Who are we?

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

Where and when is the Board meeting?

This next meeting will be held in the Council Chamber of Hove Town Hall on Tuesday 9th December 2014, starting at 4pm. It will last about two and a half hours.

There is public seating and observers can take part in an informal question and answer session with the Board prior to the formal meeting, starting at 3.30pm and they can leave when they wish.

What is being discussed?

There are eight main items on the agenda:

- Joint Strategic Needs Assessment Update
- Mental Health Crisis Care Concordat – Action Plan and Declaration of Support
- CCG Draft Commissioning Intentions
- Early Help and the Stronger Families, Stronger Communities Programme
- Brighton and Hove Winter Preparedness and NHS Capacity Planning Arrangements 2014
- Better Care Plan Fund – Update
- Housing Adaptations Update
- GP Surgery Provision in Brighton and Hove

What decisions are being made?

- The Board will note its duty to publish a Joint Strategic Needs Assessment (JSNA) under the 2012 Health and Social Care Act and approve publication of the 2014 JSNA summary updates;

- The Board will consider the approval of the Action Plan relating to the Mental Health Crisis Care Concordat;
- The Board will note the draft commissioning intentions of the CCG for 2015-2016 and consider whether they take proper account of the Joint Health and Wellbeing Strategy and JSNA;
- The Board will consider the recommendations to proceed to the next stage of the Early Help Partnership Strategy (priority 2), to support the council's decision to become an 'Early Starter' for the expended national Troubled Families programme and agree to hold discussions about the 'health offer' to the Troubled Families programme;
- The Board will note the plans to ensure that Brighton and Hove is prepared for 'winter'.
- The Board will noted the progress made to the Better Care Fund Plan;
- The Board will consider the recommendation of the Housing Committee to agree to monitor the allocation of the Disabled Facilities Grant under the Better Care Fund;
- The Board will consider a letter from Councillor Morgan regarding the provision of GP surgeries in Brighton and Hove and the response from NHS England.

Health & Wellbeing Board
9 December 2014
4.00pm
Council Chamber, Hove Town Hall

Who is invited:

J Kitcat (Chair),K Norman (Opposition Spokesperson), Jarrett, Morgan and G Theobald

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)

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 Fiona Harris (NHS England)

Who is unable to attend:

No notifications of absence were received prior to the time of printing the agenda papers.

Contact: **Caroline De Marco**
Democratic Services Officer
01273 291063
caroline.demarco@brighton-hove.gcsx.gov.uk

This Agenda and all accompanying reports are printed on recycled paper

Date of Publication - Monday, 1 December 2014

Health & Wellbeing

AGENDA

Formal matters of procedure

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

Page

42 Procedural Matters

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

43 Minutes **1 - 16**

The Board will review the minutes of the last meeting held on the 14th October 2014, decide whether these are accurate and if so agree them (copy attached).

Contact: *Caroline De Marco* *Tel: 01273 291063*

44 Chair's Communications

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

45 Formal Public Involvement

This is the part of the meeting when members of the public can formally ask questions of the Board or present a petition. These need to be notified to the Board in advance of the meeting. Ring the Secretary to the Board, Caroline DeMarco on 01273 291063 or send an email to caroline.demarco@brighton-hove.gcsx.gov.uk

The main agenda

46 Joint Strategic Needs Assessment Update **17 - 62**

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

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

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47 Mental Health Crisis Care Concordat - Action Plan and Declaration of Support **63 - 98**

Report of the Commissioning Manager (copy attached).

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

48 CCG Draft Commissioning Intentions **99 - 116**

Report of the Chief Operating Officer (copy attached).

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

49 Early Help and the Stronger Families, Stronger Communities Programme **117 - 126**

Report of the Assistant Director, Stronger Families, Youth & Communities (copy attached).

Contact: *Steve Barton* *Tel: 29-6105*
Ward Affected: *All Wards*

50 Brighton and Hove Winter Preparedness and NHS Capacity Planning Arrangements 2014 **127 - 146**

Joint report of Director of Public Health and the Chief Operating Officer of the Brighton & Hove Clinical Commissioning Group (copy attached).

Contact: *Dr Tom Scanlon* *Tel: 01273 291480*
Geraldine Hoban *Tel: 01273 574863*
Ward Affected: *All Wards*

51 Better Care Fund Plan Update **147 - 158**

Report of the Better Care Interim Programme Manager (copy attached).

Contact: *Mark Hourston* *Tel: 01273 574608*

Ward Affected: *All Wards*

52 Housing Adaptations Update **159 - 162**

Extract from the proceedings of the Housing Committee meeting held on the 10th September 2014 (copy attached).

Contact: *Caroline De Marco* *Tel: 01273 291063*

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53 GP Surgery Provision

a GP Surgery Provision **163 - 164**

Letter from Councillor Morgan (copy attached).

b GP Surgery Provision Response by NHS England **165 - 176**

Response from NHS England to the letter from Councillor Morgan (copy attached).

Public Involvement

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

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

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

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter and infra-red hearing aids are available for use during the meeting. If you require any further information or assistance, please contact the receptionist on arrival.

Fire / Emergency Evacuation Procedure

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

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

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

Health & Wellbeing

1. Procedural Business

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

(b) Declarations of Interest:

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

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

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

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

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

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

4.00pm meeting 14 October 2014

Sussex County Cricket Ground - Hove

Minutes

Present: Councillor J Kitcat (Chair), Councillor K Norman (Opposition Spokesperson), Jarrett, Morgan and G Theobald, Dr. Xavier Nalletamby, CCG, Geraldine Hoban, CCG, Dr Christa Beesley, CCG, Dr Jonny Coxon, CCG, Dr George Mack, CCG, Brian Doughty, Head of Adults Assessment (for Statutory Director of Adult Social Care), Dr. Tom Scanlon, Director of Public Health, Pinaki Ghoshal, Statutory Director of Children's Service, Frances McCabe, Healthwatch, Graham Bartlett, Brighton and Hove Local Safeguarding Children's Board, and Fiona Harris, NHS England

Also in attendance: Penny Thompson, Chief Executive, BHCC.

Part One

29 Declarations of substitutes and interests and exclusions

29.1 Brian Doughty, BHCC attended as a substitute for Denise D'Souza. Fiona Harris, NHS England attended as a substitute for Sarah Creamer.

29.2 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.

29.3 **Resolved** - That the press and public be not excluded from the meeting.

30 Minutes

30.1 **Resolved -** That the minutes of the Health & Wellbeing Board held on 9th September 2014 be agreed and signed as a correct record.

31 Chair's Communications

31.1 There were none.

32 Formal Public Involvement

(a) Petition

Petition from the users of the Community Centre currently administered by Southdown and located in Buckingham Road.

32.1 Richard Barraball presented the following Petition which was signed by 19 people.

"We the users of the Community Centre currently administered by Southdown and located in Buckingham Road do hereby petition Brighton & Hove Policy & Resources Committee to adequately fund day centres as part of the Care in the Community program of Social Inclusion. We are of the opinion that this is Value for Money as it would be far more affordable to tax payers than admission to Mill View Hospital or into A&E."

32.2 Mr Barraball explained that Buckingham Road Community Centre was a well-used resource with nice facilities. Mr Barraball stressed that it was important to have a safe environment where people could congregate and have a meal together. It was helpful to be able to talk to other service users rather than only talking to professionals. Mr Barraball stated that every organisation that tendered for services had to spend money on the tender process. This money could be used for services.

32.3 The Chair responded as follows:

"The Brighton and Hove CCG and Brighton and Hove City Council are committed to ensuring that day services support is available as part of the overall pathway of mental health care. We aim to ensure there is choice available for all service users including the provision of:

- a day centre at the Preston Park which provides support 365 days a year
- a new Recovery College starting this Autumn which offers over 20 courses across the city with Peer Support tutors co-delivering the courses

- The CCG currently spends £900,000 per annum in the commissioning of mental health day services in Brighton and Hove. The development of the Recovery College provides more choice to service users and has been cost neutral from a financial perspective. It does not represent a funding cut."

32.4 Geraldine Hoban explained that the proposed changes were part of a long term review of the whole model of care. For example, some service users had said that they wanted to access courses. Ms Hoban accepted that Day Centres fulfilled an important role. The locations had been reduced from 3 to 1. The changes were about extending choice for people in the city. It was not a funding cut. It was simply funding a different range of options. Ms Hoban asked people to contact her if the capacity in Preston Road was not sufficient.

32.5 **Resolved-** That the petition be noted.

(b) Written Question

32.6 Nick McMaster, UNISON Branch Communications Officer asked the following question:

Outcome from the Adult Drug and Alcohol Recovery Procurement Process

"It has been established that there were no legal requirements to put these services out to tender. It has been established that the new provider of the mental health and substance misuse pathway did not need to be an NHS health trust. Effectively privatising these services, decommissioning them from an established and confident local NHS provider appears a risky proposition with little impact assessment on the local health economy. With the public generally having an emotional and practical attachment to their local NHS services, why did you and your officers not consider trying to build on that local provision instead?"

32.7 The Chair stated it had been advised that the service needed to be tendered. It had been an exemplary process. He read the following statement.

"With regard to working with local NHS services to the exclusion of any other discussions on provision. It is clear that within the NHS and voluntary sector there are providers who sometimes are better placed to deliver better patient and public services. The key role of health commissioners is to deliver the best quality patient and public services possible. The re-commissioning of this service will mean a major shift in the delivery of this service, moving from a harm-reduction to a recovery model. The selection of the preferred bidder, which was made with considerable input from service users, will facilitate that service shift."

32.8 Mr McMaster asked the following supplementary question:

"It is extraordinary that the local NHS provider was not included in the tender process. Why has the service shifted to small third sector organisations?'

32.9 The Chair replied that the proposals would retain an NHS provider and local not for profit organisations. Meanwhile Sussex Partnership NHS Foundation Trust had won work elsewhere.

32.10 **Resolved-** That the written question be noted.

33 Outcomes from the Adult Drug and Alcohol Recovery Procurement Process

Introduction

33.1 The Board considered a report of the Director of Public Health which reminded members that in July 2013, the Policy & Resources Committee agreed for Public Health to commence the procurement process for the new Adult Drug and Alcohol services contract with a greater focus on recovery. The report described the procurement process that had led to the preferred bidder (Cranstoun as the lead provider in the Pavilions Partnership) being recommended for approval by the Health & Wellbeing Board and Policy & Resources Committee. The report was presented by the Consultant in Public Health Medicine/Deputy Director of Public Health and the Strategic Commissioner, Public Health.

33.2 The Deputy Director of Public Health stressed that extensive consultation had been undertaken to support the development of the new recovery focused service specification. The aim was to build on existing good practice and to have an outcome based specification. The specification did not include the contracts for in patient detoxification beds and residential rehabilitation. Evaluation of the bids had looked at quality, cost and partnership working. The Pavilions Partnership was led by Cranstoun as the lead provider and the focus would be on recovery.

33.3 If Policy and Resources Committee agreed the recommendations on 16th October, there would be a mobilisation period until April 2015, to enable the commissioner and the partnership to develop a robust and clear implementation plan taking account of changes for service users. The cost effective delivery model would complete a process that made approximately 8% savings to the Public Health budget.

Questions and Discussion

33.4 Councillor Morgan stressed that the City topped the drug death league table and saw above average levels of alcohol related health and community safety issues. Helping people deal with addiction and dependency was hugely important. Councillor Morgan recognised that the bid recommended for approval mirrored the

existing NHS/voluntary mix, but had real concerns about the proposals for the service.

33.5 Councillor Morgan raised concerns and questions about the following areas.

- The potential loss of local expertise and knowledge in the delivery of services. Why was there was a recommendation to approve a bid from a Trust and charity from out of the area?
- Why was the potential disruption to the service, staff and service users not factored in to the scoring system used to award the contract to employers from outside of Sussex?
- Why were the views of service users and local voluntary organisations not taken into account? Is there a risk that without more detail on the TUPE process, staff will inevitably start to look for other jobs as they won't want to move to a voluntary organisation where their terms and conditions can be changed after a year and where their union won't be recognised? This will lead to a major loss of local knowledge and experience.
- If the proposed new service is judged to be different to the existing SPFT one in terms of treatment and recovery, is there a risk that TUPE will be judged not to apply, with SPFT then being faced with a potential redundancy bill of hundreds of thousands of pounds? Would this not impact hugely on the local health economy?
- Should there not be a more thorough impact assessment undertaken before this decision goes ahead? It is this issue of an impact assessment on the local health economy that has now stalled the contracting out of a large chunk of clinical services to Virgin Healthcare in West Sussex.
- The procurement process for Adult Drug and Alcohol Services commenced in July 2013. Did the Council let SPFT's managers know that they wanted to emphasise the recovery aspect of the service more? What discussions took place with SPFT over doubts as to the quality of their substance misuse service in the City?
- Can you provide any evidence that these concerns were directly discussed with the Trust by those within the Council who are responsible for monitoring this type of contract?

33.6 Councillor Morgan asked the Board to look again at the tendering process and whether Sussex Partnership could build on the good partnership working it already had with a multiple of local voluntary organisations in the City. He suggested that the Board should be seeking to retain local NHS provision; local expertise and local staff wherever possible, and asked that the report be referred back for further work on a locally based and accountable service.

33.7 The Strategic Commissioner, Public Health explained that officers had followed procedures rigorously with regard to service users and TUPE. This work had been monitored by finance teams who were satisfied that the TUPE requirements had been taken into account. Service users had been at the heart of the process. Extensive consultation had taken place and an online survey had received feedback

from 250-260 people from the local community. This feedback had influenced the service specification. The Evaluation Panel had included service users throughout the process.

33.8 The Deputy Director of Public Health explained that there would inevitably be some disruption with any new service. Sussex Partnership Foundation Trust was aware that the new service would be focused on recovery.

33.9 Councillor Jarrett stated that he could understand the concerns being expressed about the loss of a lead provider from the local area. He referred to Councillor Morgan's request for an impact assessment. Councillor Jarrett did not think there would be a big impact but proposed that a decision be deferred for a short period to enable an impact assessment to be carried out on the local health economy.

33.10 The Director of Public Health stated that he appreciated the concerns being expressed about the new service but stressed that service users were totally at the heart of the proposals. Bids had been evaluated and the Pavilion Partnership, which included a number of local partners, stood out as the best bid. This was the bid that scored highest and service users support the awarding of this service to the preferred bidder. The Director stressed that everyone involved in the process cared as passionately about the NHS. The proposed new service would be the best service for people in Brighton and Hove.

33.11 The Director of Public Health stated that if the recommendations were agreed at the Board and ratified by the Policy & Resources Committee there would be a mobilisation period which was like an impact assessment. There would be open discussions during this process. If there was a deferral there was a danger that the current contract would run out before a new contract was put in place. It was important to proceed with the process.

33.12 Councillor Theobald considered that the most important people were the service users. The process started in July 2013 and there was a need to move forward straight away.

33.13 The Deputy Head of Law advised that the recommendation to award the contract to Cranstoun as the lead provider in the Pavilions Partnership had a caveat stating that the award of the contract was subject to the Director of Public Health being satisfied about the detailed delivery arrangements. The Board could recommend deferral and this may be considered to be justified where there were new facts or new information presented to the Board. It was possible that Cranstoun could challenge a decision to defer on the grounds that they were the successful bidders following a fair and transparent procurement process.

33.14 At this point Councillor Morgan moved an amendment to the recommendations. He proposed a deferral of the decision. The amendment was seconded by Councillor Jarrett. A vote was taken and the amendment was not approved.

33.15 **Resolved –**

(1) That the Policy & Resources Committee be recommended to award the Adult Drug and Alcohol Recovery Service contract to Cranstoun as the lead provider in the Pavilions Partnership at a value not exceeding £15.6m over a three year period, subject to the Director of Public Health being satisfied about the detailed delivery arrangements; and authorises the Director of Public Health to award this contract upon being satisfied as to the delivery arrangements, and to take all necessary steps in connection with the letting of the contract.

(2) That the Policy & Resources Committee be recommended to further grant delegated powers to the Director of Public Health to extend the contract at the end of the three year term, with the potential to extend the contract for a further two years if he deems it appropriate.

34 Pharmaceutical Needs Assessment - Supplementary Statement and Working Draft of PNA report of Conclusions and Recommendations

Introduction

34.1 The Board considered a report of the Public Health Principal which presented an updated supplementary statement to the 2010 Pharmaceutical Needs Assessment. The Pharmaceutical Needs Assessment was a comprehensive statement of the need for pharmaceutical services in the population of the area. The report also presented a working draft of conclusions and recommendations of the ongoing PNA for discussion. The PNA Steering Group would approve the draft of the PNA report prior to a 60 day consultation period. The final draft would be presented to the HWB in March 2015 for approval.

Questions and Discussion

34.2 Councillor Morgan mentioned that there had been issues in the past in his ward in relation to coverage. There had been a two year battle to get a replacement pharmacy following a closure. He asked for more information about coverage. The Public Health Principal replied that this detail was provided in the report. Pharmacies were positioned close to where people lived.

34.3 Fiona Harris stated that it would be useful to clarify issues with regard to the awarding of contracts. The process was carried out by NHS England. There had been some changes to make the process more focused on need. A good application from pharmacies would highlight need.

34.4 The Chair raised the issue of pharmacies in supermarkets. Fiona Harris explained that if the supermarket was undergoing a major relocation they would need to re-apply to NHS England to be included on the pharmaceutical list.

34.5 Fran McCabe stated that work carried out by Healthwatch showed that people were concerned about the out of hours service. She stressed that work needed to be carried out on informing people about the range of services on offer, and questioned whether pharmacies had sufficient capacity to take on more work.

34.6 The Chair suggested that Ms McCabe shared data with the Public Health Principal. Meanwhile, the Public Health Principal offered to share more details about the out of hours service details in the report.

34.7 Councillor Theobald reported that he had recently tried to use a pharmacy near Hove Town Hall which was about to close. The staff did not know where the nearest out of hours pharmacy was situated. Councillor Theobald suggested that notices could be placed in the windows of pharmacies stating the location of the nearest out of hours pharmacy.

34.8 Christa Beesley explained that work was being carried out to have a mobile phone enabled website to state where the nearest pharmacy was situated. However, she agreed that notices in windows would be equally useful.

34.9 Geraldine Hoban reported that a pharmacy in the Seven Dials was open to 10.00pm. She stressed that the role of pharmacies was an untapped resource in the city and should be used more. For example, this was happening within the dermatology service. Instead of attending a GP, patients could attend a local pharmacy. This could be extended to other long term conditions. She requested that this suggestion was included in the consultation.

34.10 Jonny Coxon requested that there should be an update on Epic at the Health & Wellbeing Board. There was a need for record sharing between pharmacies and GP's surgeries.

34.11 The Chair agreed that an update on Epic should be included in the forward plan for the HWB.

34.12 George Mack asked if NHS England had supported the work on the PNA. Fiona Harris confirmed that NHS England had supported the PNA. There was a partnership between NHS England who had responsibility for the commissioning of this core service and local commissioners who carried out detailed work.

34.13 Tom Scanlon stressed that work on the PNA was a shared responsibility. Partners would be building on good work.

34.14 **Resolved –**

(1) That the updated supplementary statement to the 2010 Pharmaceutical Needs Assessment (PNA) be approved.

(2) That it is noted that the paper also presents a working draft of conclusions and recommendations of the ongoing 2015 PNA for discussion as requested by the HWB at the meeting on 05/02/2014. It is further noted that the PNA Steering Group will approve the draft of the PNA report prior to a 60-day consultation period, as agreed at the HWB meeting 5th February 2014. The final draft PNA document will be presented to the HWB in March 2015 for approval.

35 Brighton & Hove Safeguarding Adults Board Annual Report 2013-14

Introduction

35.1 The Board considered a report of the Executive Director of Adult Services which presented the Brighton & Hove Safeguarding Adults Board Annual Report 2013/14. The Annual Report, attached as appendix 1, outlined work carried out across the City during the period of 2013-14, and noted the priorities for 2014-15. A protocol to ensure clarity of work between the Health and Wellbeing Board and the Adult and Children's Safeguarding Boards had been included this year as an appendix 2. The report was presented by the Head of Adult Safeguarding and the Head of Adults Assessment.

35.2 The Head of Adult Safeguarding referred to Section 3 of Annual Report which set out Performance and Practice for 2013/14. Safeguarding figures had reached a plateau due to awareness of adult safeguarding. There was a raised level of people alerting. Meanwhile, the Care Act would lead to significant changes in the coming year. For example, recording would be based on a different criteria from 2015.

35.3 The Head of Adults Assessment referred to assessments carried out under the Deprivation of Liberty Safeguards. Following a Supreme Court Judgement in March 2014 it was anticipated that the numbers of applications for authorisation of Deprivation would rise significantly.

Questions and Discussion

35.4 Councillor Jarrett thanked the Head of Adult Safeguarding for the effective work that had been carried out. Councillor Jarrett noted a steady increase in the willingness of the public to report incidents and did not anticipate a reduction in figures in the future.

35.5 **Resolved –**

(1) That the safeguarding work carried out in 2013-14, and the priorities for 2014-15 be noted.

(2) That the report be agreed for circulation.

(3) That the protocol between the Brighton & Hove Health & Wellbeing Board, the Brighton & Hove Safeguarding Children's Board and the Brighton & Hove Safeguarding Adults Board be approved.

36 Local Children Safeguarding Board Annual Report

Introduction

36.1 The Board considered a report of the LSCB Independent Chair which set out the Local Children Safeguarding Board Annual Report 2013/14. The Annual Report provided an assessment of the effectiveness of local arrangements to safeguard and promote the welfare of children. Safeguarding activity was progressing well in the area and the LSCB had a clear consensus on the strategic priorities for the coming year. A protocol for co-working between the LSCB and the HWB was attached to the report. The report was presented by Graham Bartlett.

Questions and Discussion

36.2 Pinaki Ghoshal thanked Mr Bartlett for chairing the LSCB and strengthening partnership arrangements. He noted that a great deal of work had been carried out. Amongst the issues that stood out was private fostering. This issue has caused significant concerns and there had been a need to better identify private arrangements. The increased numbers of private fostering arrangements notified is testament to the work carried out in this area. A great deal of work had been carried out in the last year on missing children and good work was being carried out on combating child sexual exploitation. Mr Ghoshal stressed that the LSCB was a learning organisation. Amongst other areas of focus, it identifies where things may have gone wrong and aim to ensure it did not happen again. Mr Ghoshal endorsed the report.

36.3 The Chair saw the learning review as a positive approach.

36.4 Councillor Morgan thanked everyone involved in the report and found it reassuring to see the depth of the work being carried out. Councillor Morgan mentioned the Rotherham inquiry into child sexual exploitation and asked for more detail on work to ensure another Rotherham case did not occur.

36.5 Graham Bartlett replied that there had been awareness regarding issues of child exploitation for some years. It was important to deal with these cases as well as to identify those at risk. Pinaki Ghoshal had chaired a meeting about this issue recently. The LSCB's models of engagement were very good. Mr Bartlett had data on this issue. He stressed the need to identify factors that put children at risk.

36.6 Mr Bartlett reported that he was aware that investigating cases of child sexual exploitation was very complex. Children could be very vulnerable and put themselves in harm's way. However, this must not deter action to help children

before they became victims of crime. The LSCB is revising its structure to deal with this issue.

36.7 Councillor Norman commented that the reports on children's and adult's safeguarding were closely related. He thanked Mr Bartlett and everyone involved in the work of the LSCB. He stressed the need to be vigilant and to report cases where there might be an issue.

36.8 Penny Thompson stated that as Chief Executive she had the responsibility of holding the Independent Chair of the Safeguarding Children's Board to account. She assured the Board that these matters were taken very seriously and officers were open, vigilant and learning from experience. Ms Thompson thanked colleagues from health and other organisations such as the police. The degree of open joint working in these demanding roles was exceptional.

36.9 Tom Scanlon thanked everyone involved in the work and stressed the need to focus on child protection plans. Dr Scanlon mentioned the work of the Multi-Agency Safeguarding Hub (MASH) which linked to work with schools and public health. There also needed to be a link with primary care.

36.10 Pinaki Ghoshal informed the Board that the Multi-Agency Safeguarding Hub had been operating for a short while. Health staff would be joining MASH from 14 December.

36.11 The Chair referred to Appendix 2 of the Annual Report. This set out details of membership and representation at LSCB meetings in 2013/14. The Chair asked if the Board could help to improve attendance.

36.12 Graham Bartlett replied that there was an attempt to demonstrate who was playing a part in the LSCB main meetings. It did not reflect the attendance at sub groups or in other LSCB activities. Members could be encouraged to take a more active role in attending meetings.

36.13 Fran McCabe referred to the figures quoted in the section of the report titled Child Protection and Children in Need Plans – Example of Multi-Agency Audit (page 125 of the agenda). She asked if the initiatives that were being put in place would address that issue.

36.14 Mr Bartlett replied that all audits had action plans in place to fill gaps. These areas would be tested. There had been a great deal of work carried out around the audit.

36.15 Pinaki Ghoshal stated that there had been an audit a year ago and the scale of the audit had been increased. There had been an improvement in the scale of practice.

36.16 **Resolved –**

(1) That the information report is noted and that members of the Board support their relevant organisations in their contribution to keep children safe from abuse and neglect.

(2) That the challenges for the LSCB in 2014/15 be noted.

(3) That the protocol for co-working between the LSCB and the HWB be approved.

37 Brighton & Hove Dementia Plan 2014-2017

Introduction

37.1 The Board considered a joint report of officers which explained that the Dementia Plan had been produced in response to the recommendations of the JSNA and built on the Dementia Plan 2012-2015. It was overseen by the Dementia Steering Group and had been arrived at through a detailed and broad process of consultation and engagement. The report was presented by the Commissioning Manager, CCG, the Public Health Programme Manager and the Commissioning Manager, Adult Social Care, BHCC (co-authors).

37.2 Key findings from the JSNA were that the city had some pockets of excellent dementia services, but they were not always joined up and there were some gaps. Key recommendations included the need for better/more: Early intervention; joined up services that support patient centred care; carers support; support to local community services & training and education.

37.3 The Commissioning Manager, CCG stated that there had been thorough consultation on the Dementia Plan. The aim was to treat dementia as a long term condition with all services being dementia friendly. The Better Care Fund for 2015/16 agreed by the Health & Wellbeing Board included an allocation of £250,000 for the Dementia Delivery Plan. The Dementia Implementation Group would oversee each project and monitor the on-going delivery of services.

37.4 The Public Health Programme Manager reported that there had been a successful consultation event on the draft plan attended by many people who had not been involved before. The discussion generated was wide ranging and interesting. The meeting would be used as a model for future consultation.

Questions and Discussion

37.5 George Mack stated that he found the Dementia Plan very comprehensive but had concerns. He questioned whether the plan was affordable and achievable and asked if the four priorities would involve too much work.

37.6 The Commissioning Manager, CCG replied that there needed to be transparency about costs. There were risks but a great deal could be achieved with £250,000. A refresher plan would be brought back to the Board following discussions.

37.7 Christa Beesley stated that there had been a modelling exercise on this issue four years ago. Savings could be made by delaying the time that people had to go into care. Dr Beesley stressed that the Dementia Plan was worth implementing but the impact would be seen over a long period of time. The plan was about early intervention.

37.8 Fran McCabe declared that she was on the Board of Age UK. She considered the Dementia Plan to be good and comprehensive. Many issues had been brought together and people with dementia were seen as 'whole persons'.

37.9 **Resolved –**

(1) That the Dementia Plan and its broad and integrated approach is endorsed.

(2) That the resources available from the Better Care fund are noted and that the Dementia Implementation Group be authorised to prioritise spending on the Plan.

(3) That the process of monitoring the progress of the Dementia Plan be agreed.

