be carried out.

42.28 Zaid Khayal stated that as a secondary student he noted that some children did not correctly fill in surveys.

42.29 The Strategic Commissioner, CYPT explained that this was recognised as an issue with this type of survey, and the raw data was accordingly 'cleaned' to ensure that it was trustworthy.

42.30 Councillor Bowden expressed concern that some young carers were completely off the radar. There were young carers looking after parents. Councillor Bowden asked what could be done to bring them into the equation. Councillor Bowden considered that the measures were a bit crude. There needed to be a more systematic level of measuring happiness.

42.31 The Strategic Commissioner, CYPT explained that there was a funded project to work with young carers. Work was carried out in schools to identify carers and officers worked closely with them. There had been a presentation from young carers to the Children and Young Peoples Committee. A national framework had been adopted for the measures.

42.32 Pinaki Ghoshal confirmed that young carers had given a powerful presentation to the Children and Young People Committee. He wanted to bring a review of the Carers Strategy to the CYP Committee in the future. They were a hidden group and the issue was complex.

42.33 Councillor Norman welcomed the Champion role. He considered that once the Champion was in place, work could proceed and progress made. The Champion could help to raise the profile of the work.

42.34 Councillor Bowden stated that as Chair of the Economic Development & Culture Committee, he was pleased that the draft strategy recognised the role of the arts in the mental wellbeing of the City. Many cultural organisations in the City had outreach programmes.

42.35 **RESOLVED** – (1) That Tom Scanlon, Director of Public Health take a 'Champion' role for Happiness and mental wellbeing on behalf of the Board.

(2) That the draft strategy be approved and that the Director of Public Health be instructed to bring the final strategy back to the Board at its meeting on 11 June 2014.

43. BETTER CARE FUND PLAN

43.1 The Board considered a report of the Executive Director, Adult Services and the Chief Operating Officer, CCG which provided details of the Brighton and Hove Better Care Fund Plan. It is a national requirement of the Better Care Fund that plans are approved by the relevant Health and Wellbeing Board.

43.2 The report was presented by Denise D'Souza, Executive Director Adult Services and by Geraldine Hoban, Chief Operating Officer, CCG, who also provided members with a PowerPoint presentation. The presentation set out the background to the Better Care

Fund and gave details of national conditions, funding and performance measures. The presentation stressed the changing needs of the city and explained the focus on frailty. The presentation explained the vision for better care in Brighton and Hove and set out principles, the approach and the plan for implementing the changes.

43.3 Denise D'Souza explained that in the course of the last few weeks conversations had taken place across the City to ensure that the submission had been agreed by partners. Geraldine Hoban explained the vision for better care and stressed that this involved using money in a more creative way. The driver was more pro-active, integrated care, looking at the whole person.

43.4 Councillor Bowden referred to the 'Better Information Means Better Care' leaflets that had been distributed to households by the NHS, concerning data sharing. He had been told by senior officers in the Health and Social Care Information Centre that commissioners were already receiving some data. Councillor Bowden asked if this information was correct, and if so, whether the data informed the Better Care Fund Plan?

43.5 Geraldine Hoban replied that there was no shortage of data. The problem was that the data was not sharable. There was a need to create a platform whereby data could be shared with the patient's permission.

43.6 Councillor Bowden referred to the emis system used by GPs practices. Emis was not able to share information with other systems.

43.7 Councillor Norman stated that the Better Care Fund Plan was the most in depth plan he had seen since he had been a councillor. He looked forward to seeing the plan endorsed. Councillor Norman referred to the principle 'access to professional support will be available 24/7'. He stressed that this would be a hard task to get right but it was a great ambition which he supported. He thanked Denise D'Souza and Geraldine Hoban for their presentation.

43.8 Councillor Norman asked which part of the City would be used to test out the integrated model.

43.9 Denise D'Souza explained that the pilot area was yet to be determined. Housing accommodation would be a key issue and an area of the City was required where these types of issues could be tested. Geraldine Hoban explained that conversations were taking place with GP practices as to where they wanted pilots to be carried out.

43.10 Jane Viner welcomed the proposed Care Co-ordinator approach. She considered that it would be good if care plans could be owned by individuals. Plans needed to anticipate the future needs of the person.

43.11 Councillor Meadows noted that it was a fairly ambitious plan. She felt that the approach was what was already happening in adult social care i.e. extra care housing. That scheme had a co-ordinator. Councillor Meadows asked what would happen if the 10.1m savings were not achieved. Councillor Meadows referred to the report which had recently been submitted to the Policy and Resources Committee which had looked at the future of BHCC provided Adult Social Care services and had suggested putting in

place an arms length management company. She asked how this would affect the Better Care Fund Plan.

43.12 Denise D'Souza explained that with regard to Extra Care Housing, there were people on site who co-ordinated the social care aspect but not the whole care element. The Better Care Plan proposal was a wider approach. In terms of Adult Social Care provider services, Ms D'Souza explained that there was a piece of work ongoing looking at options for the minority of council-commissioned social care services still provided by the council. However this was not completed yet. A range of services had been integrated with health already. The Care Bill would impact on decisions taken in the future. Officers were looking at all services to see how they fitted into the integrated approach.

43.13 The Chair stated that there was a requirement for greater integration with health services regardless of who delivered services. Denise D'Souza stressed that she wanted to see homecare providers and residential homes engaged in this process.

43.14 Councillor Meadows asked if there was a Plan B.

43.15 Sarah Creamer stated that the plan needed to be submitted to NHS England by 14 February. NHS England would need to decide if it had confidence in the plans and would consider the delivery of key performance indicators. There would be no new money in the system. There would be a need to invest in an innovative way.

43.16 Geraldine Hoban referred to the question of Plan B. She explained that there was some flexibility to mitigate not delivering all services. There would be 2 to 3 years to deal with these issues. It was known that there were inefficiencies in the service. There were a significant number of people who did not need to be admitted to hospital and there were efficiencies to be made in the system.

43.17 Councillor Shanks considered that the Better Care Fund Plan was the way forward. Councillor Shanks noted that frailty had been chosen as a focus for better care. She approved of holistic approaches and hoped the Board could build on this model.

43.18 Denise D'Souza stressed the need to look at more integrated models. This model had been based on the 'Troubled Families' work carried out in children's services.

43.19 Geraldine Hoban made the point that taking money out of the acute sector did not mean making hospitals do more for less. It was about caring for people in a better way so that they did not need to spend such a long time in hospital – thereby reducing the demand on hospital services, and enabling some economies to be made. Commissioners were working closely with the hospital trust to ensure that there was a joined-up approach.

43.20 Councillor Bowden commented that this approach used to be called Care in the Community, which aimed to get people looked after in their home settings. The Chair replied that the current plans would apply to larger areas.

43.21 The Chair stated that the Chairs of the hospital trusts had held discussions on this matter. There had been some anxiety but recognition that there was a need to work

together. Amanda Fadero, Chief Executive of NHS Sussex felt that the plan was good from her perspective.

43.22 Sarah Creamer stated that she was very impressed with the work to date. She was confident about the direction of travel.

43.23 **RESOLVED** – (1) That the first cut of the Better Care Fund planning Template as set out in Appendix 1 and 2 of this report, be approved.

(2) That the Executive Director Adult Services & Chief Operating Officer CCG be instructed to submit Appendix 1 and 2 to NHS England by 14th February in accordance with the Better Care Fund requirements.

(3) That the Board delegates to the Executive Director Adult Services & Chief Operating Officer CCG, following consultation with the Better Care Programme Board and Chair of the Health & Wellbeing Board, authority to make such amendments to the draft proposals for the administration of the Better Care Fund as they consider appropriate and to agree the final version to be submitted by 4th April 2014.

(4) That a report with a copy of the final submission be brought back to the next meeting of the Health & Wellbeing Board meeting on 11 June 2014.

44. PHARMACEUTICAL NEEDS ASSESSMENT

44.1 The Board considered a report of the Director of Public Health which informed members that the Health & Wellbeing Board has a statutory responsibility to produce and maintain a statement of the needs for pharmaceutical services of the population in the area, referred to as a Pharmaceutical Needs Assessment (PNA). NHS England uses the PNA in deciding if new community pharmacies are needed and to inform decisions on which NHS funded services should be provided by pharmacies. The regulations require every HWB to publish its first PNA by 1st April 2015. The report set out the proposed approach by Brighton and Hove. Paragraph 5.1 set out the consultation process. The report was presented by the Consultant in Public Health.

44.2 The Chair asked if it would be possible for the Board to see a draft version of the PNA in the autumn. The Consultant in Public Health confirmed that a draft copy would be circulated informally to the Board.

44.3 Sarah Creamer, Director of Commissioning, NHS England, informed the Board that NHS England was encouraging Health & Wellbeing Boards to provide as much detail as possible in the PNA. The PNA determined market entry and needed to be as robust as possible.

44.4 Councillor Meadows considered that the report was very positive. However, she expressed concern that Moulsecoomb and Bevendean, which had the highest deprivation in the city, does not have a pharmacy. People in Bevendean have to travel by bus to use a pharmacy in Lewes Road. Councillor Meadows stated that she would like to see pharmacies going back to localities.

44.5 Councillor Meadows noted that there were two pharmacies in Coombe Road. She asked why one of those pharmacies could not move to the Bevendean area? Councillor Meadows stressed that GPs surgeries should be serviced by a pharmacy.

44.6 The Consultant in Public Health explained that the report under consideration was about market entry, but these matters could be looked at as part of the process.

44.7 Councillor Shanks asked if matters such as the opening hours of pharmacies could be considered. The Consultant in Public Health explained that the process of approving pharmacies was a permissive rather than instructive process. However, a pharmacy that opened later, where needed, was more likely to get approved by NHS England.

44.8 Councillor Bowden referred to the list of consultees under paragraph 5.1 of the report. He asked if the Older Peoples Council could be included. The Consultant in Public Health agreed that this was a sensible suggestion which would be taken on board.

44.9 The Chair asked if a list of who was consulted would be included on the draft report. It was confirmed that the draft report would include this information.

44.10 Geraldine Hoban suggested that Patient Participation Groups be included in the consultation.

44.11 Sarah Creamer stressed that the development of the PNA was a discrete piece of work about market entry. The PNA was designed to do a particular set of things.

44.12 The Chair suggested that there should be a separate report for future discussion on the better use of pharmacies.

44.13 Councillor Bowden asked if Ms Creamer was talking about matters such as diabetes testing and hearing testing. Ms Creamer confirmed that these matters would be considered. Other matters to consider were overprescribing and drugs taken in the wrong order.

44.14 The Chair asked if the CCG had looked at co-pharmacies and co-location with GP surgeries. Geraldine Hoban replied that this was something that the CCG was eager to explore with the NHS England Area Team – given that primary care commissioning is an NHS England rather than a CCG responsibility.

44.15 Councillor Bowden asked if pharmacists were included in integrated teams. Geraldine Hoban explained that there were pharmacists who visited care homes. They were not community pharmacists, but part of a CCG team.

44.16 Councillor Bowden asked about access to records. If a pharmacist carried out a diabetes test that indicated a problem, did they refer the matter to the patient's GP? The Deputy Director of Public Health replied that the data was not shared and the patient would be responsible for arranging to visit their GP. Sarah Creamer stressed this was about patient choice.

44.17 **RESOLVED** – (1) That it is noted that it is a statutory requirement for the Board to produce and keep up to date the PNA as set out in 3.6 of the report.

(2) That the Director of Public Health be instructed to:

- produce a revised PNA for approval by the HWB by 1 April 2015 (and subsequent updates) and
- develop and maintain a process to identify any changes to pharmaceutical services and consider if they are substantive enough to require a revised PNA or whether this would be a disproportionate response to those changes.

The meeting concluded at 6.51pm

Signed Chair

Dated this day of

BRIGHTON & HOVE CITY COUNCIL

ADULT CARE & HEALTH COMMITTEE

4.00pm 17 MARCH 2014

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Jarrett (Chair) Councillors Phillips (Deputy Chair), K Norman (Opposition Spokesperson), Meadows (Opposition Spokesperson), Bowden, Janio, Mears, Summers and Wakefield

Co-optees: Geraldine Hoban (Clinical Commissioning Group), Dr George Mack (Clinical Commissioning Group) and Janice Robinson (Clinical Commissioning Group)

In attendance: Colin Vincent – Older Peoples Council

PART ONE

59. PROCEDURAL BUSINESS

59A Declarations of Substitute Members

59.1 Councillor Janio declared that he was substituting for Councillor Barnett.

59B Declarations of Interests

59.2 There were none.

59C Exclusion of the Press and Public

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

59.4 **RESOLVED** - That the press and public be not excluded from the meeting.

60. MINUTES

60.1 Councillor Mears and Councillor Meadow stressed that they had not yet received constitutional advice with regard to the report on New Models of Service Delivery for ASC Provider Services (paragraph 46.5).

60.2 Councillor Mears referred to paragraph 50.16 in which the Chair had stated that he would ask for a constitutional ruling on exactly what budget information should be presented to the committee. She asked if the Chair was able to provide this information.

60.3 The Chair responded as follows:-

"Under the terms of the Council's constitution the annual Budget is set by Full Council. Policy and Resources Committee has overall responsibility for the financial and other resources of the Council. Quarterly reports are provided to Policy and Resources for the purpose of identifying and managing financial risks. At the request of this Committee the relevant extract concerning Adult Care and Health from the quarterly reports with added information on financial forecasts are presented to this Committee for information. This information provides Committee with a context on the overall budget to inform and assist in discharging its delegated functions and decision making on specific recommendations concerning commissioning and delivery of Adult Social Care."

60.4 Councillor Meadows referred to paragraph 52.4 in relation to the Integrated Community Equipment Service. She had asked for a further report to be submitted to the Committee and noted that this was not included on the agenda.

60.5 The Chair reported that there had not been sufficient progress on the service to enable a report to be submitted to this meeting. He read the following statement:-

'Commissioners at Brighton & Hove City Council and the Clinical Commissioning Group are continuing to work closely in partnership with Sussex Community Trust to determine the future of the Integrated Community Equipment Service.

Estates Teams at the Council and Sussex Community Trust have identified an approximate specification for an alternative building and need to carry out further work to identify the cost of either renting adequate space or building on an appropriate site. Neither the Council nor the Trust has an existing building that is suitable for this purpose.

Sussex Community Trust are also working closely with their IT provider to develop the back office functions that will enable better provision of finance and performance data to inform commissioners and members of this committee.

Commissioners will provide a full update to in June 2014. '

60.6 The Executive Director of Adult Care & Health stressed that it was essential to have the necessary information from the Sussex Community Trust before a decision was made on the service.

60.7 **RESOLVED** – That the minutes of the meeting held on 20 January 2013 be agreed and signed as a correct record.

61. CHAIR'S COMMUNICATIONS

Better Care in Brighton and Hove

61.1 The Committee received a presentation with slides from the Executive Director of Adult Services, BHCC and Geraldine Hoban, Chief Operating Officer, CCG. The presentation set out the background to the Better Care Fund and gave details of national conditions, funding and performance measures. The presentation stressed the changing needs of the city and explained the focus on frailty. The presentation explained the vision for better care in Brighton and Hove and set out principles, the approach and the plan for implementing the changes.

61.2 The Executive Director explained that the Better Care Fund planning template had been submitted to NHS England by 14 February 2014. The current update provided details of ongoing work.

61.3 Geraldine Hoban explained that GPs would be the clinical co-ordinators of frail and elderly people. There was an intention to have GP practice clusters working together in units of 20,000 to 25,000 as integrated teams. A letter had been sent to GP practices asking for an expression of interest for working in clusters. 5% of the population would fall into the category of 'frail'. A number of stakeholder events had already been held in the city. A pilot would test the clinically led model and phase 1 would be commenced from April 2014 onwards with a role out from 2015/16.

61.4 Ms Hoban explained that operational support was key to the success of the clinically led model. There would be investment in the senior management team to the project. Capita had been employed to measure the impact of the project and look at the outcomes for the city. It would identify the benefits of working in different ways and the benefits of integrated care to reduce emergency admissions and delayed transfer of care. The next submission to NHS England was due on 4th April 2014 and further details could be shared with members post April.

61.5 Councillor Bowden asked if the pilot would include out of hours care. Councillor Bowden referred to the GP Clusters and asked about the level of protection for data sharing between GP practices and third sector partners.

61.6 Ms Hoban stressed that out of hours care was a key part of the project. 24/7 working did not necessarily mean that all services would be available 24 hours a day. There would be numbers in place for people in need to access 24/7 care.

61.7 The Executive Director explained that some protocols were in place and more would be added. All information governance arrangements would be fully considered.

61.8 Councillor Mears asked for an idea of timescales. She asked where the investment budget would come from. Councillor Mears referred to IM&T shared records and stressed that this work would require huge investment. Councillor Mears referred to GP clusters and considered that demographics would make this quite difficult. There was a need to think how this would work for residents and patients. Councillor Mears asked for more details about the human resource arrangements for the proposals. This would be a complex area with different employment contracts involved.

61.9 Geraldine Hoban explained that with regard to the investment, there would be an additional £9,000,000. The Health and Wellbeing Board would oversee the budget and decide how it was spent. More money would be placed in community services to strengthen the system. The issue of shared records was a huge challenge. Work was being carried out to realign IT systems and records in the health service. There was now a need to expand that work to realign systems with social care. An IM&T sub group would be looking at this matter. Meanwhile there would be a big stakeholder event in the summer which would discuss record sharing with the public.

61.10 The Executive Director of Adult Services reported that the Head of Performance and Contracting, BHCC was investigating IT solutions with the current supplier. The Executive Director explained that all working groups were multi agency and involved the big suppliers. The intention was for all the main providers to work together.

61.11 Councillor Meadows commented that the purpose of the Better Care proposals was to prevent re-admission to hospital. There was concern about the GPs role. GPs surgeries were currently operating 5 days a week. Councillor Meadow expressed concern about the communication between the hospital and the GPs surgeries. If a person was discharged on a Friday, they could run out of tablets and not get the necessary medication. Communication between the hospitals and GPs was critical.

61.12 Councillor Meadows mentioned the three pop up medical centres that had opened in Brighton and Hove. She had concerns about where these were located. Councillor Meadows referred to the 20,000 to 25,000 population GP clusters. It was more difficult in the suburbs to locate GPs surgeries. Taking into account the geographical layout of the city, she asked how the plan would work for the benefit of patients.