38 Cancer Screening in Brighton & Hove

Introduction

38.1 The Board considered a report of the Director of Public Health which presented an overview of screening performance in Brighton and Hove for the three NHS cancer screening programmes: bowel, breast and cervical cancer, considering uptake/coverage rates by CCG locality and by GP practice. The report made provisional recommendations for increasing cancer screening rates in the city. The paper was intended to inform members about current performance and to promote discussion as to the way forward. The report was presented by the Public Health Principal, and by the Sussex & Surrey Screening and Immunisation Lead.

Questions and Discussion

38.2 The Chair thanked officers for the cancer screening figures and asked if anything could be done to improve the screening uptake. He noted that Brighton and Hove was below the national average for screening take-up. The Public Health Principal explained that the role of public health in local authorities was to raise public awareness. From the evidence received, there were no major omissions in the work carried out. Officers needed to select priorities from a public awareness point of view. There was a need to make GP's aware of the screening rates for the three

cancer screening programmes and strategies as to how they might assist in increasing uptake could be reviewed. For example, the breast screening unit are asking GPs for the phone numbers of those who do not attend for their mammogram so that they can contact them to find out why. It was known that if people attended a first screening they were more likely to attend again.

38.3 The Sussex & Surrey Screening and Immunisation Lead officer stated that it would be helpful if the Board could support the joint work carried out by the statutory services. The City had a different social economy to the rest of the South East and there was a need to work on areas with a low screening take-up.

38.4 Councillor Morgan thanked officers for the report and noted that Whitehawk was highlighted as one locality where screening rates were low. He questioned whether the lack of a mobile screening van had contributed to the low turn-out. Councillor Morgan suggested that providing taxi vouchers to people attending appointments and sending out invitations with the GP's letter head might encourage a higher take-up. Councillor Morgan thought there would be value in having a Health Scrutiny Panel on this issue.

38.5 Councillor Theobald noted that the take up rates were not particularly good throughout the city. He asked if GP's would be notified if someone did not take up the bowel cancer test.

38.6 Christa Beesley replied that family doctors were notified and GP's headed note paper was being used to contact patients and give them a second chance to be screened in some pilot practices. Recommendations for increasing cancer screening rates in the city were included at Section 6 of the Cancer Screening document.

38.7 Dr Beesley stressed that there needed to be a response from the wider community and questioned whether employers could have a role by allowing screening in the workplace.

38.8 The Chair suggested that the issues raised in the report should be considered by a Task and Finish Group of the Health & Wellbeing Board. The Group should have a fixed end date. Fiona Harris and Fran McCabe volunteered to be members of the Group.

38.9 The Sussex & Surrey Screening and Immunisation Lead mentioned that there were Local Programme Boards and suggested that they could be linked to the HWB. The Public Health Principal mentioned that there was a Local Cancer Action Group. She suggested that that there could be a more formal link between that and the Programme Boards.

38.10 Geraldine Hoban stressed that that screening was only one part of improving cancer outcomes. The Cancer Action Group had a specified focus. There was a need to target effort where the biggest impact could be seen.

38.11 **Resolved –**

(1) That the overview of screening performance in Brighton & Hove for the three NHS cancer screening programmes: bowel, breast and cervical cancer, considering uptake/coverage rates by CCG locality and by GP practice be noted.

(2) That the provisional recommendations for increasing cancer screening rates in the city be noted.

(3) That the issues raised in the report should be considered by a Task and Finish Group of the Health & Wellbeing Board. The Group should have a fixed end date.

39 Brighton & Hove City Council Summary Report of Healthwatch B&H Performance: Year 1 - 2013/14

Introduction

39.1 The Board considered a report of the Head of Policy and Performance which provided performance information for the first year of the Healthwatch contract (2013-14). The information was attached as Appendix 1 to the report.

39.2 **Resolved –**

(1) That the report be noted.

40 Drug and Alcohol Recovery System Procurement Outcome - Exempt Category 3

40.1 **Resolved:** That the information contained in the appendix be noted.

Note: The appendix was not discussed and the Board did not exclude the press and public from the meeting.

41 Part Two Proceedings

41.1 **Resolved:** That the information contained in the appendix at Item 40 remain exempt from disclosure to the press and public.

The meeting concluded at 6.00pm

Signed Chair

Dated this day of 2014

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Joint Strategic Needs Assessment Update

1.1 The contents of this paper can be shared with the general public.

1.2 This paper is for the Health & Wellbeing Board meeting on the 9th December 2014.

1.3 This paper was written by:

Kate Gilchrist, Head of Public Health Intelligence, Brighton & Hove City Council.
Email: Kate.gilchrist@brighton-hove.gov.uk Tel: 01273 290457
Alistair Hill, Consultant in Public Health, Brighton & Hove City Council.
Email: Alistair.hill@brighton-hove.gov.uk Tel: 01273 296560

2. Summary

2.1 From April 2013, local authorities and clinical commissioning groups have had equal and explicit obligations to prepare a Joint Strategic Needs Assessment (JSNA) which provides a comprehensive analysis of current and future needs of local people to inform commissioning of services that will improve outcomes and reduce inequalities. This duty is discharged by the Health and Wellbeing Board.

2.2 The purpose of this item is to outline to the Board the local approach to needs assessment, to update the Board on progress with the JSNA since the last report in September 2013 and to ask the Board to approve the summary updates for publication, to

approve the planned needs assessment for 2015, along with the plan for updating the summary sections on a three year rolling basis.

3. Decisions, recommendations and any options

3.1 That the Board notes its duty to publish a Joint Strategic Needs Assessment (JSNA) under the 2012 Health and Social Care Act: that from April 2013 councils and CCGs have equal and explicit obligations to prepare a JSNA and that this duty is discharged by Health and Wellbeing Boards.

3.2 That the Board approve that a needs assessment for emotional and mental wellbeing of children and young people be conducted in 2015, as set out in section 4.5.3.

3.3 That the Board approves the 2014 JSNA summary section updates (Appendix) for publication.

3.4 That the Board approves the plan for updating the 84 summary sections on a rolling basis, as set out in section 4.6.2, with the development of the programme delegated the City Needs Assessment Steering Group.

4. Relevant information

4.1 **What is needs assessment?** The needs assessment process aims to provide a comprehensive analysis of current and future needs of local people to inform commissioning of services that will improve outcomes and reduce inequalities.

4.1.1 To do this, needs assessments should gather together local data, evidence from the public, patients, service users and professionals, plus a review of research and best practice. Needs assessments bring these elements together to look at unmet needs, inequalities and overprovision of services. They also point those who commission or provide services towards how they can improve outcomes for local people.

4.1.2 The common name for these needs assessments is Joint Strategic Needs Assessment (JSNA). Joint reflects that they should be carried out jointly by the NHS and councils as a requirement, but in terms of good practice should also include others locally with expertise to offer. Strategic reflects that they should be about providing the 'big picture' in terms of identifying local needs.

4.2 **National policy and guidance:** Publishing a JSNA has been a statutory requirement for Councils and NHS since 2007. From April 2013 councils and CCGs have equal and explicit obligations to prepare a JSNA under the 2012 Health and Social Care Act this duty is discharged by Health and Wellbeing Boards.[1]

4.2.2 Department of Health guidance signalled an enhanced role for JSNAs to support effective commissioning for health, care and public health as well as influencing the wider determinants that influence health and wellbeing, such as housing and education.

4.2.3 **Joint Health and Wellbeing Strategy:** The Health and Wellbeing Board jointly agree what the greatest issues are for local people based on the evidence in the JSNA in their Joint Health and Wellbeing Strategy. The Strategy sets these out, along with what the Board will do to address them and what outcomes it intends to achieve.

4.3 **Our local approach: In Brighton & Hove the scope of the JSNA has, and continues to, widen. It has moved from a summary of health status to encompass the wider determinants of health, such as education and housing, and to cover the needs and assets of different population groups. The JSNA now represents the key city wide intelligence resource that looks at the needs of the population to help plan, commission and deliver services to those who need them most.**

There are three elements to the needs assessment resources available across the city:

Overarching documents: The JSNA summary, the City Snapshot and Annual Reports of the Director of Public Health

4.3.1 The JSNA summary gives a high level overview of Brighton & Hove's population and its health and wellbeing needs. It informs the development of strategic planning and identification of local priorities, as well as commissioning and service provision.

4.3.2 The information is primarily drawn from the city's needs assessment portfolio, which includes the Annual Reports of the

[1] Department of Health. Statutory guidance published on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. 2013. Available at: http://healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/ [Accessed 27/11/2014]

Director of Public Health along with specific needs assessments and strategies. The JSNA summary is also used for the City Snapshot Report, published earlier in 2014, which provides high level facts and figures about the city.

Rolling programme of comprehensive needs assessments on a specific theme or population group

4.3.3 These form part of a portfolio of resources for the city. Themes may relate to specific issues e.g. dementia, or population groups e.g. trans. Needs assessments are publicly available and include recommendations to inform commissioning such as the dementia needs assessment which underpins the dementia action plan agreed by the Health and Wellbeing Board.

Community Insight - the information resource for the city, supported by Brighton & Hove Connected

4.3.4 Brighton & Hove Connected (http://www.bhconnected.org.uk/content/local-intelligence) is the Strategic Partnership data and information resource for those living and working in Brighton & Hove. The JSNA summary, comprehensive needs assessments and supporting data and evidence are published on this website. Community Insight provides local data and maps on the population of the city http://brighton-hove.communityinsight.org/.

4.3.5 Other key elements in our local approach

- **Inequalities and protected groups:** The summaries and in depth needs assessments systematically identified local inequalities in terms of equalities groups, geography and socio-economic status. In addition, there are summary sections which bring together the needs of protected groups.
- **Joint Strategic Assets Assessment:** in addition to reflecting a needs based approach, our JSNA process aims to identify the assets and strengths of communities that influence health and wellbeing and which can be supported in order to achieve improve outcomes.
- **Voice:** The voice of professionals, patients, service users and the public provides important evidence for the JSNA. Where we do not currently have this evidence it is included in 'what we don't know'.

- **What we don't know:** Where there is a lack of local data, if possible, other studies and evidence have been used to produce estimates for the city. Where this is the case, or where there are complete gaps, it is clearly identified.
- **Local consultation:** Wider engagement is central to the JSNA. Each in depth needs assessment has considerable engagement with the public and professionals.

4.4 **City needs assessment steering group:** A steering group oversees the programme of needs assessments. Membership includes the Clinical Commissioning Group, HealthWatch, Public Health, Adult Social Care, Children's Services, Communities Equality & Third Sector team, Housing, Community Works, Sussex Police and the two universities.

4.5 In depth needs assessments

4.5.1 The following additional needs assessments have been published in 2014 and are available at http://www.bhconnected.org.uk/content/needs-assessments:

- Dementia
- Homeless health audit

4.5.2 Needs assessments currently in progress are:

- **Trans needs assessment** delivered as part of the Trans Equality Action Plan.
- **Pharmaceutical needs assessment:** draft presented at the October 2014 Health and Wellbeing Board meeting.

4.5.3 **Priorities for 2015 needs assessment (for approval by the Health and Wellbeing Board):** In addition to the Trans and PNA, which will report in 2015, priorities for future needs assessment have been reviewed with the Needs Assessment Steering Group members, as well as Public Health, CCG, Adult Social Care, Children's services. This process has been informed by future strategic and commissioning priorities. **It is recommended that a needs assessment on the emotional health and mental wellbeing of children and young people is prioritised.**

4.5.3.1 Emotional health and wellbeing, including children and young people, is a current priority area for the Health and

Wellbeing Board (highlighted by the local Health and Wellbeing Strategy and the recent publication of Happiness: Brighton & Hove Mental Health and Wellbeing Strategy).

4.5.3.2 The needs assessment will support the Clinical Commissioning Group in its review of Child and Adolescent Mental Health Services (CAMHS) but will be broader than solely considering mental health services.

4.6 Summary updates

4.6.1 **2014 summary updates (for approval by the Health and Wellbeing Board):** In 2014 a small number of sections were updated to reflect evidence from the in depth needs assessment completed in the previous year. These are available in the Appendix to this paper. The updates will be published on the needs assessment site: http://www.bhconnected.org.uk/content/needs-assessments. The updated summary sections are:

- Children and young people with autistic spectrum conditions (following recommendations from the 2014 Overview and Scrutiny Committee)
- Gender identity and trans people (updated to reflect that the comprehensive needs assessment is currently in progress)
- Dementia (updated to reflect the comprehensive needs assessment published in 2014)
- Homelessness and rough sleepers (updated to reflect the homeless health audit published in 2014)
- Ageing well (updated to reflect the Adult Social Care Market Position Statement – previous ageing well and Adult Social Care sections combined due to overlap)
- Life expectancy and healthy life expectancy
- Main causes of death

4.6.2 **Planned approach for 2015 (for approval by the Health and Wellbeing Board):** The shadow Board previously agreed that all summary sections should be updated in 2013 to reflect new evidence from the 2012 Health Counts Survey, the 2011 Census and to include a call for evidence from the community and voluntary sector but signalled this would not be required each year.

4.6.2.1 To make the best use of limited officer resource across the City Council, and partners, we are proposing to update sections as part of a rolling programme with each section updated at least once every third year.

4.6.2.2 It is suggested that the development of the programme for these updates is delegated to the City Needs Assessment Steering Group.

4.6.2.3 Sections that have already been identified to be updated in 2015 include:

- Good nutrition and food poverty (following recommendation from October 2014 Policy and Resources Committee);
- Trans (to reflect the completed comprehensive needs assessment); and
- Primary Care (to reflect changes in GP surgery provision locally and compare with up to date demographic needs data).

5. Important considerations and implications

5.1 **Legal**

The Health and Social Care Act 2012 (s196) requires the function of preparing a JSNA to be discharged by the Health and Wellbeing Board. The recommendations in this report are consistent with this requirement.

S218A of the NHS Act 2006 (as amended) and the NHS Pharmaceutical Services and Local Services Regulations 2013 require Health and Wellbeing Boards to develop and update pharmaceutical needs assessments from 1st April 2015.

Lawyer Consulted: Elizabeth Culbert Date: 10th November 2014

5.2 **Finance**

The resources required to support this work are funded by the ring-fenced public health grant and will be reflected within the 2015/16 public health budget.

Finance Officer Consulted: Anne Silley Date: 12/11/14

5.3 **Equalities**

The City Needs Assessment Steering Group, including equalities leads for BHCC & NHS Brighton & Hove, has strengthened the city

needs assessment guidance to include equalities strands. Strategies using the evidence in the needs assessment may require an EIA but not the needs assessment. Equalities implications are considered in all needs assessments; however it is worth noting the relevance of the trans needs assessment and homeless audit in tackling health inequalities in vulnerable groups.

5.4 Sustainability

5.4.1 No implications

5.4.2 Sustainability related issues are important determinants of health & wellbeing and these are integrated in the summary. The JSNA will support commissioners to consider sustainability issues.

5.5 Health, social care, children's services and public health

5.5.1 The JSNA summary sets out the key health and wellbeing and inequalities issues for the city and so supports commissioners across the city in considering these issues in policy, commissioning & delivering services.

5.5.2 Children Services, Adult Social Care and the CCG are part of the City Needs Assessment Steering Group and have agreed to the suggested needs assessments for 2015 and signed off the summaries updated in 2014.

6 Supporting documents and information

The JSNA 2014 summary updates are available in the Appendix.

The published needs assessments are available at: http://www.bhconnected.org.uk/content/needs-assessments

Community Insight is available at: http://brighton-hove.communityinsight.org/

Appendix: 2014 JSNA Summary Updates:

2. Our approach to needs assessment

What is needs assessment?

The needs assessment process aims to provide a comprehensive analysis of current and future needs of local people to inform commissioning of services that will improve outcomes and reduce inequalities.

To do this, needs assessments should gather together local data, evidence from the public, patients, service users and professionals, plus a review of research and best practice. Needs assessments bring these elements together to look at unmet needs, inequalities and overprovision of services. They also point those who commission or provide services towards how they can improve outcomes for local people.

The common name for these needs assessments is **Joint Strategic Needs Assessment (JSNA)**. Joint reflects that they should be carried out jointly by the NHS and councils as a requirement, but in terms of good practice should also include others locally with expertise to offer. Strategic reflects that they should be about providing the 'big picture' in terms of identifying local needs.

National policy and guidance

The Local Government and Public Involvement in Health Act (2007) placed a duty on local authorities and Primary Care Trusts to work in partnership and produce a JSNA.[1]

The 2012 Health and Social Care Bill set out changes, with the transfer of Public Health to councils, new Clinical Commissioning Groups (CCGs) and the creation of Health and Wellbeing Boards from April 2013. Department of Health guidance states that councils and CCGs have equal and explicit obligations to prepare a JSNA; this duty discharged by Health and Wellbeing Boards.[2]

The guidance signalled an enhanced role for JSNAs to support effective commissioning for health, care and public health as well as influencing the wider determinants that influence health and wellbeing, such as housing and education.

[1] Department of Health. Guidance on Joint Strategic Needs Assessment. 2007. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081267.pdf [Accessed 23/04/2012]

[2] Department of Health. Statutory guidance published on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. 2013. Available at: http://healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/ [Accessed 18/07/2003]

Our local approach

In Brighton & Hove there are three elements to the needs assessment resources available:

Overarching documents: The JSNA summary, the City Snapshot Report and Annual Reports of the Director of Public Health

The JSNA summary gives a high level overview of Brighton & Hove's population and its health and wellbeing needs. It is intended to inform the development of strategic planning and identification of local priorities.

The information is primarily drawn from the city's needs assessment portfolio, which includes the Annual Reports of the Director of Public Health along with specific needs assessments and strategies. The JSNA summary is also used for the City Snapshot Report which provides high level facts and figures about the city.

Rolling programme of needs assessments on a specific theme or population group

A rolling programme of comprehensive needs assessments forms part of a portfolio of resources for the city. Themes may relate to specific issues e.g. mental health and wellbeing, or population groups e.g. children and young people. Needs assessments are publicly available and include recommendations to inform commissioning.

Community Insight - the information resource for the city, supported by Brighton & Hove Connected

Brighton & Hove Connected (http://www.bhconnected.org.uk/content/local-intelligence) is the Strategic Partnership data and information resource for those living and working in Brighton & Hove and is the home for needs assessments and their supporting data and evidence. Community Insight provides local data on and maps of the population of the city http://brighton-hove.communityinsight.org/.

City needs assessment steering group

Since August 2009, a steering group has overseen the programme of needs assessments. This includes the JSNA, but is broader and encompasses

needs assessments typically outside of health and wellbeing.

In 2011 the group broadened its membership to reflect this and now includes the Community and Voluntary Sector Forum (CVSF), Sussex Police and the two universities, in addition to the existing members from the city council, Clinical Commissioning Group and HealthWatch.

Local consultation

The JSNA summary develops from feedback and consultation. 2012 in particular saw changes to the way it was produced. These changes were informed by the new guidance, Outcomes Frameworks for Public Health, Adult Social Care and the NHS, but also from consultation with local partners and the community and voluntary sector. In particular:

- The CVSF conducted a gap analysis of the JSNA summary in January 2012.
- In March 2012 we held a seminar for thematic partnership chairs, councillors, commissioners, community and voluntary sector representatives and providers on plans for the JSNA and Joint Health and Wellbeing Strategy.
- In July 2012, the draft summary was consulted on and the JSNA informed by the responses.
- The 2013 update included evidence gathered from a call to evidence from the community and voluntary sector.
- In 2014 a small number of sections were updated to reflect evidence from the in depth needs assessment completed in the previous year.

Inequalities and protected groups

Over the last two years the summary has more systematically identified local inequalities in terms of equalities groups, geography and socio-economic status. Each report section has inequalities clearly evidenced. The 2011 Census and 2012 Health Counts Survey have added considerably to this evidence for the 2013 summaries. In addition, there are sections which bring together the key needs of protected groups.

Joint Strategic Assets Assessment

JSNAs should not focus solely on needs but also identify assets of local communities. Our approach to building assets into needs assessments is given in section 6.5.4. This was informed by the March 2012 event. The 2010 Annual Report of the Director of Public Health mapped community resilience[3] and is an important resource for JSNA.

Voice

The voice of professionals, patients, service users and the public provides important evidence for the JSNA. This is embedded throughout this summary, and where we do not currently have this evidence it is included in 'what we don't know'.

What we don't know

Throughout the summary, where there is a lack of local data, if possible other studies and evidence have been used to produce estimates for the city. Where this is the case it is clearly identified.

Assessing impact

In previous years we have listed the health and wellbeing issues for the city. In 2012 we tried to identify more systematically the impact on the city's population. The approach is set out in Section 3 along with the highest impact issues for the city. This fed into the prioritisation process for the Joint Health and Wellbeing Strategy and will be repeated to inform the next Strategy/refresh.

Joint Health and Wellbeing Strategy

The Health and Wellbeing Board have jointly agreed what the greatest issues are for local people based on the evidence in the JSNA. The Strategy sets these out along with what the Board will do to address them and what outcomes it intends to achieve. It does not include everything, but focuses on the key issues that make the biggest difference by partners working together.

Further information

This summary, along with the portfolio of needs assessments and local data is available at: http://www.bhconnected.org.uk/content/needs-assessments

[3] NHS Brighton and Hove and Brighton & Hove City Council. Resilience: Annual Report of the Director of Public Health 2010. http://www.bhconnected.org.uk/content/reports

4.2.5 Gender identity and trans people

Why is this issue important?

The term transgender, or trans, is used as an umbrella term to describe people whose gender identity differs from their biological sex at birth. Some transgender people will choose to transition socially and some will also take medical steps to physically transition to live in the gender role of their choice.

The term trans also includes a broader group of people who find their personal experience of their gender differs from the assumptions and expectations of society, such as people who are intersex, androgyne, polygender or genderqueer. They may also experience some of the issues related to being labelled by others as a gender that doesn't match their gender identity.

National research reveals significant inequalities in health and wellbeing faced by trans people[1,2,3] including an increased risk of mental ill health.

There is no reliable information regarding the size of the trans population in the UK. Recent estimates[4] suggest that 0.6% to 1% of adults may experience some degree of gender variance. A small proportion will have presented for, and undergone, medical gender transition (approximately 12,500 and 7,500 respectively).

Key outcomes

National outcomes

None of the indicators in the national Public Health, NHS or Adult Social Care Outcomes Frameworks are specifically focussed on trans people, but cover all people. However gender reassignment is a 'protected characteristic' in the Equality Act 2010 and public sector organisations are required to have due regard to the need to advance equality of opportunity and eliminate discrimination faced by trans people.[5]

Local outcomes

In 2013 a Brighton & Hove Trans Equality Scrutiny Panel made a set of recommendations to address trans needs and set up some clear outcomes for the Council and NHS. Both the Council and NHS have adopted these recommendations and are in the process of turning them into outcomes.

Following this, a needs assessment is currently in progress and will report by the end of March 2015 – this JSNA section will then be updated to reflect the evidence within the needs assessment.

Impact in Brighton & Hove

In 2006, a survey, Count Me In Too[1], was conducted of the LGBT population of Brighton & Hove. Of a total of 804 respondents, 5% (43) were trans, although it is unclear if this representation is proportionate.

A 2009 report[6] used data from health services to estimate the prevalence of "people who have presented with gender dysphoria" by police force area level. This suggested that Sussex had the highest prevalence in England (more than twice the national average) and the report concluded that this was related to the perception that Brighton & Hove is a favourable environment for trans people.

In the 2012 Brighton & Hove Health Counts survey 0.9% of respondents (18 out of 2,014) indicated that they did not identify as the gender they were assigned at birth.

Allsorts, a project based in Brighton to support and empower young people under 26 years who are lesbian, gay, bisexual, trans* or unsure (LGBTU) of their sexual orientation and/or gender identity, are in contact with 55 young trans* people.[7] Each quarter Allsorts survey the young people they are in contact with and the latest survey (January-March 2013) was completed by nine trans* young people. All had experienced mental health problems (things like depression and anxiety that had left them feeling unable to cope) and had felt low and had been troubled by fears, obsessive thoughts or habits.

With a small sample it is not possible to compare exact percentages from this survey with all young

[1] Browne K, Lim J. Count Me In Too. Trans People. Additional Findings Report. University of Brighton and Spectrum; 2008.
[2] Williams et al. The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document; 2013
[3] MacNeil et al. Trans Mental Health Study 2012. The Scottish Transgender Alliance, 2012
[4] GIRES. The Number of Gender Variant People in the UK - Update 2011. GIRES; 2011
[5] Mitchell, Howarth. Trans Research Review. Equality and Human Rights Commission. Research Report 27; 2009.
[6] Reed et al. Gender Variance in the UK: Prevalence, Incidence Growth and Geographic Distribution. GIRES; 2009
[7] Allsorts submission in the 2013 JSNA call for evidence

people, however the results indicate some significant health and wellbeing issues within this group. More than two thirds of respondents, in the last three months had:

- suffered some form of homophobic/ biphobic/transphobic incidents/ discrimination/ harassment or bullying
- difficulties with relationships
- been drunk

More than a third of respondents had:

- done something to injure or harm themselves
- contemplated suicide
- had unprotected sex[7]

In 2013 the results of the Brighton & Hove Trans Equality Scrutiny Panel were published.[8] This aimed to highlight the challenges and inequalities facing transgender people locally and to make some recommendations for change. It set out to answer the question: *what needs to be done to make things fairer for trans people to live, work and socialise in the city*?

The panel identified:

- A lack of knowledge on numbers and needs of trans people accessing services. The report recommended a needs assessment is conducted.
- The importance of health and health services including experience of primary care and the transition pathway (including Gender Identity Clinic), and mental health needs. Therefore a number of recommendations are made for health bodies, including the Clinical Commissioning Group.
- Some evidence of inadequate or inappropriate service provision in Housing, adult social care, sports and leisure. Many of these findings echoed those reported in Count Me In Too.

Where we are doing well

The community has a number of assets, in the form of independent support groups, including the Clare Project, Transformers (run by the Allsorts Youth Project), FTM Brighton and MindOut.

Local good practice includes:

- the publication of a Trans* Inclusion Toolkit for schools and colleges[9] (jointly produced by Brighton and Hove City Council and Allsorts Youth Project)
- the LGBT Health and Inclusion Project, which is commissioned by the City Council and the Clinical Commissioning Group to consult local LGBT people, and use the information gathered to improve access to services, service provision and delivery.

The Allsorts survey suggests that less than a third of young trans* people they surveyed had taken drugs in the last three months, and over two thirds had never smoked. Although over a third of young people had had unprotected sex in the last three months, the same number had been tested for an STI in the same period.[7]

Local inequalities

Overall, Count Me in Too demonstrates higher needs among trans people than the LGB community. Directly comparable information is not available in all cases for the whole population, so in some cases the results below are compared with the LGB community.

Count Me In Too[1] found that the majority of the trans respondents were White British (93%) and identified as female (67%). Trans respondents were significantly more likely to be over 45 years than the LGB respondents, with only 9% under 26. Over a third of trans people surveyed (35%) reported a disability or long-term health impairment. This is significantly higher than the proportion of disabled working age women and men in the city (19% and 20% respectively for 2010/11).

As well as being more likely to report long-term health impairments, only 44% of trans people reported that they were in 'good/very good' health, compared with 76% of all people in the city.[10]

[8] Brighton & Hove City Council. Brighton & Hove Trans Equality Scrutiny Panel. 2013

[9] Brighton & Hove City Council. Trans Inclusion Toolkit: Supporting transgender and gender questioning children and young people in Brighton and Hove schools and colleges; 2013

[10] Brighton & Hove City Council. The Place Survey; 2008.

Count Me In Too found that trans people report difficulties in accessing a trans friendly or non-transphobic GP; find sexual health information that is appropriate to their gender identity or sexuality; and that there is general dissatisfaction with gender reassignment services. Opinions echoed those found nationally[11]: that there were delays in access to the service and that the 'one size fits all' approach was unacceptable.

Count Me In Too[1] reported that trans people were twice as likely to have thoughts of suicide and five times more likely to have attempted suicide in the past year than LGB people, with only 26% reporting 'good/very good' emotional wellbeing. 86% of trans people reported mental health difficulties, including depression (76%) and anxiety (71%). Respondents described the need for mental health support both during and after transition.