61.13 Geraldine Hoban agreed that systems were not currently working in a joined up way. Joined up care was the right way forward. GPs might not necessarily be the care co-ordinator. It might be a member of the third sector. The Better Care programme would look at how to connect care with the hospitals and improve communication between integrated teams. The purpose of the pop up centres was to provide additional primary care, particularly at weekends when GP surgeries were closed. Feedback from patients had been positive. Ms Hoban agreed that the east pop up centre was too close to the A&E department. A more suitable location was being sought. The centres were currently being piloted.

61.14 Councillor Wakefield referred to the Integrated Homeless Programme Board. She stressed that there were many groups in the city who were difficult to reach and that there were some vulnerable people who did not have access to doctors. She asked how they would be included in the structure.

61.15 Geraldine Hoban explained that if a person was not registered with a GP it did not mean that they could not access integrated care. They would be encouraged to register with a GP but even if they were not registered, it was possible for them to be identified through other services.

61.16 Councillor Bowden referred to the involvement of Capita. He asked for more details about the contract. Geraldine Hoban explained that Capita would be working for three months with the CCG, during which time they would quantify the spend on frailty in the city. The value of the contract was £38,000. They would report to the Better Care Programme Board.

61.17 Councillor Janio asked how the proposals were being communicated to people in the city. He was concerned that the proposals were not being communicated to people who used the services.

61.18 Geraldine Hoban agreed that there had not been a great deal of public engagement up to now. There would be public consultation when the pilot commenced. The role of the public was key and there would be an Engagement Sub-Group.

61.19 The Executive Director stressed that Penny Thompson, Chief Executive, BHCC was chairing a meeting with the Chief Executives of the health trusts, and staff were engaged in the process. She stressed the need to work differently in order to have sufficient resources in the system.

61.20 Councillor Bowden asked why patient groups were not engaged at this stage. Geraldine Hoban explained that there had been some conversations with patients, and public and third sector organisations. When the pilot commenced, patients would be fully consulted and their views would be crucial.

61.21 Councillor Mears asked how the pilot would be monitored. The Executive Director explained that the Health and Wellbeing Board would monitor the pilot.

61.22 Councillor Norman commented that he considered that the presentation and the following discussion to be time well spent. He was pleased the meeting had gone ahead as scheduled.

61.23 **RESOLVED** – That the presentation be noted.

62. CALL OVER

62.1 **RESOLVED** – That all items be reserved for discussion.

63. PUBLIC INVOLVEMENT

63.1 There were no petitions, written questions or deputations from members of the public.

64. MEMBER INVOLVEMENT

64.1 The Committee noted that there were no petitions, written questions, letters or Notices of Motion received from members.

65. FINANCE REPORT TBM9

65.1 The Committee considered a report of the Executive Director of Finance & Resources and the Chief Finance Officer, Brighton and Hove CCG which set out the revenue and capital financial position on Adult Services, NHS Trust Managed S75 Budgets and Public Health.

65.2 The Head of Business Engagement presented the paper and explained that the full Council had agreed the budget on 5th March. A detailed budget book would be circulated to members. A budget of £73.6m had been agreed for adults. Adult savings amounted to £4.8m. One off resources would be provided for adult care reforms. The ring fenced Public Health budget had increased and the CCG planning for 2014/15 and future years was set out in paragraphs 3.7 to 3.9 of the report.

65.3 Councillor Mears referred to the Corporate Critical – Community Care Budget (Older People) set out on page 27 of the agenda under Adults Assessment. She noted the detailed explanation and asked how the overspend would be addressed.

65.4 The Executive Director stated that officers were looking at a range of options including the use of other buildings and services.

65.5 Councillor Mears asked about the conditions attached to the Public Health grant. The Chair replied that he would arrange for the Director of Public Health to provide a briefing.

65.6 **RESOLVED** - (1) That the financial position for the 2013/14 financial year as reported at TBM9 (December 2013) be noted.

66. MARKET POSITION STATEMENT

66.1 The Committee considered a report of the Executive Director of Adult Services which informed members that the White Paper 'Caring for our Future' introduced a duty on Local Authorities to promote diversity & quality in the provision of care services. The Department of Health urged Local Authorities to create a Market Position Statement that would be useful for providers of care services in planning their businesses.

66.2 The Market Position Statement (MPS) outlined the Commissioning priorities for Adult Social Care services, Brighton & Hove, and highlighted the key factors influencing developments in the care market.

66.3 The Market Position Statement also detailed areas of work that Adult Social Care would be concentrating on in future.

66.4 The report was presented by the Head of Commissioning & Partnerships, aided by the Commissioning Manager. Members would receive a full colour version of the final document.

66.5 The Executive Director of Adult Services informed members that the document had been shared with commissioning colleagues across the council. Feedback from the Care Homes Commissioning Group had been positive. Providers thought it was a useful document.

66.6 Councillor Meadows considered that it was a useful document for third sector and private providers. She asked how self funders care costs would be managed. The Head of Commissioning & Partnerships explained that more work needed to be carried out with regard to that issue. The matter would be addressed as more details of the Care Bill were received.

66.7 Councillor Mears found it an interesting document. Councillor Mears referred to the section on demographic and prevalence data. She noted that this section reported that 73% of people stated that they had no religion. She asked why this information had been included. Councillor Mears felt this was a misleading statistic in the document. Councillor Mears referred to the section 5.1 in relation to sheltered housing allocation. She asked for reassurance that the allocation was through the council's homemove scheme.

66.8 The Head of Commissioning & Partnerships explained that there was no particular relevance to the statistic about religious belief. The statistics were received from Public Health. The Commissioning Manager reported that officers were keen to work with faith groups. There had been a productive meeting the previous week with church representatives about the need to work together.

66.9 The Head of Commissioning & Partnerships referred to the question about sheltered housing allocation. She explained that officers were working closely with colleagues in housing. All the content in the document had been checked with housing officers and there would be collaborative working with housing colleagues.

66.10 Councillor Janio welcomed the document. He referred to the statistics set out in the section on demographic and prevalence data. He stated that people were not good at reading statistics. He suggested taking out the percentages and replacing them with baseline figures.

66.11 Colin Vincent of the Older People's Council expressed his concerns about the document. He stated that on first reading, he felt that it could be said that the council were abrogating responsibility for adult social care, particularly in relation to older people. The document appeared light on scrutiny and contractual details. Mr Vincent stated that at the moment the Adult Care & Health Committee had a degree of scrutiny. He would have grave concerns if the committee was to be disbanded. In the meanwhile, he would share the document with the Older People's Council.

66.12 The Executive Director of Adult Care & Health explained that the document was not about abrogating responsibility. The document was for providers and possible providers in the city. There was a duty to assess need and the document showed that these were the sort of services that were required. The Commissioning Manager stated that she would be attending the Older Peoples Council to give a presentation on the document.

66.13 The Chair stressed that the document was not about shirking responsibility but about being clear about services and who would provide them. It was an absolute priority to ensure that safeguarding and quality control would continue regardless of who provided the services.

66.14 The Executive Director of Adult Services explained that officers wanted the document to be of a reasonable size to ensure its readability. There were supporting documents providing details of contracts and contractual support.

66.15 Councillor Norman considered the document to be a relatively easy read. In relation to Mr Vincent's comments, he stressed that the council had a scrutiny process in place. Councillor Norman asked how powerful was the word 'urged' in paragraph 1.1 of the report.

66.16 The Committee Lawyer replied that although there was not a statutory requirement to produce a Market Position Statement, there was an expectation on the part of Central Government that the Statement would be created and produced.

66.17 **RESOLVED** - (1) That the key messages in the document attached in Appendix 1: Adult Social Care Market Position Statement be noted.

67. ITEMS REFERRED FOR COUNCIL

66.1 **RESOLVED -** That no items be referred to Council

The meeting concluded at 5.55pm

Signed Chair

Dated this day of

HEALTH & WELLBEING BOARD	Agenda Item 5 Brighton & Hove City Council

Subject:		**Brighton & Hove Health & Wellbeing Board (HWB): New Terms of Reference**
Date of Meeting:		**10 June 2014**
Report of:		**The Director of Public Health**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 29-1038**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The Terms of Reference for the Brighton & Hove Health & Wellbeing Board (HWB) were recently amended (at Full Council on May 08 2014).

1.2 **Appendix 1** to this report includes the report that was agreed at Full Council on 8th May 2014 which sets out the vision for the new Board and its proposed ways of working.

2. RECOMMENDATIONS:

2.1 That HWB members note the revised Terms of Reference for the Health and Wellbeing Board (**Appendix 1**)

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The Council and the CCG have revised the Brighton & Hove HWB Terms of Reference in order to better position the HWB as a system leader for citywide health and wellbeing issues. Full details of the revisions and the rationale for change are included as **Appendix 1** to this report.

3.2 In recognition of the new membership and terms of reference for the Board and the establishment of the new Health and Wellbeing Partnership, a report will be brought to the next meeting of the Board with proposals for effective public engagement and ways of working.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 This is a report for information.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None to this report for information.

6. CONCLUSION

6.1 This is a report for information – the rationale underpinning the HWB changes is detailed in the report to Full Council (**Appendix 1**).

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 The Health & Wellbeing Board will manage funds that are part of a formal joint commissioning arrangement, and pooled funds (e.g. the Better Care Fund). This will bring new accountabilities for monitoring delivery against significant funding streams.

Finance Officer Consulted: Anne Silley *Date: 15/05/14*

Legal Implications:

7.2 The legal framework and responsibilities of the Health and Wellbeing Board are addressed in **Appendix 1**.

Lawyer Consulted: Elizabeth Culbert *Date: 15/05/14*

Equalities Implications:

7.3 None specifically to this report for information.

Sustainability Implications:

7.4 None specifically to this report for information.

Any Other Significant Implications:

7.5 None specifically to this report for information.

SUPPORTING DOCUMENTATION

Appendices:

1. Extract from the Health & Wellbeing report to 08 May 2014 Full Council

Documents in Members' Rooms

None

Background Documents

None

Council	Agenda Item 117
8 May 2014	Brighton & Hove City Council

Subject:		**Health & Wellbeing Board**
Date of Meeting:		**8th May 2014** 1st May 2014 - Policy & Resources Committee
Report of:		**Monitoring Officer**
Contact Officer:	**Name:**	**Abraham Ghebre-Ghiorghis** **Tel: 29-1500**
	Email:	**Abrahm.ghebre-ghiorghis@brighton-hove.gcsx.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 This report proposes changes to the role, purpose and ways of working of the Health & Wellbeing Board to reflect the need for greater co-ordination and integration of health and local authority functions.

1.2 The proposals go beyond the minimum requirements of the Health & Social care Act 2012 and involve a fundamental change to the governance of health and wellbeing in the city. They provide for a "system leadership" across health and local authority by pooling together resources and decision making between the Council and the Clinical Commissioning Group (the CCG.)

1.3 The proposals in this paper are intended to enable the Health & Wellbeing Board to have real decision-making powers in the commissioning and delivery of services that have a bearing on health & wellbeing outcomes, including health, adult social care, public health, children and young people, housing and other services. They also propose structures for engagement and development of shared vision and direction across all health and local authority sectors in the City

2. RECOMMENDATIONS:

2.1 That Committee recommends to Council that:

(i) the proposals set out in paragraphs 6.7 to 11.2 and appendix 2 to the report be agreed;
(ii) the proposed changes come into effect immediately after Annual Council meeting on 15th May 2014;
(iii) the Chief Executive be authorised to take all steps necessary, conducive or incidental to the implementation of the proposals, including entering into section 75 Agreements;
(iv) Note the intention to provide system leadership, achieve greater joint commissioning and integration of services between the Council and the CCG;

(v) agree to keep the effectiveness of the arrangements under review.

(vi) Agree the recommendations of the Independent Remuneration Panel regarding allowances for the Lead Member for Adult Social Services as set out in paragraph of the report.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The Council's Health & Wellbeing Board (HWB) has been in existence since 1st April 2012, initially in shadow form and, since 1st April 2013, as a statutorily constituted committee of the Council. In the days leading up to the creation of Health & Wellbeing Boards, there was considerable interest and discussion at national and local level. The expectation at that time was for Health & Wellbeing Boards to become "super committees" and fundamentally change the way that local authorities and the health service work by bringing different players together: being a catalyst for change and deeper integration*.*

3.2 Despite the laudable aims, the HWB in Brighton & Hove (as with other HWBs) has not been as effective as it could potentially be. The pressure on resources, the increasing conditionality of central government funding (through the better care system) and the new requirements under the Care Bill mean there is an urgent need to examine the existing arrangements and identify a better way forward. The current structures and governance arrangements are inadequate to deliver a more strategic, co-ordinated delivery of services.

3.3 There is a need for system leadership across health and local authority in the City to provide the necessary leadership and governance structure to achieve grater integration and co-ordinated approach resulting in better outcomes for the residents of the city.

3.4 The proposals in this paper are designed to facilitate an ever greater level of joint commissioning and integration of services between the health and local authority sectors. They will be reviewed at regular intervals with a view to ensuring that they remain relevant and reflect the health & wellbeing aspirations of the city.

4. The Legal Requirements

4.1 Section 194 Health and Social Care Act 2012 (the 2012 Act) requires first-tier local authorities (County Councils and Unitary Authorities) to establish a Health and Wellbeing Board for their area. More detailed requirements are set out in the Local Authorities (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013.

4.2 **Composition:** the 2012 Act provides that a HWB must consist of (1) at least one councillor (2) the Director of Adult Social Services, the Director of Children's Services, the Director of Public Health (3) a representative of the Local Healthwatch organisation for the area of the local authority (4) a representative of the relevant Clinical Commissioning Group, and (5) A representative of such other persons, or representatives of such other persons, as the local authority thinks appropriate.

4.3 **Functions:** the 2012 Act requires that HWBs **must**:-

- Prepare a Joint Strategic Needs Assessment;
- Prepare a Health and Wellbeing Strategy;
- Prepare a Pharmaceutical Needs Assessment (once every three years)
- Encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner;
- Provide such advice or other support they think appropriate for the purpose of encouraging the making of arrangements under s75 NHS Act 2006 (ie pooled budgets, lead commissioning and/or integrated provision of health related services);

4.4 The Act also provides that the HWB **may**:-

- Encourage persons who arrange for the provision of any health related services in its area to work closely with the HWB;
- Encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health related services in its area to work closely together;
- Exercise any other functions that are exercisable by the Council; (NB. Please note that the Council is prohibited from delegating its health overview and scrutiny functions to the HWB – see Section 196 (4) of the Health and Social Care Act 2012).

4.5. **Decision- Making**: it is expected that most decisions are taken by consensus (acclamation) without a need for show of hands. All councillor members of the board are automatically voting members. The Council has the power to decide whether the non-elected members of the Board are voting or non-voting members of the Board (see section 6 of the Regulations). The default position is that all members of the Board have one vote each.

4.6. **Status:** A HWB is to be established as a *Committee* of the local authority (see s194(12) of the Act). The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 modify the rules in relation to committees for HWBs. The Regulations enable the functions of the HWB that are set out in the Act (referred to in paragraphs 2.2 and 2.3 above) to be discharged by a sub-committee of the Board (but not by officers.) The Regulations enable other functions (other than the 2012 Act functions) that are given to the Board by the local authority to be discharged by a sub-committee or by officers.

4.7. **Proportionality:** the Regulations disapply the rules requiring political proportionality on committees for the purposed of the HWB. This means the composition of the Board does not necessarily need to reflect the relative number of seats each political group has at Council. Indeed, it is possible for all Members of the Board to come from the same political group in the Council.

4.8. **Ways of working**: the HWB has a committee status, which means that all the rules in the Local Government Act 1972 regarding access to meetings, agenda and background papers apply to the Board. All its meetings are required to be in public unless discussing confidential or exempt business.

4.9. **Overview & Scrutiny of Health:** the Health Service Act 2006 and the Local Authorities (Overview & Scrutiny Committees Health Functions) Regulations 2013 make provision for overview and scrutiny of health matters by local authorities. Unlike the previous Regulations, the 2013 Regulations confer the function of health scrutiny, including referrals to the Secretary of State, on the local authority itself, not the Overview & Scrutiny Committee. Strictly speaking therefore, full Council could retain that function. The Regulations allow the Council to delegate the health scrutiny function to a committee of the Council. However, it is not allowed to delegate this to the Health & Wellbeing Board. Furthermore, the power of referral of matters to the Secretary of State is to be exercised by full Council only and cannot be delegated.

5. The Current Arrangements in Brighton & Hove

5.1 The approach adopted in Brighton & Hove at the time the Board was created was stated at intended to be "transformational" rather than "transactional." In practice however, given the uncertainty regarding the role of the Board and the limited nature of the powers given to the board under the Act , the Council established the Board with the minimum powers necessary to comply with the Act.

5.2. The Board was constituted in shadow or pilot forum for the first year (1st April 2012 to 31st March 2013.) At the end of the shadow period, the Board was formally constituted as a statutory body under the 2012 Act with no substantive change to the arrangements in the pilot period.

5.3. c**urrent composition**: the current composition of the Board is 7 Councillors, 3 Officers (Director of Adult Social Services, Director of Children's Services and Director of Public Health) 2 representatives from the Clinical Commissioning Group 1 representative from Healthwatch and 1 co-optee from the Youth Council.

5.4. The Council or the Board (which can co-opt people in its own right) have not co-opted any other members. The current Councillor and CCG representation is above the statutory minimum specified in the Act and set out in paragraph 2.2 above.

6. Effectiveness of current arrangements

6.1. There is evidence of extensive joint working between local health and local authority services and there are good relations between local authority and NHS managers. The HWB has succeeded in overseeing the introduction of the joint needs assessment. However, the Board has been less effective in providing strategic leadership and increasing integration of health and local authority services. This is more so especially when judged against the budgetary and service challenges facing the Council and the health service over the next 5 years.

6.2. The LGA have developed a tool kit for diagnosis and development of Health & Wellbeing Boards with 5 indicative levels of development. Against the LGA development criteria, it seems that the Brighton & Hove's HWB is probably at stage 2 and steps need to be taken to take it to a higher, "mature" or "exemplar," level. Some of the shortcomings are functional and some are related to the form and ways of working. In particular:

(a) There is a need for “system leadership” which is missing in existing arrangements and which would be difficult to achieve using existing structures;

(b) Despite the provision in legislation authorising the delegation of additional functions to HWBs, Brighton & Hove has not used this to give the Board additional powers. Virtually all functions relating to Children’s Services and most of Adult Social Care and Public Health are still discharged through the traditional committees (Children and Young People and Adult Care & Health as well as the Joint Commissioning Board.) The committees are where “it all happens,” not at the Health & Wellbeing Board. The existence and role of the board is hardly noticed outside those attending;

(c) The Board has the legal status of a committee and is run like any other committee. The opportunity was not taken to modify the normal procedures to make them fit for purpose;

(d) There is lack of clarity in the relationship between the Board, the decision-making committees and the Local Strategic Partnership;

(e) The Board could play a greater role in developing a joined up, outcome-focused budget strategy for the various functions. The existing arrangements with limited powers of the Board have not been effective in the achievement of these objectives;

(f) There is no clear officer leadership for the Board in a way that can be seen in other committees. There is a need for active agenda shaping and a guiding role from senior officers.

(g) The increasing pressure on resources due to the budgetary situation together with the increasingly changing demography and health needs of the population require a better co-ordinated and empowered system leadership. The requirements of the Better Care Fund and the changes to be introduced under the Care Bill also require a new and different integrated approach. The current arrangements are fragmented and not equipped to deal with the challenges.

(h) There is no effective mechanism for securing consensus across health organisations and the local authority in the city.

6.3. It should be emphasised that any shortcomings in realising the full potential of the H&WB have been largely the result of its limited terms of reference and ways of working designed for normal committees rather than lack of effort or leadership on the part of those involved. In fact, much of what has been achieved has been despite rather than because of its limited remit and ways of working.

Experience from Other Authorities

6.4 Officers have made enquiries of many local authorities to see if there are any that have been successful in developing effective HWBs in the way it was intended when they were introduced. The result was disappointing though not surprising.

None of them seem to have delegated any meaningful functions beyond the mandatory statutory ones and most of them are operating in ways similar to the one in Brighton & Hove.

6.5 The LGA improvement and development tool kit referred to above is based on their review of various HWBs. This could be used as an additional tool to check where we are and identify areas for action/improvement. But what is clear is that, at the end of the day, we have to develop our own, local, Brighton & Hove arrangement that will deliver the outcomes we want.

7. The Way Forward

7.1 Having considered the challenges facing local authorities and the health sector, and taking into account national requirements, it is proposed to take a bold step to make fundamental changes to the existing governance arrangements. This is described in more detail in the following paragraphs.

Functions

7.2 It is proposed that the Health & Wellbeing Board retains all of its existing functions, including decisions regarding the Better Care Fund;

7.3 In addition to its existing delegated functions, it is proposed that the Board be given full delegated powers from the Council to discharge all of its public health, adult social care & health and children & young people functions;

7.4 It is proposed that the Board's delegated functions include the power to deal with matters currently comprised in any joint arrangements with health (section 75 arrangements, Joint Commissioning Board etc).

7.5 The Board should have referred functions regarding the "people" side of housing and, in particular, housing-related support to vulnerable adults and children.

7.6 **CCG related functions:** it is proposed that the H&WB has the following remit regarding CCG related functions:

A. Leadership and Agenda Setting and Accountability

- To help shape the commissioning strategy of the CCG and ensure the CCG's commissioning intentions align with the health needs of the City.
- To promote creative and innovative approach to health and wellbeing using the freedoms afforded by pooled funds.
- To promote the agenda on integration - both in terms of sharing commissioning resource but also in terms of delivering a far more joined up service for people living in the City.
- To hold the CCG to account for the impact of their commissioning decisions ensuring that:
  - health outcomes are improving in the way they should;

- health inequalities are proactively addressed in commissioning plans.

§ Provide collective leadership to a whole range of City wide collaborative working and whole system issues - including emergency planning, resilience and preparedness, urgent care etc.

B. Decision-making

§ To approve the commissioning plans of the CCG.

§ To manage funds that are part of a formal joint commissioning arrangement or pooled fund (e.g. the Better Care Fund).

§ To help shape and comment on the strategic direction and commissioning intentions of the CCG.

§ To hold the CCG and other partners to account.

7.7. It is proposed that the H&WB is given referred powers regarding any functions of the Council and the CCG relating to the health and wellbeing of people who live, work or visit Brighton & Hove. These will include, but are not limited to, housing, transport, environmental health, arts and culture.

7.8. The full version of the proposed terms of delegation for the Health & Wellbeing Board is set out in Appendix 2 to this report.

8. Other Structures

8.1. **Children and Young People Committee** It is proposed that the existing Children and Young People Committee be retained with general children's services functions, but with the intention that the focus of the committee will be on matters relating to education and youth services. The functions of the committee will also be comprised in the delegations to the HWB, which will mean that they have concurrent delegations, but the Director of Children's Services will decide what issues should be referred to the Children and Young People's Committee with the presumption being that all business, except matters relating to education and youth services will, as far as possible, be dealt with by the HWB. The Lead Member for Children and Young People will be consulted on any matters affecting Children and Young People. The ways of working will provide for the Lead Member being able to attend and speak at the Board meeting on matters affecting children and young people.

8.2. **Health & Wellbeing Overview & Scrutiny Committee:** It is proposed to retain the existing Health & Wellbeing Overview & Scrutiny Committee, which will serve as the statutory Health Overview and Scrutiny Committee. It is however proposed to move the statutory education co-optees from the scrutiny committee to the Children and Young People Committee. This is because the focus of H&WO&SC has been on health and, given the new focus for the Children's Committee regarding education and youth services, it makes sense for these to be co-opted into the Children's Committee. By law, they are entitled to vote as members of the committee on any matters relating to education.

8.3. There will be a link, though not a formal reporting line, between the **Children Safeguarding Board** and the **Adult Safeguarding Board** and the Health & Wellbeing Board.

8.4. **Officer Executive Board** It is proposed that there be an Officer Executive Board consisting of the Directors of Children, Adults and Public Health and Head of Housing from the Local Authority and two representatives from the CCG. Additional members from provider and other organisations, as agreed by the Board, may attend some or all meetings of the Board depending on the agenda. The function of the Board would be:

- Make decisions, under existing officer delegations, on matters that the Board considers do not require Member level decision;
- To propose items of business to go to Member level decision-making (HWB or Children);
- To help co-ordinate and plan the agenda of the HWB;
- To deal with other matters that the Board members consider appropriate.

8.5. A structure chart showing the different parts of the arrangements together with a committee structure chart as attached as appendix 1 is shown in the appendix to this report.

9. Composition and Chairing of the Board

9.1 It is proposed that:

(i) the Board be chaired by the **Leader of the Council**. This will reflect the important, cross-cutting, role of the Board and is in line with the practice in many authorities, including East Sussex CC;
(ii) that the **Lead Member for Adult Care & Health** be a member of the Board;
(iii) although there is no legal requirement to do so, it is proposed, to reflect political proportionality principles, that there be 3 opposition members of the Board (currently 2 conservative and 1 Labour);
(iv) that the CCG be represented by 5 members. These will be decided by the CCG but are likely to include the Chair, the Chef Operating Officer, a member of the Local Members group, a lay member and the Accountable Officer;

Non-Voting Members

(v) That the statutory officer co-optees (Directors of Children, Adults and Public Health) be non-voting Members of the Board;
(vi) That the statutory health watch co-optee be retained as a non-voting member;
(vii) That the Chair of the Children Local Safeguarding Board be a non-voting member of the Board;
(viii) That a representative of NHS England be a non-voting member of the Board;

(ix) That membership of the Youth Council Co-optee be discontinued and that a Youth Council representative/s continue to be co-opted into the Children and Young People Committee.

9.2. Although the Board will be chaired by the Leader of the Council, the statutory Lead Member for Adult Social Care and Health is expected to take the lead on most issues and be responsible for the discharge of the functions set out in the national guidance for Lead Members for Adult Social Services. The scope of the role was considered by the Independent Remuneration Panel and it was agreed that the role should attract the same allowance as the chair of a policy committee. As the Adult Care and Health Committee is being discontinued, this ill not add any expenditure and, when the allowance for the Deputy Chair of the Adult Committee is taken into account, this would be a net saving.

10. Health & Wellbeing Partnership

10.1 It is proposed to create a Health & Wellbeing Partnership that brings together all key players and stakeholders at regular, at least twice yearly, intervals. The purpose is to share information, report on progress, develop a shared agenda and shared direction. The Partnership will consist of Members of the HWB and other co-optees agreed by the Health & Wellbeing Board from time to time, including representatives from Health providers in the City and the Community and Voluntary Sector.

10.2. Any organisation represented in the partnership may appoint a person to represent it and may send a substitute to meetings of the partnership.

10.3 The Health & Wellbeing Board will have the power to agree amend the terms of reference and membership of the H&W Partnership.

11. Health & Wellbeing Board Ways of Working

11.1 At the moment, the Health & Wellbeing Board is being run along traditional committee lines. There is an argument for exploring a different style of meetings depending on what is being discussed. These could include:

- Traditional committee type meetings for specific decisions;
- More deliberative type meetings to discuss general long term strategy;
- Include sessions for developmental/information sharing activities;
- Disapplying the rules in Council standing orders regarding questions, deputations, petitions or make arrangements for these to be presented in some but not all meetings;

11.2 What is clear is that the overall arrangements should be such that the Board is able to make decisions quickly and operate more like a Board and less like a committee. It is therefore proposed that the following arrangements apply to the Board:

- Anything in current standing orders (Rules of Procedure) which is the result of legal requirements and will apply to the Board;
- All other provisions of Standing Orders will apply to the Board unless the Board agrees otherwise;

- § In the application of standing orders, the Chair will have discretion to apply the rules with flexibility having regard to the nature of the business;
- § The above rules will be incorporated into the Council Procedure Rules

11.3 As part of the arrangements the Chairs of Committees whose functions are comprised in the delegations to the Board but are not members of the Board will be able to attend and speak at meetings of the Board on matters affecting the functions of their committees (for example children and young people and housing.)

11.4 As part of its remit, the Health & Wellbeing Board will have particular regard to equalities and inclusion and the effective engagement of communities of interest in progressing proposals affecting them.

12. COMMUNITY ENGAGEMENT & CONSULTATION

12.1 The proposals in this report were consulted on with Group Leaders, the Cross Party Constitutional Working Group and the CCG. The CCG are fully supportive of the proposals and any comments from the Member groups referred to above were taken into account in finalising the proposals.

13. CONCLUSION

13.1 For the reasons set out in the report, it is vital that the Council adopts new arrangements to reflect the challenges facing both organisations with ever increasing co-ordination, systems leadership and integration.

14. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

Under the proposed arrangements the Health & Wellbeing Board will manage funds that are part of a formal joint commissioning arrangement, pooled funds (e.g. the Better Care Fund). This will bring new accountabilities for monitoring delivery against significant funding streams including the Better Care Fund which in 2015/16 will be £19.6 million, and S75 arrangements for Children's and adults services.
The HWB will influence the development of the budget strategies for the Council and the CCG.

Finance Officer Consulted: Anne Silley *Date: 09/04/14*

Legal Implications:

14.2 These are addressed in the body of the report.

Lawyer *Abraham Ghebre-Ghiorghis* *Date: 020314*

Equalities Implications:

14.3 The arrangements will enable the Council and the CCG to tackle inequalities in health more effectively by having the ability to make decisions across service areas. As stated in paragraph 11.4 of the report, the Board will be mindful of the need to engage and consult communities affected by the Board's proposals.

Sustainability Implications:

14.4 There are no sustainability implications arising directly from this report.

Any Other Significant Implications:.

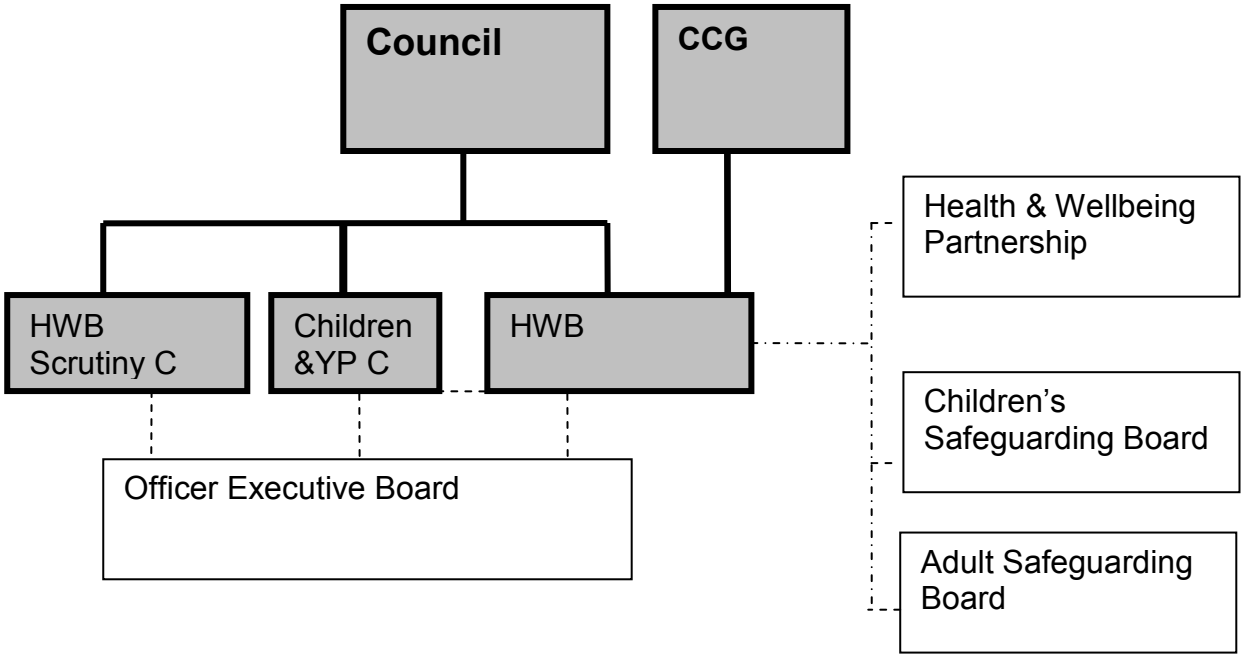
14.5 None.

SUPPORTING DOCUMENTATION

Appendices:

1. Structure Chart
2. Draft terms of reference

Appendix 1


Council
CCG
HWB Scrutiny C
Children &YP C
HWB
Officer Executive Board
Health & Wellbeing Partnership
Children's Safeguarding Board
Adult Safeguarding Board

APPENDIX 2

HEALTH & WELLBEING BOARD
Explanatory Note

General

The Health & Wellbeing Board (HWB) is established as a Committee of the Council pursuant to Section 194 of the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013.

Purpose:

The purpose of the Board is to provide system leadership to the health and local authority functions relating to health & wellbeing in Brighton & Hove. It promotes the health and wellbeing of the people in its area through the development of improved and integrated health and social care services.

The HWB is responsible for the co-ordinated delivery of services across adult social care, children's services and public health. This includes decision making in relation to Adult Services, Children's Services, and decisions relating to the joint commissioning of children's and adult social care and health services (s75 agreements).

Composition

Voting members:-

5 elected Members
5 CCG representatives (For CCG to decide but expected Chair; Chief Operating Officer; 1 LMG Chair, 1 lay member and the Accountable Officer)

Non-voting members

Executive Director Children Services;
Executive Director Adult Services;
Director of Public Health;
Representative from HealthWatch.
Representative NHS England;
Chair of Children's Local Safeguarding Board;

Delegated Functions

General

1. To provide system leadership to the health and local authority functions relating to the health and wellbeing of the people who live, work and visit Brighton & Hove;

2. To promote integration and joint working in health and social care services across the City in order to improve the health and wellbeing of the people of Brighton & Hove;

3. To provide City-wide strategic leadership to public health, health, adults and children's social care commissioning, acting as a focal point for determining and agreeing health and wellbeing outcomes and resolving any related conflicts;

3. To approve and publish the Joint Strategic Needs Assessment (JSNA) for the City;

4. To approve and publish a Joint Health & Wellbeing Strategy (JHWS) for the City, monitoring the outcomes goals set out in the JHWS and using its authority to ensure that the public health, health, adults and children's commissioning and delivery plans of member organisations accurately reflect the Strategy and are integrated across the City;

5. To receive the Clinical Commissioning Group's draft annual commissioning plan and to respond with its opinion as to whether the draft commissioning plan takes proper account of the relevant Joint Health and Wellbeing Strategy. Where considered appropriate by the HWB, to refer its opinion on the annual commissioning plan to the National Health Service Commissioning Board and to provide the CCG with a copy of this referral;

6. To receive the Local Safeguarding Children's Board's Annual Report for comment; and also the Adults Annual Safeguarding Report

7. To support joint commissioning and make pooled budget arrangements where agreed by the HWB that this is appropriate;

8. To establish and maintain a dialogue with the Council's Local Strategic Partnership Board, including consulting on its proposed strategies and reporting on outcomes in line with the City's Performance and Risk Management Framework.

9. To involve stakeholders, users and the public in quality of life issues and health and wellbeing choices, by

    - communicating and explaining the JHW Strategy;
    - developing and implementing a Communications and Engagement Strategy;

10. To represent Brighton & Hove on health and wellbeing issues at all levels, influencing and negotiating on behalf of the members of the Board and working closely with the local HealthWatch;

11. To appoint non-voting co-optees in compliance with relevant legislation and guidance;

12. To operate in accordance with the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013.

13. To review annual progress against city priorities in line with the national public health outcomes framework.

14. To receive reports from relevant programme boards and related multi-sector committees with a remit for public health in order to inform the Health and Wellbeing Strategy including: the Alcohol Programme Board, the Substance Misuse Programme Board, the Healthy Weight Programme Board and the Sexual Health Programme Board.

Better Care Fund

15. To discharge all functions relating to the better care fund that are required or permitted by law to be exercised by the Board, including

(a) to agree the strategic planning;

(b) manage the pooled budget

(c) oversee and performance manage the planning as well as the practical and financial implementation of the fund.

16. To receive and approve any other plans or strategies that are required either as a matter of law or policy to be approved by the Health and Wellbeing Board.

17. **Adult Social Services**

(a) To exercise the social services and health functions of the Council in respect of adults;

(b) To exercise all of the powers of the Council in relation to the issue of certificates to blind people and the grant of assistance to voluntary organisations exercising functions within its area of delegation;

(c) To exercise the functions of the Council in relation to the removal to suitable premises of persons in need of care and attention.

18. **Public Health**

To exercise the Council's functions in respect of public health, including but not limited to:

- sexual health
- physical activity, obesity, and tobacco control programmes
- prevention and early detection
- immunisation
- mental health
- NHS Healthcheck and workplace health programmes
- dental public health
- social exclusion
- seasonal mortality;

To exercise any other functions which transferred to the Council under the Health and Social Care Act 2012.