Trans people are more likely to experience hate crime both in the street and at LGBT venues, with 26% reporting experiences of physical violence. 47% reported direct or indirect discrimination from providers of goods, services or facilities in the city, and 64% had experienced domestic violence, compared with 18% of men and 28% of women nationally.

The apparent under-reporting of hate crime, including trans related incidents, was noted by the Trans Equality Scrutiny Panel.[7] There is a need to improve the processes and systems for the recording of transphobic crimes and incidents.

Count Me In Too[1] also highlighted inequalities in employment and housing. Trans respondents were 11 times less likely to earn over £30,000 a year and the majority earned less than £10,000 a year. A third of trans respondents lived in social housing; over half reported that they had struggled to find housing; and 36% had experienced homelessness.

Predicted future need

As the trans population of Brighton & Hove ages, they will have additional needs for health and wellbeing. Little is currently known about what these needs will be, as this will be the first generation who have taken hormone therapy for a prolonged period, or undergone gender reassignment surgeries in the 1960s or 1970s.[12]

What we don't know

The number and demographics of trans people living in the city is unknown. With no published research into the health and wellbeing of trans people since Count Me In Too it is unclear if the inequalities above have changed. Indeed, work has been done to reduce them, e.g. the LGBT Health and Inclusion Project intervention ('Clued Up') to increase uptake of sexual health services among trans people.

The trans needs assessment, to be published by the end of March 2015, should address some of these evidence gaps.

Key evidence and policy

The Equality and Human Rights Commission, the Government Equalities Office and the Home Office recently published guidance for public authorities on meeting the needs of trans people, including recommendations for healthcare providers, local government and social care.[13] [14] [15]

Recommended future local priorities

1. Implement the action plan agreed based on the recommendations of the Brighton & Hove City Council Trans Equality Scrutiny review.
2. Continue joint working with the trans community through the LGBT Health and Inclusion Project.
3. Improve knowledge by conducting a multiagency needs assessment.
4. Support existing assets of the trans community: independent, volunteer-run support groups.

http://consult.brighton-hove.gov.uk/portal/lsp/place/place08 [Accessed 06/08/2013]

[11] Equality and Human Rights Commission. A review of access to gender reassignment services (England Only);2011http://www.equalityhumanrights.com/legal-and-policy/equality-act/

[12] Age UK. Transgender issues in later life. Factsheet 166; 2010.

[13] Equality and Human Rights Commission. Provision of Goods, Facilities and Services to Trans People. Guidance for public authorities in meeting your equality duties and human rights obligations; 2010.

[14] Government Equalities Office. Equality Act 2010: What do I need to know: A quick start guide to gender reassignment for voluntary and community organisations in the provision of goods and services; 2010.

[15] Home Office. Advancing Transgender Equality: A plan for action. HM Government. London, UK; 2011

4.2.5 Gender identity and trans people

Key links to other sections

- Emotional health and wellbeing;
- Suicide prevention

Further information

Count Me In Too
http://www.countmeintoo.co.uk/

The LGBT Health Inclusion Project
http://lgbt-hip.org/

Brighton & Hove Trans Equality Scrutiny Panel
http://www.brighton-hove.gov.uk/content/council-and-democracy/councillors-and-committees/trans-equality-scrutiny-panel-2013

Last updated

August 2014

5.1 Life expectancy and healthy life expectancy

Why is this issue important?

Life expectancy tells us how long a baby born today would be expected to live if they experienced the current mortality rates of the area they are born in throughout their lifetime.

Whilst other factors, such as biological or genetic disposition, are important, social inequalities are a key driver of ill-health. It has been estimated that the NHS contribution to any future reduction in the life expectancy gap, whilst significant, is limited and that other factors (the social determinants of health) such as education, employment and housing have a greater impact.

Key outcomes

- ***Increased healthy life expectancy (Public Health Outcomes Framework)***
- ***Reduced differences in life expectancy and healthy life expectancy between communities (Public Health Outcomes Framework)***
- ***Life expectancy at 75 for males and females (NHS Outcomes Framework)***

Impact in Brighton & Hove

Table 1: Life expectancy and healthy life expectancy

	Brighton & Hove	Regional Centres	South East	England
Life expectancy at birth (2011-2013)				
Males	78.8	78.1	80.4	79.4
Females	83.1	82.5	83.9	83.1
Life expectancy at 65 years (2011-2013)				
Males	18.6	18.1	19.3	18.7
Females	21.2	20.8	21.7	21.1
Healthy life expectancy at birth (2010-2012)				
Males	63.6	67.9	65.8	63.4
Females	66.5	72.0	67.1	64.1

Source: Office for National Statistics

Life expectancy in Brighton & Hove is 78.8 years for males and 83.1 for females (2011-2013). Whilst females in the city can expect to live the same length of time as nationally, life expectancy for males is seven months lower than in England (79.4 years for males and 83.1 years for females).

With healthy life expectancy of 63.6 years for males and 66.5 years for females this means, on average, males live for 15.1 years with a limiting long-term illness or disability and females 16.5 years (2010-12). This also has implications in terms of the increasing retirement age, which will mean people are working with health conditions, or on sickness/disability benefit.

Life expectancy at age 65 years is 18.6 years for males and 21.2 years for females in the city compared with 18.7 and 21.1 years respectively for England.

Where we are doing well

Life expectancy in the city is as high as it has ever been, and is continuing to increase at a pace of around five months each year for both males and two months each year females (2006-08 to 2011-13).

Mortality rates are falling, and this is the case for the most affluent and most deprived people in the city.

Female life expectancy is the same as nationally.

Local inequalities

Despite the narrowing gap in life expectancy between men and women, men tend to develop and die from many conditions earlier than women.

The *slope index of inequality in life expectancy* gives a measure of the hypothetical difference in life expectancy between the most deprived and least deprived individuals. It is a more sensitive measure than the difference in mortality between the most deprived and least deprived quintiles of population as it looks at differences in life expectancy across the whole population.

In 2010-2012 the slope index was 8.7 years for males and 6.0 years for females in Brighton & Hove (Table 2). For both males and females this gap is now narrower than nationally.

The gap has narrowed from 10.6 years for males in 2006-10 and from 6.6 years for females.

Mortality rates in the city are falling in all groups (and therefore life expectancy rising), and between

5.1 Life expectancy and healthy life expectancy

2006-2010 and 2009-2013 the relative inequality gap has remained the same, an improvement as this had been widening previously.[1] However there are still large inequalities in the City with the mortality rate of the most deprived person being nearly twice that of the least deprived (1.8 in 2006-10 and 2009-2013).

For the five years 2009 to 2013, 19% of deaths were attributable to deprivation – that equates to 2,534 deaths, around 500 deaths per year.

Table 2: Life expectancy inequality (in years) by gender, Brighton and Hove

	Brighton & Hove	England
Inequality in life expectancy[2] at birth (2010-2012)		
Males	8.7	9.2
Females	6.0	6.8
Inequality in healthy life expectancy[5] at birth (2010-2012)		
Males		19.4
Females		19.8

Source: Public Health England. Public Health Outcomes Framework Data Tool.

Predicted future need

A challenge in reducing health inequalities is that while the mortality rate for all groups in the city is expected to improve, it is improving faster in more affluent areas, so local inequalities are expected to increase without intervention:

- The mortality rate in the most deprived quintile in the city is projected to become twice that in the least deprived by 2012.[3]
- Whilst mortality rates are lower for females, the relative gap is expected to increase to almost the level of the gap in men by 2012 (2.0 for males and 1.9 for females).[4]

What we don't know

Ethnicity is not recorded on death registration in England. Information on death certificates is restricted to the deceased's country of birth - traditionally used as a proxy for ethnic origin. However, the value of this has diminished over time as subsequent generations have been born in England. In 2012, Scotland became the first UK country to record ethnic origin on death certificates. Death registration also does not record religion, sexual orientation, transgender or whether someone was a carer and life expectancy is not calculated based upon marital status as it is a whole population measure.

Current figures on healthy life expectancy are partly based upon 2001 Census data and are therefore relatively old. The Office for National Statistics is due to publish revised figures, incorporating 2011 Census data on health status, but this is not yet available.

Key evidence and policy

Fair Society, Healthy Lives, the Marmot Review of Health Inequalities provides a strategic review of health inequalities in England.[5] A life-course based approach is taken, because of the cumulative impact of social, economic, psychological and environmental experiences on health and health inequalities. Five age groups are identified:

- Pre-birth and early years (up to age 5)
- Children and young people in early education (age 5–16)
- Early adulthood (age 17–24)
- Adults of working age (age 25–64)
- Adults of retirement age (age 65+)

Looking at the contribution of specific causes of death to the life expectancy gap between the most

[1] South East Public Health Observatory. Health Inequalities Gap Measurement Tool. http://www.sepho.nhs.uk/gap/gap_national.html [Accessed on 21/08/2012].

[2] Inequality in life expectancy and disability free life expectancy are measured by the slope index of inequality and are measured in years. More information on the indicator is available at http://www.apho.org.uk/default.aspx?RID=110504 [Accessed on 21/08/2012].

[3] Mortality data has a time lag in its availability and so 2012 data are projected figures.

[4] South East Public Health Observatory. Health Inequalities Gap Measurement Tool. http://www.sepho.nhs.uk/gap/gap_national.html [Accessed on 21/08/2012].

[5] Marmot, Fair Society, Healthy Lives: Strategic Review of Health Inequalities Post 2010, 2010. Available at: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review [Accessed 21/08/2012]

5.1 Life expectancy and healthy life expectancy

deprived quintile in Brighton & Hove and the national average for men, the biggest contributor is coronary heart disease, followed closely by lung cancer, chronic cirrhosis of the liver, suicide and undetermined injury, and other accidents. For women, coronary heart disease and other cardiovascular diseases are the biggest contributors to the gap, followed by lung cancer, other cancers, and suicide and undetermined injury.[6]

The Department of Health has identified the key interventions for reducing the life expectancy gap between the most and least disadvantaged areas (based upon previous PCT areas):

- Greatly increasing the capacity of smoking cessation clinics
- Increasing the coverage of effective therapies for secondary prevention of cardiovascular diseases in people aged less than 75 years
- Primary prevention of cardiovascular disease (all ages) and hypertension through treatment with antihypertensives and statins
- The early detection of cancer
- Interventions aimed at reducing mortality from respiratory diseases, alcohol-related diseases and infant mortality

Matrix for Health England developed a prioritisation method to inform investment in preventative health interventions, based upon the cost-effectiveness, impact on health inequalities, and percentage of people affected.[7] The results for Brighton & Hove are shown in Table 3.

Recommended future local priorities

The Public Health Strategy for England is adopting the Marmot Review[8] approach and this will be built on locally. Marmot concluded that reducing health inequalities would require action on six policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

Recommendations around inequalities are throughout the relevant JSNA sections.

Key links to other sections

This section links to many within the JSNA but sections with specific reference here include:

- Main causes of death
- Coronary heart disease
- Cancer
- Suicide and suicide prevention
- Alcohol
- Maternal and infant health
- Smoking
- Physical activity
- Diet

Last updated

November 2014

[6] London Health Observatory, Health Inequalities Intervention Tool available at:http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesInterventionToolkit.aspx

[7] http://help.matrixknowledge.com/

5.1 Life expectancy and healthy life expectancy

Table 3: Matrix for Health England order of priority for preventative health interventions evaluated to date for Brighton & Hove – national and local interventions.

Category	Intervention	Priority Ranking	Priority Score	Affordability	Certainty
Alcohol	Increases in taxation to reduce population consumption of alcohol	1	11.30 %	★★★	★★☆
Smoking	Increases in taxation to reduce population smoking rates	2	9.62 %	★★★	★★★
Smoking	National mass media campaigns for reducing population smoking rates	3	9.46 %	★★★	★★★
Diet, physical activity, obesity	National mass media campaigns to reduce population levels of obesity	4	9.10 %	★★★	★★☆
Smoking	Brief interventions delivered in GP surgeries to improve quit rates	5	8.98 %	★★☆	★★★
Alcohol	Brief interventions delivered in GP surgeries to reduce problem drinking	6	8.70 %	★★☆	★★☆
Diet, physical activity, obesity	Brief interventions delivered in GP surgeries to improve uptake of physical activity	7	8.63 %	★★☆	★★★
Smoking	Nicotine replacement therapy to improve quit rates	8	8.25 %	★★☆	★★★
STI / teenage pregnancy	Screening and treatment for reducing the prevalence of Chlamydia	9	7.38 %	★★★	★★☆
Diet, physical activity, obesity	School based group education to reduce population levels of obesity	10	7.25 %	★★★	★★☆
STI / teenage pregnancy	School based group education for increasing rates of condom use and reducing STIs and unwanted pregnancy	11	6.00 %	★★☆	★☆☆
Statins	Statins for primary prevention of stroke and heart disease (demonstrating QALYs for two example CVD risk groups)	12	4.26 %	★☆☆	★★☆
Mental health	Assessment and support of caregivers for preventing depression in caregivers	13	0.95 %	★☆☆	★★☆
Mental health	Screening and treatment to prevent depression in retirees (age over 65 years)	14	0.12 %	★★★	★★★

Source: Matrix for Health England

5.2 Main causes of death

Why is this issue important?

We need to know how many people are born and die each year – and the main causes of their deaths – in order to have well-functioning health systems.[1]

Key outcomes

- ***Mortality rate from all cardiovascular disease (including heart disease and stroke) in persons less than 75 years of age (Public Health Outcomes Framework, NHS Outcomes Framework)***
- ***Mortality rate from cancer in persons less than 75 years of age (Public Health Outcomes Framework, NHS Outcomes Framework)***
- ***Mortality rate from Liver Disease in persons less than 75 years of age (Public Health Outcomes Framework, NHS Outcomes Framework)***
- ***Mortality rate from respiratory disease in persons less than 75 years of age (Public Health Outcomes Framework, NHS Outcomes Framework)***
- ***Excess under 75 mortality rate in adults with serious mental illness (Public Health Outcomes Framework)***

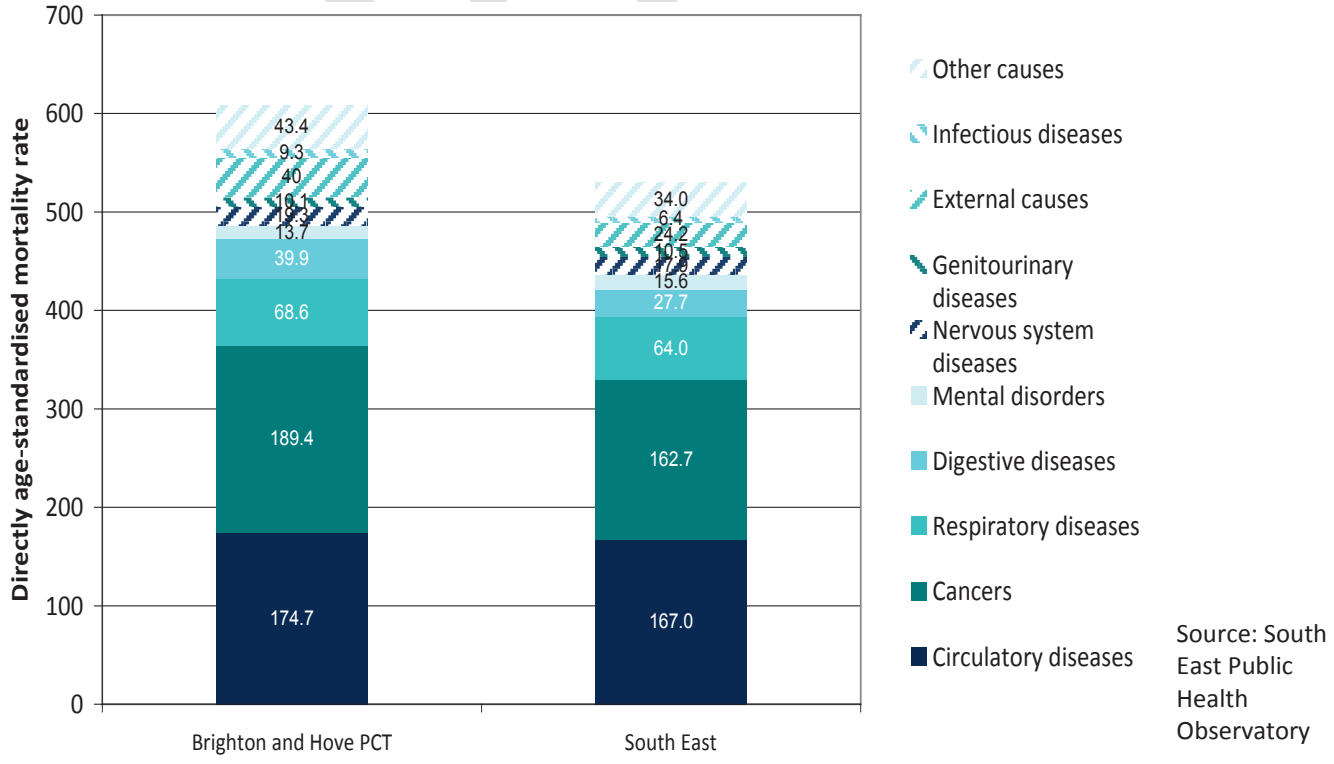
Impact in Brighton & Hove

The commonest causes of death within the city are cancers, circulatory diseases, respiratory diseases and digestive diseases (including liver diseases).

In 2013 there were a total of 2,065 deaths of Brighton & Hove residents. The main causes of death were cancer (29%), followed by circulatory conditions (27%) and respiratory conditions (13%). However just over one in twenty deaths in the city (6%) are not caused by disease – these are predominantly accidents or suicide (See figures at end of section).

The main causes of death in the city are similar to the South East but in Brighton & Hove mortality rates are higher for all disease groupings with the exception of mental disorders and genitourinary diseases (Figure 1).[2]

Figure 1: Cause-specific mortality profiles for Brighton & Hove and the South East, 2005-2009 (directly age standardised rate per 100,000)



Source: South East Public Health Observatory

[1] World Health Organisation. Civil registration: why counting births and deaths is important. Fact sheet N°324; 2007.

[2] South East Public Health Observatory. Health Inequalities Gap Measurement Tool. Available at http://www.sepho.nhs.uk/gap/gap_national.html [Accessed on 21/08/2014]

5.2 Main causes of death

Cancer: Mortality from all cancers in under 75 year olds is higher in Brighton & Hove than England and significantly higher than across the South East. Mortality rates for cancer in this age group in the city had been increasing since 2002-04 but in 2008-10 were around the 2002-04 level, and have continued to fall. Cancer is explored in more detail in the cancer section.

Heart disease and stroke: Between 2010 and 2012 in Brighton & Hove the mortality rate among the under 75s due to heart disease & stroke was 80 per 100,000 population, compared with 81 in England and 69 in the South East. This is explored in more detail in the relevant section of the report.

Respiratory diseases: The mortality rate in the city for respiratory diseases for those aged under 75 years is similar to the England rate, but for mortality from respiratory disease considered preventable it is significantly higher (2010-2012).

Liver disease & chronic liver disease: Mortality rates in those aged under 75 years are significantly higher in Brighton & Hove than in England (2010-12). This is also the case for liver disease considered preventable.

Excess under 75 mortality rate in adults with serious mental illness: Excess premature mortality in adults with serious mental illness is high, both nationally and in Brighton & Hove with mortality rates in the city for those in contact with Secondary Mental Health Services almost three times higher than those not in contact with these services (2011/12). Across England this excess is over three times higher but we do not do significantly better than England.

Where we are doing well

The recent trend in circulatory disease deaths and cancer deaths for those aged under 75 years in Brighton & Hove has been downwards, with premature cardiovascular mortality almost halving since 2001-2003 and premature cancer mortality at its lowest rate for the last decade.

The mortality rate for communicable diseases is significantly lower in Brighton & Hove than England and continues to fall.

Local inequalities

Age: The breakdown of cause of death is very different for children, adults and older people. Since there are a small number of deaths in children in the city each year it has not been possible to produce charts showing the main causes of death. In 2013 there were 11 deaths of children aged under one year, with an additional five deaths of children aged 1-14 years.

In 2013 there were 712 deaths of people aged under 75 years (see figures at end of section). Here, the main cause of death is cancer (40%) followed by circulatory disease (17%). Death not caused by disease is the third most common causes of death in this age group and comprises over one in 10 deaths (13%).

For those aged 75 years or over (see figures at end of section), the most common causes are circulatory diseases (31%), cancer (23%) and respiratory diseases (16%). In 2013 there were 1,353 deaths in this age group.[3]

Gender: The main causes of death (for all ages) are similar for males and females. The main difference is the higher proportion of deaths in males to external causes (mainly accidents, suicide and drug or alcohol poisoning). The proportion of deaths to circulatory diseases and cancer are similar for both males and females.

Ethnicity: In England information on death certificates is restricted to the deceased person's country of birth which is traditionally used as a proxy for ethnic origin. However, the value of this has diminished over time as subsequent generations have been born in England. In 2012, Scotland became the first UK country to record ethnic origin on death certificates.

In Brighton & Hove 90% of deaths registered were of individuals born in the UK. This picture has remained fairly constant since 1999 when 91% were. This picture is very different to that seen in births where the proportions born outside the UK are considerably higher but this is because births are more responsive to recent changes in immigration due to the younger age of people migrating to the UK.

[3] Office for National Statistics. Vital Statistics Tables. 2012

5.2 Main causes of death

Table 1 shows the top ten countries of birth (outside of the UK) of registered deaths in 1999, 2003, 2007 and 2011. There has been little change over the 13 year period, with Ireland, India, Poland and Germany the commonest countries of birth across most years shown.

Table 1: Deaths (numbers) for the ten most common countries of birth for non-UK born individuals, Brighton & Hove 1999, 2003, 2007 and 2011

1999		2003		2007		2011	
Country	Number	Country	Number	Country	Number	Country	Number
Ireland	67	Ireland	49	Ireland	58	Ireland	54
India	25	India	21	India	22	India	18
Poland	13	Germany	19	Germany	16	Poland	10
Germany	11	France	13	Poland	13	Germany	8
Italy	10	Canada	9	Canada	9	Australia	7
Canada	8	Austria	7	South Africa	8	Italy	7
France	8	Italy	7	Egypt	6	South Africa	7
South Africa	7	Poland	7	France	6	Iran	6
Egypt	6	South Africa	7	Italy	5		
Australia	5	United States	7				
All deaths	**2,995**	**Total**	**2,792**	**Total**	**2,366**	**Total**	**2,081**

Source: Office for National Statistics, registered deaths in the given year

Deprivation: Figure 2 compares mortality rates for the most deprived quintile and the least deprived quintile in the city. The large difference seen in overall mortality is present for all commonest causes of death except for diseases of the nervous system or genitourinary system.

Circulatory death rates have been falling overall, for the most and least deprived quintiles in the city. However the mortality rate is higher in the more deprived areas. Between 2008 and 2010 circulatory death rates in those aged under 75 years in the most deprived quintile of the city were three times higher than for the least deprived quintile. This difference has increased: for the period 2001-2003 the rate in the most deprived quintile was twice that in the least deprived quintile.

For cancer, under 75 deaths rates are increasing in the most deprived group. In 2001-2003 cancer mortality for the under 75s was 1.5 times higher in the most deprived quintile compared with the least deprived and by 2007-2009 this had increased to 1.9.

Predicted future need

If current trends continue, the ONS projects that by 2016 there will be 1,900 deaths per year and deaths will remain at this level until 2030.[4] Without a change in current trends, inequalities in all deaths and early deaths from cancer and circulatory diseases will widen.

What we don't know

Ethnicity is not recorded on death registration in England, nor is religion, sexual orientation or gender reassignment or caring status.

See specific sections for recommended future local priorities

Key links to other sections

- Coronary heart disease
- Cancer
- Respiratory disease
- Suicide

[4] ONS sub national population projections (2012 based). Available at: http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Sub-national+Population+Projections#tab-data-tables [Accessed on 27/08/2014].

5.2 Main causes of death

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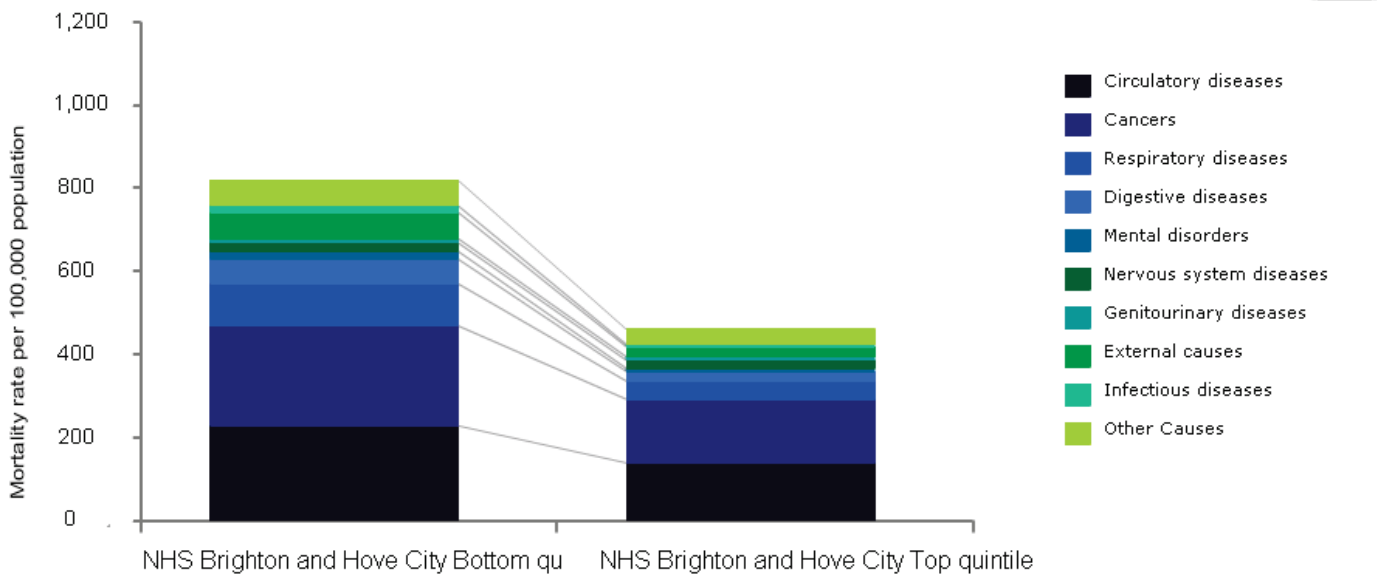
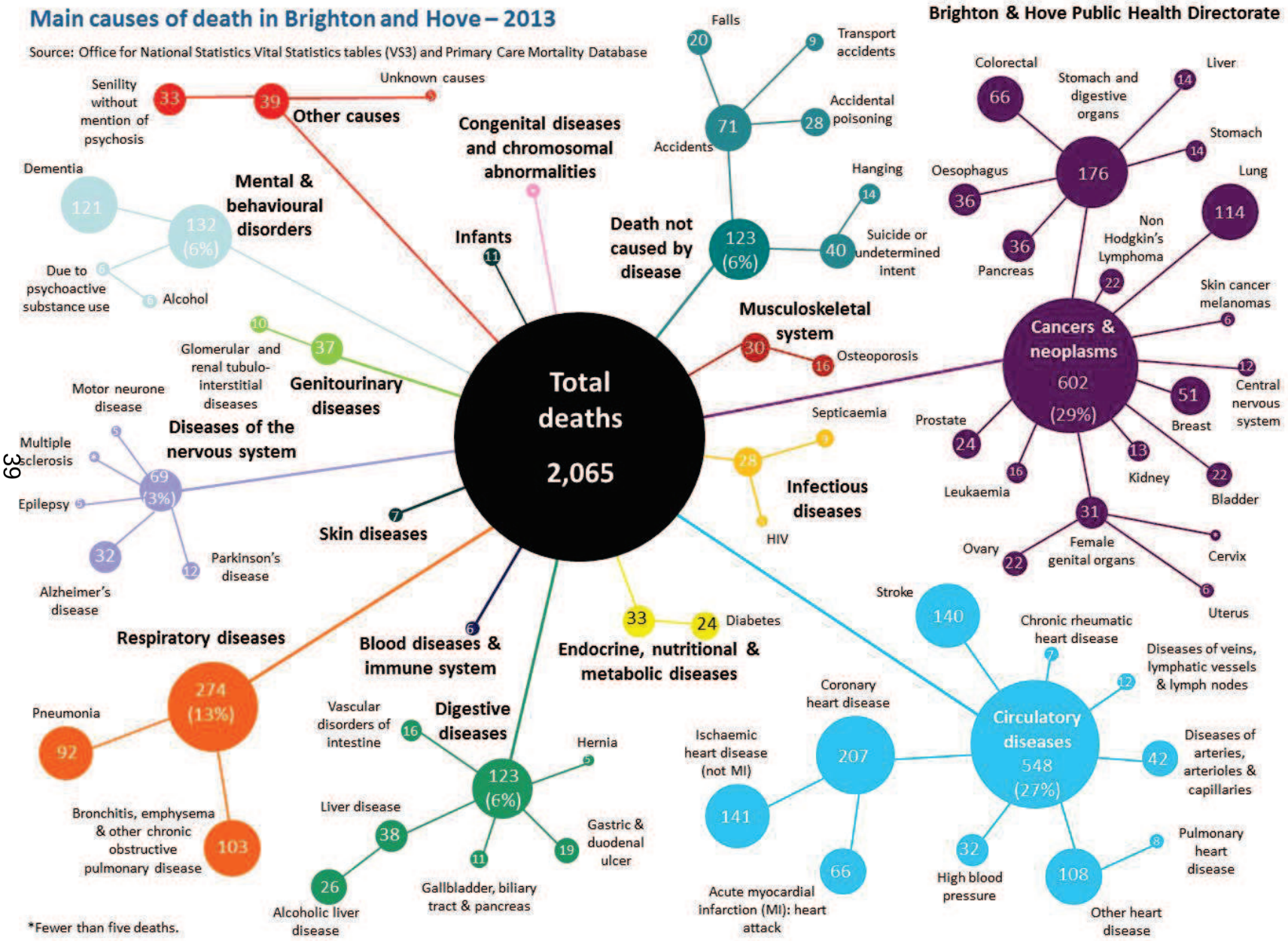
Figure 2: Mortality rate per 100,000 population for the most and least deprived quintiles of deprivation in Brighton & Hove, 2005-2009



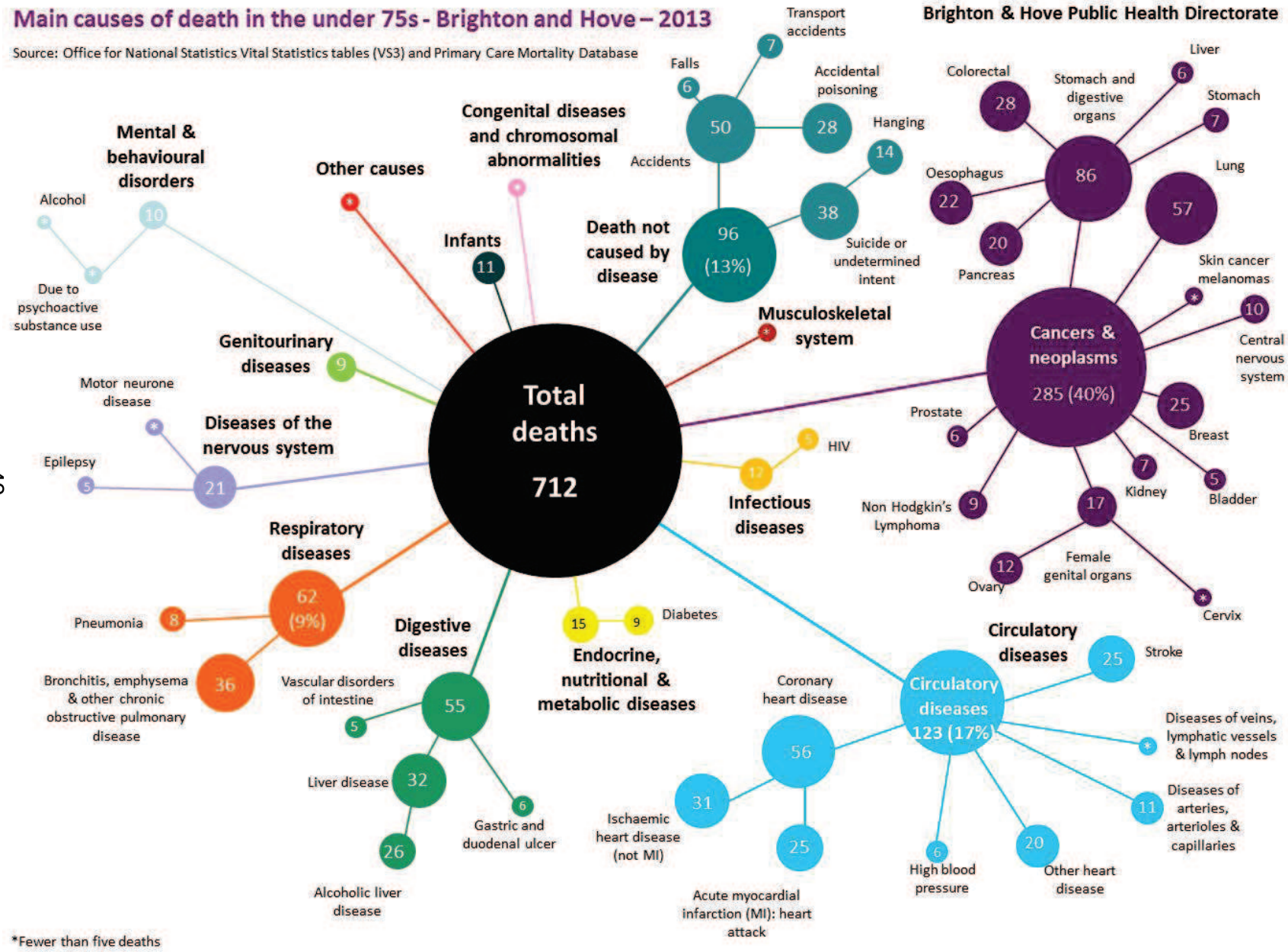
Source: South East Public Health Observatory Health Inequalities Gap Measurement Tool

5.2 Main causes of death

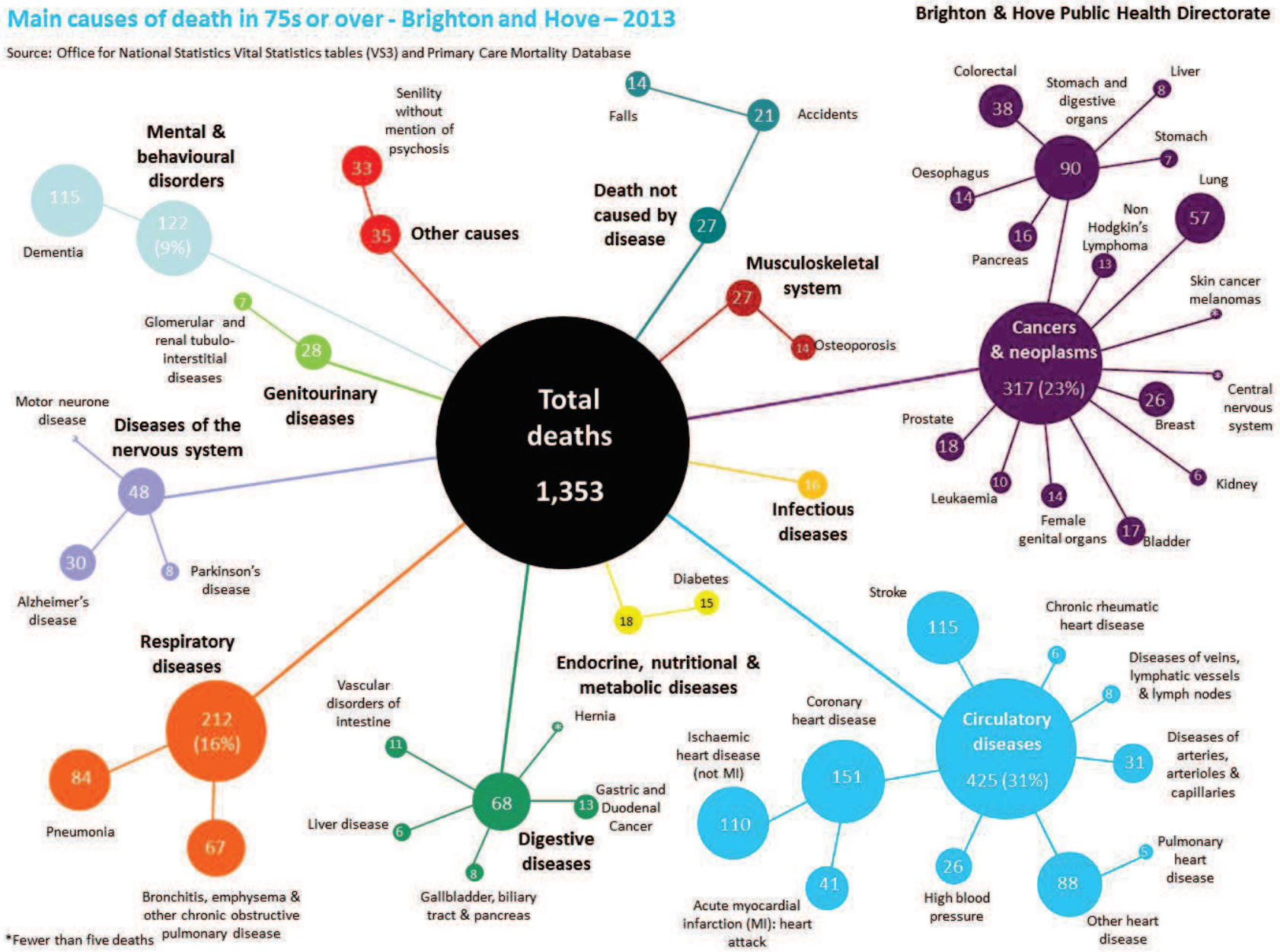
Brighton & Hove JSNA 2014



5.2 Main causes of death



5.2 Main causes of death



Why is this issue important?

This section summarises the needs of people who are sleeping rough on the streets and includes those in insecure, temporary accommodation such as hostels.

Homelessness and rough sleeping have been increasing nationally in recent years. Between Autumn 2010 and Autumn 2013 the national rough sleeper snapshot count rose 37% with numbers rising most rapidly in London and the South of England.[1]

Health and wellbeing needs are high among rough sleepers. In particular, there is a high prevalence of mental ill-health and drug and alcohol dependency. Other common problems include physical trauma (especially foot trauma), skin problems, respiratory illness and infections (including hepatitis A, B & C).[2]

Nationally, it is estimated that the use of inpatient hospital care by people who are sleeping rough or living in insecure accommodation (such as hostels) is eight times higher than in the general population aged 16-64 years.[2]

The average age of death for a homeless person is 47 years old compared to 77 for the general population, with death from drugs and alcohol being particularly common.[3]

Key outcomes

Rough sleeping is not included as an indicator in NHS, Public Health, or Adult Social Care Outcomes Frameworks. There are a number of related indicators including suicide and alcohol hospital related admissions.

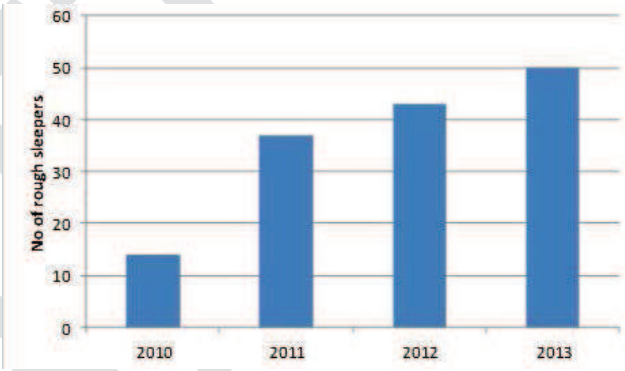
The Common Data Framework (formerly the 'Supporting People Outcomes Framework') enables local authorities to monitor outcomes for vulnerable adults accessing housing-related support. Key outcomes measure how client needs have been met across key areas of economic wellbeing, work and learning, health, accommodation and enabling choice and control.

One of the key performance indicators for Band 2 hostel accommodation is planned moves to greater independence. Of those leaving hostels in 2011/12 53% moved on to greater independence, an increase of 3% on the previous year. In Supported Band 3 accommodation 89% moved on to greater independence, this was also an increase of 3% on the previous year.

Impact in Brighton & Hove

Locally there has been a sharp increase in the number of recorded rough sleepers in the city. In November 2010 the official rough sleeper street count figure was 14, in 2011 it was 37 and in 2013 this figure had risen to 50 (Figure 1).

Figure 1: Total rough sleepers found on the annual street count 2010-2013



Source: Department for Communities and Local Government

The rough sleeper count does not give a complete picture of the scale of the issue. A group of partner agencies, led by the council, took part in an estimate exercise in March 2013. The aim of the exercise was to estimate the number of people sleeping rough on one 'typical' night in Brighton & Hove. The final estimate figure was 90 individuals. CRI, who deliver services to this group locally, worked with 588 rough sleepers in 2010/11, 732 in 2011/12 and 1,163 in 2012/13 a 98% increase over three years.

This increase in rough sleepers places pressures on health, housing support services and other statutory partners.

In 2013 a Homeless Health Needs Audit was conducted in Brighton & Hove homeless services, which included analysis of data from 302 respondents. This confirmed the high levels of physical, mental, and substance misuse needs in this population. For example:

- 84% reported at least one physical health problem

[1] Department for Communities and Local Government. 2014
[2] Wright NMJ and Tompkins. How can health services effectively meet the health needs of homeless people? Br J Gen Pract. 2006 April 1; 56(525): 286–293.
[3] Crisis. Homelessness Kills. 2012

- 85% reported at least one mental health issue (nearly four in ten had been diagnosed with depression)
- 40% reported that they were a drug user or recovering from a drug problem
- 26% reported that they used alcohol at a harmful level
- Many had other health risks, for example, 73% were smokers (of whom one in two said they would like to stop)
- Coverage of flu vaccination amongst those eligible was low
- 39% had attended A&E at least once (the most common reasons for the visit were accidents, mental health and alcohol use)
- 25% had been admitted to hospital (the most common reasons were alcohol use, accidents and stomach pains).

This audit built on findings reported in previous JSNAs that indicated high mortality rates and high levels of hospital attendances, admissions and readmissions in homeless people[4,5].

Current Housing Commissioning strategies[6] include priorities that aim to improve outcomes by:

- Helping clients to move on to more independent accommodation through the Brighton & Hove Integrated Support Pathway[7]
- Increasing accommodation options for locally connected rough sleepers
- Increasing housing and support options for people with no local connection to find accommodation and support outside of the city
- Developing psychological intervention support
- Developing personalisation in support packages
- Focusing on the recovery and reintegration agenda
- Improving support and access for those with a Dual Diagnosis or multiple complex needs
- Preventing unplanned hospital admissions.

Where we are doing well

Local commissioned services working with this client group are well co-ordinated within a successful local partnership structure which includes commissioned and non-commissioned services. These include:

- The 'No Second Night Out' project. This aims to target those new to rough sleeping and move them off the streets before they become entrenched. In 2012/13 this project saw 76 individuals supported with 98% being accommodated. Within CRI rough sleeper services 1163 individuals were supported with 90% of these having a positive accommodation, treatment or care outcome. Less than 1% of those who were supported to leave the streets by CRI returned within 2 weeks.
- At First Base Day Centre in 2011/12 an average of 52 rough sleepers were seen per day; of these 397 had a planned support programme, 225 accessed sport and fitness programmes, 308 were seen by St Johns Ambulance and 313 were seen by an oral hygienist.
- Brighton & Hove operates a severe weather shelter (SWEP) to ensure that rough sleepers are housed when the temperature drops below 0 degrees for three nights in a row. The provision run by Brighton Housing Trust has coped with increasing demand in 2012/13
  - In 2011/12 SWEP was open for 21 nights and provided 541 bed spaces between January and February 2012.
  - In 2012/13 SWEP was open for 44 nights providing a total of 1714 bed spaces from November 2012 to April 2013.
  - The average (mean) number of individuals accommodated each night during SWEP was 26 in 2011/12 and 40 in 2012/13.
- The alcohol nurse was introduced to work intensively with hostel residents with alcohol dependency issues. Between May 2011 and May 2012 the cohort of clients worked with reduced their emergency call outs (Ambulance) by 37%, their presentations at A&E by 29% and their hospital admissions by 18%. Evictions

[4] NHS Brighton and Hove and Brighton & Hove City Council. Vital: Annual Public Health Report of the Director of Public Health. 2011.
[5] www.bsuh.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=387306 [Accessed 25/08/2012].
[6] Homelessness Strategy 2014-19 and Commissioning Strategy for Housing-Related Support, 2011-2015.
[7] For more details see the Brighton & Hove Homelessness Strategy.

from hostel accommodation were also greatly reduced for this client group.

A major local initiative to improve services and the health and wellbeing of the homeless has been established as part of the Better Care programme to transform housing and social care for homeless people by 2016. Involvement of representatives of homeless people is at the heart of designing the new services, which will be closely linked with existing housing related support and mainstream health services. In addition to long established health services (such as Brighton Homeless Healthcare at Morley Street) the initiative brings together newly established services including:

- Hostels Health Team, established in 2013 by Sussex Community Trust to provide assessment, treatment and advice for those with chronic conditions and physical health needs.
- Pathway Plus, which aims to improve outcomes by improving hospital admission and discharge, and follow up, linking with existing housing and health services.

Local inequalities

The rough sleeper and single homeless population is not representative of the wider population of Brighton & Hove. The characteristics of respondents to the homeless health audit were:

- 78% male; 22% female
- 69% were aged 45 or under; 28% were aged 45-65; and 3% were aged over 65
- 72% were White British and 28% from a Black and Minority Ethnic group
- 89% indicated that they were UK nationals
- 50% reported that they had a disability
- 13% were lesbian, gay or bisexual (LGB)
- 2% identified as transgender (although this finding was based on small numbers)
- 7% indicated that they had left care services for young people in the last five years

Some key findings in relation to inequalities were:

- Respondents aged 46 or over had significantly higher rates of physical health problems, and 26-45 year olds had a higher rate of mental health conditions
- LGB respondents were significantly more likely to have a physical health problem and a diagnosed mental health problem
- There were significantly higher rates of smoking and drug use in White British and hostel residents.

Predicted future need

The impact of the Welfare Reform Bill is still being felt with reductions in council tax relief, changes to Disability Living Allowance, the reduction of Housing Benefit to over occupiers, the cap on overall benefits payments and the introduction of Universal Credit still being rolled out in England and Wales.[8] We predict that these changes will increase the number of individuals unable to sustain their accommodation in the coming year.

The significant increase in numbers of rough sleepers which we have witnessed in recent years has placed unprecedented pressure on existing services and we expect this to continue at a time of decreasing funding.

What we don't know

We don't know about many of the hidden homeless in our city who may be living in squats, sleeping on sofas, and staying with friends and family, and are therefore not captured in local needs data. Nationally one study has shown that of 437 single homeless individuals 62% were hidden homeless and a quarter had never accessed any accommodation provided by a homeless or housing organisation.[9]

We cannot estimate the number of people affected by welfare reform who will subsequently have an episode of rough sleeping.

Key evidence and policy

Vision to end rough sleeping: No Second Night Out nationwide, 2011. Department for Communities and Local Government

[8] Homeless Link response to Welfare Reform Bill 2011 http://homeless.org.uk/news/homeless-link-response-welfare-reform-bill [Accessed on 25/08/2012].

[9] Crisis, K Reeve with E Batty, The Hidden Truth about Homelessness – Experiences of Single Homelessness in England, May 2011

http://www.communities.gov.uk/publications/housing/visionendroughsleeping

Making every contact count – a joint approach to preventing homelessness August 2012 www.gov.uk/government/publications/making-every-contact-count-a-joint-approach-to-preventing-homelessness

Recommended future local priorities

1. Develop a more integrated approach to improving outcomes by transforming health and social care for homeless people
2. Commission services and resources to support the No Second Night Out strategy and implement the refreshed 2014-2019 Homelessness Strategy Develop further rough sleeping prevention initiatives across Sussex with neighbouring authorities

Key links to other sections

- Housing
- Mental health
- Substance misuse
- Alcohol
- Dual diagnosis
- Urgent care

Further information

Brighton & Hove City Council homelessness webpage http://www.brighton-hove.gov.uk/index.cfm?request=c306

2014 Homeless Health Audit and Rough Sleeping and 2013 Single Homeless Needs Assessment are available at: http://www.bhconnected.org.uk/content/needs-assessments

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October 2014

5.1 Children and young people with Autistic Spectrum Conditions

Why is this issue important?

Autistic Spectrum Conditions (ASC) are developmental disorders causing differences in reciprocal social interaction and social communication, combined with restricted interests and rigid repetitive behaviours, often with lifelong impact. People with ASC also frequently experience a range of cognitive, learning, language, medical, emotional and behavioural problems. These problems can substantially affect a person's quality of life, and that of their families and carers, and lead to social vulnerability.[1] ASC is a spectrum which means that, although people with ASC share certain difficulties, their condition affects them in different ways.

People with ASC have high levels of additional needs with 70% having at least one other mental or behavioural disorder and 40% having at least two disorders, most commonly anxiety, Attention Deficit Disorder (ADHD) and Oppositional Defiant Disorder (ODD).[2]

Children and young people with ASC may be diagnosed at various ages, and this process can be lengthy. Transitioning between primary and secondary school and between children and adults services can cause added worry and disjointed care, this is particularly the case in children without significant learning disabilities who may go from being supported to having nothing on transitioning to adult services.[2]

Key outcomes

None of the indicators in the Public Health, NHS or Adult Social Care Outcomes Frameworks are specifically focused on ASC.

Impact in Brighton & Hove

There are 59,000 children and young people aged 0-19 resident in Brighton & Hove,[3] and around 31,550 children and young people attending schools in the city (excluding independent schools).[4]

Prevalence of ASC in the UK is estimated at between 0.2 and 1%,[5,6] data from the UK General Practice Research Database showed diagnosed prevalence of ASC in 8 year olds of 3.8 per 1000 boys and 0.8 per thousand girls.[6] The Special Needs and Autism Project looking at children in South Thames found higher rates estimated at 1% prevalence in 9-10 year olds when children with SEN are screened for ASC.[5]

This means that we would estimate between 118 and 590 children and young people aged 0-19 in the city to have a diagnosis of an ASC at any time, and around 65 to 315 children and young people in Brighton & Hove schools.

Each local authority has a statutory responsibility to hold a register of disabled children. In Brighton & Hove this is The Compass database administered by Amaze, a local parent support CVS organisation. Registration on the Compass is voluntary and there has been a steady increase in the number of registered children with up-to-date records from 1,480 in 2008/09 to 1,908 in 2012/13 (29% increase). The associated incentive leisure/sporting card means the voluntary register has a much higher sign-up than most local authority registers.

In July 2014 The Compass had 481 0-19 year olds registered with an ASC, this is the most common diagnosis accounting for 29% of all aged 0-19 registered on the database. Males were more heavily represented with 390 registrations compared to 91 female. Between April 2009 and April 2014 the number of children 0-19 registered on Compass with ASCs has risen by 24%,[7] in line with the general rise of 0-19 year olds registered on the database. There has been substantial work increasing access to register on the database, which may explain this overall rise.

[1] National Institute for Health and Care Excellence. Autism, January 2014. NICE Quality Standard 51 (QS51) http://guidance.nice.org.uk/qs51

[2] Brighton & Hove City Council, Services for Children with Autism Scrutiny Panel report, April 2014 http://present.brighton-hove.gov.uk/Published/C00000728/M00004870/AI00039830/$FinalreportforServicesforchildrenwithautismfinalApril2014withoutDRAFTmarks.doc.pdf accessed 23/9/2014

[3] ONS mid-year estimate 2013 aged 0-19 years in Brighton 59,009, rounded in text http://ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Estimates#tab-data-tables accessed 3/10/14

[4] Schools, Pupils and their characteristics: January 2014. Office of National Statistics, Department for Education local authority and regional tables:SFR15/2014 https://www.gov.uk/government/statistics/schools-pupils-and-their-characteristics-january-2014 accessed 3/10/14

[5] Baird G, Simonoff E, Pickles A et al. Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP). Lancet 2006 Jul 13;368(9531):201-5

[6] Taylor B, Jick H, MacLaughlin D. Prevalence and incidence rates of autism in the UK: time trend from 2004-2010 in children aged 8 years. *BMJ Open* 2013;**3**:e003219 doi: 10.1136/bmjopen-2013-003219

[7] Amaze Compass data 2014

5.1 Children and young people with Autistic Spectrum Conditions

Nationally, 20.8% of statements of Special Educational Needs (SEN) are for autism8. In Brighton & Hove there are 185 children with ASC with a statement, representing 18% of children with SEN statement.[9]

The Autistic Spectrum Condition Support Service (ASCSS) offers support for state schools with one or more pupils with a diagnosis of an ASC. There are currently 285 pupils with ASC on the diagnosed pupil database of the ASCSS: pupils included are in pre-school settings, and mainstream Primary and Secondary Schools, in Brighton & Hove.[10]

For an ASC diagnosis in Brighton & Hove children and young people have to be referred by a professional to Seaside View Child Development Centre (Seaside View). The process for assessment has two stages: a general development assessment at stage 1 and a more detailed multi-disciplinary ASC specific clinic at Stage 2. An estimated 86 children were seen from July 2012 - July 2013 and around 64% of these received a diagnosis of an ASC.[11]

51.6% of children with ASC on the Compass database have moderate to profound learning difficulties, the majority of these have moderate difficulties, at 27.0%, or severe difficulties, at 22.5%.[12]

Where we are doing well

An ASC working group was established in the spring 2013, with representation from parents/carers, the voluntary sector and professionals from education, health (including the Child and Adolescent Mental Health Service (CAMHS)) and social work services. This group has been instrumental in taking forward a partnership approach to developing services for children and young people with ASC.

In April 2014 Brighton & Hove City Council published the Services for Children with Autism Scrutiny Panel report. This examined services for children and young people with autism within Brighton & Hove and included input from parents/carers and service providers. The report laid out 20 recommendations for action around home support, available information, pathways to diagnosis, training and awareness.[13] Responses to the recommendations were accepted by the Health and Wellbeing Board in July 2014.[14,15]

Local inequalities

Of the 421 children registered with ASC within Brighton & Hove, 390 were male compared to just 91 female, this equates to a ratio of approximately 4:1 male to female, which is what is seen nationally.[16]

83% of those on the Compass database are White British.