19. **Partnership with the Health Service**

(a) To exercise the Council's functions under or in connection with the adult services partnership arrangements made with health bodies pursuant to Section 75 of the National Health Service Act 2006 ("the section 75 Agreements").

(b) To exercise the Council's functions under or in connection with the children and young people's partnership arrangements made with health bodies pursuant to section 75 of the National Health Service Act 2006 and section 10 of the Children Act 2004 ("the section 75 Agreements") to the extent they are in force;

20. **Learning Disabilities**

To discharge the Council's functions regarding Learning Disability.

21. **Children's Services**

To exercise the Council's functions:-

(a) In relation to social services for children and young people;

(b) All the Council's functions as a local education authority and youth services. Without prejudice to the forgoing, it is expected that this function will normally be discharged via the Children and Young People Committee who has concurrent delegated powers;)

(c) Any other functions comprised in partnership arrangements with other bodies connected with the delivery of services for children, young people and families.

22. **Clinical Commissioning Group Functions**

A. Leadership and Agenda Setting and Accountabilty

- To receive and comment on the commissioning strategy of the CCG, help shape the same and ensure the CCG's commissioning intentions align with the health needs of the City.
- Promote creative and innovative approach to health and wellbeing using the freedoms afforded by pooled funds.
- Promote the agenda on integration - both in terms of sharing commissioning resource but also in terms of delivering a far more joined up service for people living in the City.
- Hold the CCG to account for the impact of their commissioning decisions ensuring that:
  - health outcomes are improving in the way they should;
  - health inequalities are proactively addressed in commissioning plans.
- Provide collective leadership to a whole range of City wide collaborative working and whole system issues - including emergency planning, resilience and preparedness, urgent care etc.

B. Decision-making

- § To agree the commissioning plans of the CCG (if H&WB does not agree the plan, it can refer it to NHS England.)
- § To manage funds that are part of a formal joint commissioning arrangement or pooled fund (e.g. the Better Care Fund).

- Help shape and comment on the strategic direction and commissioning intentions of the CCG
- Hold the CCG and other partners to account.

23. **Referred functions**

The Board shall have referred function on any matter relating to any matter that has implications for the health and wellbeing of the City. This includes, but is not limited to:

- § Housing
- § Environmental health and licensing
- § Transport
- § Arts and Culture

24. **Reserved matters**

The following matters will be reserved from the delegations to the Board:

- Final decisions on any matters that are reserved to full council or the CCG by law and cannot be delegated;
- Final decisions on matters reserved to full Council under the Council's Budget and Policy framework
- Matters that have corporate budgetary or policy implications that go beyond health and wellbeing
- The Externalisation (outsourcing) or bringing in-house any Council services (which shall be referred to the Policy & Resources Committee for final decision.)

HEALTH & WELLBEING BOARD	Agenda Item 6 Brighton & Hove City Council

Subject:		**Better Care Fund Plan update**	
Date of Meeting:		**10 June 2014**	
Report of:		**Executive Director, Adult Services & Chief Operating Officer, CCG**	
Contact Officer:	**Name:**	**Gill Brooks**	**Tel: 01273 574635**
	Email:	**gill.brooks1@nhs.net**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 Every Council and CCG is required to develop a Better Care Plan that must then be approved by The Health and Wellbeing Board.

1.2 The purpose of this report is to provide an update on:

- Progress of the Brighton and Hove Better Care Plan;
- The two locations for Phase One of the Better Care Plan; and
- The implementation of an integrated model of care for Brighton and Hove's homeless population.

2. RECOMMENDATIONS:

2.1 That the Health & Wellbeing Board notes the final Better Care Fund Plan for Brighton and Hove and the amendments made following the original submission.

2.2 That the Health and Wellbeing Board notes the progress made with Phase One and with the Homeless programme.

3. CONTEXT/ BACKGROUND INFORMATION

Update on Better Care Plan

3.1 The Better Care Plan was previously approved by the Health and Wellbeing Board on 14 February 2014.

3.2 Following the initial Better Care Plan submission from Brighton and Hove feedback from NHS England was received. They stated the Plan showed a good level of partnership working and using existing service developments for improving user experience and outcomes from care.

3.3 The Plan was then updated to provide more detail and clarification and re-submitted on 4 April 2014. The Chair of the Health and Wellbeing Board approved the final submission.

3.4 More detail was provided in the following areas:

- Describing mitigating strategies that will need to be deployed should the interventions not deliver the desired outcomes;
- Articulate more clearly the impact on providers; and
- Include more detailed financial information and clarity on where the funding is taken out of the health system and how the initiatives will then deliver the improvements in the metrics.

3.5 It is likely that further clarification will be required by NHS England on the submitted Plan with regards the level of ambition and mitigations against any risks to delivery following recent national media communications and announcements. The Better Care Board will ensure that the Health and Wellbeing Board are informed accordingly.

Update on Frailty model

3.6 In Brighton and Hove we intend to scope and develop an integrated and holistic Frailty model for residents who are vulnerable and who have complex needs. This will be delivered by a multi-disciplinary team who will consistently consider both the mental and physical health & social care needs of the individual. The team will facilitate a more formal involvement of carers, independent care providers and the community and voluntary sector in the partnership. People will be empowered to direct and personalise their care and support based on their individual needs, encouraging them to self-manage. Care will be co-ordinated in a single place to ensure service users and carers only need to tell their story once. This will be supported by electronic sharing of data with all involved in providing care, and the development of a single care plan that is reviewed, updated and shared appropriately. Care Co-ordinators will take responsibility for active co-ordination of care for the full range of holistic support.

3.7 GP's will play a significant role in local areas in supporting the coordination of people's care. The Practice will be at the heart of the Frailty model and therefore we offered open expressions of interest to every GP Practice in the City to be involved with Phase One Frailty. Due process was followed and a decision was made at the Better Care Board on 24 April. Due to the large amount of interest and enthusiasm for being involved in Phase One across a number of GP Practices, the Board agreed to include two geographical areas for Phase One. The two areas are:

- St Peter's Medical Centre and Park Crescent in Central locality with an East population; and
- Sackville Medical Centre, Wish Park Surgery and Central Hove Surgery in the West locality.

3.8 Over the next three months service users, carers and local providers associated with the two geographical areas will scope and design a new integrated model of care. During 2014/15 we will test the model before full City-roll out in 2015/16.

Update on integrated homeless model

3.9 A homeless integrated model is currently being developed and implemented in Morley Street Surgery in Central locality. The model involves a Primary Care Hub separated into two strands: a virtual hub in the form of an integrated team of healthcare professionals, and the physical location of a hub requiring identification of premises. The wider multi-disciplinary team includes health,

social care and housing professionals providing care to hostels, an in-reach and outreach element, care co-ordination and navigation roles and advocacy support.

3.10 Over the coming months there will be development workshops with stakeholders, and providers including representatives from relevant support work streams. The first of these will result in agreement on the key elements of an integrated model.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Every Council and CCG was required to develop a Better Care Fund Plan in line with the national guidance.

4.2 The integrated Frailty model will be developed and tested in 2014/15 through Phase One. Following full evaluation, an options appraisal will be developed outlining the options for full City roll out.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 The Brighton and Hove vision for an integrated model of care is based on feedback from public, patients, service users and carers. A key theme that has emerged from Clinical Commissioning Group and Brighton and Hove City Council public events is that whilst there are many excellent care and support services available in the City they do not always work well in terms of an overall system of care centred round keeping people well at home. Further details are contained in *The Better care Plan, Section d*).

5.2 Recent stakeholder events (in March 2014) have taken place to ensure that users/ patients/ carers and staff agree with the Integrated care vision and aims and ensure they can express their views at this early stage of development.

5.3 Formal arrangements to obtain on-going feedback will be put in place as an integral part of the Brighton and Hove Better Care Programme plan to ensure that service user and carer views drive the new model of care. This will include participation in Phase One development workshops, public meetings, the use of GP practices patient participation groups as well as a formal service user and carer reference group.

6. CONCLUSION

6.1 Brighton and Hove City Council and the CCG have produced a Better Care Fund Plan in line with the national guidance that has been approved by the Health and Wellbeing Board on 14 February 2014 with approval of final submission by the Chair of the Health and Wellbeing Board on 4 April 2014.

6.2 The detail of the Better Care Plan can be found at:

http://www.brighton-hove.gov.uk/content/council-and-democracy/councillors-and-committees/health-wellbeing-board

6.3 The Better Care Board has agreed the locations of Phase One, to develop the integrated care model, to scope and test the model and implement during 2014/15 before full City roll-out in 2015/16.

6.4 The Integrated Homeless Board has also started to implement an integrated model of care for Brighton and Hove's homeless population.

7. FINANCIAL & OTHER IMPLICATIONS:

7.1 The Better Care Fund Plan shows spend of £7.632 million in 2014/15 and £19.660 million in 2015/16 across health and Adults Social Care. Within the plan £0.35 million of non-recurrent funds from the transforming change budget line have been set aside for the frailty pilot. Monitoring will be put in place to quantify the cash and non-cash benefits of the pilots.

Finance Officer Consulted: Anne Silley/ Debra Crisp Date: 08/05/14

7.2 The Health and Wellbeing Board has responsibility to oversee and monitor the implementation of local Better Care Fund Plans and it is therefore important for the Board to receive this report with the final submission that was made in April and details of the progress made to date.

Lawyer Consulted: Elizabeth Culbert Date: 12/05/14

Equalities Implications:

7.3 An equalities impact assessment will be carried out once more detailed plans have been developed for the integrated models of care.

7.4 The development of integrated models of care will potentially affect staff from a range of health social care and independent sector providers. Further more detailed assessment will be carried out as the integrated work plan develops.

Sustainability Implications:

7.5 The Better Care Fund aims to provide funding enable each local areas manage pressures and improve long term sustainability.

7.6 The CCG, as part of its authorisation process committed to developing a Sustainable Commissioning Plan. The CCG sustainability Plan includes the following priorities which are relevant to the Better Care Fund:

- Ensuring our clinical pathway designs address prevention, quality, innovation productivity and integration;
- Delivering our duties under the Social Value Act of 2012 and embedding social value and community assets in our procurement practice; and
- Facilitating enablers such as the roll out of electronic prescriptions.

Crime & Disorder Implications:

7.7 None.

Risk and Opportunity Management Implications:

7.8 None.

Public Health Implications:

7.9 The Better Care Plan aims to improve the lives of the population of Brighton and Hove, including reducing inequalities.

7.10 Corporate / Citywide Implications:

The Better Care Plan will affect other work plans across the City, in particular Finance and Housing.

Any Other Significant Implications:

7.11 None.

SUPPORTING DOCUMENTATION

Documents in Members' Rooms
None.

Background Documents
None.

HEALTH & WELLBEING BOARD

Agenda Item 7
Brighton & Hove City Council

Subject:		**Brighton and Hove CCG 5 Year Strategic Plan 2014-2019 and 2 year Operating Plan 2014 - 2016**		
Date of Meeting:		**10 June 2014**		
Report of:		**Geraldine Hoban, Chief Operating Officer, Brighton and Hove Clinical Commissioning Group**		
Contact Officer:	**Name:**	**Geraldine Hoban**	**Tel:**	**574863**
	Email:	**Geraldine.Hoban@nhs.net**		
Ward(s) affected:		**All**		

FOR GENERAL RELEASE.

1. SUMMARY AND POLICY CONTEXT:

1.1 Clinical Commissioning Groups (CCGs) are required by NHS England to produce a 5 year strategic plan covering the period 2014 -2019 and a 2 year operating plan covering 2014 – 2016.

1.2 The NHS England planning guidance, Everyone Counts: Planning for Patients, describes the key components of each plan. Both should be based on the needs of the local population as described in the Joint Strategic Needs Assessment, aligned to the priorities described in the Joint Health and Wellbeing Strategy and must clearly articulate how the system will address health inequalities and improve health outcomes. The 5 year plan should describe long term strategic aims and objectives and the 2 year plan should set out in more detail the work programmes designed to deliver the strategic vision.

1.3 Brighton and Hove CCGs 5 year plan builds on and refreshes the 2012-2017 Strategic Commissioning Plan. It sets out the vision and objectives of the CCG and demonstrates how we will harness our clinical and managerial skills, expertise and energy to improve the quality and outcomes of healthcare for our population in the context of the financial challenges facing the NHS.

1.4 The Operating Plan for Brighton and Hove Clinical Commissioning Group (CCG) describes how we intend to deliver the vision outlined in our 5 Year Strategy 2014-2019.

1.5 It summarises detailed Quality, Innovation, Productivity and Prevention (QIPP) plans which will help us deliver the system vision outlined in our 5 Year Strategy 2014-2019 and ensure our legal and statutory duties are met including delivery of an agreed financial surplus.

1.6 Health & Wellbeing Boards have statutory powers to consider local CCG commissioning plans, and in particular to assure themselves that such plans accord with the needs and priorities identified in the local Joint Strategic Needs Assessment (JSNA) and Joint Health & Wellbeing Strategy (JHWS).

2. RECOMMENDATIONS:

2.1 That the Health and Wellbeing Board –

2.1.1 Note the content of the plans;

2.1.2 Agree that the CCG plans do align with the local needs and priorities identified in the JSNA and JHWS.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The 5 year plan is divided in to 8 key strategic areas. The below sections contain a summary of each strategic objective and the associated programmes of work planned for the next two years.

3.2 **Strategic Objective 1:** Align our commissioning to the health needs of our population and ensure we are addressing health inequalities across the City.

3.2.1 We identify need by working with public health staff to develop the overview of local health and wellbeing needs, and inequalities, known as the Joint Strategic Needs Assessment (JSNA). This comprehensive document also takes account of the patient voice, benchmarking and activity data, and quality indicators.

3.2.2 We know that we have poor outcomes for some health conditions in the City, in particular 1 and 5 year survival rates for lung and colo-rectal cancers. In order to address this we have strengthened collaborative arrangements for cancer which were somewhat fragmented by changes to the commissioning landscape and have re-established the Cancer Action Group – a multi-agency group of professionals and commissioners working to ensure a joined up approach to cancer commissioning and care. Working with our member GP practices (and specifically targeting the more deprived parts of the City) we will continue to focus on improving early detection, diagnosis and onward referral rates. We will include Cancer as a permanent item for discussion at our monthly performance meetings with BSUH and alongside our NHS England colleagues (who have the responsibility for directly commissioning radiotherapy, chemotherapy and more specialist cancer procedures) ensure the necessary improvements in booking of first appointments, communication around test results, access to specialist nursing support and a sustainable configuration of radiotherapy provision across Sussex.

3.2.3. Whilst life expectancy in Brighton and Hove is higher than it has ever been, there persists a differential in terms of life expectancy for those who live in the most deprived areas of the City. Women who live in the most deprived areas can expect to live to 80 years in comparison to their more affluent counterparts who live on average to 84 years. For men the differential is even greater at 71.7 and 81.7 years respectively. In order to address this gap in life expectance and improve mortality and morbidity in the City overall, the CCG has this year earmarked £0.5m to fund initiatives

which have been shown to impact on known areas of inequality. These areas will be informed by an audit of premature mortality currently underway with all general practices in the City. Once we know the specific areas in which the most significant improvements could be made we will commission a range of targeted interventions such as:

- Improved use of statins to address cardiovascular amongst patients with chronic obstructive pathway disease.
- Improving anticoagulant therapy for all patients over 65 with atrial fibrillation.

3.2.4 We are also very aware and proud of the diverse community that we service in Brighton and Hove and recognise the need to specifically target the needs of our most vulnerable and excluded communities. We have a very significant programme of development for improving healthcare for our homeless population, a programme of training for all staff in GP practices in the City (and CCG Clinicians) on transgender awareness and a continued focus on engaging the views of our communities through our jointly commissioned engagement with excluded groups such as LGBT Hip and Friends of Gypsies and Travellers.

3.3 **Strategic Objective 2:** Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care

3.3.1 We are determined to put patients at the heart of what we do as a CCG and see shared ownership of the commissioning agenda and shared responsibilities for health as a key priority.

3.3.2 We recognise that patients want to be fully engaged in making choices about their care and to deliver this we will ensure that every person with a long-term condition or disability has a personalised care plan supporting them to develop the knowledge, skills and confidence to manage their own health.

3.3.3 We plan to review our engagement strategy and refresh it in light of best practice and the duties set out in Transforming Participation in Health and Care. We have a good track record of engaging with patients in service design but recognise we could do better at feeding back on how the patient voice is translated in to meaningful service improvement. In response to this we are currently undertaking a three month consultation in the city covering the following areas:

- Individual Participation – people in control of their own care
- Public Participation – communities with influence and control
- Insight and feedback – understanding peoples experience.

3.4 **Strategic Objective 3:** Increase capacity and capability in primary and community services so that we focus on preventative and proactive care – particularly for the most frail and disadvantaged communities;

3.4.1 General Practice accounts for 9 out of 10 of all patient contacts with the NHS and demand has never been greater. Primary care professionals are now seeing more patients than ever with complex co-morbidities. An ageing population, rising patient expectations and persistent health inequalities are some of the challenges facing primary care in the face of an impending crisis in recruitment and retention of the future workforce.

3.4.2 In 2014/15 the CCG will finalise its Primary Care Strategy which will set out how we plan to address the challenges above and improve access and the experience of care for patients. We will consult with our member practices and partners in the City regarding an expression of interest to NHS England on taking on the direct commissioning of primary care services for the City. In the meantime we will continue to commission models of care that develop skills and capacity within primary and community teams and shift the focus of care away from acute and bed based models to ones that are more proactive, preventative and community focused.

3.5 **Strategic Objective 4:** Plan services that deliver greater integration between health, social care and housing and promote the use of pooled budgets;

3.5.1 Providing responsive pro-active care in the community is a key priority for Brighton and Hove CCG. We know from feedback from patients and their carers that they want services to be more holistic and more personalised. They want services to be supportive of them to achieve self-care and to be able to plan their future care (care planning); services which involve them in decisions about their care (shared decision making) and services which support them in their own homes without having to go to hospital if there are alternatives (care closer to home).

3.5.2 Together with the Social Care and under the auspices of the Better Care Fund, the CCG is delivering a programme of work that will transform the way in which frail and vulnerable people will be cared for in the City. Through funding more proactive case finding of vulnerable people and active care management of all people over 75 and people at risk of emergency admissions we will develop integrated community teams who work in a much more co-ordinated and consistent way to deliver a package of support and care to this cohort of people. The development of these integrated teams will centre around clusters of general practice with registered populations of 20-25,000 patients and include not only statutory service providers but third sector support, independent providers and nursing /care homes. We will pilot the integrated teams in 14/15 within two areas – one in West Hove and one in Central/East Brighton. The learning from these pilots will inform the roll out of the model across the City in 15/16 and onwards.