Predicted future need

The number of children and young people living in Brighton & Hove is predicted to slowly increase and is projected at 62,000 persons aged 0-19 in 2024,[17] compared with 59,000 in 2013. Although there has been a marked increase in diagnosis of ASC in the last 30 years, the numbers have plateaued since the early 2000s so we wouldn't expect much change in prevalence in the coming years.[18]

[8] Department for Education, Statistics Children with special educational needs: an analysis – 2013 https://www.gov.uk/government/publications/children-with-special-educational-needs-an-analysis-2013 accessed 3/10/14

[9] REF Alison's report

[10] Figure provided by ASC Support Service on 7/10/14

[11] Brighton & Hove City Council, Services for Children with Autism Scrutiny Panel report, April 2014 http://present.brighton-hove.gov.uk/Published/C00000728/M00004870/AI00039830/$FinalreportforServicesforchildrenwithautismfinalApril2014withoutDRAFTmarks.doc.pdf accessed 23/9/2014

[12] Amaze Compass data 2014

[13] Brighton & Hove City Council, Services for Children with Autism Scrutiny Panel report, April 2014 http://present.brighton-hove.gov.uk/Published/C00000728/M00004870/AI00039830/$FinalreportforServicesforchildrenwithautismfinalApril2014withoutDRAFTmarks.doc.pdf accessed 23/9/2014

[14] Agenda item 16, Health and Wellbeing Board, Brighton & Hove City Council. 29 July 2014 http://present.brighton-hove.gov.uk/Published/C00000826/M00005481/AI00041396/$Item16ResponsetotheScrutinyPanelresponsefinal16714v4GRedit.doc.pdf accessed 3/10/14

[15] Minutes Agenda item 16 Health and Wellbeing Board 29 July 2014 http://present.brighton-hove.gov.uk/ieIssueDetails.aspx?IId=43067&PlanId=0&Opt=3#AI41396 accessed 3/10/14

[16] Taylor B, Jick H, MacLaughlin D. Prevalence and incidence rates of autism in the UK: time trend from 2004-2010 in children aged 8 years. *BMJ Open* 2013;**3**:e003219 doi:10.1135/bmjopen-2013-003219

[17] ONS 2012 based Subnational Population Projections for Regions in England, 29-May 2014 http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Sub-national+Population+Projections#tab-data-tables accessed 18/9/2014

[18] Taylor B, Jick H, MacLaughlin D. Prevalence and incidence rates of autism in the UK: time trend from 2004-2010 in children aged 8 years. *BMJ Open* 2013;**3**:e003219 doi: 10.1136/bmjopen-2013-003219

5.1 Children and young people with Autistic Spectrum Conditions

Taking the higher estimate of 1% prevalence we would expect 620 people with ASC in this age group. This means there will be a moderate increase of 25 extra young people with ASC in Brighton & Hove in 10 years.

What we don't know

There is not a single definitive database of children and young people with a diagnosis of autism in the city, the reporting through Compass is voluntary, and so does not contain full information regarding local patterns of ASC.

Key evidence and policy

National Institute for Health and Care Excellence (NICE), Autism Quality Standard, Jan 2014 (QS51). This quality standard covers autism in children, young people and adults, including both health and social care services.
http://guidance.nice.org.uk/qs51

National Institute for Health and Care Excellence. Autism diagnosis in children and young people (CG128): Recognition, referral and diagnosis of children and young people on the autistic spectrum, September 2011
http://www.nice.org.uk/guidance/CG128

The NICE pathway for Autism works in line with the guidance:
http://pathways.nice.org.uk/pathways/autism

Children and Families Act 2014. This bill aims to make life better for children and young people with SEN. The existing system for Educational Statements, School Action and School Action Plus, will be replaced by a single Education, Health and Care Plan (EHCP) that will remain in place until a young person is 25 years old (up from 18 years at the moment).
http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

There is no national policy specifically in relation to children and young people with ASC. However, The Autism Act (2009) requires each local authority to develop a local autism strategy for the provision of health and social care services for people with autism (aged 14 years and older).
http://www.legislation.gov.uk/ukpga/2009/15/introduction

Recommended future local priorities

Summary of Scrutiny Report Recommendations:

- Nominated key workers for all children with ASC
- A pathway for children with autism but neither learning difficulties nor mental health Issues
- Improved home support for families
- CAMHS and Seaside View services to put parents at the heart of their provision
- CAMHS and Seaside View to have open and accountable monitoring frameworks
- Clearer accountability lines for all tiers of CAMHS
- Improve links between Health Visitors and GPs
- All schools take up training to become 'autism aware'
- All Governing Bodies to undergo SEN training and be given copies of Scrutiny Report
- Consideration to be given to increasing funding of ASC support service
- Monitoring of all relevant plans and strategies including those for transition to adulthood
- Appoint an Autism Champion
- ASC working group to oversee Scrutiny Panel recommendations
- Joint Strategic Needs Assessment (JSNA) to include a section on children with autism
- Creation of a youth club for young people with autism

Key links to other sections

- Children and young people with disabilities
- Adults with Autistic Spectrum Conditions

Further information

Services for Children with Autism Scrutiny Panel report, April 2014:
http://present.brighton-hove.gov.uk/Published/C00000728/M00004870/AI00039830/$FinalreportforServicesforchildrenwithautismfinalApril2014withoutDRAFTmarks.doc.pdf

5.1 Children and young people with Autistic Spectrum Conditions

Draft Plan for families and children with ASC. Working in Partnership to meet the needs of children and Young People with Autism in Brighton & Hove 2013-2017. 'Better outcomes, better lives' Response to the scrutiny panel report: Services for Children with Autism, this was the report taken to the Health and Wellbeing Board: http://present.brighton-hove.gov.uk/Published/C00000826/M00005481/AI00041396/$Item16ResponsetotheScrutinyPanelresponsefinal16714v4GRedit.doc.pdf

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October 2014

7.3.9 Ageing well

Why is this issue important?

Older people (those aged 65 or over[1]) are the fastest growing population group in England and Western Europe. Growing old is not the same as growing infirm. The rate of decline in health and wellbeing is largely determined by factors related to lifestyle as well as external social, environmental and economic factors and people can take some control over their ageing. There is solid evidence that promoting physical and mental health in older people prevents or delays the onset of disability as do public policy measures, such as promoting an age-friendly living environment.[2,3,4,5]

Material conditions, social factors and the interaction between them influence how well individuals age. The life satisfaction and general wellbeing of older people is reduced when they are isolated, poor, in ill-health, living alone or in unfit housing and rundown neighbourhoods, when they require or are a carer or live in a care home. Bereavement presents an additional threat to quality of life.[6] Transport is another important factor in determining older people's ability to access vital amenities and allowing older people to remain independent and active in later life as well as helping people stay connected.

There has been a national policy shift towards an adult social care and health service that has prevention, early intervention and enablement at its core, as well as choice and control over services through personalisation. This approach has the potential to enhance wellbeing and save money.

Key outcomes

- ***Older people's perception of community safety (Placeholder) (Public Health Outcomes Framework)***
- ***Falls and injuries in the over 65s (Public Health Outcomes Framework)***
- ***Health related quality of life for older people (Public Health Outcomes Framework)***
- ***Hip fractures in the over 65s (Public Health Outcomes Framework)***
- ***Excess winter deaths (Public Health Outcomes Framework)***
- ***Dementia and its impacts (Public Health Outcomes Framework)***
- ***Fuel Poverty (Public Health Outcomes Framework)***
- ***Enhancing the quality of life for people with dementia (NHS Outcomes Framework)***
- ***Enhancing the quality of life for people with long term conditions (NHS Outcomes Framework)***
- ***Helping older people to recover their independence after illness or injury (NHS Outcomes Framework)***
- ***Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation service (Adult Social Care Outcomes Framework)***
- ***Enhancing quality of life for people with care and support needs (Adult Social Care Outcomes Framework)***
- ***Delaying and reducing the need for care and support (Adult Social Care Outcomes Framework)***
- ***Ensuring that people have a positive experience of care and support (Adult Social Care Outcomes Framework)***

[1] In the absence of any guidance as to definition of 'older', this summary is using 65 or over as the starting point .
[2] Banks J, Breeze E, Lessof C, Nazroo,J. Retirement, health and relationships of the older population in England: The 2004 English Longitudinal Study of Ageing (Wave 2). 2006.
[3] Bassey EJ. Physical capabilities, exercise and ageing. Reviews in Clinical Gerontology 1997; 7(4): 289–297.
[4] Center for Lifespan Psychology. Annual report 2003–2004. Available at: www.mpib-berlin.mpg.de/sites/default/files/media/pdf/25/lip_report_11.pdf . [Accessed April 2011]
[5] World Health Organization. Global age-friendly cities: a guide. 2007. Available at: http://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf [Accessed 16/05/2013]
[6] Brighton & Hove Annual Report of the Director of Public Health 2010: Resilience. Available at: http://www.bhlis.org/needsassessments/publichealthreports [Accessed 26/05/2013]

7.3.9 Ageing well

Impact in Brighton & Hove

Currently there are 35,800 people aged 65 or over in the City; 20,100 females and 15,800 males[7], with the ratio of women to men increasing with age.[8]

The largest percentage of residents aged 65 years and over are in five wards, with over half the City's older people living in the 40% most deprived areas for older people in England, and some in the 4% most deprived. The West locality has the highest number of older people and prevalence of stroke, diabetes and dementia. In seven wards, fewer than one in ten people is aged 65 years or over.[9]

Brighton & Hove has a relatively large proportion of older people living alone and potentially isolated who are more dependent upon public services. Single pensioner households are higher than average (14,500 households comprise single people aged 65 or over) and the majority of people aged 75 or over live alone; of those living alone, 34% are male, 61% female.[6, 10]

The City has almost twice the national suicide and undetermined injury death rate in older people. Up to 16% of people aged 65 and over have depression, 2–4% have severe depression.[6]

Older people feel less safe in their neighbourhoods after dark, particularly those on low income or in more deprived areas – 45% of those aged 75 and over compared to 23% of all residents.[11]

The majority (62%) of people with a limiting disability (more likely to be older people) do no 30 minute sessions of moderate intensity sport and active recreation a week compared to 38% of people without a limiting disability. Only 7% of adults aged 55 years and over participate in at least three 30 minute sessions of sport per week.[12]

Some older people require assistance and support to be able to make use of free travel.[6]

Many older people in the City may not claim the benefits to which they are entitled and which would increase their resilience.[6]

In some areas of the City, 12% of men over 50 have an average weekly alcohol consumption of over 35 units, well above recommended limits.[13]

There are many carers, including 11,500 aged over 50, with increasing numbers of older parent carers of adults with LD/autism. Significant numbers of carers report feeling out of control of their daily life, lonely and detached from society and want support for their own issues.[14]

Across all sectors older people are presenting with more complex needs.

Older people with increasing levels of need are being discharged early from hospital to be supported at home by informal/formal carers, this potentially increases their isolation.

The Brighton and Hove Better Care Plan[15], published in 2014, has a focus on improving outcomes in 'frail' people (it should be noted that not all older people are frail and many of our frail population are in younger age groups, however much of the action described within this plan will benefit older people). The plan describes how improved services for our frail and vulnerable population will help them to stay healthy and well by providing more pro-active preventative services that promote independence and enable people to fulfil their potential.

There are an estimated 92 Extra Care and Sheltered housing schemes in Brighton &Hove providing 2,929 homes specifically for older people.[16] Extra Care Housing is housing designed with varying levels of care and support available on site. People who live in Extra Care Housing have their own self contained homes, their own front doors and rights to occupy the property.

A Business Case for Extra Care Housing is currently being commissioned. It will establish detailed

[7] Figures do not sum due to rounding
[8] Office for National Statistics. Population Estimates for England and Wales, Mid-2011 (2011 Census-based). Released: 25 September 2012. Available at http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-262039 [Accessed 17/07/2013]
[9] Census 2011. ONS
[10] Institute for Public Care. Projecting Older People Population Information System (POPPI). Available at: http://www.poppi.org.uk/ (registration required). [Accessed 30.05.2013]
[11] Brighton and Hove Safe in the City Partnership. Older people and Community safety – extract from the Strategic Assessment of Crime and Disorder: 2010.
[12] Brighton & Hove physical activity and sport needs assessment. 2012 http://www.bhlis.org/needsassessments
[13] University of Kent. Health Counts: Analysis of a survey of people aged over 50 in Hangleton and Knoll and Queen's Park. 2005/6.
[14] Department of Health. Government Information for Carers. www.carers.gov.uk .
[15] Available at http://www.brighton-hove.gov.uk/content/council-and-democracy/councillors-and-committees/health-wellbeing-board [Accessed 03/10/2014]
[16] Brighton &Hove City Council. Adult Social Care. Market Position Statement. March 2014

short, medium and long term local demand/need projections to enable identification of the types of provision that will most appropriately meet the objective of reducing residential care costs.

New forms of sheltered housing and retirement housing have been pioneered in recent years to meet the needs of older people.

There are 12 independent home care providers who hold a contract with the council and there are 43 home care providers registered with the CQC across the city.[15] Home care services provide assistance with personal care, practical tasks and support for informal carers. There are different levels of support available, from maintaining and improving levels of independence, to providing high levels of support to people who are highly dependent, including End of Life Care.

Personalisation and personal budgets should have significantly changed the way services are delivered to improve the older person's experience, however outcomes are mixed and take-up of direct payments by older people locally has declined.

People can choose to have a home care provider or Personal Assistant (PA) to provide their care. "Support with Confidence" is the approved Brighton &Hove City Council PA scheme, that includes training and background checks.[15]

There are 2,326 registered care home beds in the city, provided in 29 nursing homes and 81 residential homes. There is estimated to be a low level of vacancies within care homes in the city. The council spent £43, 289m on care homes in 2012/13, double the amount spent on home care/community support and over half the Adult Social Care budget. The average length of stay is 33 months in a care home and 21 months in a nursing home. The council has four care homes providing short stay rehabilitation and reablement services, in the city.

A number of people are placed in care homes out of the city, including 179 people over 65 and 174 people with dementia. This can be to live near a family member but for some it is due to lack of capacity in the city.[15]

The local NHS and Brighton & Hove City Council (BHCC) both fund 'gateway' organisations to ensure older user voices inform decision making, including BME elders. There are many older people user-led organisations/groups including MindOut (peer support for LGBT elders with mental health issues); Hangleton and Knoll 50+ Group which coordinates health activities; The Neighbourhood Care Scheme which is directed by users and is a good neighbour scheme to primarily isolated older people; Lifelines volunteers (all 50+) which designs and delivers individual and group activities in partnership with an extra care housing scheme.

Local research evidences that older people want a person centred approach to daily living.[17] Findings have also been developed into learning resources and are feeding into local policy and practice.

Research also reveals the very different experiences that constitute old age and the varied factors that affect wellbeing at this stage of life. Relationships of different types are important and the resources and capacities that people have to adapt to personal and social changes can make a big difference to people's sense of being well in old age. In addition, security, feeling like you 'belong', and being confident that help is there if you need it are all important.[15]

Research suggests that there is a danger that definitions that emphasise physical health, people's capacity to plan and set goals, and to be active within their communities, may exclude people for whom old age is accompanied by illness, a reduction in physical horizons because of mobility problems and who, because of advanced old age, are focused on being well in the present rather than planning for the future.[15]

Where we are doing well

Brighton & Hove has recently been affiliated by the WHO into its Age Friendly City network. This will encourage active ageing by optimizing opportunities for health, wellbeing and participation. This strategic approach which has cross-party support will raise the profile of older people, prevention and wellbeing services.

Brighton & Hove has nearly double the national average of independent active older people and a smaller proportion with high care needs. Healthy

[17] Ward L. Barnes M. Gahagan B. Well-being in old age: findings from participatory research. University of Brighton & Age UK Brighton & Hove. 2012. http://www.brighton.ac.uk/sass/older-people-wellbeing-and-participation/Full-report.pdf

life expectancy and disability-free life expectancy at age 65 years are higher for females in Brighton & Hove than in England.[6]

The new Ageing Better partnership has identified best practice engagement, including outreach, home visits, a range of information dissemination and proactive engagement to enable access by older people, in neighbourhoods or across communities of identity/interest.

Day activities were reviewed by older people and their carers, resulting in a radical new way of commissioning services.

Free bus travel has helped reduce social isolation among older people.

Older people in the City appear to be more satisfied with their local area than those in younger age groups, with those aged between 65-74 years most satisfied. They are also more likely than to be satisfied with public services and feel they work to make areas cleaner and greener.[18]

Although older people are less willing to give up smoking, once they have decided to quit they seem to be more successful than younger age groups.[6] By the age of 75 years or over, for males and females, smoking prevalence reaches its lowest point (5% for males and 10% for females).[19]

The 2012 Health Counts Survey showed that residents aged 65-74 years were most happy: 78% for men and 77% for women compared with 72% for all adult respondents. In addition, whilst just 58% of survey respondents felt very or fairly strongly that they belonged to their immediate neighbourhood, this feeling increases with age for both men and women: 78% of those aged over 75 years feel very or fairly strongly that they belong compared to just 46% of those aged 18-24 years.[20]

Older people in some wards in Brighton & Hove appear to have a better diet than the average younger person.[21]

A relatively high proportion of older people have higher level qualifications and the proportion with no qualifications is lower than England. Brighton & Hove has a large number of organisations providing adult learning at affordable cost.[6]

A higher proportion of older people participate in groups making decisions affecting their local area and a significant proportion contribute through volunteering, in line with the national picture.[15] Sense of belonging increases with age for both males and females, with 78% of those aged over 75 years feeling very/fairly strongly that they belong compared to 46% of those aged 18-24 years.[16]

Older people are less likely than younger people to be victims of crime or a repeat victim of crime.[15]

The City has a strong and broad range of voluntary and statutory sector services which support vulnerable older people and enable them to participate in community activities, including older people/user led organisations/groups. Public sector funding for Voluntary and Community organisations (VCOs) is dependent on evidence of user involvement in design and delivery of services which continue to evolve in response to feedback.

Arts organisations have engaged older residents to help redesign programming, exhibitions and staff training to increase the older audience, now up by 6% on 2003.

The City's Active for Life team designs and delivers activities with older people in targeted neighbourhoods, which helps raise awareness of what is on offer, significantly improving uptake.

Independence is important to older people; older people's home care services are increasing in line with a decrease in care home placements. Similarly the demand for Extra Care Housing is increasing. Assistive technology is being actively promoted demonstrating positive outcomes. There are over 5,000 telecare users in the city supported by the council's CareLink Plus service. There is a need to expand telecare into new areas, including medication dispensing and reminding solutions. Home care and care home providers also need to use telecare as a cost effective way of meeting an individual's goals for a more independent life.[15]

[18] Brighton & Hove City Council. Brighton and Hove Place Survey. 2008.
[19] Brighton & Hove City Council. Health Counts in Brighton & Hove 1992-2012
[20] Brighton & Hove City Council and NHS Brighton & Hove. Annual Report of the Director of Public Health. Happiness: the eternal pursuit. 2012/13. Available at: http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/Director%20of%20Public%20Health%20Annual%20Report%202013_web_0.pdf [Accessed 15/08/2013]
[21] University of Kent. Health Counts: Analysis of a survey of people aged over 50 in Hangleton and Knoll and Queen's Park. 2005/6.

Local inequalities

Relative to East Brighton and other deprived parts of the City, the deprivation scores of the wards where higher numbers of older people live are quite low.

Brighton & Hove has a relatively high proportion of 'non-decent homes', and the highest rates are where the head of household is aged 85 years or over.[22]

The oldest owner occupiers (85+) are more likely than all other older people to move into communal establishments that may offer less independence, which could be due to a shortage of private sheltered or extra care housing schemes that also provide an element of support.

Some LGBT groups experience significant marginalisation and are less likely to feel that their local area is inclusive. Older LGBT groups experience discrimination, especially in communal accommodation.

There are isolated BME elders, including travellers. Service providers find it difficult to reach out to them - the BME needs assessment due in 2013 will inform future service development.[23]

Healthy life expectancy and disability free life expectancy at age 65 years is similar for males in Brighton & Hove and in England, but longer for females. The majority of people aged 75 years and over in Brighton & Hove live with a long term condition, as do a significant proportion of those aged under 75 years (38% of males aged between 65-75 years). Those who are married, in a civil partnership or living as a couple were significantly less likely to have a limiting long-term illness (21%) than all respondents, those who were separated or divorced (42%) or widowed (56%) were significantly more likely to have a limiting long-term illness.[16]

There is a clear relationship between self-perceived health and age, with the percentage of respondents who say they are in good or better health falling from 93% of 18-24 year old to 54% of those aged 75 years or over in 2012.[16]

Eating five a day is significantly more common in females (59%) than males (46%). For females, the percentage increases with age from 18-24 year (50%) to 65-74 years (75%) but falls in those aged 75 years or over. For males there is an increase in the percentage eating five a day from 32% at 18-24 years to 52% of 35-44 year olds, the figures for those aged 45-74 are then similar with a fall to 48% for those aged 75 years or over.[16]

The Integrated Household Survey 2009-2010 indicates that Brighton & Hove has the lowest level of religious belief in the country, however the data are not broken down by age or gender.

Males aged 50 years and over are more likely to be victims of crime than women aged 50 years and over.[9]

Nationally, 42% of carers are men and 58% women. This is reflected in the figures for carers aged 50 and over in the City; 43% of whom are men and 57% women.[24]

Predicted future need

Although the proportion of older people living in the City has fallen in recent years, the population aged 65 years or over is predicted to increase and become more ethnically diverse. The largest projected increases are in the 70-74 and 90 and over age groups.[25] This will have implications for housing need.

The City is currently a high user of care homes but is committed to providing alternative accommodation options, in particular extra care housing. It's predicted there will be a need for an additional 700 places in Extra Care Housing by 2030.[15] Ideally new models will include provision designed by older people, keeping them active and less socially isolated.

The council's Independence at Home team will work closely with Community Short Term Services to support people at risk of hospital admission, support people being discharged and promote opportunities for reablement.[15]

[22] Brighton & Hove Private Sector House Condition Survey. 2008

[23] Brighton & Hove Gypsy and Traveller Rapid Health Needs Assessment. 2012. Available at: http://www.bhlis.org/needsassessments

[24] Department of Health. Government Information for Carers. Available at: www.carers.gov.uk [Accessed 18/04/2013]

[25] Office for National Statistics. Interim 2011 based sub national population projections. http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-274527 [Accessed 12/06/2013]

7.3.9 Ageing well

Increasingly, older people will be purchasing care using their personal budgets and advocacy services will become more important as people navigate their way around the health and social care system.[15]

Baby boomers have different aspirations and are keen to lead service design, which could lead to innovative and inclusive solutions for older people.

What we don't know

We do not have information on all protected characteristics of older people including ethnicity, religion, marital status and we lack comprehensive information on sexual orientation.

We need to know more about Extra Care Housing, with the commissioning of the Business Case.

Key evidence and policy

World Health Organization. Global age-friendly cities: a guide. 2007. whqlibdoc.who.int/publications/2007/9789241547307_eng.pdf

NICE Guidance: PH16 Mental wellbeing and older people: 2008 http://guidance.nice.org.uk/PH16

Recommended future local priorities

1. There is a need to raise the profile of older people in the City and develop a joined up approach to service provision that places older people firmly at the core and emphasises prevention and early intervention - the WHO Age-Friendly City approach will provide a vehicle to take this forward, as will the Council's new Commissioning Prospectus approach to commissioning and co-ordinating day services for older people.
2. Older people's active participation and contribution to community groups, schools and other neighbourhood activities should be encouraged as it builds resilience.
3. Better partnership working between agencies that support older people would help to mitigate the risk of cuts in public spending – the Ageing Better partnership is a good example.
4. Services and benefits should be publicised in the right places to ensure that older people access them, with information in a range of formats – not just web based.
5. Loneliness and isolation of older people, including carers, BME and LGBT elders should be addressed along with increasing the number of older people actively participating in a full range of activities and services. Some older people need to be assisted and accompanied to ensure they access services. Ways to provide such support need to be developed.
6. It is important to focus not just on the very elderly but also on the younger cohort of older people if future health and wellbeing problems and associated costs are to be reduced.
7. We need culture change across the City so that participation and engagement by older people is actively encouraged and older people are visible and involved as leaders in the City. Strategic involvement of older people in service design and delivery, along with active promotion of positive images of ageing, are important steps to taking this forward.
8. Adult Social Care will work to deliver its commitments set out in the Market Position Statement, 2014.

Key links to other sections

- Social connectedness, community resilience and community assets
- Emotional health and wellbeing
- Dementia
- Fuel poverty
- Housing

Further information

Ward L. Barnes M. Gahagan B. Well-being in old age: findings from participatory research. University of Brighton and Age UK Brighton & Hove. 2012. http://www.brighton.ac.uk/sass/older-people-wellbeing-and-participation/Full-report.pdf

As Time Goes By: Thoughts on Well-being in Later Years. University of Brighton and Age UK Brighton & Hove. 2012

Brighton & Hove Annual Report of the Director of Public Health 2010: Resilience. http://www.brighton-

hove.gov.uk/content/health-and-social-care/health-and-wellbeing/annual-report-director-public-health

Adult Social Care. Market Position Statement. March 2014. http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/FINAL%20MARCH%20ASC%20Commissioning%20Statement%20Report.pdf

Last updated

September 2014

7.5.11 Dementia

Why is this issue important?

Dementia presents a huge challenge to society and will do increasingly in the future. There are approximately 662,373 people aged 65 and over in England with dementia.[1] Dementia costs the UK economy £23 billion a year and this will rise to over £27 billion a year by 2018; the number of people with dementia in the UK doubles every 20 years and will rise to 1.7 million by 2050.[2]

Dementia is a syndrome which results in a progressive decline in multiple areas of function, including memory, reasoning, communication skills and the skills needed to carry out daily activities. Individuals may also develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering, which complicate care and can occur at any stage of the illness. There are different types of dementia caused by different diseases of the brain, including Alzheimer's disease and vascular dementia. These diseases affect the brain in different ways and produce different symptoms.

Carers of people with dementia are often old and frail themselves, with high levels of depression and physical illness, and a diminished quality of life. Dementia is a terminal condition but people can live with it for 7–12 years after diagnosis.[2]

The prevalence of both early onset and late onset dementia increases with age, doubling with every five-year increase across the entire age range from 30 onwards. Overall, 10% of deaths in men over 65 years, and 15% of deaths in women over 65 years are attributable to dementia.[1]

There is evidence that people with dementia have worse clinical outcomes than people with the same conditions without dementia. This contributes towards longer length of stay in general hospitals. Nationally, it is estimated that two thirds of people in care homes have dementia and 40% of these people are not in specialist dementia care homes.[3]

Apart from family members or friends, who provide the vast bulk of care and support, home care is probably the single most important service involved in supporting people with dementia in their own homes. The Commission for Social Care Inspection (CSCI) has found that good-quality, flexible home care services contribute significantly to maintaining people's independence, reducing social isolation, preventing admissions to care homes and hospitals, and supporting carers.[4]

Historically, dementia has been under diagnosed, both locally and nationally. It is estimated that only a third of people with dementia receive a formal diagnosis or have contact with specialist services at any time in their illness. Also, such diagnosis and contact often occur late in the illness and/or in crisis when opportunities for harm prevention and maximisation of quality of life have passed.[4]

Contrary to social misconception, a great deal can be done to help people with dementia.[5] Dementia should be diagnosed early and well so that people with dementia and their carers can receive treatment, care and support to enable them to live as well as possible with dementia.[6]

Key outcomes

- ***Health related quality of life for older people (Public Health Outcomes Framework)***
- ***Estimated diagnosis rate for people with dementia (Public Health and NHS Outcomes Framework)***
- ***Improving experience of healthcare for people with mental illness: Patient experience of community mental health services (NHS Outcomes Framework)***
- ***Enhancing quality of life for people with dementia -estimated diagnosis rate for people with dementia (NHS Outcomes Framework and Public Health Outcomes Framework); a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life (Adult Social Care Outcomes Framework, Placeholder and NHS Outcomes Framework)***

[1] Institute for Public Care. Projecting Older People Population Information System (POPPI). Available at: www.poppi.org.uk (registration required) [Accessed 30th September 2014]

[2] Alzheimer's Society. Facts on Dementia. Available at: http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=535&pageNumber=2 [Accessed 23/05/13]

[3] Commission for Social Care Inspection (CSCI). See me, not just the dementia. 2008

[4] Commission for Social Care Inspection (CSCI). Time to Care? London: TSO. 2006

[5] NICE/SCIE. *Dementia: Supporting people with dementia and their carers in health and social care*. London: TSO. 2006

[6] National Audit Office. Improving services and support for people with dementia. London: TSO. 2007

7.5.11 Dementia

Impact in Brighton & Hove

It is estimated that in 2014 there are 2,849 people aged 65 years or over with dementia in the City, based on applying national prevalence rates to the local population.[1] It is estimated that there are currently 61 people with early onset dementia.[7]

Dementia has been included in the Quality and Outcomes Framework (QOF) measures for GP practices since 2006/07. Since that time the proportion of the GP registered population on local practice dementia registers has increased slightly from 0.3% to 0.4% in 2011/12 (reflecting an increase in actual numbers from 937 to 1,132).[8] This compares to 0.6% in England and in the South of England Commissioning Region. It is also lower than the 12 other Surrey and Sussex Commissioning Groups. QOF data is not adjustable by age, so care should be taken when making comparisons to other CCGs, particularly those in Surrey and Sussex, as Brighton &Hove has a lower proportion of people aged 65 or over.[9]

Explanations put forward for under-diagnosis include the stigma associated with dementia which prevents people from going to their GP about memory loss, as well as dementia being considered by some people, including GPs, as a normal part of ageing.[10] Lack of diagnosis is a key factor that prevents people seeking the treatment they need and gaining support during early stages. [11]

Since 2010/11 the number of anti-dementia drugs prescribed in primary care has doubled from 7,250 to 14,211 in 2012/13. This is likely to be due to changes in prescribing practice as NICE guidance lifted restrictions on limiting these drugs from patients with moderate to severe dementia and extending them to those with early stage dementia. Anti-psychotic prescribing is now relatively low compared to 2009. In 2011/12, 52% of patients were having their medication reviewed at least every 12 weeks.[9]

There were 522 admissions to secondary care where dementia was the primary or secondary condition between 2010/11 and 2012/13. This is likely to be an under estimate as dementia is unlikely to be the primary reason for admission and is not always recorded as the secondary condition.[9] Since October 2012 a dementia CQUIN has been in place to assess patients aged 75 or over admitted for over 72 hours, for a diagnosis of dementia.