3.5.3 We anticipate one of the key cohorts of our population that will benefit from the new approach will be people with dementia and their carers. Only one third of estimated numbers of people in the City that have dementia have a formal diagnosis. Lack of diagnosis limits access to the relevant care and support and increasing diagnosis rates is a key element of our

Better Care Plan. The current system of care (which largely separates physical and mental health care) does not provide the optimal model for managing care holistically. We know from audits in acute sector activity that people with dementia are much more likely to be admitted to hospital than people without dementia and the reason for admission is related to their physical health issue (for example a Urinary Tract Infection) rather than related to their dementia. We also know that length of stay for people with dementia is longer than for people without. The new holistic model of multi-disciplinary care that manages dementia and other long terms conditions will bring significant benefits in terms of the ability to provide care closer to home and reducing hospital admissions. We will invest in additional capacity within our memory assessment service to increase our identification rate from 44% to 67% in 2014/15.

3.6 **Strategic Objective 5:** Design high quality urgent care services that are responsive to patient needs and delivered in the most appropriate setting;

3.6.1 We know that although overall numbers of patients presenting at A&E because of an emergency or urgent condition continues to fall, there are many people still attending A&E who could more appropriately have been managed by other community alternatives. We know from feedback from the public that they are confused about the other options available and the responsiveness of A&E to deal with their problem (largely within 4 hours 24/7 is not replicated in other parts of the health system. We also know that the patients who are admitted through A&E are generally have more complex and a higher level of need than in previous years.

3.6.2 Working with our acute hospital and other partners in the health system we will maintain our focus on providing high quality alternatives to A&E, consistently achieving the 4 hour target wait in A&E and minimise the need for handover delays from the ambulance service. Specific areas of development in 14/15 will be:

- Continuous improvements in the NHS 111 service;
- Increasing the GP support to ambulance crews around alternatives to conveying patients to hospital;
- More proactive discharge planning and therapy support for people admitted to hospital.

3.6.3 We have begun a major programme of work to re-model the front door of A&E so that it becomes a primary care led service, integrating a walk-in element, out of hours access to GPs and a minor injury unit. The specification for this new model will be completed and consulted on in 2014/15 with a view to procuring the new service in 2015/16.

3.7 **Strategic Objective 6:** Integrate physical and mental health services to improve outcomes and the health and wellbeing of all our population;

3.7.1 Improving mental health and wellbeing is a key priority for the CCG and we are striving to ensure that mental health has equal status to physical

health and both are integrated within all our pathways of care. The City has high levels of mental health need both in terms of numbers and degree of complexity and major transformational change has taken place within mental health services over the last few years in order to provide a greater focus on preventative care and support as early as possible.

3.7.2 Specific areas of focus for the coming year are:

- Development of an integrated pathway of care for people with a dual diagnosis to be in place by April 2015;
- New pathways for health care in young people with eating disorders;
- Implementing increased psycho-social support in our musculoskeletal, dermatology and diabetes services.

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3.8 **Strategic Objective 7:** Deliver a sustainable health system by ensuring our clinical care models, commissioning and procurement processes and internal business practices reflect the broader sustainability agenda and deliver on our duties under the Social Value Act.

3.8.1 We are committed that from the outset of commissioning and procurement processes we co-design services with patients and the public and build elements of social value into our care pathways and service specifications. We will to communicate a clear and unambiguous message about our intention to include social value in our procurement methodology whenever we communicate with service providers and to incorporate measures of social value in our evaluation of bids and resulting contracts.

3.8.2 Our recently appointed clinical lead for sustainability will be working with General Practices in the City, supporting them with energy efficiency and looking at ways to strengthen the connection between General Practice and the Council's initiatives around fuel poverty, exercise referral etc. as well as reducing waste around medicine prescribing and recycling devices such as inhalers.

3.9 **Strategic Objective 8:** Exploit opportunities provided by technology to deliver truly integrated digital care records, derived from the GP Record as the primary source which will be made 'Fit for caring, fit for sharing' through a programme of information management and data quality initiative.

3.9.1 The CCG plans set out how the enormous potential benefits of information to improve patient safety, outcomes and experience, reduce inequalities and improve efficiency can be released by ensuring that high quality integrated information is available where and when required to support good decision-making by clinicians, patients and managers.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 Our plans have been pulled together following an extensive year-round engagement process with:

i. our member practices:
- we have identified primary care based clinical leads for each of our key commissioning areas whose role it is to link back to member practices;
- bi-monthly discussions and workshops with each of our three Localities (West, Central and East) on commissioning plans;
- on-line surveys on specific re-commissioning issues;

ii. patients and the public:
- quarterly public events discussing key themes;
- regular meetings with third sector organisations contracted to provide feedback from traditionally excluded groups;
- quarterly meetings with Healthwatch to triangulate feedback on services;
- Feedback from Patient Participation Group (PPG) members via elected Patient Reps on Locality Management Groups, established PPG network;
- Specific consultations with patients, public and other stakeholders for each of our major programmes of work

iii. The City Council,
- We have a regular Joint Officers Group where our draft plans have been discussed at the earliest stage and co-designed. The Council are represented on our CCG Governing Body where commissioning plans are regularly discussed;
- Our Plans align with the Health and Wellbeing Strategy for the City and are signed off in draft and final form by the Health and Wellbeing Board;
- Plans for the Better Care Fund have been agreed with the Health and Wellbeing Board and our governance structures around strategic planning and operational delivery of integrated plans are being strengthened.

iv. neighbouring CCGs and co-commissioners from NHS England:
- We have a memorandum of understanding with neighbouring CCGs to act as a co-ordinating commissioner for Brighton and Sussex University Hospitals. As such we have led the process on developing commissioning intentions for the Trust on behalf of our neighbouring CCGs and ensuring these align with NHS England and longer term strategic aims around the 3Ts Development. There are robust governance mechanisms in place to ensure collaboration between commissioners and with the Trust.
- Wherever possible and appropriate the CCG will work with the wider health economy to commission services. There is a Sussex-wide programme of work agreed by CCGs and undertaken by Sussex Collaborative Delivery Team (SCDT) hosted by Eastbourne, Hailsham and Seaford CCG.
- Through the Sussex Collaborative 3 monthly meetings occur with Area Team including the SCN, Specialised Commissioning and Director of commissioning. To gain an understanding and work out how the different priorities impact on co commissioners and how the different organisations can work together.

- The CCGs in Sussex are represented at the National NHS England Specialised Commissioning Led work on Pathways. There are members on the overall Steering Group and Co-leads on Trauma and Paediatric Pathways.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1.1 The CCG financial plans comply with the NHS financial framework. The CCG has maintained a carry forward surplus of 4% in 2014/15. This will drop to 2.5% (c£9m) in 2015/16 and then over the 5 year period ultimately down to 1.5% in line with national guidance. The CCG will keep plans under review, seeking to make additional 'invest to save' plans if possible and bring forward savings.

5.1.2 The plans for 2014/15 include responding to the NHS England request to increase our planned surplus. Application of funds in 2014/15 is aimed at delivering significant savings in 2015/16 and 2016/17. These are mainly to release funds to add to the Better Care Fund (£10.4m).

5.1.3 The Better Care Fund is being established in part using monies from the 2.5% non-recurrent expenditure fund within the CCG in 2014/15 to release savings in 2015/16 and 2016/17. By 2015/16 the fund should stand at £19.7m.

5.1.4 The CCG has built up a fund as recommended nationally by NHS England to ensure that it moves from 2013/14 into 2014/15 in the strongest position it can be in. This gives the Brighton health and social care system the ability to be ambitious with its transformational schemes and realistic in terms of the profile of both investments and savings.

Finance Officer Consulted: *Anne Silley* *Date: 27/05/2014*

Legal Implications:

5.2 The 5 and 2 Year Plans set out how the CCG will meet its legal and statutory obligations as required by the Health and Social Care Act 2012.

Lawyer Consulted: *Sandra O'Brien* *Date: 27/05/2017*

Equalities Implications:

5.3 An EIA has been undertaken for each programme of work described in the plans.

Sustainability Implications:

5.4 None identified.

Crime & Disorder Implications:

5.5 None identified.

Risk and Opportunity Management Implications:

5.6 The risks associated with delivery of the plans have been identified and will be added to the CCGs Corporate Risk Register and monitored through the CCG Governance arrangements.

Public Health Implications:

5.7 The plans address the health issues and inequalities issues identified in the JSNA.

Corporate / Citywide Implications:

5.8 The plans address the key health and wellbeing issues in the City and describe how CCG corporate objectives will be met.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 A process of prioritisation based on need was used to determine the content of the plans.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 Brighton and Hove CCGs plans reflect the needs of the local population and identifies the actions required to reduce health inequalities in the City.

SUPPORTING DOCUMENTATION

Appendices:

Appendices are not attached to this report but can be found using the link below.

The documents are:
Brighton and Hove CCG 5 Year Strategic Plan 2014 - 2019
Brighton and Hove CCG 2 year Operating Plan 2014 - 2016

The link is:
http://www.brighton-hove.gov.uk/content/council-and-democracy/councillors-and-committees/health-wellbeing-board

Documents in Members' Rooms

Brighton and Hove CCG 5 Year Strategic Plan 2014-2019
Brighton and Hove CCG 2 year Operating Plan 2014 - 2016

Background Documents

None

HEALTH & WELLBEING BOARD	Agenda Item 8 Brighton & Hove City Council

Subject:		**Update on progress with the Independent Drugs Commission's Report**		
Date of Meeting:		**Tuesday 10th June 2014**		
Report of:		**Tom Scanlon**		
Contact Officer:	**Name:**	**Peter Wilkinson**	**Tel:**	**29- 6562**
		Linda Beanlands	**Tel:**	**29-1115**
	Email:	**peter.wilkinson@brighton-hove.gov.uk** **linda.beanlands@brighton-hove.gcsx.gov.uk**		
Ward(s) affected:		**All**		

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The purpose of this report is to update the Health and Wellbeing Board on the progress made with the Independent Drugs Commission's recommendations from 2013 and on the feedback from the Commission's review in April 2014.

2. RECOMMENDATIONS:

2.1 That the Health and Wellbeing Board notes the progress made with the recommendations and the response from the Independent Drugs Commission and agrees to the Safe in the City Partnership and Substance Misuse Programme Board monitoring future progress with the recommendations.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 In 2012 the Safe in the City Partnership established an Independent Drugs Commission to review the current state of drugs problems in the city and the approach being taken by local services to address these issues. The Drugs Commission addressed four key areas and in April 2013 published its final report and recommendations. The final report was received by the Safe in the City Partnership and the Health and Wellbeing Board and a plan for the Substance Misuse Programme Board to address the recommendations was developed. In April 2014 the Independent Drugs Commission reviewed the progress made and provided a written response in May 2014 (Appendix 1)

3.2 The Independent Drugs Commission organised its work and recommendations around four key challenges and has framed its response in this way. The Commission's response is complimentary about the work undertaken locally to address their recommendations. Their response highlights areas that have gone well and the areas of continuing concern.

The areas that have gone well include;

- The analysis of the factors leading to drug related deaths and the work related to the feasibility of establishing a drug consumption room.
- The work being done by the police and health services to reduce the diversion of prescription drugs including benzodiazepines.
- The first aid overdose training and the wide use of naloxone.
- The widened focus of the police's new control strategy to drug related supply with a focus on organised crime and identifying emerging trends in drug use
- The new intelligence and information sharing systems across the community safety partnership
- The strengthening of the delivery of the prevention education curriculum in schools and youth settings, the new Public Health Schools' programme and the Early Help pathway
- The new local services such as the evening access clinic and the novel psychoactive substances outreach worker.
- The ongoing work around Dual Diagnosis including integrated assessments – though it is important that the work done to date is translated into successful outcomes.
- The expanded recovery network of volunteers, buddies and champions.

The areas of continuing concern include;

- The future of the Injectable Opioid Treatment programme
- Ensuring continuity of engagement with substance misusing prisoners pre and post release.
- Although the Liaison and Diversion scheme is well established individuals need to be adequately tracked and responded to throughout mental health services.
- Maintaining investment in youth work and activities with future financial pressures
- The need to see the impact of the shift to a recovery focus on actual outcomes. This includes addressing the current decline in the number of users successfully leaving treatment services.
- Ensuring that the new services are welcoming and appropriate for 18-25 year olds.

3.3 The action plan (full action plan available at http://www.brighton-hove.gov.uk/content/council-and-democracy/councillors-and-committees/health-wellbeing-board
- key points summarised in Appendix 2) summarising the local progress made in response to the recommendations was presented to the Independent Drugs Commission in April 2014. The action plan describes both the actions taken in response to the recommendations and the ongoing work.

3.4 The Health and Wellbeing Board was specifically identified in two of the Independent Drug Commission's recommendations;

3.5 The first recommendation was that "The Health and Wellbeing Board and Safe in the City Partnership should convene a working group led by the local authority, NHS and Police, to explore and make recommendations about the feasibility of

establishing a form of consumption room as part of the range of drug treatment services in the city".

3.6 Appendix 3 summarises the work of the group considering the feasibility of establishing a Drug Consumption Room (DCR) in Brighton and Hove. This was presented to the Independent Drugs Commission in April 2014. The evidence suggests that a DCR could meet the needs of some injecting drug users in Brighton and Hove. However, at the present time the overall need of the local community, not just injecting drug users, is not considered to be sufficient by local organisations to agree to support establishing a DCR. This includes the lack of support for a local accord (regarding the implementation of the law) which would be required to allow the DCR to operate. The conclusion is that it is not currently feasible to establish a DCR.

3.7 The second recommendation was that "The Health and Wellbeing Board should investigate the value of rolling out a programme of overdose response/first aid training for drug users, and the professionals who work with them.

3.8 The Drug Commission report acknowledged that there was already a programme of overdose response and first aid training in place. St John Ambulance provides first aid training for overdoses to service users and their carers or family, as well as for some staff groups. This training is provided in drug services, hostels and day centres. Currently St John Ambulance is planning to extend this programme to include other key people within an individual drug user's recovery network.

3.9 Naloxone reverses the effects of opiates such as heroin and the consequences of an opiate overdose. Naloxone syringes are given to service users to keep with them. The service user receives training in recognising an opiate overdose, first aid training including putting someone into the recovery position, the use of Naloxone and the importance of calling an ambulance. Service users prescribed Naloxone sign a consent form for another individual to administer Naloxone in the case of an opiate overdose.

3.10 During 2013 a total of 321 Naloxone mini-jets were given to 262 individuals. Naloxone is also dispensed in the hospital Accident and Emergency Department. Hostel staff and other services such as the Rough Sleeper's Team have received training in the use of Naloxone. Naloxone is also provided to prisoners leaving Lewes prison. During the past year a new multi-dose version of Naloxone has been introduced and is being distributed locally. There has also been a national consultation by the Medicines and Healthcare products Regulatory Agency (MHRA) on the possibility of making Naloxone more widely available. Local services responded positively to the consultation.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Appendix 3 details the work done as regards the feasibility of establishing a DCR

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 Through the substance misuse service user involvement worker there is regular consultation, including with people in recovery and with service users. As part of

this ongoing work there was consultation regarding a DCR, which was considered by the feasibility working group.

6. CONCLUSION

6.1 The Health and Wellbeing Board is recommended to note the actions taken in response to the Independent Drug Commission's recommendations and the Commission's response.

6.2 It is proposed that the Safe in the City Partnership and Substance Misuse Programme Board monitor the future progress made with the recommendations.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 The Director of Public Health's 2014/15 budget for prevention and support to drugs abuse in adults is approximately £5.3 million which is committed against a number of contracts. The costs associated with implementation of the recommendations from the Independent Drugs Commission are being met by partners, providers, and from the Public Health budget.

Finance Officer Consulted: Anne Silley Date: 15/05/14

Legal Implications:

7.2 There are no legal implications arising from the recommendations in this report, which are for noting.

Lawyer Consulted: Elizabeth Culbert Date 12/05/14

Equalities Implications:

7.3 There are none to this report which is for information. Equalities issues will continue to be considered by the Substance Misuse Programme Board.

Sustainability Implications:

7.4 There are none to this report for information. These will continue to be considered by the Substance Misuse Programme Board.

SUPPORTING DOCUMENTATION

Appendices:

1. Response of the Independent Drugs Commission May 2014

2. 2014 Action Plan summary– In response to the Independent Drug Commission for Brighton & Hove. Full action plan available in members' rooms and at http://www.brighton-hove.gov.uk/content/council-and-democracy/councillors-and-committees/health-wellbeing-board

3. Update on Drug Consumption Room Feasibility Working Group June 2014

Documents in Members' Rooms

1. 2013 Independent Drugs Commission for Brighton & Hove
2. 2014 Action plan in response to the Independent Drugs Commission

INDEPENDENT DRUGS COMMISSION FOR BRIGHTON & HOVE

Final analysis and conclusions
May 2014

Introduction

The Independent Drugs Commission for Brighton and Hove began its work in 2012. Initiated at the suggestion of Caroline Lucas MP, and containing a mix of independent members and observers from the City Council, Health Authorities and Sussex Police, the Commission reviewed several aspects of the problems associated with drug markets and drug use in Brighton and Hove. In April 2013, we came up with our analysis, and put forward a list of 19 recommendations to improve the situation, for the local authorities to consider as they developed their prevention, treatment, health promotion and law enforcement strategies.

At that point, we agreed to return for one final meeting a year later – in April 2014 – to receive reports on progress against each of these recommendations, and whether the drugs situation in Brighton was improving or worsening. It was also the point at which the city Health and Wellbeing Board would report back to the Commission on the outcome of its feasibility study into setting up a Consumption Room in the city.

The review meeting was held on April 29th, and this report is the Commission's final articulation of our findings. We have been impressed and flattered by the amount of work and serious consideration given to our recommendations by the local authorities, and we hope that our analysis and recommendations have contributed in some way to the improvement of policies and services around illegal drug markets and drug use in the city. A number of working groups were convened by the relevant authorities, which met throughout the year to review progress and options on responding to drug related deaths, improving the criminal justice responses, protecting young people, and providing drug treatment.