Between June 2013 and March 2014, 236 assessments were completed by the Memory Assessment Service (MAS), 180 dementia diagnoses made and 56 carers assessments were also completed.

Patients with dementia should be reviewed within primary care at least every 15 months. In 2011/12 local performance was 76% which was slightly lower performance than for England and the South East Coast Strategic Health Authority (79% and 78% respectively).[12]

Brighton & Hove has 111 registered care homes with 2,326 beds. A recent survey of 43 homes representing 1,239 beds, self- reported 854 residents (69%) with dementia – this is likely to be an underestimate.[9]

The council spent £15.7 million on home care in 2012/13. There are no figures available on the proportion of these clients with dementia but most home carers will be supporting someone with memory loss.[9]

As the cost of care for people with dementia is embedded across the whole of the health and social care system, including acute hospitals, mental health services, residential and nursing homes, it is difficult to determine the precise costs of dementia care.

Where we are doing well

The Heath and Wellbeing Board have identified dementia as a priority for the city and the Joint Health and Wellbeing Strategy includes a section on dementia. A Dementia Joint Strategic Needs Assessment was completed in 2013 and has informed the development of the Brighton & Hove Dementia Joint Strategic Delivery Plan 2014/17.

[7] Institute for Public Care. Projecting Adult Needs and Service Information. Available at: www.pansi.org.uk (Registration required) [Accessed 01.10.2014]
[8] Health and Social Care Information Centre . QOF prevalence data tables 2011/12 available at: https://catalogue.ic.nhs.uk/publications/primary-care/qof/qual-outc-fram-11-12-pct/qual-outc-fram-11-12-pcts-prev.xls [Accessed on 23/05/2012]
[9] BHCCG and BHCC. Dementia Needs Assessment. May 2014.
[10] NHS Brighton and Hove and Brighton & Hove City Council. Annual Report of the Director of Public Health. Brighton & Hove. 2011
[11] Brighton & Hove Joint Dementia Plan. NHS Brighton & Hove, Brighton & Hove City Council. 2012
[12] Health and Social Care Information Centre. Quality and Outcomes Framework (QOF). 2011/12. http://www.hscic.gov.uk/qof [Accessed on 23/05/13]

7.5.11 Dementia

Progress made since the 2012/15 Dementia Plan includes:

- Launch of the Memory Assessment Service, which includes support from Dementia Advisers and Carers' Needs Assessment Workers.
- Secured Department of Health capital funding to make the environment dementia friendly in primary care, acute, community services and care home settings e.g. the refurbished Brunswick Ward at Nevill Hospital has reopened as the Lindridge Nursing Home.
- Reconfiguration of mental health services to create a Living Well with Dementia Team.
- Expansion of the Care Home In-Reach Service to support independent sector care and nursing homes, in particular identifying alternatives to anti-psychotic medication.
- The Alzheimer's Society provides Dementia Café's, Singing for the Brain, the Carer Information and Support Programme, Dementia Support Service, Home Support Respite Service and Carers' Support groups.
- Increased capacity in the Community Rapid Response Service to offer crisis and Short Term Community Support, to enable more people with dementia to be supported at home and avoid hospital admission.
- A dementia champion and specialist dementia nurse posts have been funded at Royal Sussex County Hospital. A dementia pathway has been developed in the hospital to provide a memory screen to 90% of patients over 75 who have been admitted for more than 72 hours. The hospital has also adopted the Butterfly scheme to promote education and a common care approach to patients with dementia. The Emerald Unit specialist dementia ward has opened at Royal Sussex County Hospital.
- A Dementia Friendly Guide has been developed for use by community groups and organisations.
- Specialist resources are being developed to improve the End of Life Care for people with dementia.

Local inequalities

Dementia affects men and women in all social and ethnic groups. There is limited local evidence available on whether dementia has a differential impact on equality groups. Nationally, dementia is more common in women with two thirds of people with dementia being women.[3] This is largely due to longer female life expectancy. Research suggests early onset dementia is more common in men.[9]

Although there is no good quality data available on the prevalence of dementia in different ethnic groups, it is likely to be more prevalent amongst Asian and Black Caribbean elders. This is because some of the risk factors for dementia (high blood pressure, diabetes, stroke and heart disease) are more common in these communities. Nationally it is estimated dementia will increase seven-fold by 2051 in BME groups as these populations age.[13]

Nationally, it is known that people with Downs syndrome are at greatly increased risk of developing dementia with a lower age of onset than the general population. This is of increasing importance as the life expectancy of people with Downs syndrome is increasing. Rates of dementia are also higher in people with learning disabilities other than Downs syndrome.[14] There are currently 13 individuals on the Community Learning Disability Team's dementia care pathway, aged between 45 and 80 years, seven of them have Down's Syndrome.[9]

Lesbian, Gay and Bisexual people with dementia are more likely to require Adult Social Care support, as they are more likely to live on their own and less likely to have children or see family members. They may also fear prejudice and discrimination from support groups and residential care staff, which may put them off seeking help with their dementia.[15]

Based on national research it is likely that at least 71% of people with dementia have a carer. In

[13] All Party Parliamentary Group on Dementia. Alzheimer's Society. Dementia Does Not Discriminate. July 2013.

[14] http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=103

[15] Musingarimi, P (2008). Social Care issues affecting Older Gay, Lesbian and Bisexual People in the UK. A policy brief. London ILC. Cited in Don't Look Back? (2010) Equality and Human Rights Commission, Manchester.

Brighton & Hove this equates to over 2,300 carers or 10% of all carers in the city.[16]

Research findings indicate that abusive behaviour by family carers towards people with dementia is common, with a third reporting important levels of abuse and half some abusive behaviour.[17] A YouGov survey commissioned in 2008 found that 19% of carers of people with Alzheimer's sometimes or often feel threatened by the person they care for.[18]

Brighton & Hove is included in the Pan Sussex Integrated End of Life Dementia Pathway. This aims to improve the end of life care for people with dementia, and enable more to die in their preferred place of death; increase advance care planning for people with dementia; and increase practitioners' knowledge and skills about end of life dementia care.

Other inequalities experienced by some people with dementia include people in the early stages not being referred for diagnosis by GPs. There is also a lack of affordable local authority funded specialist dementia beds in the city, so that 150-200 people are placed in accommodation outside the city (some people will have chosen this to live nearer relatives). People with severe dementia have less choice of care homes and people who can't afford to pay for their own respite have to wait longer to access it. Those without their own transport can face long journeys travelling to and from day centres.[9]

Predicted future need

By 2030, it is projected that the number of people aged 65 years or over with dementia will increase to 3,892 (Table 1).[1]

The number of people with early onset dementia is projected to increase by 21% (to 69) by 2020.[7]

However, these figures do not take into account the current under-diagnosis of dementia. If levels of diagnosis improve, the proportional increases could be much greater (The Memory Assessment Service has been set a target of increasing the dementia diagnosis rate from 54% to 67% by 2015). Nor do they take account of the anticipated decrease in dementia due to the reduced number of people at risk of cardio-vascular disease, though this is likely to be offset by the increase in obesity.

Table 1: Number of people aged 65 or over predicted to have dementia by age, 2014 and 2020 projection

	2014	2030
65-69 years	143	189
70-74 years	222	302
75-79 years	392	507
80-84 years	647	909
85-89 years	728	889
90 plus	717	1,097
Total 65 +	**2,849**	**3,892**

Source: Institute for Public Care. Projecting Older People Population Information System. www.poppi.org.uk

What we don't know

The Dementia JSNA found gaps in information in the following areas: the number of people with a dementia diagnosis living in care homes or receiving home care; how many people with dementia receive personal budgets or direct payments, how many people are self-funding their dementia care; the extent of dementia by ethnic group or protected characteristic groups, apart from gender; the number of people with dementia being admitted to acute hospitals.

Key evidence and policy

The Prime Minister's Challenge on Dementia was published in 2012. This made key commitments for driving improvements in health and care; developing dementia friendly communities that understand how to help and better research. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/146773/dh_133176.pdf

A National Dementia Strategy was published in 2009 and updated in 2010. It identified four

[16] Brighton & Hove Multi-Agency Commissioning and Development Strategy for Carers Refresh 2012-2013
[17] Cooper C et al. Abuse of people with dementia by family carers: representative cross sectional survey. BMJ 2009;338:b155
[18] YouGov. YouGov / Channel Four Survey Results. 2008. http://iis.yougov.co.uk/extranets/ygarchives/content/pdf/C4%20results%20alzheimers.pdf [Accessed on 26/08/2012]

priority areas to improve the quality and outcomes of care for people with dementia and their carers:

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

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/168220/dh_094051.pdf

Other key documents include:

Quality standard for supporting people to live well with dementia – NICE April 2013
https://www.nice.org.uk/guidance/qs30/resources/guidance-quality-standard-for-supporting-people-to-live-well-with-dementia-pdf

The NICE-SCIE guideline on supporting people with dementia and their carers in health and social care. National Collaborating Centre for Mental Health. 2006. Modified October 2012
http://www.scie.org.uk/publications/misc/dementia/

A report into prevalence. Dementia UK. 2007
http://www.alzheimers.org.uk/site/scripts/download.php?fileID=2

Quality outcomes for people with dementia: Building on the work of the National Dementia Strategy. Department of Health. 2010
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135771/dh_119828.pdf.pdf

Living well with dementia: A national dementia strategy - good practice compendium. DH. 2011
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147541/dh_123475.pdf.pdf

Brighton & Hove Clinical Commissioning Group and Brighton & Hove City Council. Dementia Needs Assessment. May 2014.
http://www.bhconnected.org.uk/sites/bhconnected/files/JSNA%20dementia%202014.pdf

Recommended future local priorities

The Brighton & Hove Dementia Joint Strategic Delivery Plan 2014-17 sets out the key action areas for development, based on the JSNA findings:

- Develop a single point of dementia information for public, professionals and carers.
- Workforce dementia training, including care home, homecare workers, sheltered housing, extra care housing, homeless services, learning disability services, community and voluntary workers.
- Good quality early diagnosis and support before and after diagnosis.
- Develop advice, support and capacity building in primary care.
- Ensure joined up integrated care for people with dementia and their carers.
- Create a Dementia Action Alliance to develop a Dementia Friendly Community.
- Ensure mainstream services are dementia friendly.
- Encourage uptake of direct payments and personal health care budgets by people with dementia and their carers.
- Continue to improve: number of carers receiving assessments, access to respite, training, awareness and support.
- Explore how to involve wider community in sheltered and extra care housing.
- Consider how to increase dementia friendly design of homeless accommodation.
- Explore ways of increasing dementia awareness of Estate Agents and Landlords.
- Promote telecare and telehealth to staff.
- Continue to develop and implement the End of Life Care in dementia pathway.

Key links to other sections

- Ageing well
- Mental health
- Adults with learning disabilities

Further information

NHS Brighton & Hove, Brighton & Hove City Council. Brighton & Hove Dementia Joint Strategic Delivery Plan 2014-17.

Last updated

October 2014

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Mental Health Crisis Care Concordat

1.1. The contents of this paper can be shared with the general public.

1.2 This paper is for the Health & Wellbeing Board meeting on 9 December.

1.3 This paper was written by

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Brighton and Hove CCG.
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2. Summary

2.1 In February the Department of Health published "Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis" (Appendix C). The Concordat is a statement that has been signed up to by organisations such as the Association of Ambulance Chief Executives, Pubic Health England, the Association of Directors of Social Services and the NHS Confederation. The Concordat describes what good crisis care should look like and includes high level statements about what agencies should be doing to ensure that good crisis care is delivered locally.

2.2 The expectation was that locally commissioners and partner agencies would review their crisis care arrangements against the Concordat checklist and develop a multi agency action plan for addressing any gaps and areas where further development is needed. It was also expected that these action plans would be approved by the local Health and Wellbeing Board and accompanied by a declaration of support by local agencies.

2.3 The purpose of this paper is to provide the HWB with

- information about the mental health crisis care arrangements available in Brighton and Hove
- an opportunity to approve the proposed action plan prior to submission to the Department of Health

2.4 The action plan covers actions proposed for both adults and children who experience a mental health crisis in Brighton and Hove.

3. Decisions, recommendations and any options

The Health & Wellbeing Board is asked to approve the proposed action plan.

4. Relevant information

4.1 The Mental Health Crisis Care Concordat is a national statement about what good crisis care looks like for people experiencing a crisis in their mental health. The messages in the Concordat are supported by key organisations such as the Associations of Directors of Social Services, the NHS Confederation, NHS England and the Local Government Association.

4.2 To ensure that good crisis care exists throughout the country, commissioners and local partner agencies have been asked to take stock of their crisis care arrangements and to develop local action plans that address gaps and areas for development. The expectation was that this was done in collaboration with key local agencies.

4.3 A local stocktake has taken place and this is attached for information at appendix A. From this an action plan (appendix B) has been developed to address gaps and areas for development - this has been developed in collaboration with the police, BHCC ambulance service, third sector and Sussex Partnership Foundation Trust.

4.4 Over recent years there has been significant focus on mental health crisis care services and improvements have been made. The action plan focuses in on a few areas where we know there are still issues to address and gaps to fill.

4.5 We have developed a 24/7 mental health liaison team in A&E and we have expanded and are continuing to expand the availability of a community based response for people with a mental health crisis. We have also services from the third sector to complement statutory services and to support people who might not traditionally access mainstream services. We have set up the Lighthouse Service to work with people with personality disorder who are often frequent users of A&E. And we have worked closely with organisations such as MIND to raise awareness of local crisis care services.

4.6 We have identified 4 areas where further significant work is still needed and this is what our action plan focuses on.

i *Embedding the latest round of changes to the urgent care pathway*

£283k is being invested in extending the operating hours of the community mental health rapid response service until 10pm. The service is also being integrated with the assessment and treatment service. These 2 changes will enable the resources to be used more flexibly and should make it more possible for the service to respond to requests for community based visits. We are also embedding nurse prescribing in the team so there is least reliance on medical support from a psychiatrist and the availability of medical support to the team is also being strengthened. These changes build on changes to the urgent care pathway that were implemented in January 2013 . Coupled with the Mental Health Liaison Team at A&E, it means that we have a 24/7 access to face to face and telephone expertise from a mental health professional for any adult experiencing a mental health crisis. This is a key component of the Crisis Care Concordat.

ii *Strengthening the crisis support arrangements for children and young people*.

The stocktake highlighted the fact that we do not have comparable crisis care arrangements for children and young people. Provision does exist but we do not think it is sufficient The standard response time from tier 3 CAMHS (Sussex Partnership Foundation Trust) is

to provide a first contact response to urgent referrals within 4 hours. This applies to referrals within or outside of normal hours. The Sussex Mental Health Line is able to provide telephone advice overnight. In addition the CAMHS Crisis Resolution and Home Treatment service (CRHT)/ Urgent Help service adds to existing packages of care for children and young people with acute mental health needs. The service operates 0900-2000 weekdays with a weekend service in order to meet crisis and home treatment needs during this period.

As part of the review of CAMHS more generally we are scoping out the feasibility of 24/7 mental health liaison service in the Royal Alexander Children's Hospital as well as the availability of 24/7 telephone support.

iii *Reducing the number of people take to custody after they have been picked up by the police under section 136 of the Mental Health Act.*

4.7 In Brighton and Hove there are 2 places of safety where people can be taken when they have been picked up on a section 136 – Hollingbury police custody suite and the purpose built section 136 suite at Millview. In 2013/14 167 people were taken to the custody suite and 103 were taken to Millview. In some parts of the country no one is taken to police custody. Sussex is an outlier nationally.

4.8 There are a number of reasons why this is the case locally including

- staffing levels and the presence of severely unwell people on the wards at Millview have meant that sometimes the suite has had to be closed
- occasionally exclusion criteria applied by Millview have meant patients have been turned away from the suite
- the suite at Millview is only able to accept one patient at a time so at busy times when the suite is in use other patients have had to go to custody

4.9 A number of actions have been agreed locally to address this problem, specifically;

- SPFT is considering whether the suite could be expanded to accommodate more than one person at a time;

- the pathway between the police and the mental health liaison team and the mental health rapid response service is going to be strengthened through awareness raising but consideration is

also being given to providing the police with more support from each of these teams which could potentially avoid someone being sectioned on a S136 altogether

4.10 In other parts of the country the introduction of street triage is being used to reduce the number of people picked up on a section 136 and ultimately reduce the pressure on places of safety. This arrangement is currently being piloted around the country. We will await the outcome of the evaluation before making a decision as to whether this is something we will implement in Brighton and Hove and assess how this fits with the improvements that have already been made to the urgent care pathway

iv *Ensuring that people are conveyed to the place of safety in an ambulance*

Currently in Brighton and Hove patients are conveyed to the places of safety in caged police vehicles. Everyone agrees that this is not acceptable. Negotiations are underway with SECAMB to build this activity into their contract from April.

Next steps

4.11 We are currently seeking sign up to the action plan and an accompanying declaration of support from senior officials from Sussex Partnership Foundation Trust, Brighton and Hove City Council , Brighton and Sussex University Hospital, the third sector, ambulance service, SCT and Sussex police.

4.12 Subject to securing HWB approval and once we have secured support from local stakeholders the action plan and declaration will be submitted to the Department of Health and we will put in place arrangements to deliver and oversee the action plan.

4.13 There has been user engagement that has informed the urgent care pathway changes (outlined above) and we will continue to work involve users and carers in the development of the crisis care plan.

5. Important considerations and implications

5.1 Legal

5.1.1 There are no legal implications arising from this paper.

5.2 **Finance**

5.2.1 Most of the planned improvements can been made within existing resources although additional resources are required to implement the changes to the pathway for children and young people . A bid was made to NHS England for some non-recurrent to resilience money that was available for mental health. Unfortunately the bid was unsuccessful. The CCG is currently assessing whether additional resources can be prioritised for implementation in 2015-16.

5.3 **Equalities**

5.3.1 An equalities impact assessment was carried out as part of the urgent care work undertaking in 2012 and this will be updated to take into account the next stage of our plans.

5.4 **Sustainability**

5.4.1 There are no relevant sustainability implications in this paper.

5.5 **Health, social care, children's services and public health**

5.5.1 The action plan has been developed collaboratively with key partners across the health and social care system in Brighton and Hove.

6 Supporting documents and information

The following documents are attached:
Appendix A local stocktake against the Concordat
Appendix B action plan

The following document has been placed in Members' Rooms and published as a supporting document on the council's web site:
Appendix C the Concordat

A. Access to support before crisis

When I need urgent help to avert a crisis, I, and people close to me, know who to contact at any time, 24 hours a day, seven days a week. People take me seriously and trust my judgement when I say I am close to crisis, and I get fast access to people who help me get better.

A1 Early intervention – protecting people whose circumstances make them vulnerable

Please say how you will improve outcomes for people approaching crisis point.

24/7 crisis support is available for people experiencing a crisis in their mental health. This support comprises

- 24/7 access to telephone support from mental health professionals
- community based crisis support (9am -10pm) that is able to respond within 1 hour and is able to attend to people in setting of their choice – this is for people known and not known to services
- 24/7 mental health liaison team (for adults) at local A&E
- round the clock access to medical support including assess to OOH support via an on call rota
- signposting to services by NHS 111
- care plans for everyone known to services include details about how to access services in the event of a crisis
- web based information about how to access local crisis support services is widely available – key information points include the local MIND website, SPFT website, CCG and BHCC websites
- awareness in primary care of what is available
- availability of 24/7 crisis response home treatment team which provides supports in the community to enable them to remain at home when they are unwell. Where appropriate this team will facilitate admission to a bed
- 27/7 access to telephone support from mental health professionals – CAMHS Consultant on call
- CAMHS specific Urgent Help Service (CRHT) available until 8pm weekdays and 10am until 6pm weekends and bank holidays

The Lighthouse service supports people with a diagnosis of personality disorder. Members of this service have access to:

- A 7 days a week partnership service
- Individualised Care Plans
- Peer support workers
  Web-based support (IRIS)

IBIS Plans:
All adult patients identified as frequent attenders have updated information regarding needs and crisis support pathways uploaded onto IBIS.

All patients on CPA have an up to date Crisis Plan that they, their GP and other services/individuals (e.g. Carers) involved in their treatment and support are aware of that specifies individualised crisis/ risk management strategies and pathways, relevant contact numbers etc.

The early intervention psychosis service offers:

- Crisis Plans which are developed in collaboration with patients based upon work to help identify when they might be experiencing a deterioration in their mental health and detailing strategies which might be employed to help with this. Crisis plans also provide contact details for support when EIP staff are not available
- Risk assessments are undertaken at the point of entry into the service and are based upon referral information, discussions with the patient and where possible carers and family (see below). They are reviewed regularly and in response to changes in the levels and nature of risks. Risk assessments are used as a basis for Risk Management plans.
- Where the patient has given their permission (18+) carers and family members are involved in planning patient care, the identification and management of risks
- Where permission has not been given carers and family members can be supported through the provision of more general information regarding contact numbers in the event of a deterioration in the patient's mental health and by information regarding psychosis.
- All medical reviews are shared with the patient's GP
- Crisis plans, contingency plans and the overall care plan are reviewed regularly.

The city has an annual suicide prevention action plan. This is agreed by a multi-agency group, chaired by the Director of Public Health, and includes representatives from mental health secondary and primary care services, the Mental Health Liaison Team at A&E, CCG, voluntary sector, police, probation, ambulance and fire &rescue services, and Universities. The action plan for 2013-14 includes:

- identification of hotspots (on seafront and railways) and action to address this – signage, training, CCTV at stations;
- clinicians' meetings to identify learning from individual deaths by suicide, bringing together GP and mental health services staff;
- training for acute staff in A&E on self-harm, designed to raise awareness

and challenge stigma – audits show this has been effective;
- advice sent out to GP practices on debt, financial difficulty and mental illness;
- leaflets for the public, for the LBGT community developed and resources for those bereaved by suicide in development;
- training on suicide prevention, self-harm, mental health awareness for those working with a range of vulnerable groups, including BME, LGBT, those in contact with criminal justice system, high risk occupations, etc.
- Grassroots Suicide Prevention is working towards 'Suicide Safer City' status for Brighton & Hove; this includes training, tackling taboos about open discussion, and the development of Suicide Safer Organisations.

We have secured funding to develop crisis support for people with a learning disability. This service is still being scoped.

Have you considered:
- How to make people aware of who to contact in a crisis
- A combination of early intervention services that meet local need
- Joint crisis care planning
- The role of primary care
- Vulnerable groups, including BME communities, people with learning difficulties, people with physical health conditions, people with dementia and children and young people
- Suicide prevention

This checklist is based upon the 'I' statements made within the Concordat. It is intended as a prompt to help people working on local Declarations develop local action plans.

B. Urgent and emergency access to crisis care

If I need emergency help for my mental health, this is treated with as much urgency and respect as if it were a physical health emergency. If the problems cannot be resolved where I am, I am supported to travel safely, in suitable transport, to where the right help is available.

I am seen by a mental health professional quickly. If I have to wait, it is in a place where I feel safe. I then get the right service for my needs, quickly and easily.

Every effort is made to understand and communicate with me. Staff check any relevant information that services have about me and, as far as possible, they follow my wishes and any plan that I have voluntarily agreed to.

I feel safe and am treated kindly, with respect, and in accordance with my legal rights.

If I have to be held physically (restrained), this is done safely, supportively and lawfully, by people who understand I am ill and know what they are doing.

Those closest to me are informed about my whereabouts and anyone at school, college or work who needs to know is told that I am ill. I am able to see or talk to friends, family or other people who are important to me if I so wish. I am confident that timely arrangements are made to look after any people or animals that depend on me.

B1 People in crisis are vulnerable and must be kept safe, have their needs met appropriately and be helped to achieve recovery

Please say how you will ensure that people in mental health crisis will not be turned away but will be safe and find the support they need 24/7.

Face to face and telephone crisis support is available across the city 24/7.

People who present at or who are taken to the Royal Sussex County Hospital will be supported by the Mental Health Liaison Team (Adults). This team has access to a dedicated room where patients can be supported in a calm and safe environment.

The ambulance and police services is aware of the support options and is able to call though to services to service to establish whether community support can be provided or whether the patient needs to be taken to hospital.

Where practical community based crisis support can be provided to support patients outside of hospital settings.

The ambulance service has access to IBIS records for around 100 adult mental health patients, including many frequent callers which provide key information about a patient's needs. This information is intended to enable the ambulance crew to provide the most appropriate level of response.

Presentations to Ambulance Services / 999

- Emergency Operations Centres (EOC) and 111 have access to both mobilising an ambulance response, accessing crisis services and GP Out of Hours services
- By encouraging other health providers to use IBIS there will be greater knowledge of an individual's needs and both routine and crisis care plans
- NHS Pathways modules are in place to allow for the assessment of MH

crisis and both local and national variations are being produced to reflect the urgent response required

- SECAmb will always seek to convey patients to the most appropriate destination according to their health needs which may mean A+E or another destination subject to local agreements
- Control Centre Protocols for decision making / directed access to different options e.g. as above as alternatives to blue-light attendance
- Control Centre / Data-base with details of known mental health patients Conveyance to A&E if necessary / indicated.
- Where young people/children are frequent callers SPFT works with police to share relevant information about the care plan with consent

Have you taken account of:

- All agencies the person may turn to first
- Options that are community-based, close to home, least restrictive and appropriate to the individual

B2 Equal access

Please say how you will address equality of access and outcomes for people in mental health crisis, with particular reference to engagement with BME communities.

Written information about local crisis services is available in a variety of languages and formats

Translation and interpretation services are available for NHS services 24/7 at short notice

Equality and diversity training is a mandatory training requirement for all staff.

All services have an identified BME Lead who links into services to ensure service provision is culturally appropriate/ diverse. All services have undergone an EHIRA.

All ambulance policies and procedure are subject to EA process and cannot be approved without this process

B3 Access and new models of working for children and young people

Please say how you will ensure children and young people with mental health problems have access to crisis care.

Tier 3 of CAMHS offers community based crisis support for children and young people between 9am – 5pm , Monday to Friday . The T3 CAMHS Team has a dedicated daily Duty Clinician and Duty Psychiatrist who are able to respond to urgent and emergency referrals and offer support and assessment when required. T3 CAMHS provides a 4 hour response to urgent referrals where required and offers assessment and treatment advice to colleagues at the RACH including on site assessments when necessary.