The Commission recommendation that attracted most attention was that the local authorities should look at the feasibility of setting up a consumption room style facility in the city to reduce the risk of drug related deaths, and also to minimise drug dealing related litter and nuisance in public places. We were impressed with the structured and comprehensive way in which the working group addressed this question – involving all local stakeholders, and national and international experts – and accept the working group's reasons for deciding not to proceed with this sort of development at this time.

We would like to thank the Commissioners for all the work they have put in to this process over the last 2 years, all those who attended and gave evidence at our meetings, and the representatives of the Council who made the whole process work smoothly. We send our best wishes to all those involved in minimising drug related harm in the city, and hope that their future efforts are successful.

Peter James, Chairman Mike Trace, Vice-Chairman

CHALLENGE 1:
Are the current strategies to prevent drug related deaths sufficient to achieve a significant reduction in the coming years?

How well has the process gone?

It is clear that the process of analysing the factors leading to drug related deaths in the city has improved in recent years, and officers now have a comprehensive system for understanding these risks, and turning that learning into changes in policies and practices. Unfortunately, there continues to be an unacceptably high rate of overdose deaths, but it seems that there is no single cause, and the various risks arise from the chaotic nature of many users' lifestyles.

Our specific recommendation for the local authorities to examine the feasibility of opening a consumption room was treated with due seriousness. The city council and Sussex Police established a working group that looked at the need, likely impact, legal situation, and practical considerations. Their conclusion was that a consumption room was not a priority for Brighton and Hove at this time – the working group was convinced by the international evidence on the potential benefit from these facilities, but thought that they would have little impact on the types of factors that were contributing to deaths in the city. Members of the working group were also concerned at the cost implications, in a time of budget pressure, and also advice from the Home Office that opening such facilities would contravene UK law.

What do we see as working particularly well? (examples of good practice)

The improved auditing of coroners reports (22 undertaken in 2012 and 32-35 for 2013) and the establishment of routine serious incident and vulnerable adult reviews are enabling the dissemination of learning to treatment staff and specific recommendations of improvements within Harm Reduction Plans. To assist, root cause analysis training is being undertaken for those leading the reviews.

The Commission noted that the police will continue to prioritise responding to Class A drugs, however, action has been taken to increase knowledge about and improve the flow of intelligence about the misuse of prescription drugs. Increased screening oversight and investigation of drug related deaths and stronger links between the coroner and police are assisting the identification of prescription drugs as contributing to drug related deaths. A briefing pack on the content, availability and risks associated with the range of drugs being used in the city is circulated to service providers and professionals, together with other high profile information. Seminars for G.Ps are delivered.

These actions, together with the GP Prescribing Incentive Scheme (targets for each GP surgery), the introduction of individual reduction plans for each service user and other initiatives are resulting in decreases in the prescribing of benzodiazepines in the city.

Joint test purchasing operations with Trading Standards have targeted Head Shops in the city and forensic information sought to establish content. Public Health/NHS England in its recently published document, has noted good practice in terms of – nurse follow up – clinical records being cross referenced

In response to the Commission's recommendation, the working group explored the potential for expanding the Opioid Treatment Programme. Analysis showed at least 37 individuals eligible for Injectable Opioid Treatment (IOT). There is clear national evidence of the cost benefits of the programme; as yet, future funding is not secured.

The Commission welcomed the significant expansion of Naloxone and "First Aid for Overdose" training. The expanded programme (St John's Ambulance) covers service users, families, carers, hostels and the wider recovery community.

What are the areas of continuing concern?

Provisional figures show that there were 32-35 drug related deaths for 2012/13 which, while an increase compared with 2011/12, is significantly below the average recorded during the recent ten years.

The costs of the Opioid Treatment Programme to be possibly absorbed within the Re-Tendering arrangements for Substance Misuse Services from 2015. Also to explore potential of funding from the Office of the Police & Crime Commissioner.

Ensuring continuity of engagement with prisoners both pre and post release is critical. A pan-Sussex review of Integrated Offender Management will ensure effective transfer of information between the Liaison & Diversion Scheme, Prison, DART and Community based IOM teams at point of sentence and through the Offender journey from custody to community.

CHALLENGE 2: Are the policing, prosecution and sentencing strategies currently pursued effective in reducing drug related harm?

How well has the process gone?

The Commission had identified two broad areas which were the basis of more detailed recommendations: the first was the importance of having a standing information and intelligence sharing structure that collated real time information on the fast changing local drug markets and the second was the need for all services to be able to respond to a wider range of drugs (as well as Class A drugs).

There is clear evidence that the members of the working group have made significant progress in these two broad areas. Participating in a Home Office led, Forensic Early Warning system is an example of the thorough approach that has been taken to this issue (testing of substances seized by police not believed to be class A and information sharing with partners).

A review of the Liaison and Diversion pilot project (incorporating a health hub) for those within the criminal justice system was concurrent with the work of the Independent Commission, providing some opportunity to influence considerations about the future of the pilot. The good news that the pilot was selected as one of ten projects for continuation funding until 2017 and its transfer of governance to NHS England will further secure the practice of early identification and assessment of the health care and substance misuse needs of those within the criminal justice (including court and prison) processes.

What do we see as working particularly well? (examples of good practice)

While the police confirm their ongoing priority as identifying and responding to Class A drugs, they have put in place a new control strategy which widens the focus of operations to ‘drug related supply with a focus on organised crime groups’ and on identifying emerging trends in drug use. This has resulted in increased resources and capacity of the crime investigation team.

The functionality of intelligence and information sharing systems across the community safety partnership have been comprehensively reviewed; new arrangements are in place to:

- complete drug markets profiles every two years and an annual interim update
- report and integrate information from the community into the wider intelligence systems of the police and Partnership
- establishment of bi-monthly regular multi–agency, drugs intelligence meetings (process yet to begin)
- service providers recording links between new psychoactive substances and offending
- drug alerts circulated following laboratory reports from all drug seizures and identification of substances of concern.

Positive outcomes are already being evidenced: those who are causing the most harm are increasingly targeted through enforcement or support into treatment and new dealing groups are being identified and prioritised based on their level of harm.

The Liaison & Diversion scheme is providing the services of a psychiatric nurse at all access points throughout the criminal justice process: as well as the initial assessment, individuals are tracked and supported throughout including by outreach support.

What are the areas of continuing concern?

The multi-agency Drugs Intelligence sharing meeting has yet to be fully integrated into day to day practice – information from this mechanism needs to be promptly presented to police, health, social and youth services to inform their work.

While the Liaison and Diversion scheme is well established, more work is needed to ensure individuals are adequately tracked and responded to throughout mental health services.

The police are to explore the benefits of selecting a cohort of offenders for conditional cautioning to fully engage with treatment services as an alternative to being brought to court. They are to visit the pilot project in South Yorkshire and share the findings with partners.

A pan-Sussex review of Integrated Offender Management is in process. Its completion will embed the role of the substance misuse services.

CHALLENGE 3: Are we doing enough to protect young people and to enable them to make informed decisions around their own drug use and involvement in drugs markets?

How well has the process gone?

Progress has been made during the year to broaden drugs education and information messages across schools and youth settings both within the local authority Youth Service and the Youth Collective, 8 CVS youth centre partners. There is evidence of examples of how improvements have been put in place in the process of identification and sharing of real time information that is then taken directly to the population affected, e.g. school based response to concern about the promotion of the Neknomination on social networking sites. as Also the linking the young people's specialist service, ruok? to the networks attached to sharing of police intelligence. The new launch of the PH Schools Programme was also recognised as an initiative that will further support the improvement of universal health outcomes for young people.

Improvements are in place to develop and implement an early help approach to responding to the needs of children, young people and families. The Youth Collective has been commissioned to provide open access youth activities and links with other activities across the city attached to sports and arts. There are increasing examples where the early help / targeted / specialist services for young people have linked and diverted young people to alternative activities. Plans are in place to build on the communication process. There have been changes and improvements to increase access for young people to low cost bus fares.

There has been increased support for young people and alcohol as Oasis secured additional funding. Ruok? has increased their support and involvement for families of their service users and there is evidence of changes for families involved in social care systems where their children are affected by substance misuse as a result of some focused workforce development work. The feedback from the transition worker is that the systems are working well. It was identified as a gap in provision that existing services are not meeting the changing use of substances and level of need for 18 – 25 years which is being addressed in the current retendering process for a new Recovery Service.

What do we see as working particularly well? (examples of good practice)

The areas that are working well and to be developed from 2014 are as follows:

- Strengthening curriculum delivery of prevention education in schools and youth settings.
- Joint working between services providing specialist and targeted support to young people affected by substance use, with youth providers who deliver alternative activities for young people
- The new PH Schools programme.
- Early help pathway and single point of access
- Ruok and extended parental involvement.
- Specialist SM post in social care

- Transitions from young people services to adult services for substance misuse.
- The new procurement process which is implementing a fair and transparent process to the purchasing of a new recovery service which takes account of our recommendations and impressive service user involvement.

What are the areas of continuing concern?

- Young People Services need to implement their agreed action to join the Community Intelligence Network and further enhance their ability to take away from it integrated information.
- Consideration needs to be given to proactive engagement with the Independent School sector and with Language Schools.
- The challenge to maintain investment in youth work and youth activities within the financial pressures of the future, where many areas have seen disinvestment in youth services.
- Whilst there are well established identification and assessment tools in place, regular monitoring of their use and of associated problems needs to be re-established.
- There needs to be more linkage between service providers, including mental health, and the universities, particularly in respect of the sizeable 17-19 age group, some of whom will be locally based. Transition to adult services will need to be well managed.
- The challenge of intervening with children and young people who are at risk at an early enough stage for them to be willing to engage and for preventative work to be effective. But this must be balanced against a level of scrutiny and robustness that is acceptable to families, carers and communities.

CHALLENGE 4: To what extent does the treatment system meet the treatment and recovery needs of the citizens of Brighton & Hove?

How well has the process gone?

A conclusion of the Independent Commission was that while the recovery agenda was increasingly embedded throughout the structure of services, there was no doubt that those services need to be more flexible and responsive to meet the needs of those who use non-class A drugs and the diverse drug using population in the city. The Commission was supported in this view with information from the Joint Strategic Needs Assessment, Equality Impact Assessments and most importantly, from feedback from service users.

The developments led by the Substance Misuse Programme Board to establish domain groups (the golden thread/ recovery group and the harm reduction and emerging trends groups) had established a structure which afforded every opportunity for service improvements.

The Commission were also satisfied that the opportunity to structure and deliver services differently is being fully exploited by all those participating in the re-tendering process for substance misuse services from 2015 and that service user consultation will continue to fully inform the re-tendering process.

The Commission noted that the current forums for service users and carers were very effective but that ways of providing further support and addressing what was perceived to be an over-reliance on specific individuals needed to be found. There have been significant developments during the life of the Commission which go a long way to meeting this particular concern.

There was a high level of concern expressed throughout the life of the Commission, that those with substance misuse service needs and who had dual diagnosis, were at worst excluded from being able to successfully access mental health services or at best, could not access combined mental health and substance misuse assessments. The Commission found that much progress had been made following its recommendations, in terms of the Sussex Partnership Foundation Trust taking lead responsibility with an agreement that developing mental health services which are accessible to substance misusers will be a key priority for the coming two years. Multi –agency steering groups are established which are recognising the high prevalence in the city of the combinations of mental illness, drug and alcohol use, self-harm, suicide, drug related deaths and homelessness. The aim is therefore to improve data recording and information sharing and to develop clear service and care pathways, building on the service mapping and screening tools which are now in place. The Better Care multi-agency programme is also identified as a route through which more integrated care will in due course, be provided for those who are homeless and particularly vulnerable.

What do we see as working particularly well? (examples of good practice)

An expanded Public Health Schools Programme has facilitated all PSHE leads in schools receiving substance misuse training. From September, the medical and teaching schools will include education and training on substance misuse

Evening clinics are providing new access points, including for those using new psychoactive substances and those who would otherwise not access traditional services. An NPS outreach worker also links those presenting elsewhere, including from Brighton University, A&E and hostels. Cannabis cessation work is delivered. The evening clinics are beginning to see increased numbers of people who are using NPS, party drugs and Performance and Image Enhancing drugs. So far, brief interventions have been delivered to 94 individuals.

A new pain management clinic targets those for whom chronic pain is a barrier to their recovery. There are strong links with sexual health services assisted by a designated LGBT worker in treatment services.

A substance misuse nurse is seconded to the children in need team and Advice Contact and Assessment Service are to review the training needs of social care staff.

Two staff from the Department of Work and Pensions are operating outreach clinics in substance misuse provider premises.

An expanded network of volunteers, buddies and champions is substantially increasing the peer mentors and recovery champions in the city. 25 trained mentors are already placed in city services and more mentors are working towards completing their training. There are 9 well established service user forums in Brighton & Hove and new service user representatives now sit on strategic groups.

An independent recovery community is well established in the City (Cascade Creative Recovery), following on from a successful UK 4th Recovery Walk. Charity status has been achieved and additional funding is awarded from PH England. Premises are secured for an Independent Recovery Café, volunteers recruited and an opening planned in the summer.

A recovery & Re-integration fund is available for service users to make applications for small amounts of funding – assisting with accessing training and employment & other types of recovery based activities

In the area of meeting the needs of those substance misusers who also have mental health needs, the commission are re-assured by the good progress in establishing the foundations for delivering integrated assessments and care pathways; they particularly note the shared care plan pilot and new IT systems, the identification of dual diagnosis champions and of the specialist nurse within mental health teams, the provision of staff training and the additional capacity within mental health accommodation.

What are the areas of continuing concern?

The ‘architecture’ of the recovery agenda is in place but yet to see the extent of outcomes; systems to ensure feedback is received need to be put in place: ‘mystery shopping’ will be one way of doing this.

Sustaining and further extending intelligence gathering on changes in national and local patterns of drug use and ensuring that information informs the development of future service delivery is essential

Other areas where further attention is needed, particularly:

- confirming the extent to which new services are welcoming and appropriate for those within the 18-25 age group and transitioning from young people’s to adult services
- embedding improved social care and outcomes for families where substance misuse is an issue
- further improving links with housing, including responding to an awaited report on extensive consultation with those in hostels; one finding may be the need for extending further recovery mentors in hostels
- identifying the underlying reasons for the reducing numbers of those successfully completing treatment

The Commission are of the view, that while good progress has been made in relation to establishing an integrated service structure, it is crucial that the current process of retendering the main drug treatment services in the city results in a high quality, accessible, and recovery oriented treatment system, that meets a wide range of needs.

Appendix 2 May 2014. Summary of action plan in response to the Independent Drug Commission for Brighton and Hove.

Challenge 1: Are the current strategies to prevent drug related deaths sufficient to achieve a significant reduction in the coming years?		
Recommendation (abridged)	**Key points**	**RAG Rating**
1: The DAAT and Public Health strengthen the mechanisms for regular auditing, analysis and reporting of Coroners and Serious Incident and Vulnerable Adult reports which provide information on the factors leading to drug related deaths, accidental overdoses and suicides.	• Coroner's audit completed for 2012. Audit of 2013 ongoing. • Serious incident, vulnerable adult and local deaths reviews undertaken routinely. • Recommendations for learning disseminated.	**GREEN**
2: That the criminal justice agencies, together with the Director of Public Health, take action to reduce the use, diversion and dealing of prescription drugs. In particular • A more proactive and robust enforcement response to the diversion of and dealing in prescription only and Class C drugs. • The dissemination of clear guidelines, information and advice to G.Ps, drug treatment services and drug users about the risks of overdose and death following the use of alcohol, benzodiazepines and opiates in combination.	• Improved flow of community intelligence. • Briefing pack produced for police about prescription drugs. • Joint working between police and trading standards around legal highs and head shops. • CCG prescribing incentive scheme continues to focus on reducing benzodiazepine prescribing. Guidance for prescribers on CCG website. • Posters on risks of overdose aimed at users circulated to local services and information displayed in GP surgeries.	**GREEN** **AMBER**
3: Explore the feasibility of establishing a form of consumption room as part of the range of drug treatment services in the city.	• Working group has concluded that at present it is not feasible to establish a DCR in Brighton and Hove.	**GREEN**
4: Consider ways of expanding the capacity of the positively evaluated Injectable Opioid Treatment.	• Estimated that 37 additional people are eligible for IOT. Estimated average annual cost per person is £14,000. • Little scope for reducing costs of Diamorphine. • Evidence of cost-effectiveness relies on crime reduction. • Ongoing local and national evaluation of effectiveness to inform future commissioning of services.	**AMBER**

5: Investigate the value of rolling out a programme of overdose response/first aid training for drug users, and the professionals who work with them.	• St John Ambulance delivers first aid for overdose training to service users, services, hostels and day centres. • Plans to expand the first aid programme to key people in substance misusers' recovery networks. • Naloxone distributed widely including substance misusers being released from prison.	**GREEN**
6: Ensure that continuity of engagement of prisoners at particular risk of overdose, pre and post release, is effective in reducing drug related deaths.	• The review of Integrated Offender Management will assist better communication between services. • Drugs Intervention Programme (DIP) Team track substance misusers before they are released from prison and discuss treatment plans with prison Drug and Alcohol Recovery Team. • Drug users released from prison and willing to engage are taken onto the DIP caseload for twelve weeks and, where possible, are met on release from Lewes Prison • Assertive outreach of those failing to keep appointments.	**AMBER**
Challenge 2: Are the policing, prosecution and sentencing strategies currently pursued effective in reducing drug related harm?		
Recommendation (abridged)	**Key points**	**RAG Rating**
1: Establish a standing intelligence and information sharing structure that collates real time information from multiple sources on local drug markets and emerging trends.	• Drug market profile to be completed every 2 years with an interim profile annually. • Mapping of drug intelligence completed and template for community intelligence circulated. • Review of Integrated Offender Management to ensure information sharing processes in place. • All police drug lab results collated.	**GREEN**
2: Create mechanisms for the information and analysis that comes out of this process to be used rapidly to inform tactical, strategic and operational planning decisions by the police, prevention and treatment services.	• New substances and risks circulated immediately via drug alert distribution. • Drug intelligence meetings include relevant young people's services.	**GREEN**

3: Extend the effective principles of Operation Reduction (enforcement combined with diversion and treatment) beyond the focus on opiates and crack cocaine to include the wider range of drugs being used by adults and young people.	• Dealing of Class A drugs remains the priority, but new control strategy allows a wider focus on drug related harm and supply with a focus on organised crime groups not necessarily linked to acquisitive crime. • Possible pilot project to introduce a conditional caution for offenders to engage with treatment services.	**AMBER**
4: Report to safe in the City on the extent to which the new Liaison and Diversion and Health Hub arrangements are being targeted effectively, and achieve high retention and recovery rates. Outreach workers working closely with mental health workers in police custody and courts.	• Surrey & Sussex one of ten pilot sites for scheme. Funded until 2017. • Diversion strategy will be set out as part of Sussex Integrated Offender Management review.	**AMBER**
5: That while the diversion strategy will work within legal frameworks already available under the Misuse of Drugs Act and utilize new Sentencing Council Guidelines, where this framework inhibits the effective implementation of the diversion strategy, then the national authorities should be made aware of the constraints.	• Police confirm sentencing guidelines are not inhibiting good outcomes.	**GREEN**
6: Sussex Partnership Foundation NHS Trust should provide information to all partners, drug users and the public about the service capacity, processes and pathways available for those with dual diagnosis. (See also Challenge 4 recommendation 3)	• The Trust's Dual Diagnosis strategy details programme of work to improve access to services. • Training for staff including use of shared care plans. • Dual Diagnosis champions' network established within the Trust.	**AMBER**
Challenge 3: Are we doing enough to protect young people and to enable them to make informed decisions around their own drug use and involvement in drugs markets?		
Recommendation (abridged)	**Key points**	**RAG Rating**
1: Drugs information and education should be embedded within the Health and Wellbeing agenda, and in particular should make use of the information arising from the 'real-time' information sharing mechanism referred to in the previous section.	• Revised curriculum being developed across school and youth settings. • Public Health Schools Programme launched for students and staff. To be extended to work with local colleges once school programme established. • Information sharing through social media and via professionals.	**AMBER**

	• Relevant services for young people attending drug intelligence meetings.	
2: Commissioners and service providers should respond to the need to invest in the strengthening of protective factors, in particular enabling young people to undertake activities that are alternatives to the problematic use of alcohol and drugs and reduce their sense of being marginalized.	• Early-help youth pathway with single point of access in place. • Youth Collective programme links vulnerable young people with a selection of activities. Initial phase linking young people using substances with youth and sports activities has had favourable reports.	**AMBER**
3: There should be a coherent continuity of care between generic young people's services and the specialist drug services, with service delivery reflecting emotional, as well as chronological, age within the context of a person centred approach and which also responds to the wider needs of the family where they impact on the wellbeing of the young person. This approach should include the promotion of a range of social media and electronic technology for accessing information and advice, together with an emphasis on attracting young people from minority groups and those in transition to adult services	• Ru-ok? continues to provide a Tier 3 service for young people. • Adult services work flexibly with a young person. Highlighted within recovery service retender specification. • Specialist post seconded from adult substance misuse services into Children In Need/Advice Contact and Assessment Service to support staff to work more effectively with families where substance misuse is an issue. • New piece of work with Black and Minority Ethnic Young People Project to extend their specialist support to the community setting.	**AMBER**
Challenge 4: To what extent does the treatment system meet the treatment and recovery needs of the citizens of Brighton & Hove?		
Recommendation (abridged)	**Key points**	**RAG Rating**
1: Identify and recognise the diversity of people in the city who require access to drug information, advice and treatment services and for whom the current service offers are not sufficiently attractive.	• Identified and addressed through needs assessments including the joint strategic needs assessments. • Equalities Impact Assessment for retendering process identified under-represented groups. • LGBT worker in treatment services. • New clinics aimed at people using New Psychoactive Substances (NPS) provided on two evenings.	**GREEN**
2: Ensure that the service specifications used in the retendering process enable the following developments:	• New recovery service in place from April 2015. • NPS outreach worker post being piloted.	**AMBER**

• New ways of providing information and advice about risks and access to services are put in place, which meet the needs of the diverse and hard to reach population; arrangements may include facilities for on line assessment and advice, provision within mainstream GP and other generic service settings. • Professional and academic bodies in the city include within their educational curriculum, some training which will enable the medical, health, social care and teaching workforce in the city to identify and skilfully respond to the needs of the city's population who are at risk of and/or are using drugs. • The development of a city wide recovery culture is promoted and embedded throughout the treatment system, and related settings. To facilitate this process, specific support is given to services and groups who are developing structures for those in recovery to provide mutual support to each other, and also social, housing and employment opportunities. • The re-orientation of the treatment system to meet the needs of the 18 -25 age groups, and other under-represented and minority groups. • Services are responsive to the changing patterns of drug use, with the flexibility to respond to new intelligence written into service contracts.	• New jointly operated pain management clinic between substance misuse services and pain clinic. • Developing programme for Performance and Image Enhancing Drugs. • BSUHT alcohol clinical champion addressing training for junior doctors. • From September 2014, Brighton University is planning updates within wellbeing workshops and introducing updates on drug and alcohol awareness for students on professional courses including teaching, medicine, nursing and pharmacy • Recovery culture promoted in all services. Peer support groups and mentors. • New project with local DWP (job centre) ready to start. • Recovery and reintegration grant fund • New evening clinics • NPS outreach worker attends young people's centre, A&E, Universities, hostels and available during night-time and via social media. • See above. Domain group of substance misuse programme board focuses on emerging drugs.	
3: The access needs of individuals with a dual diagnosis should be urgently addressed, supported by the availability of well trained and person-centred staff able to provide combined mental health and substance misuse assessments. (see also challenge 2 rec 6)	• Universal screening tool being piloted in hostels. • Joint assessment and shared care plans in place • Substance misuse service HUB to remove barriers to referral.	**AMBER**

	• Retender of service misuse service prioritises Dual Diagnosis and integrated care model. • Better Care Frailty focus includes those with complex needs such as Dual Diagnosis • New referral pathway to primary care wellbeing service in place to increase access to Cognitive Behavioural Therapy for stable substance misuse users.	
4: The current forums for service user and carer consultation will significantly assist implementing the recommendations in this section. However, a review of the support needs for forum members should be undertaken, particularly to address and avoid the over-reliance on specific individuals, and putting in place arrangements which draw on wider support networks such as Recovery Champions and Peer Mentors.	• Second cohort of recovery mentors completed training and now in placements. • Wide network of volunteers, recovery buddies and champions including within local providers. • Well established service user forums • New service user representatives sitting on strategic groups including contract reviews • Increasing number of “SMART” recovery trained facilitators. • Cascade Creative Recovery, an independent recovery community, actively recruiting volunteers to help develop local recovery capital including opening a recovery café.	**GREEN**

Appendix 3 - Update on Drug Consumption Room Feasibility Working Group

Health and Wellbeing Board. Tuesday June 10th 2014

Peter Wilkinson, Public Health, Brighton and Hove City Council

Purpose of paper

The purpose of this paper is to provide an update for the Health and Wellbeing Board on the progress made with the recommendation regarding the feasibility of establishing a local Drug Consumption Room (DCR).

Summary

The evidence suggests that a DCR could meet the needs of some injecting drug users in Brighton and Hove. However, at the present time the overall need of the local community, not just injecting drug users, is not considered to be sufficient by local organisations to agree to support establishing a DCR. This includes the lack of support for a local accord (regarding the implementation of the law) which would be required to allow the DCR to operate. The discussions and work continue but currently the conclusion is that it is not feasible to establish a DCR.

Membership of working group and way of working

The Substance Misuse Programme Board identified the leads for each recommendation in the Independent Drug Commission's report and formed the Independent Drug Commission Working Group. One of the recommendations was to establish a working group to consider the feasibility of developing a Drug Consumption Room (DCR). The membership of the Independent Drug Commission Working Group was supplemented with additional people with a specific interest in the possible development of a drug consumption room ((see appendix 1). A workshop was held in December 2013 (appendix 2).

Key issues

The working group considered the following key issues. The main points for each issue are summarised below;

1. *To consider the evidence of need for a drug consumption room within Brighton and Hove.*

- The elevated rates of problem drug misuse demonstrated the need but did not on their own make the case for establishing a DCR in Brighton. The improvement in the number of drug related deaths since 2009 suggested that the current strategies to reduce the number of drug related deaths are having an impact.
- The issue of wound infections and the high rates of hepatitis B and C demonstrated a high local need, but the question was asked whether

this need could be equally or better met through an alternative service rather than through establishing a DCR?
- Regarding drug litter and public injecting the data did not make a strong case for a DCR. However, it is felt that there is significant under- reporting. This is being investigated further.
- The findings from the service user consultation supported having a DCR. But the list of potential benefits again raised the issue whether resources would be better spent on meeting the needs of the local population through an alternative service rather than through a DCR?

2. To review the evidence for the potential benefits and harms to service users and the community from establishing a drug consumption room. A local review of the evidence has been undertaken. For the purposes of this paper the summary below is from the 2013 Supervised Injection Services Toolkit from the Toronto Drug Strategy. There is extensive, peer-reviewed research that supervised injection services are actively used by people who inject drugs, in particular people at higher risk of harm, and that demonstrates the following public health and community safety outcomes:

- reductions in overdose deaths;
- reductions in behaviours that cause HIV and hepatitis C infection – NB as distinct from reducing infection rates.
- increased use of "detox" and addiction treatment services;
- reductions of unsafe injection practices;
- reductions in public drug use;
- reductions in publically discarded needles; and,
- no increases in crime in the area surrounding the supervised injection service.

3. To identify the key legal issues which currently could prevent a drug consumption room from being established and what is required for a drug consumption room to operate within the law.

- In October 2013 the Home Office stated: "The Government has no plans to allow drug consumption rooms, which [would break] laws whereby possession of controlled drugs is illegal."
- The Association of Chief Police Officers (ACPO) is also clear on its position: "Recent evidence suggests that overall drug misuse in the UK is falling. Government policy on drugs enforcement is very clear and our job as police officers is to enforce the law. Drug Consumption Rooms or "Shooting Galleries" as they are often referred to as are illegal in the UK. Such facilities would have the potential to impact on local communities as a whole, attracting drug users to one area and also create a hotspot for associated criminality and anti-social behaviour."
- Sussex Police is currently in agreement with both the Home Office and ACPO positions and would not support a DCR where illicit drug use and supervision of drug use took place. Whilst the service supports officers to use their discretion when undertaking their duties, a principle equally applicable when considering how to reduce the harm caused by illegal drug use, there are a fundamental concerns around the

proposal and rationale for introducing DCRs. These include: DCRs are unlawful; there is not a clear evidence base from elsewhere in the UK setting out the benefits of introducing DCRs in Brighton and Hove; there is insufficient evidence of community/public support for the introduction of DCRs in Brighton and Hove; there is the potential for an increase in crime and disorder/anti social behaviour in areas where DCRs are introduced not only impacting local residents and businesses but the wider community as neighbourhood policing resources are diverted from other areas of the city

4. *To consider whether the drug consumption room should be a safe injection facility or should include provision for the smoking of drugs.*

- The law would need amending to accommodate smoking of cannabis or opium, but compliance with smoke-free regulations would be necessary for public safety, requiring most likely a heated unenclosed space. The working group agreed to focus on a safe injecting facility and not to consider a DCR for smoking drugs in the first instance.

5. *To propose potential operating models, costs and locations for the drug consumption room*

- The evidence suggests that most drug users, who use in public places, will use the drug within 500 metres of where they bought it. The model would be best placed within existing services. Options include hostels, day centres, or treatment settings.
- Local providers do not consider that any of the current settings from which drug treatment recovery services are delivered are appropriate for the co-location of a DCR. It is felt that a DCR would clearly conflict with the messages around recovery. Their preferred model would be a stand-alone porta-cabin piloted at different “hot-spot” locations around the city.
- A DCR with two staff (including at least one nurse) at any given time open 24 hours every day has an estimated cost of £500,000 per annum.
- Some of the uncertainty around the DCR can be limited by developing it from a smaller pilot or as a rigorously evaluated research study. This could either be as a DCR attached to another service or be a mobile pilot service. The latter would avoid planning concerns.

6. *To propose alternative services for the unmet needs of the street community?*

- Wider roll-out of Naloxone to hostels and other venues, rather than just to individuals.
- Resource a Recovery Mentor / Warrior Down service to build a circle of assertive engagement ‘friends’ around people who are known to be at high risk of overdose.
- Working with the police to adapt the Emergency Assessment Centres model to support the drug injecting street community into treatment services.
- Additional resource into further reduction of benzodiazepine prescribing and diversion.

- Robust root cause analysis research focused on in-depth analysis on people with a history of overdose. Intensive targeted interventions for those most at risk of overdose.
- Extra capacity for detoxification beds, including longer-term residential rehabilitation.
- It is acknowledged that some of these proposals should be developed regardless of whether a DCR were being established or not.

The current situation

Following the workshop further meetings were held to consider the possible models for a DCR and to develop alternative services. It is important to acknowledge that the police are not the only organisation which is not supportive of establishing a local DCR. The shift in focus for substance misuse services from a focus on harm reduction to recovery has put a greater emphasis on abstinence from drugs. Other organisations represented on the working group are unlikely to support a DCR for this reason.

Another issue is the source of funding for a DCR. In the present financial and political climate it is unlikely that statutory agencies would consider providing resources for a DCR unless there was very good evidence of potential benefits and associated cost savings. It has been suggested that certain charitable organisations, with a particular interest in substance misuse, may consider funding such a proposal. This has been explored, but it is limited at present by the theoretical nature of the application.

Conclusion

The evidence suggests that a DCR could meet the needs of some local injecting drug users. However, at the present time the overall need of the local community, not just injecting drug users, is not considered to be sufficient by local organisations to agree to support establishing a DCR. This includes the lack of support for a local accord (regarding the implementation of the law) which would be required to allow the DCR to operate. The discussions and work continue but currently the conclusion is that it is not feasible to establish a DCR.

APPENDIX ONE; **Membership of Independent Drug Commission Working Group and additional members of Drug Consumption Room Feasibility Working Group (*)**

Brighton and Hove City Council Linda Beanlands, Kerry Clarke Kathy Caley /David Brindley, Elizabeth Culbert*, Simon Ellery*, Cllr Rob Jarrett, Graham Stevens, Liz Tucker, Peter Wilkinson (Chair)

Brighton and Hove Clinical Commissioning Group Barbara Pawulska, Becky Jarvis, Linda Harrington

Brighton Housing Trust Nikki Homewood

CRi Micky Richards*/Kye Phoenix*

MIND Rick Cook

Oasis Jo-Anne Welsh*

Surrey and Sussex Probation Trust Leighe Rogers

Sussex Partnership Foundation Trust Charlie Freeman*, Michael Mergler /Jonathan West

Sussex Police Paul Betts, Julie Wakeford

APPENDIX TWO: WORKSHOP WEDNESDAY 11TH DECEMBER 2013

A workshop was held in December 2013 to review progress and to identify the barriers still to be addressed. The workshop was facilitated by Neil Hunt, an expert in DCRs.

The key points from the workshop were:

- Focus on safe injecting and not smoking at the present time.
- Need to look for external funding to assess the feasibility of bringing in funding as DCR won't be funded initially from local funds.
- What would be an acceptable pilot proposal for a DCR? Start small and build it onto an existing service or a mobile unit?
- Is the level of need great enough to support a DCR? Reasonable to conclude that a DCR would benefit some local injectors. However, at the present time the overall need for the local community, not just injectors, is not considered to be sufficient by some local organisations to agree to support establishing a DCR. At the present time, without a local accord we can't progress, so currently it is not feasible to establish a DCR.
- We need to be developing our outreach programmes to meet the needs of local people who would otherwise benefit from access to a DCR.

HEALTH & WELLBEING BOARD	Agenda Item 9 Brighton & Hove City Council

Subject:		**Disability and Special Educational Needs Review**
Date of Meeting:		**10 June 2014**
Report of:		**Executive Director, Children's Services**
Contact Officer:	**Name:**	**Regan Delf, Acting Assistant Director, Children's Services** **Tel: 293504**
	Email:	**Regan.delf@brighton-hove.gcsx.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The report sets out the terms of a review of Disability and SEN services, including related Health services.

2. RECOMMENDATIONS:

2.1 That the Board notes the commencement of the review and approves the scope, vision and aims.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 There are a number of contextual factors that make a review of Disability ,SEN, and related Health services a productive way forward at the current time, notably:

3.1.1 The government is introducing wide-ranging reforms to the way services for children and young people with SEN and disabilities are delivered through the Children and Families Act from September 2014

3.1.2 New demands from the SEND reforms (Special Educational Needs and Disability) require local authorities to commission services jointly with our Health colleagues and to be clear about such arrangements through the LA's published 'Local Offer'

3.1.3 A review of the current Section 75 commissioning agreement in relation to health service provision is being undertaken

3.1.4 Families continue to feedback that services are not always sufficiently well-aligned or responsive to the specific needs of their children and young people and also that choice can be limited in terms of provision, hence there is scope for further improvement .This issue was reinforced following a recent scrutiny report on services for children and young people with ASC

3.1.5 Changes to the ways schools are funded through the High Needs Block (HNB) part of the Designated Schools Grant (DSG) means that we need to ensure sustainable models of special educational provision for the future particularly for special schools and special units and facilities

3.1.6 For financial sustainability into the future, services and provision need to be delivered increasingly within a best value context with maximum on-going efficiencies

3.1.7 Our aim is to for any efficiencies to come first and foremost through integrated, innovative and flexible models of delivery that provide for young people close to home and allow choice and control for parents and young

3.2 The vision for the review is as follows:

`Our vision is to provide inclusive fully integrated disability, care, health and education services to children and young people with special educational needs and disabilities . Services will be personalised to each child and family. Families will have as much choice and control over services and provision as possible. Quality of provision will be excellent and promote measurably improved outcomes and better lives into adulthood. Streamlined well-integrated systems and efficiencies will enable the vision to be achieved within the value for money framework that the council is required to operate`

3.3 The key aims of the review are:

- To create inclusive fully integrated SEN, health, care and disability provision of outstanding quality ranging from 0-25 years
- To ensure excellent practice in identification and assessment of SEN and disability
- To provide a new framework for joint commissioning of services
- To deliver high quality provision and services within a value for money context, acknowledging need for on-going efficiencies in council spending
- To ensure that full account is taken of the recommendations from the recent ASC scrutiny panel
- To improve transition arrangements to adulthood and ensure extended assessment and provision from 19 to 25 years
- To provide choice for families and facilitate best use of integrated personalised budgets and direct payments
- To engage parents and young people effectively at all levels of strategic and decision-making forums

3.4 Four cross-cutting strategies will under-pin the review and ensure it is conducted on a secure footing:

- Engagement of children and young people and their families
- Accommodation
- Value for money and savings
- Communication and consultation

Governance of the review will come from a specially constituted Governance Board consisting of high level representation from Children's Services, CCG, schools and parents.