Tier 4 – Acute services are provided in the form of inpatient, day, and crisis resolution and home treatment services. The Crisis resolution and home treatment (CRHT) is accessed via tier 3 services and emergency presentations in Accident and Emergency departments or in relation to the mental health act. The CRHT is the gateway to an inpatient mental health bed if this is required. This service is age appropriate and delivered in line with Quality Network for Inpatient CAMHS standards and currently has an outstanding rating.

The service has the following key features, (Every Child Matters, DH 2003), which provides a statement of both its values and its commitment to a comprehensive CAMHS provision based on assuring multi agency and multi-disciplinary working:

- Child and young person focussed
- Family friendly
- Have an ability to meet the most complex mental health needs of children and their families.
- Be part of a network of care for children and young people with severe, challenging and complex problems.
- Be able to provide intensive home treatment for 3-5 face to face contacts per week. Specialist consultation and advice to Tier 3 teams.
- Provision of initial assessment of referrals in order to detail goals prior to admission if required which will occur in close collaboration with locality Tier 3 services.
- Intensive home and community assessment and treatment for young people and children whose needs can be met whilst remaining at home. Without this service they would require admission into hospital.
- Facilitating prompt and timely discharge from the in-patient setting with follow up work when indicated.
- Contributing to the 24/7 face to face and on-call crisis assessment where acute interventions are determined to be necessary (provided in conjunction with the in-patient service), alongside working age services.

The primary purpose of the CAMHS CRHT is to provide an intensive home treatment service to children and young people who are presenting with acute

mental health needs or emotional disturbance to a degree where the levels of risk they pose indicate an inpatient admission may be necessary. This will enable young people where possible to be supported in remaining at home and reduce the need for an inpatient admission and ensure appropriate and a timely access to and discharge from the inpatient service.
In addition, the service will respond to mental health crises of children and young people out of normal office hours as well as undertaking a gate-keeping role for admission to the CAMHS Tier 4 Day & Inpatient Adolescent unit. The inpatient accommodation at Chalkhill is purpose built for the age group.

Teen to Adult Personal Advisors (TAPA) is a young person's mental health service (14-25 years) provided by SPFT in partnership with Sussex YMCA, Impact initiatives and Allsorts to meet the mental health needs of young people across the city who are `hard to reach`. They use an assertive outreach approach that is holistic and person-centred which means they will meet with, engage, advise and support young people wherever they feel most comfortable.

Have you addressed:

- Age-appropriate accommodation for under-18s
- Support for young people making transitions into adult services
- Involvement of parents
- Robust partnership working and communication between primary and secondary care agencies
- Involvement of schools and youth services
- Keeping children and young people informed about their care and treatment

B4 All staff should have the right skills and training to respond to mental health crises appropriately

Please say how staff will gain the knowledge, awareness and skills needed for multi-agency working in crisis response

All SPFT staff undergo Mandatory Training in respect of Clinical Risk Assessment and Management, Care Programme Approach and Safeguarding – which, in addition to core clinical assessment, escalation and care planning elements include guidance and support in respect of multi-agency pathways and partnership working.

All staff engage in regular clinical and managerial supervision, case load review sessions and multi-disciplinary clinical team meetings where specific patients, pathways, care plans and multi-agency working needs and arrangements are

discussed.

Specific pathways, referral and joint care planning arrangements/ protocols are in place between core adult mental health services and Substance Misuse and Secure and Forensic Services.

Grassroots is a local voluntary organisations that supports the prevention of suicide. It is commissioned to raise awareness about and provide training and education to frontline professionals about suicide and self-harm. Commissioners are also currently procuring mental health awareness training as well as training about mental wellbeing awareness and promotion.

Youth projects and organisations including Right Here and RUOK ? have carried out training in primary care to support clinicians to understand young people's needs.
In the ambulance service

- all University Qualified Paramedics have received education and experience in a Mental Health Setting
- There have been local initiatives to raise the awareness of MH in Ambulance Staff
- Paramedic Practitioners complete a module on Mental Health as part of their training programme
- Paramedic Practitioners also receive update training and a 1 day placement with a crisis team
- There is also the possibility of an e-learning package to be available for all staff via the Trust's e-learning website

In the Summer of 2014 Sussex Police revamped and updated the training for officers and staff, specifically the Communications lesson plan. This plan now focuses on mental ill-health. The session includes group work on how to identify signs and symptoms of mental ill-health and then develops into a group discussion on what officers / staff could do to adapt their communication style to assist them in dealing with the situation they are involved in. The session balances the need to make adjustments with their own personal safety and dealing with the circumstances that called for a police presence. A practical scenario has also been trailed and this is under review to ensure it adds value. This lesson plan now forms part of all Sussex Police programmes (Regular Officers, Specials, PCSOs, and

Police Staff).

In addition, Sussex Police call handlers now receive a bespoke training package on mental health and how to communicate with someone over the telephone that is in distress and seeking help and support.

Sussex Police works closely with our partner, Sussex Partnership NHS Foundation Trust as their staffs play a key role in training Police officers and staff. The Police, Courts, Liaison and Diversion practitioners deliver training to Custody officers and staff and Street Triage nurses working with uniformed officers in Eastbourne provide on-going support and advice to a wide range of officers and staff.

There is also the computer based training package from the National College of Policing "Responding to people with mental ill health or learning disabilities" and this is mandatory training for key groups of officers and staff.

There are also pockets of training being provided with local groups and organisations and Sussex Police is constantly striving to ensure we provide our staffs with the right training to be able to deliver an excellent service to the public in Sussex who have a mental illness, learning difficulty or vulnerability.

Have you addressed:

- Management advice and support
- Awareness of local mental health and substance misuse services and how to engage them
- Training arrangements across NHS, social care and criminal justice organisations
- Understanding of locally agreed roles and responsibilities

B5 People in crisis should expect an appropriate response and support when they need it

Please say how you will ensure a prompt, high quality response that works towards the Access to services statement in NICE's Quality standard 14 for service user experience in adult mental health

24/7 crisis support is available across the city – see response to A1 for details.

Specific response times details:
Community mental health crisis: 4 hour response time from initial referral/ contact by patient/ referrer.

A&E: 1 hour response time for urgent referrals to the Mental Health Liaison Team

(adults).

Mental Health Act Assessment/ AMHPs:4 hours to assess and 6 hours to complete assessment for both adults and children and young people

There are plans to increase the availability of OOH face to face support for patients under the secondary mental health services (moving to an extended community-based Duty/ Crisis Response service available until 10pm, 7 days a week).

There is access to telephone support 24 hours a day, 7 days a week via the BURs service (24/7), support by the provision of the Mental Healthline OOH.

T3 CAMHS provides a 4 hour response to urgent referrals where required and offers assessment and treatment advice to colleagues at the RACH including on site assessments when necessary.

Have you addressed:

- Time from referral to face-to-face assessment
- 24 hour helpline
- 24/7 availability of crisis resolution and home treatment teams
- Commissioning that allows for beds to be readily and locally available in response to urgent need
- Commissioning provision for under 18 year olds that ensures local provision for young people in urgent need
- Availability and use of crisis plans and advance statements

B6 People in crisis in the community where police officers are the first point of contact should expect them to provide appropriate help. But the police must be supported by health services, including mental health services, ambulance services, and Emergency Departments.

Please say what you will do to ensure sufficient NHS places of safety, reduce the inappropriate use of police custody suites as places of safety, and put in place a local protocol for the approach to be taken when a police officer uses powers under the Mental Health Act.

Section 136:

- There is an NHS purpose built S136 suite/ place of safety
- There are agreed operational protocols and pathways (including Authority to Exclude from NHS Place of Safety) and regular multi-agency (police, CCG, NHS/LA) meetings to review working arrangements and activity/ exceptions relating to use of S136 and police/ NHS place of safety facilities
- There is an AMHP and S12 medic on-call rota

- AMHP response times: 4 hrs to commence and 6 hrs to complete assessment
- Qualified nursing staff undertake mandatory Fitness to Detain training
- The mental health in-patient facility has a dedicated Unit Co-ordinator (24/7) who supports admissions and the operation of the NHS 136 Suite

Mental health is Police business but often the Police are the only agency who can provide a truly 24/7 response in a timely manner. If there were safe alternatives or services who could intervene at the time the person was having their crisis and in the location where the crisis occurs, Police would not have to use their powers of detention under s136 mental health Act 1983 as often.

Once someone is detained under s136 they must be removed to a place of safety. The Mental Health Codes of Practice have always stated that Police cells should only be used as a place of safety in exceptional circumstances.

Exceptional has never been defined but should really be held for those people who are so violent that they need to be physically restrained, and if released could seriously hurt themselves or others. There are inherent dangers with physically restraining someone in this situation for any period of time, especially when they are displaying signs of excited delirium or other medical conditions. Police officers cannot be expected to medically diagnose someone at the scene of an incident.

They should have immediate access to a medical professional with the option of taking the person to A&E for an emergency medical intervention if required. If there is no physical emergency but the person is violent then a Police cell is probably more appropriate. It should never be the case that someone is refused access to an alternative place of safety because it is closed due to lack of staff, because the person is displaying disturbed behaviour or they are intoxicated. This is not exceptional, this is the norm, and Police cells are then used as the default position and the regular backup to the NHS.

The mental health Codes of Practice state that a mental health assessment should begin within 4 hours of the person being ready to assess and completed within 6. This is usually not complied with as depending on time of day and day of week, it may not always be possible for an AMHP and Doctor to be available together. People detained in Police custody are not seen as a priority for an assessment; there are no fast track options to have people assessed. Statistics show that a child or young person detained under s136 will remain in the cell longer than an adult waiting for an assessment due to the shortage of specialists in this field.

Transfers between places of safety do occur but this is rare. It is incumbent on the Custody staff to keep contacting the hospital place of safety to see if there are

able to accept the detainee and at busy times in custody it is not always possible for the staff to keep calling. The hospital places of safety rarely if ever call custody to say they are free to take someone.

In each area there is a multiagency group who monitors the use of s136 within that locality; it looks at reasons for refusals and closures of the place of safety.

Have you addressed:

- Timescales for health and social care services to respond to police
- Police officer training
- What happens if a police cell is used – fast-tracking assessment or transfer, data recording, review and learning
- Ensuring any use of police stations is truly exceptional
- The needs of children and young people
- Healthcare staff taking responsibility
- Timeliness of assessments
- Understanding of roles and responsibilities and arrangements for escalation

B7 When people in crisis appear (to health or social care professionals or to the police) to need urgent assessment, the process should be prompt, efficiently organised, and carried out with respect

Please say how you will ensure that people who need formal assessment under the Mental Health Act will receive a prompt response and that arrangements for their care, support and treatment are put in place in a timely way.

Protocols that have been developed and shared with all the relevant agencies that set out the arrangements for supporting people who need formal assessment under the Mental Health Act. These protocols include

- the arrangements for securing an approved mental health professional to carry out the assessment
- details about the role of the unit co-ordinator
- arrangements for emergency admission to beds
- arrangements for supporting people detained under S136 of the Mental Health Act

Access to local in-patient beds if required:

- Bed Management function: 24/7 support for in-patient facilities to support AMHPs and other professionals seeking access. OOH escalation process via on-call Manager and Director if required.
- Commissioners have agreed additional local overflow provision if required (Hove Priory).

Monthly joint police/NHS meetings review use of NHS and Police Places of Safety. Reviews include detailed analyses of the Authority to Exclude cases. Protocol recently reviewed and revised to support increased use of NHS Place of Safety. Staff recently updated re, communication and training in relation to Authority to Exclude.

T3 CAMHS provides a 4 hour response to urgent referrals where required and offers assessment and treatment advice to colleagues at the RACH including on site assessments when necessary.

Have you addressed:

- Best practice guidance on timescales for section 12 doctors and approved mental health professionals (AMHPs), i.e. within 3 hours
- Assessment of children and young people
- Bed availability and sufficient provision of AMHPs
- Least restriction and avoiding stigmatisation

B8 People in crisis should expect that statutory services share essential 'need to know' information about their needs

Please say how you will introduce appropriate data sharing about people's needs and circumstances

SPFT is committed to further increasing the use of IBIS records so that the ambulance service has access to key information regarding patients, particularly those who are frequent callers and attenders. These records include information about any advance statements, crisis plans, dependents, communication requirements and physical impairments.

Multi- disciplinary team meetings take place to share information about complex patients and to ensure that crisis plans are developed and shared.

SPFT have robust clinical governance and safeguarding polices and procedures in place. All patients have a level one risk assessment which will determine if escalation to a mutli-disciplinary level two assessment is required. In certain very complex cases, clinicians can call upon the Trustwide Clinical Risk Panel for review and input to the formulation and planning processes.

SPFT have a Lead Nurse for Safeguarding and a named doctor who can provide specialist advice and support into complex Safeguarding cases for adults and children.

Pan-Sussex information sharing protocols and procedures are in place to support sharing of essential information relating to risk management and Safeguarding issues.

S115 Crime and Disorder Act 1998 gives a Relevant Authority the power (not the duty) to share information in a wide range of circumstances, including the prevention and detection of crime, If there is a risk of harm to the person, or a risk of harm to others (including children). Information sharing should be proportionate and justified but it often needs to be exchanged fast time. Many medical practitioners are nervous about giving out information and will seek authority to do. This can cause unacceptable delays and before the information has been provided an irreversible decision has been made.
There needs to be clear and robust information sharing agreements in place that staff members can read and understand that cover emergency and slow time situations. In an emergency situation there needs to be a member of staff immediately available to take the request from the enquiring agency and respond.

The Police Courts Liaison and Diversion Service and the Street Triage Service have specific information sharing agreements between the relevant authorities involved in delivering the service. The ability for information to be shared in these instances has been invaluable and are at the foundations of both services.

Have you addressed:

- The range of information that may need to be shared including communications needs, physical impairments, crisis plans and advance statements, and any dependents.

B9 People in crisis who need to be supported in a health based place of safety will not be excluded

Please say how you will ensure that people are not excluded from health-based places of safety / Emergency Departments due to intoxication, history of violence or lack of appropriate provision for people with personality disorder

There are 2 places of safety in Brighton – Millview Hospital and Hollingbury police station. The only reasons that a person will be excluded from accessing the suite at Millview is if they being actively violent or threatening and in these cases individuals will be taken to police custody.

If the Unit Co-ordinator at Millview is seeking to exclude a detained person from the Suite and they are not currently violent or aggressive then they will need to demonstrate robust risk information to support their decision.

As referenced previously there is an agreed Authority to Exclude policy and protocol and exceptions are routinely reviewed in monthly joint police/NHS meetings. This policy is included in the on-call Manager's guidance to support Manager's involved in any escalations.

Unit Co-ordinators and qualified (Band 6) nursing staff all undertake Fitness to Detain training. Beyond issues of active violence/ aggression – if a patient has a suspected head injury or may have been the victim of a serious crime (requiring the immediate support of the FME) they will probably be unsuitable for the NHS Place of Safety.

The Lighthouse (previously outlined) provides additional community-based support for patients with PD (excluding Anti-social PD) with a view to reducing/ preventing crises emerging.

Have you addressed:

- Staff skills in screening, assessing, diagnosing and monitoring people who are intoxicated
- What circumstances may pose too high a risk
- Commissioning of services that can respond to the needs of people with personality disorder and prevent escalation into crisis, in line with NICE guidance

B10 People in crisis who present in Emergency Departments should expect a safe place for their immediate care and effective liaison with mental health services to ensure they get the right ongoing support

Please say how you will ensure that Emergency Departments provide a safe place for people in crisis and that people receive treatment that is on a par with standards for physical health, with adequate liaison psychiatry services in place, and a local forum for agreeing protocols and escalation issues.

A dedicated room is available to the mental health liaison team to support patients.

Clear protocols exist between A&E and the mental health liaison team for referral between services. Once a patient is deemed by A&E staff to be medically fit, onward referral to the MHLT can be progressed.

There are clear KPIs in relation to response times for the MHLT receiving urgent/priority referrals from A&E:

- *1 hour response*. The team is expected to be able to triage and assess a patient with an urgent need within an hour of the request being made or within an hour of the patient becoming medically fit.

- *4 hour response*. The team is expected to provide a 4 hour response, where the mental health problem is putting the patient's physical health, other patients of staff at immediate risk.

As referenced previously all MHLT staff are suitably qualified and skilled in assessing, care planning and liaising in relation to patient's presenting with mental health issues/ crises. All MHLT and CRHT staff undertake the ASSIST training in addition to Mandatory training requirements relating to assessing mental health presentations, risk assessment and management, MHA/MCA and PMVA.

If any form of restraint is required whilst a patient is attending A&E/RSCH – this duty rests with BSUH staff.

It is our intention to invest in children and young peoples crisi services as follows:

Crisis pathway and acute mental health liaison

There is some psychological support at The Royal Alex Children's Hospital (RACH) for children with long term conditions, but not for those who attend A&E and/ or are admitted in a crisis. There is a recognised need for mental health liaison with RACH but the exact model has yet to be defined and depends on the demand, need and acuity of children and young people. This would need to be for Sussex residents as well as Brighton and Hove as RACH take children and young people from a wide catchment area. The intention is to invest in 2015/16 in this service.

The aim of the service would be to:

- Improve the quality of care for those experiencing mental problems whilst they are being cared for at Royal Sussex County hospital (RSCH) and/ or Royal Alex Children's Hospital (RACH) and to integrate mental health care with physical health care;
- Enhance the skills of non-mental health professionals to better equip them to support patients with a mental health problem;
- Reduce emergency admissions and A&E attendances for children and young people with mental health problems by:
  providing a rapid access assessment and treatment for patients experiencing a crisis in their mental health
  securing onward referral to community mental health services where appropriate;
  providing telephone advice between 8pm and 8am;

- Provide in patient mental health care to patients when they have been admitted to both short stay wards as well as general hospital wards, where there is concern over their mental state; and
- Reduce the length of stay for patients following admission by planning for discharge as soon as a patient is admitted.

Have you addressed:

- Safe, appropriate and respectful treatment of people who are suicidal or self-harming
- Identification of mental health problems and referral
- Staff skills in connection with suicide risk, including NICE guidelines and legal requirements
- Emergency Department staff's adherence to the NICE quality standard on self-harm
- Ensuring that the use of restraint procedures is safe and that there is provision for the safe use of rapid tranquillisation in Emergency Departments – see NICE guidance on the management of disturbed behaviour and Positive and proactive care: reducing the need for restrictive interventions.

B11 People in crisis who access the NHS via the 999 system can expect their need to be met appropriately

Please say how the 999 system ensures an appropriate response.

There is 24/7 access to mental health advice and support for all professionals via the community and A&E BURs service.

MHLT offer student placements to ambulance, BSUH and other health and social care staff.

People calling 999 will be assessed by SECAmb via NHS Pathways, there are also Clinical Supervisors (Paramedics and Nurses) who can assist in complex calls and upgrade response as required.

In some areas staff and EOC can access Crisis teams direct and OOH services can be contacted directly by staff at scene and EOC

All 999 calls to the Police in Sussex are taken by experienced call handlers and Police officers. None of these call handlers are nurses or are employed to give advice regarding mental health or physical health. The call taker records all necessary information and depending on the nature and degree of risk will assign a Police response accordingly. Our call handlers will engage people in distress in a

conversation and do all they can over the telephone to keep that person safe. The only response we have is to send a Police officer and if it's obviously a physical injury/need then we will contact the ambulance service and ask them to attend.

The Police have no agreements with any other health teams or services to respond to incidents that have a clear mental health element to them. The Police have no access to GPs, and if they do, many GPs will not even tell the Police whether someone is registered with their practice. The officer will usually attend the incident knowing very little if anything about the person is distress but will ultimately do all they can to ensure the person's safety.

Have you considered:

- Mental health advice available to the 999 ambulance control room 24/7
- Enhanced training for ambulance staff
- Flexible working across ambulance trust boundaries.

B12 People in crisis who need routine transport between NHS facilities, or from the community to an NHS facility, will be conveyed in a safe, appropriate and timely way

Please say how you will ensure safe, appropriate and timely transport.

As per S6 MH Act – police do not convey patients who are detained/ require conveyance following decision to detain to in-patient units.

1. SECAmb currently only commissioned to provide S136 transport in Kent area, consequently in Brighton and Hove police vehicles are generally used to convey individuals to the place of safety
2. Commissioning of this activity is required
3. Currently the only vehicles available to transport in an emergency would be a Double Manned Ambulance
4. PTS vehicles may be used for routine or less acute presentations not requiring an emergency response

In line with the mental health Codes of Practice the Police service would rather people were conveyed by Ambulance in a timely manner and not conveyed by Police vehicles. In cases of exceptional violence when a Police vehicle would be the most appropriate method of transport a medical professional (paramedic) should travel with the detained person til they arrive at the place of safety or A&E.

Currently, once someone is detained under s136 mental health Act 1983 the only vehicles they are transported in, to the place of safety are Police vehicles. The vehicle could be a marked Police car, an unmarked Police car (street triage only)

or a marked caged Police van.

Following an assessment in the community if there are unacceptable delays in the ambulance service responding or the ambulance service are refusing to take the patient then they will be transported in a Police vehicle, unless the AMHP is prepared to arrange a private ambulance, which would be the preferred choice of the Police.

Have you made sure that:

- Police vehicles are not used to transfer patients between units within a hospital
- Caged vehicles are not routinely used.

B13 People in crisis who are detained under section 136 powers can expect that they will be conveyed by emergency transport from the community to health based place of safety in a safe, timely and appropriate way

Please say how you will ensure safe, appropriate and timely transport.
See above

Are you:

- Meeting response times and standards in the national ambulance service protocol
- Avoiding the use of police vehicles and caged vehicles.

C. Quality of treatment and care when in crisis

I am treated with respect and care at all times.

I get support and treatment from people who have the right skills and who focus on my recovery, in a setting which suits me and my needs. I see the same staff members as far as possible, and if I need another service this is arranged without unnecessary assessments. If I need longer term support this is arranged.

I have support to speak for myself and make decisions about my treatment and care. My rights are clearly explained to me and I am able to have an advocate of support from family and friends if I so wish. If I do not have capacity to make decisions about my treatment and care, any wishes or preferences I express will be respected and any advance statements or decisions that I have made are checked and respected. If my expressed wishes or previously agreed plan are not followed, the reasons for this are clearly explained to me.

C1 People in crisis should expect local mental health services to meet their needs appropriately at all times

Please say how you ensure that there is a safe response to crisis 24/7, on a par

with that for physical health emergencies.

Services that support people experiencing a crisis in their mental health do operate to standards that correspond to the standards expected in physical health care crisis management. Individuals requiring support in the community as well as in A&E can expected to be supported within 1 hour.

As with physical health the crisis services have performance measures which are monitored by commissioners.

All in-patient facilities including the NHS Place of Safety are SSA compliant. There is no use of CCTV in the NHS Place of Safety.

Does the service response provide for the dignity of the person in crisis?

C2 People in crisis should expect that the services and quality of care they receive are subject to systematic review, regulation and reporting

This is mainly a Care Quality Commission responsibility but please say how, as service providers, you will monitor the quality of your response to people in crisis.

The performance and quality of local services is reported on monthly to commissioners and monthly performance and quality meetings also take place

There are multi agency monthly meetings held in the localities of the s136 places of safety where any adverse issues can be raised.

All officers whether operation or in custody must document when they have used force on a person, this is internally monitored.

There are monthly meetings within Sussex Police to monitor the safety of all people detained in Police custody in line with the Guidance on the safer detention and handling of persons in Police custody. There are also standards set within the Police and Criminal Evidence Act 1984, Codes of Practice, which must be met.

Any complaints made about someone's care whilst in the "Care" of Sussex Police will be internally investigated in the first instance either by the appropriate Inspector or the Professional Standards Department. We are also regularly inspected by Her Majesty's Inspector of Constabularies, a member of whom is from the CQC. There is also scrutiny from the Independent Police Complaints Commission.

C3 When restraint has to be used in health and care services it is

appropriate

Please say what you are doing to implement the guidance Positive and proactive care and the Mental Health Act 1983 Code of Practice in relation to restraint.

SPFT have an annual PMVA Training Plan and have established a PPC Forum to review and revise current policy and operational protocols to align with recent guidance (PPC, April 2014).

SPFT have a Zoning Protocol to ensure that risk management and PMVA approaches are aligned to patient need and presentation.

Following a Safer Staffing review staffing levels are routinely monitored and issues can be escalated to on-call Managers OOHs to ensure safe staffing levels are adhered to at all times.

Local protocols are in place between SPFT and the police in relation to the management of violent/aggressive patients when accessing/ in-patient in NHS facilities.

Police should only be called to assist staff when they have effectively lost control of a violent patient. Police should not be called because there is not enough appropriately trained staff available to assist with the control and restraint of a patient. The Police intervention should be minimal and once control is regained the patient should be immediately handed back to the care of the nursing staff and the Police leave. Patients should be managed within the hospital and there should not be an expectation that Police will remove a patient into the cells because the hospital cannot safely manage their patient.

If nursing staff are trained, but unwilling to restrain a violent patient then it is not reasonable for the Police to be asked to do so.

Have you addressed:

- Staff training
- Staffing levels
- Protocols for if the police are called to manage patient behaviour, and ongoing mental health staff responsibility for the patient's health and safety.

C4 Quality and treatment and care for children and young people in crisis

Please say how you will ensure that the treatment and care of children and young people is appropriate to their needs, and that they are informed, involved and enabled to have a voice

SPFT CAMHS have operational protocols, policies and training in relation to Care Planning, Risk Assessment and Management and Crisis Plans – which include advanced directives and care plans where appropriate.

The voice of the children and young people is central to the planning and delivery of individualised plans of care. All children and young people are given the opportunity to meet with a CAMHS clinician alone. Gillett competency is always considered where appropriate.

Once assessed and treatment is indicated each child and young person has an allocated CAMHS Lead Professional who ensures that the service user and their family are fully informed, involved and have a voice in the collaborative treatment process.

CAMHS is actively encouraging of user involvement. The Brighton CAMHS team has allocated staff who take a specific interest in engaging young people in service development, design and delivery. The CAMHS Team has established good links with the local MIND young person's representative. Young people are involved in the recruitment and interview of CAMHS staff where appropriate with the support of MIND.

Service user participation is a standing agenda item on CAMHS Business Meeting Agenda's and Local Governance Forum Agenda's.

The TAPA Team is a discretely commissioned team of Teen to Adult personal advisors who engage with young people who are unable to engage with Tier 3 CAMHS. It is a A Young Persons Mental Health Service (14-25 year olds)

TAPA is a service provided by Sussex Partnership NHS Foundation Trust in partnership with the Children & Young Peoples Trust, Sussex Central YMCA, Impact Initiatives and Allsorts to meet the mental health needs of young people across the city who are 'hard to reach' by current mental health services or who themselves find current mental health services 'hard to reach'.
TAPA workers provide direct mental health work to young people and young adults and advice, consultation and training to professionals and young people. Supporting where appropriate access to mainstream mental health services

In addition there are a number of 3rd sector drop in centres across the city where young people can access information and support . These services can also sign post and refer young people to crisis support if appropriate.

Have you addressed:

- Age appropriateness of information and approaches to involvement

- Advocacy and support to make complaints
- Family contact
- Treatment close to home
- Key worker support
- Age appropriate environments

D. Recovery and staying well / preventing future crises

I am given information about, and referrals to, services that will support my process of recovery and help me to stay well.

I, and people close to me, have an opportunity to reflect on the crisis, and to find better ways to manage my mental health in the future, that take account of other support I may need, around substance misuse or housing for example. I am supported to develop a plan for how I wish to be treated if experience a crisis in the future and there is an agreed strategy for how this will be carried out.

I am offered an opportunity to feed back to services my views on my crisis experience, to help improve services for myself and others.

Please say what you will do to optimise recovery and prevention.