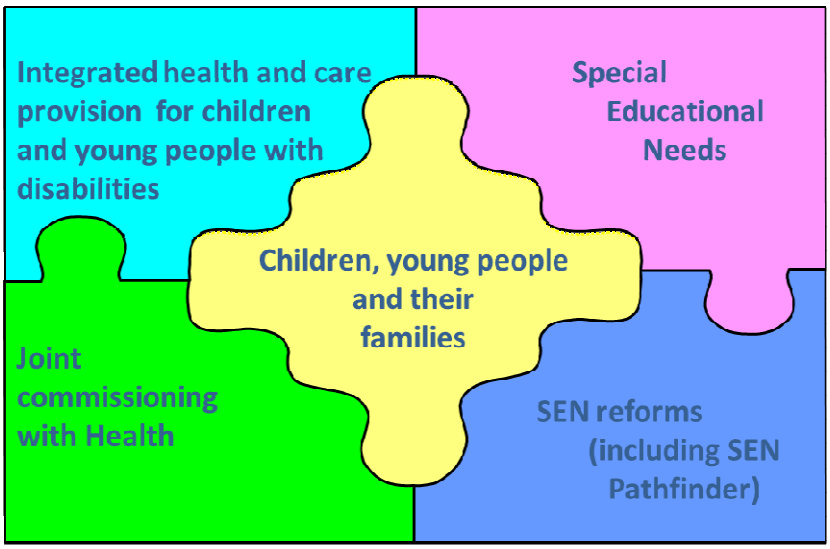
3.5 The newly amalgamated SEN and Disability Board will help support and steer the work of the review and provide a reference group

3.6 It is proposed to engage an external consultant for a prescribed number of days to provide objectivity and support with research and review methodology

3.7 The proposed timeline for the review is as follows:

- End July 14 – project initiation completed
    - Key partners informed of review scope and remit
    - Initial consultation complete
    - Young person's engagement strategy in place
    - Value for money strategy in place
    - External consultant engaged
- End of Aug 14 – preliminary report on project first stage
- End of November 14 – review of all providers and services concluded
- **End of December 14 – draft final report published**
- End of February 15 – consultation responses incorporated and final report and recommendations
- End of March 15 – report and recommendations agreed by committee

3.8 The four areas covered by the scope and remit of the review are set out below with services for children, young people and families at the heart:



4.0 Integrated health and care provision for children and young people with disabilities includes:

- The current model of integrated service delivery via Seaside View
- The children's homes at Drove Road and Tudor House
- Fostering
- Respite and short breaks
- Agency placements

- Direct payments
- Potential new provision possibly linked with East and West Sussex

4.1 Special Educational Needs includes:

- Special schools including agency placements
- Special Facilities
- SEND provision in mainstream schools, PRUs and alternative provision
- Education support services
- Staff training and development

4.2 Joint commissioning with Health includes:

- New joint commissioning arrangements with CCG, Public Health and NHS England
- Review of service delivery for mental and physical health - CAMHS, therapies, specialist health services at Seaside View
- Review of jointly funded Community and Voluntary Sector (CVS) contracts
- Review of parental engagement services at aMAZE

4.3 SEN reforms (including SEN national champion Pathfinder) include:

- `Local Offer` phase 2
- Education, Health and Care Plans (EHCPs)
- 19-25 agenda and links with adult services
- Personalised budgets
- Joint commissioning
- Associated workforce reform
- National champion role

5. COMMUNITY ENGAGEMENT AND CONSULTATION

5.1 Key to the success of the review will be the quality of engagement of children and young people, their parents, carers and families

5.2 One of the cross-cutting strategies underpinning the review will be an engagement strategy with children and families as exemplified in the diagram above:

6. FINANCIAL & OTHER IMPLICATIONS:

6.1 The SEND review will be set in a value for money framework and will seek efficiencies where appropriate to meet targets for council funding in future years.

6.2 The aim is for any savings to be identified through improved integration of services and provision such that streamlining of delivery can produce further improvements at lower cost.

Finance Officer Consulted: Name Steve Williams Date: 14/05/2014

Legal Implications:

6.3 Local authorities have a statutory duty to keep their arrangements for special educational provision under review (section 315 Education Act 1996). The review proposed in this report will span the introduction of wide ranging new SEN reforms contained in the Children and Families Act 2014 which are due to come into force on 1 September 2014. Section 27 of the new Act (which will replace section 315 of the 1996 Act) is more prescriptive regarding the duties of the Local Authority when reviewing SEN provision, in particular requiring the Authority to consult with a defined list of parties, including children and young people with SEN and disabilities and their parents, academies, early years providers, children's centres and Youth Offending Teams. Local Authorities are also under a new duty to have regard to the relevant Joint Strategic Needs Assessment and Health and Wellbeing Strategy when carrying out reviews under this section.

6.4 Key reforms to be introduced by the 2014 Act include:

- The introduction of Education, Health and Care Plans (EHCPs) to replace Statements of SEN, to be co-constructed between families and the Local Authority
- The extension of the remit for EHCPs from 0-25 years (currently 0-19 years) and the extension of the statutory nature of Plans into all forms of further education, training and apprenticeships
- The introduction of 'personalised budgets' to be available to families where children have EHCPs attracting 'top-up' funding (i.e. above the level of delegated funding for SEN normally provided by schools)
- The requirement to publish a 'local offer' of services and provision available for SEND
- New requirement to commission education, health and social care services and provision jointly with Health (CCG, Public Health and NHS England Area Team as appropriate)

Lawyer Consulted: *Serena Kynaston* *Date:14/05/2014*

Equalities Implications:

6.5 An Equalities Impact Assessment will form part of the review as there are significant implications for a large group of young people with special needs and disabilities.

Crime & Disorder Implications:

6.6 The draft SEN Code of Practice places new requirements on Local Authorities to consider the special needs of young people attending the Youth Offending Service

6.7 Increased identification of need amongst young offenders may lead to targeted provision that helps to reduce offending behaviour

Risk and Opportunity Management Implications:

6.8 A risk management assessment will be completed as part of the review process

Public Health Implications:

6.9 A representative from Public Health will be on the Governance Board for the review to ensure all implications are fully recognised

Corporate / Citywide Implications:

6.10 The review aims to further corporate priorities as follows:

6.10.1 Tackling inequality
The gaps in achievement, health, well-being and longer term life chances for CYP with SEN and disabilities are far too wide still and this review aims to improve outcomes via improved sustainable and integrated service provision

6.10.2 Engaging people who live and work in the city
The review will have a strategy to engage parents/ carers and CYP at its heart

6.10.3 Modernising the council
The new SEN reforms in the Children and Families Bill and the need to secure a sustainable financial footing for services going forward for the future will be addressed in the review

7. EVALUATION OF ANY ALTERNATIVE OPTION(S):

7.1 The alternative option is to bring in the new SEN reforms and maintain SEND services within the context of a reducing council budget without a review of services and provision

7.2 The risk in the option above is that services and provision across agencies as they stand currently will not offer the fully integrated service to children and families required by new legislation

7.3. A further risk is that the status quo in provision and services for SEND may not offer best value for the public purse in a changing national and local financial context and may not therefore be sustainable into the future

8. REASONS FOR REPORT RECOMMENDATIONS

8.1 The report is outlining a review of services and provision for children and young people with SEND for the reasons given above.

SUPPORTING DOCUMENTATION

Appendices:

None at this initiation stage of the review

HEALTH & WELLBEING BOARD	Agenda Item 10 Brighton & Hove City Council

Subject:		**Providing homes for people with learning disabilities**
Date of Meeting:		**10th June 2014**
Report of:		**Executive Director, Adult Services**
Contact Officer:	**Name:**	**Karin Divall** **Tel: 29-4478**
	Email:	**Karin.divall@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The Adult Social Care Market Position Statement (March 2014) sets out the strategic direction for social care services, with an emphasis on maintaining independence and offering a personalised approach. All social care services need to meet the demands of a population which has increasingly complex needs, and make best use of resources.

1.2 The Learning Disability Accommodation and Support Plan (2011-14) set out three key objectives to meet the range of accommodation needs for people with learning disabilities in the City:

- Better commissioning of specialist services
- Reshaping the local market to better meet local need
- Maximising independence through move on, prevention, and community support

1.3 The strategic direction for the council's directly provided Learning Disability Accommodation Service (LDAS) is to continue to provide services for people with the most complex needs and/or challenging behaviours, whilst supporting people to live as independently as possible.

1.4 Phase One of the LDAS strategy took place during 2013 and resulted in the consolidation of some services, the closure of houses in New Church Road and Old Shoreham Road and the creation of a larger women-only residential care service. A further commissioning review has since been carried out to determine how to continue providing high quality support and care whilst achieving the required savings and efficiencies.

1.5 The commissioning review has informed the proposals for Phase Two of the LDAS strategy, as described in sections 4 and 5 of this report.

1.6 The council's Budget Strategy for 2014/15 included savings of £150,000 (full year effect £300,000) in relation to the proposed Phase Two of the LDAS strategy.

2. RECOMMENDATIONS:

2.1 That this Board agree to a 90 day consultation with service users and their families and carers about the transfer of part of the council's Learning Disability Accommodation Service, as identified in Table 3, to private and voluntary sector providers.

2.2 That following this consultation, a report is brought back to this Board to consider the outcome of the consultation and to make their recommendations to the Council's Policy and Resources Committee.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The in-house Learning Disability Accommodation Service (LDAS) provides a mix of residential care and supported living services. These are primarily in street properties, with two of the services being provided to residents in self-contained flats and the remainder mainly in shared houses. Some of the buildings are owned by the Council, some were transferred from the Health Authority and others are owned by Registered Social Landlords.

3.2 The current configuration is based on a response to the closure of large long stay hospitals (Foremost) about 20 years ago when the principle of "an ordinary house on an ordinary street" was applied. Since that time, people with learning disabilities have increased longevity, increased complexity of need and increased expectations of independence and citizenship.

3.3 LDAS provides 62 units of accommodation; 43 units of supported living across 8 services and 19 units of residential care across 4 services, as follows:

TABLE 1:
Learning Disability Accommodation Services (LDAS), currently provided by Brighton & Hove City Council

Service Name	Service Type	Configuration	Total service capacity
Beaconsfield Villas	Supported Living	Shared House	5
Burwash Lodge	Supported Living	Shared & individual flats	7
Cromwell Road	Supported Living	Shared & individual flats	7
Ferndale Road	Supported Living	Shared House	2
Hawkhurst Road	Supported Living	Shared House	2
Hawkhurst Road	Supported	Shared House	4

	Living		
Mantel House	Supported Living	Individual flats	8
Rutland Gardens	Supported Living	Shared House	8
Beaconsfield Villas	Residential Care	Shared House & individual flats	5
Leicester Villas	Residential Care	Shared House	4
Preston Drove	Residential Care	Shared House	5
Windlesham Road	Residential Care	Shared House	5
Total - All Services			62

3.4 The needs of the people in these services varies from people with mild learning disabilities living semi-independently, through to people with severe learning disabilities and complex needs including physical and health needs. Some people have challenging behaviours, and some are on the autistic spectrum, with associated communication needs.

3.5 131 council staff are currently employed to deliver the Learning Disability Accommodation Service, which currently accommodates 59 people across the services (with 3 vacancies).

3.6 The LDAS is part of a wider market of accommodation services for people with learning disabilities. There are 24 residential care homes provided by 15 private and voluntary providers, and 35 supported living services provided by 17 private and voluntary sector providers. Therefore LDAS makes up approximately 14% of the learning disability residential care sector and 19% of the learning disability supported living sector.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The recent commissioning review of LDAS has shown that the service has developed as a mix of registered residential accommodation and supported living, with only some services supporting people with the most complex needs. Some services support people with very complex challenging behaviour. However, in many services, including most of the supported living services, the levels of need are lower and most individuals are less complex.

4.2 The LDAS has higher costs than equivalent services provided in the private and voluntary sector. Opportunities for reducing cost through efficiencies are now limited and will not be enough to achieve the required savings.

4.3 The commissioning review found that that three of the four registered residential care homes and two small supported living services do provide for people with very complex needs and/or challenging behaviour & that that these services are in demand, they are good quality and they fit within the model for council provided specialist services. These services are:

TABLE 2:
Future shape of LDAS, provided by B&HCC, as set out in these proposals

Service Name	Service Type	Configuration	Total service capacity	No. of current people
Ferndale Road	Supported Living	Shared House	2	2
Hawkhurst Road	Supported Living	Shared House	2	2
Beaconsfield Villas	Residential Care	Shared House & individual flats	5	5
Preston Drove	Residential Care	Shared House	5	5
Windlesham Road	Residential Care	Shared House	5	5
Total - All Services			19	19

4.4 Outside of this core of specialist residential and supported living services the level and complexity of need within the remaining services overall is more mixed and generally lower. These services do not fit within the recommended future scope of in-house accommodation services which should support people with the most complex needs, and there are some long term vacancies so demand is not as strong. These services are:

TABLE 3:
Services to be tendered, as set out in these proposals

Service Name	Service Type	Configuration	Total service capacity	No. of current people
Beaconsfield Villas	Supported Living	Shared House	5	5
Burwash Lodge	Supported Living	Shared & individual flats	7	6
Cromwell Road	Supported Living	Shared & individual flats	7	7
Hawkhurst Road	Supported Living	Shared House	4	4
Mantel House	Supported Living	Individual flats	8	7
Rutland Gardens	Supported Living	Shared House	8	7
Leicester Villas	Residential Care	Shared House	4	4
Total - All Services			43	40

4.5 The commissioning review identified that the services in Table 3 could be re-provided in the private and voluntary sector, at lower cost, and that there is no reason to believe that the private and voluntary sector could not deliver very successful, high quality services to these people.

4.6 Of the total of 131 staff who work in LDAS, 62 staff work in the services in Table 3 and would be affected by these proposals.

5. PROPOSAL

5.1 It is proposed that a consultation is undertaken with service users, their families and carers regarding the future provision of support and care. The proposal would be to retain the registered residential services and specialist supported living services as set out in Table 2 as directly provided Council services, but cease to directly provide the care and support within the services set out in Table 3.

This would mean the support and care services delivered in the services identified in Table 3 would, through a competitive tendering process, transfer from Brighton and Hove City Council to the private or voluntary sector. The homes that individuals live in would not change because of this process but the organisation responsible for the provision of their support and care would.

TUPE is likely to apply to approximately 62 council staff who would see their work, jobs and employment transfer from the council to the new provider.

For the people living in the services and their families this would mean that they would continue to live within their existing homes with the same people they currently share with and their care would continue to be provided based on their assessed needs.

However the consultation and the potential change of care provider from the council to another provider will raise anxieties, particularly for families and carers, about the quality of future provision of these services and concerns about the possibility of a change in the level of service being provided. Reassurance can be given that quality and outcomes in the private and voluntary sector is equal to LDAS, as evidenced through reviews by the Care Quality Commission and the council's commissioning & contracts units. Similarly, any prospective transfer of employment is likely to be a cause of concern for affected employees and the council's recognised trade unions.

6. COMMUNITY ENGAGEMENT & CONSULTATION

6.1 It is recommended that a 90 day consultation commence with service users and their families and carers regarding the recommendation to transfer the provision of some support and care services into the private or voluntary sector.

6.2 The consultation with the service users directly affected by these proposals will need to take account of their individual needs including where appropriate a risk assessment to determine the likely impact of consulting with each individual, their capacity to engage in the consultation and the most appropriate means of consultation with them and any appropriate support from an advocate.

6.3 Alongside the consultation with service users we will also engage and consult our trade unions and staff about the potential transfer of services prior to any transfer decision being made.

7. CONCLUSION

7.1 People with learning disabilities should be supported to live as independently as possible and be members of their community. The accommodation provided by the council is expensive and the quality is comparable to the voluntary and private sectors. This report sets out a proposal to consult with service users and their families about a change in the way that support and care is provided.

8. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

8.1 The option set out in paragraph 5.1 shows potential savings of £0.232 million per annum and opportunities to generate further efficiencies against a gross service budget of £5.6million. The savings target for 2014/15 is £0.15 million assuming a part year effect with a full year effect of £0.3 million; it is likely that further savings will be required year on year based on the medium term financial strategy. In addition there are unachieved savings from previous years of £0.421million which need to be addressed. Current unit costs are high compared with equivalent services provided by the private and voluntary sector and are also high against benchmarked other authorities providing in house residential services.

8.2 The cost of the consultation will be met from the Adults budget. Two of the homes were transferred from Health under Valuing People Now and any change of use would need to be agreed by Health. The financial implications following the consultation period will be costed and the potential for savings, the impact on income streams, and housing benefit evaluated. The progress in delivering savings in 2014/15 will be reported through the TBM process.

Finance Officer Consulted: Anne Silley *Date: 23/05/14*

Legal Implications:

8.3 The Local Authority has a duty to ensure the assessed needs of learning disabled adults are met including care and accommodation needs. In meeting this duty the Local Authority should promote personalisation affording people choice and control in terms of their care needs being met. The Local Authority must have regard to individual's Human Rights in particular the Right to Family Life enshrined in Article 8 of the European Convention on Human Rights. In addition it is incumbent upon the Local Authority to meet the demands of the public purse and make provision for statutory services whilst ensuring value for money within the means available.

The proposals contained in this Report include a consultation over a period of time as recommended in guidance; consultation must take place with those

persons affected or potentially affected by the proposals and ensure a fair and transparent process. Consultation must take in to account the specific needs of this potentially affected group. As identified in the body of this Report the proposals could have an effect on employment with the result that TUPE will apply.

The Health and Wellbeing Board has strategic responsibility concerning the effective delivery of adult care services and to make recommendations to Policy and Resources Committee concerning changes in provision and commissioning of such services. The Board therefore has the power to agree the recommendations in paragraph 2 of this Report.

Lawyer Consulted: Sandra O'Brien *Date: 12 May 2014*

8.4 Equalities Implications

Budget EIAs has been produced covering service user and staffing impacts of the savings proposals associated with these financial savings. A full EIA will be completed to support the preferred option.

8.5 Any Other Significant Implications:

These proposals will have implications for staff and for families and carers. Learning Disabilities Accommodation services are provided in family houses across the City. There are no sustainability, crime and disorder or public health implications associated with a proposal to consult contained within this report.

SUPPORTING DOCUMENTATION

Appendices:

1. None

Documents in Members' Rooms

1. None

Background Documents

1. None