SPFT operational protocols, policies and training in relation to Care Planning, Risk Assessment and Management and Crisis Plans – which include advanced directives and care plans where appropriate.

There is a Long Term Service User policy and protocol in place to support the re-referral of patients back to specialist services if required following discharge.

All patients have a care plan and have information on how to access support and treatment in times of crisis. Care planning is undertaken in a person-centred manner in consultation with patients/ carers/ other professionals as required.

SPFT have worked with commissioners to establish and implement Dual Diagnosis Care Plans to support integrated working between mental health and substance misuse services working collaboratively with patients.

There are a range of mental health and criminal justices services/ initiatives supporting patients including a Mental Health Court Diversion Service and RMNs based in custody suites across the City.

Have you addressed:

- Crisis planning including advance statements – see NICE guidance on crisis planning

- Entry and discharge criteria including fast track access back to specialist care for people who may need it in future
- Protocols for people not eligible for the Care Programme Approach, for accessing specialist and social care
- Integrated, person-centred pathways
- Coordinated approaches for people with co-existing mental health and substance misuse problems, with service specifications that require a speedy crisis response
- Joined up support in criminal justice settings.

Crisis care arrangements for adults and young people in Brighton and Hove

Context

The urgent care pathway for adults experiencing a mental health crisis has been the focus of much work and investment in Brighton over recent years. And whilst there are still improvements to be made we have got the foundations of a service for adults that reflects the spirit of the Concordat. However all local partners acknowledge that the main area where work needs to be done is addressing the problem we have locally whereby a disproportionate number of people being picked up by the Police on a Section 136 are being taken to custody rather than being supported in the Place of Safety in our local mental health hospital. The other area for local development that has been acknowledged is, putting in place crisis support arrangements for children and young people and this is the subject of a local review .

A detailed analysis of crisis care arrangements is available on request. But the key features are

- 24/7 telephone and face to face support from a mental health professional for adults comprising a 24/7 team in A&E and community based team which can carry out community visits between 8am until 8pm
- crisis planning for all patients subject to the Care Programme Approach (CPA) and IBIS records (ambulance records) as appropriate for people discharged from Mill View and frequent callers / attenders to both out of hours and urgent care services.
- specialist services for people with personality disorder and perinatal mental health problems
- specialist support commissioned from the 3rd sector services to complement statutory services – this include the provision of an information and advice service

Areas for further development and timescales for delivery

Area for development	Actions to be taken	Timetable	Responsibility
Enhancing the community response for adults in crisis	Extending the opening hours of the community based mental health rapid response service until 10pm to reduce the need for individuals to go to A&E Introducing nurse prescribing into the mental health rapid response service to enable more timely availability of medication where required Integrating the mental health rapid response service with the Assessment & Treatment service duty system so that people known and new users have equitable access to a crisis response On-going promotion of the availability of the mental health rapid response service. Continued focus on the development of IBIS plans for known and frequent users so that the ambulance service has key information about prospective callers. Expanding the availability of the Lighthouse service for people with personality disorder so that an alternative to A&E and psychiatric admission exists for more people with a personality disorder.	January 2015	Sussex Partnership Foundation Trust (SPFT) South East Coast Ambulance Service & Sussex Partnership NHS Foundation Trust
Reducing the number of people taken to custody when picked up by police under s136 of the Mental Health Act and ensuring that children	To develop a plan in Brighton and Hove so that children and young people are not taken to custody as a place of safety from April 2015. Link with potential new mental health liaison service at RACH (see below)	Jan-March 2015	CCG, SPFT, Brighton and Hove City Council, and Sussex Police

and young people are not taken to custody as a place of safety from April 2015	To consider whether it would be possible to utilise duty doctors at Mill View Hospital to provide required medical input to hospital place of safety.		SPFT
	To review the escalation policy for the hospital place of safety so that communication about when the suite is not available , and when it is open again following a closure, is communicated to the police in a more timely and consistent way and so that commissioners are also notified.		SPFT, Sussex Police
	To continuously review the s136 activity data and to provide regular multi agency challenge to all cases taken to custody.		CCG commissioners
	To define CCG expectations for the use of the hospital place of safety and hold SPFT to account through contract monitoring		CCG commissioners SPFT & CCG Commissioners
	To consider whether the hospital place of safety could be reconfigured to accommodate more than one person at a time. This would also require a review of staffing arrangements across the acute unit. This would need to be done against the backdrop of the proposed changes to the rules around what can be designated a place of safety		
	To ensure a sustainable Approved Mental Health Professional Service is available throughout Brighton & Hove on a 24 hour basis		BHCC
	To ensure robust availability of a S12 trained doctor for Mental Health Act activity across a 24 hour period		CCG Commissioners/NHS England
	To consider using the hospital places of safety routinely to support assessment under Section 135 Mental Health Act		SPFT/CCG commissioners
	To strengthen the links between the MHLT and mental health rapid response service through further awareness raising. And to scope out		

	the possibility of the police having more direct access to both teams prior to a Section 136 being put in place. To consider whether any of the principles of the street triage model could be embedded into the existing urgent care pathway once the proposed integration of the mental health rapid response service and ATS has taken place. This could for example include considering whether there is scope for a member of the community based mental health rapid response service being more available to support the police at key times over the weekend . To further review the case for street triage using by developing a data set to support an economic evaluation of the urgent care investment activities including the Lighthouse and combination of Enhanced BURS and the ATS duty service. To complete this work in conjunction with the evaluation of the national street triage pilot and other actions to increase the usage of the hospital place of safety.		SPFT/CCG commissioners/Sussex Police SPFT/CCG commissioners
Ensuring that adults and young people picked up by the police under S136 are generally conveyed to the place of safety by ambulance and not a police vehicle	To negotiate with SECAMB that this activity is incorporated into the 2015/16 contract with clear timescales for delivery	For inclusion in SECAMB contract from 1 April 2015	CCG commissioners and SECAMB
Put in place crisis response arrangements for children and young people so that they have information about and access to support	As part of the Joint Strategic Needs Assessment for children and young people's emotional health and mental wellbeing, current crisis response and care will be considered and recommendations made to improve the service accordingly. A whole system review, consultation and service improvement for children's emotional health and mental wellbeing services for Brighton and Hove. Part of the review will develop service	Spring 2015 2015/16	Public Health CCG Commissioners

	improvements in crisis response and care for children and young people, their families/ carers.		
	Development of a crisis pathway and acute mental health liaison team at The Royal Alex Children's Hospital in Brighton within 2015/16. The team would provide support for children and young people who attend A&E as well as supporting them and the hospital staff if they need to be admitted and through to discharge home. They would also provide a telephone support line and the service would be available out of hours.	2015/16	CCG Commissioners
	Scope the potential to expand the established IBIS anticipatory care programme for adults, to children and young people who repeatedly require services due to crises, whereby (with their consent) their care plans are uploaded on to the SECAMB system so that SECAMB can be made aware of the plan and act accordingly.	2014/15	CCG Commissioners, SPFT and SECAMB
	Continue to ensure that where appropriate, SPFT share part of child's or young person's care plan with Sussex Police or other agencies so that they are aware of the plan and act accordingly.	2014/15	SPFT and Sussex Police

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Brighton and Hove Clinical Commissioning Group Commissioning Intentions 2015/16

1.1 The contents of this paper can be shared with the general public.

1.2 This report is for the Health & Wellbeing Board meeting on the 9th December 2014.

1.3 This paper was written by:

Ramona Booth, Head of Planning and Delivery, Brighton and Hove CCG.
Email: Ramona. Booth@nhs.net
Geraldine Hoban, Chief Operating Officer, Brighton and Hove CCG
Email: Geraldine.hoban@nhs.net

2. Summary

2.1 As part of the CCGs annual planning programme emerging commissioning intentions are shared with stakeholders, partners, patients and the public and provider organisations.

2.2 Following consultation and feedback the finalised Plan for 2015-16 will come back to a future meeting of the Health and Wellbeing Board for final sign off and will subsequently be published in April 2015.

2.3 The attached document sets out the emerging commissioning intentions of the CCG for the period 2015/16. These build on existing plans and are informed by needs assessment.

3. Decisions, recommendations and any options

3.1 That the Health and Wellbeing Board note the draft commissioning intentions of the CCG for the period 2015-2016.

3.2 That the Health and Wellbeing Board gives its opinion on whether the draft commissioning intentions 2015-1016 take proper account of the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment.

4. Relevant information

Background and Context

4.1 The CCG Strategic Commissioning Plan 2014–2019 outlines clinical priorities and commissioning programmes over five year period and is aligned to the Joint Health and Wellbeing Strategy.

4.2 In 2014 the CCG developed an operating plan which outlined how, over the two year period 2014-2016, the CCG planned to deliver its strategic goals.

4.3 The two and the five year plan were approved by the Health and Wellbeing Board in June 2014.

Refreshing the Plans

4.4 This year the CCG are required to refresh the second year of its Operating Plan. To do this we will revisit our existing plans and update where necessary based on the Joint Strategic Needs Assessment and detailed needs assessments undertaken in the past year.

4.5 During 2014 we have developed the themes from our strategic plan in to a number of detailed implementation plans including the Better Care Plan, Wellbeing Strategy, The Primary Care Strategy and the Operational Resilience and Capacity Plan. Collectively these will form the basis of our 2015/16 plans.

4.6 In addition to delivering the strategic direction for the CCG these commissioning intentions must also take into account national planning guidance as it emerges. Detailed planning guidance and financial allocations will be confirmed in December 2014.

Consulting and Developing

4.7 Whilst our commissioning plans are refreshed on an annual basis our engagement programme runs throughout the year. During this year we have engaged with:

- our member practices: bi-monthly discussions with each of our three Localities on commissioning plans;
- patients and the public: regular public events discussing key themes including frailty, Happiness and proactive care;
- Excluded communities: regular meetings with and feedback from third sector organisations contracted to provide feedback from traditionally excluded groups such as LGBT, gypsies and travellers, disabled people;
- Patient and Participation Groups: via the PPG Network and Governing Body Lay representation;
- The City Council: co-produced plans such as the Better Care Plan, Happiness Strategy;
- Neighbouring CCGs and co-commissioners from NHS England: Whole system plans, such as the Operational Capacity and Resilience Plan, developed in conjunction with other NHS commissioners and overseen by the System Resilience Group;

4.8 A summary of our draft commissioning intentions will be sent to all members of Patient Participation Groups and distributed widely across the City. Feedback can be submitted via the CCG website or at the public event in January 2015.

5. Important considerations and implications

5.1 Legal

5.1.1 The National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) requires Clinical Commissioning Groups to consult the Health and Wellbeing Board on its draft commissioning plan and seek the Board's opinion as to whether the draft takes proper account of the joint health and wellbeing strategy. The Health and Wellbeing Board must also be consulted on further revisions or drafts.

Legal comments from Elizabeth Culbert 28.11.14

5.2 **Finance**

5.2.1 Commissioning Intentions are required to include broad financial assumptions for the CCG only. These are included in section 3.

Finance comments from Debra Crisp 28.11.14

5.3 **Equalities**

5.3.1 Equality Impact Assessments will be conducted on specific commissioning plans.

5.4 **Sustainability**

5.4.1 Section 9 in the attached document deals with sustainability.

5.5 **Health, social care, children's services and public health**

5.5.1 Public Health has been involved in the identification of commissioning priority areas and production of the Commissioning Intentions document.

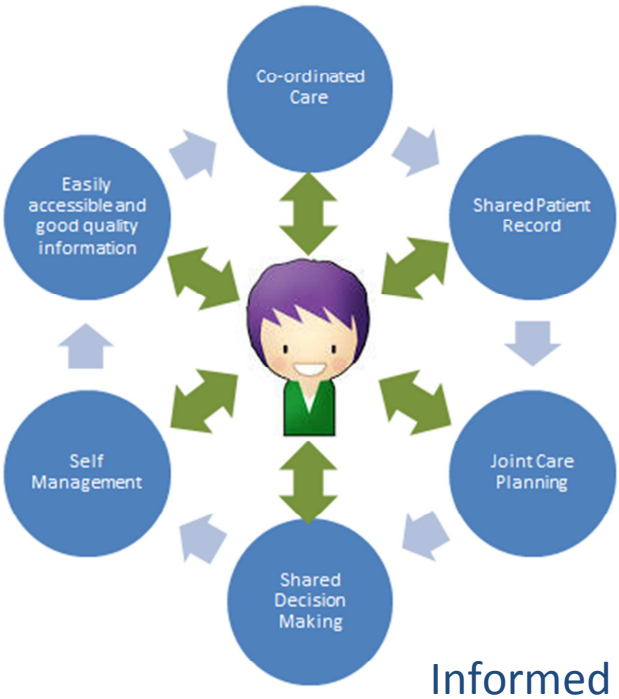
6 Supporting documents and information

6.1 Appendix 1 - Brighton and Hove CCG Draft Commissioning Intentions

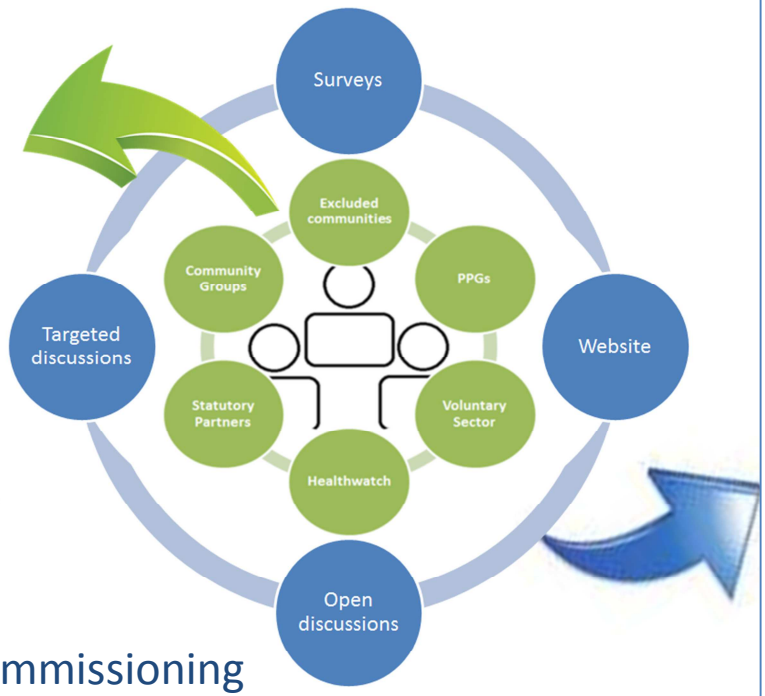
Brighton and Hove CCG Draft Commissioning Intentions

2015/16

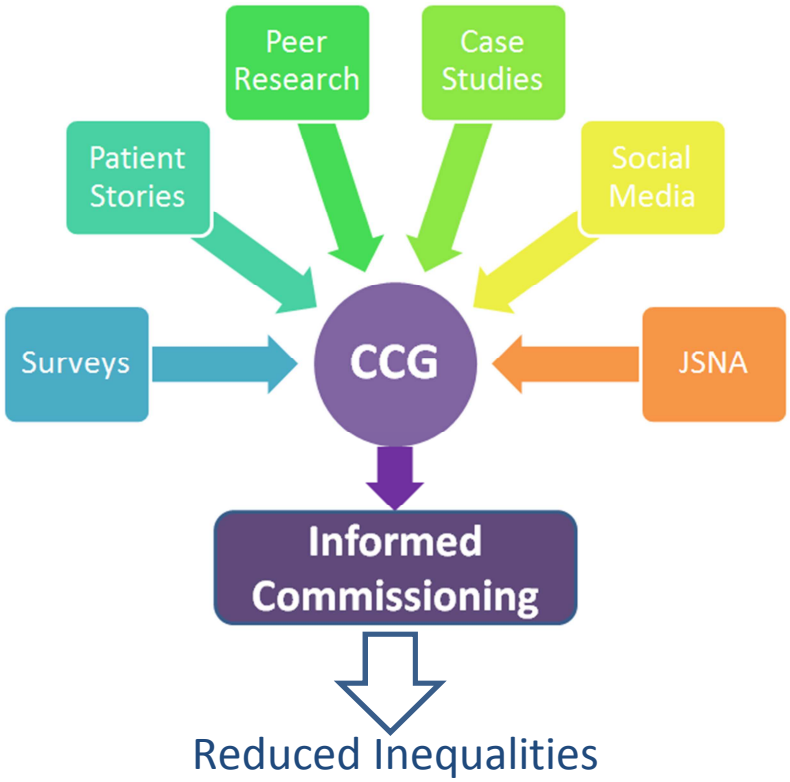
Empowered Patients



Involved Public



Informed Commissioning



Contents

1. Introduction

Last year the CCG produced a 5 Year Plan setting out its long term strategic objectives and an Operating Plan which outlined how, over the two year period 2014-2016, the CCG planned to deliver its strategic objectives.

This year the CCG are required to refresh the second year of its Operating Plan. To do this we will revisit our existing plans and update where necessary based on the Joint Strategic Needs Assessment and detailed needs assessments undertaken in the past year. We will work with our partners to ensure that our commissioning intentions align with other strategic plans in the city.

During 2014 we have developed the themes from our strategic plan in to a number of detailed implementation plans including the Better Care Plan, Happiness Strategy, Primary Care Strategy and the Operational Resilience and Capacity Plan.

This document brings together the commissioning intentions from the existing plans and identifies areas where needs assessment suggest we need to focus our attention in 2015/16. These commissioning intentions are draft and will be developed over the coming months in light of national guidance and detailed financial analysis. A final plan will be produced and published in April 2015.

2. Developing our plans

Our Commissioning Intentions have been pulled together following an extensive year-round engagement process with:

i. our member practices: bi-monthly discussions with each of our three Localities on commissioning plans;
ii. patients and the public: regular public events discussing key themes including frailty, Happiness and proactive care;
iii. Excluded communities: regular meetings with and feedback from third sector organisations contracted to provide feedback from traditionally excluded groups such as LGBT, gypsies and travellers, disabled people;
iv. Patient and Participation Groups: via the PPG Network and Governing Body Lay representation;
v. The City Council: co-produced plans such as the Better Care Plan, Happiness Strategy;
vi. Neighbouring CCGs and co-commissioners from NHS England: Whole system plans, such as the Operational Capacity and Resilience Plan, developed in conjunction with other NHS commissioners and overseen by the System Resilience Group;

A summary of our draft commissioning intentions will be sent to all members of Patient Participation Groups and distributed widely across the City. Feedback can be submitted via the CCG website or at the public event in January 2015.

3. Financial and planning context

National planning guidance, including guidance on financial allocations, will be published in December 2014. For the purposes of this document we have used last year's planning assumptions. These numbers are therefore a guide and will be subject to change.

Table 3.1: Initial Planning Assumptions

	2015-2016
Growth on CCG Opening Allocations	2.00%
Tariff (Mandatory)	-1.10%
Non Mandatory (Non-PbR, Tariff)	-1.30%
Activity Growth	2.35%
CQUIN	2.50%
Prescribing Inflation (before new drugs)	5.00%
Contingency	0.50%
Integrated Transformation Fund (est)	3.00%
Non Recurrent Expenditure Reserve	2.00%
Planned Surplus (1)	1.50%

We are currently reviewing actual and planned expenditure, to evaluate the impact of existing cost pressures in future financial years and to fully understand the impact of the use of non-recurrent funding sources for some schemes.

New funding will need to be identified where schemes are expected to continue, but are not currently included in 15/16 plans.

A number of factors are likely to impact on the financial position in 15/16, which will become clearer in the next few months once the financial framework is published and the roll forward position becomes clearer.

4. Service Specific Commissioning Intentions

4.1.Community Services

Our longer term approach to community services, as described in our Better Care Plan, is to develop integrated care focused on our frail and vulnerable residents. Substantial change to the way the system works together to provide care and community services are a key part of this programme. Services will be redesigned and care will be provided by multi-disciplinary teams based around clusters of GP practices, building on the Integrated Primary Care Team model.

Comprehensive assessment and care planning are essential components of the Better Care Programme. We will bring together a wide range of views from clinicians, health care professionals, individuals and their carers to develop a standard assessment and care plan. With the support of IM&T we will develop a secure electronic method of shared access across the system.

Personal Health Budgets are a key aspect of personalisation - with the aim of improving outcomes by

placing individuals at the centre of decisions about their care. By working alongside health service professionals to develop a care plan, and through taking ownership of a known budget, individuals will achieve greater choice and control of the services required to support their needs. The PHB project is integral to the CCG vision for the local frail population by actively promoting individual's ability to stay healthy and well by providing 'whole person care', promoting independence and enabling people to fulfil their potential..

The table below sets out the key 2016 work programmes which come under the banner of Better Care:

Table 4.1.1: Better Care Projects

Work stream	Description
Integrated Frailty	We will bring together the learning from the phase 1 practices and other related projects such as proactive care and EPIC. This will be used to shape the future integrated model of care. During 15/16 we will evaluate phase 1, design and implement phase 2.
Integrated Homeless	
Personalised Care Planning	
Personal Health Budgets	For 15/16 the proposal is to extend PHBs beyond continuing healthcare in line with the NHS Mandate objective to offer PHBs to those in the community who may benefit from them. The focus will be on implementing PHBs for a small cohort of patients with long term conditions through the Better Care Frailty Phase 1 and Homeless workstreams.

Whilst we are working on our longer term plans for integration, we will continue to strengthen our community services. Demand in terms of both volume and complexity continues to rise. We have strong services to prevent hospital admission and are continuing to strengthen services to facilitate earlier discharge from hospital as well as enhance some of our smaller more specialist community services. We need to strengthen our specialist community services and move to a model whereby they can consistently support more generic primary and community teams with the care for patients with complex needs as well as the develop the skills within the broader primary care and community workforce. The table below describes areas we intent to explore over the coming months:

Table 4.1.2: Community Services Work Streams

Work stream	Description
Integrated Respiratory Service	Brighton & Hove has the highest proportion of COPD admissions accounted for by multiple attenders in Kent, Surrey and Sussex. Currently 46% of admissions coded as 'COPD' are those who have also been admitted in the previous year. There is scope to improve outcomes for our population by redesigning the model of care. There are numerous examples of integrated respiratory models. The evidence from elsewhere suggests demonstrable improvements can be made by the system working with a more coordinated approach: for example preventing premature mortality relating to COPD, improved patient outcomes in terms of health-related quality of life, as well as reductions in A&E attendances and unnecessary emergency admissions through timely diagnosis and access to evidence based treatments

Work stream	Description
Lower Urinary Tract (LUTS) Pathway	The vast majority of people with LUTS are referred into secondary care (Urology). Evidence suggested that many of the referrals into secondary care that could have been supported within primary or community care settings The proposal is to explore diverting activity from secondary care through the enhancement of capacity in SCT's bowel and bladder services.
Lymphedema Pathway	NICE guidelines 'Improving Supportive and Palliative Care for Adults with Cancer (2004)' make a clear recommendation about the need for lymphedema services, the various service levels that need to be available to manage complex cases and also preventative work. There are potential links with tissue viability services for many lymphedema patients so the proposal is to develop an integrated tissue viability and lymphedema service that is accessible to adults with any form of lymphedema. At the present time we estimate that between 10-30% of people with lymphedema in the city are receiving a specialist service.
Anti-coagulation	During 2012 there were some major changes in the guidance on the treatment for the prevention of stroke and systemic embolism in atrial fibrillation. Three new oral anticoagulation (NOAC) drugs have come onto the market. Two of these, Dabigatran etexilate (March 2012) and Riveroxaban (May 2012), have NICE approval and the third, Apixaban has a final appraisal determination. None of these drugs require the regular monitoring that warfarin requires. Since 2012 there has been on-going growth in prescribing of NOACs and they currently account for around 7.5% of anticoagulant prescribing. The proposal is to re-tender the service in line with the CCG's procurement requirements and to assess the impact on the NOAC's in terms of any new model of care.
Short Term Services	Review the model for step up/step down and rehabilitation services ensuring we have the right model and capacity within the City. We need to provide services that ensure people avoid being admitted to hospital wherever possible and following a stay in hospital they are discharged appropriately and their independence maximised.

Work stream	Description
Dementia	Key findings from the 2014 JSNA for dementia were that the city has some pockets of excellent dementia services, but they are not always joined up and there are some gaps. We need to take more of a whole system approach to the way we commission dementia services. Key recommendations include the need for better/more: • Diagnosis and earlier intervention • Joined up services that support patient centred care • Carers support • Support to local community services • Training and education A Dementia Plan has been produced which was formally signed off by HWB in October 2014. It aims to treat dementia as a 'long-term condition', aligning dementia services with physical health services so a holistic approach is taken to the care of people with dementia. Better Care Funds of £250K have been identified and new multi-agency Dementia Partnership Board has established to agree prioritisation of funds oversee the delivery of the Plan.

4.2.Mental Health

Brighton and Hove has comparatively high levels of mental health need. Strategically our approach to improving mental health is to prevent ill-health developing. This requires a whole system response to address some of the broader risk factors relating to mental illness such as employment and housing.

The national strategy No Health Without Mental Health provides the overarching framework and Brighton and Hove now has its own local Happiness Strategy to improve mental health and wellbeing which aims to make mental health part of everyone's business. This local strategy represents a real change in direction from our historical approach which was largely been about the strategic direction of mental health services rather than the way the whole system can work together.

Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s. It is therefore essential that we have the right support early on in people's lives to help to prevent mental illness from developing and to mitigate its effects when it does.

Over the last few years our strategic approach has been to shift from inpatient care to community care and we have reduced our local adult inpatient acute bed capacity by 20% and re-invested this funding into community services.

The plan is to continue to strengthen mental health pathways and services providing as much support in the community wherever possible and also integrating mental health support.

The Mental Health Crisis Care Concordat sets out expectations that "No one in a crisis will be turned away". The CCG is working with local stakeholders to ensure local delivery which involves embedding already agreed changes to the urgent care pathway, making sure we have comparable crisis care arrangements for

children, and trying to ensure as few people as possible are taken to custody under s136 of the Mental Health Act .

From 1 October 2014 the CCG took back commissioning responsibility for child and adolescent mental health from Brighton and Hove City Council. This provides us with an opportunity to ensure there is sufficient focus on supporting mental health at a young age as part of an overall system of care as well as ensuing there are effective pathways at the transition point into adulthood. We know from local intelligence that there are improvements we need to make to services and the system of care and we are planning to undertake a local multi-agency review of emotional health and mental wellbeing support to children and young people which will be underpinned by a joint strategic needs assessment. This piece of work will inform future models of care for the City.

Mental Health is also key to our Better Care Plans both the frailty and the homeless work programmes Work is on-going to work out how resources can best be aligned to the new cluster based multi-disciplinary teams that are being developed.

Table 4.2.1: Mental Health Work Streams:

Work stream	Description
Improved Complex Trauma Pathway	The complex trauma pathway is fragmented and there are gaps in terms of provision. The majority of sexual and domestic abuse counselling is not commissioned but funded by recipients and charitable funding. The proposal is to develop a complex trauma pathway for survivors of sexual abuse and domestic abuse.
Psychological Interventions to People with Psychosis	A recent audit indicated people with psychosis under the care of Sussex Partnership Foundation Trust highlighted that their care packages included limited availability of psychological therapy despite evidence of the effectiveness of family therapy and Cognitive Behavioural Therapy. NICE recommends that all people with psychosis should be offered one or both of these interventions.
Psychological Support "gap" between Primary and Secondary Mental Health Services	Preparation for Payment by Results in Mental Health has mapped optimal care pathways against current service availability. This has identified a group of people whose needs may fall between a gap in service. Typically, the needs of this group are too complex for the Wellbeing services but not severe enough to require the coordinated multi-disciplinary input of secondary care mental health services. The detail of the service model is being worked through but could include the community and voluntary sector and/or an extension to the Practitioner role which is provided as part of the Wellbeing Service.

Work stream	Description
Development of a Pathway for Medically Unexplained Pathway	MUS are common [20% of Primary Care Consultations and up to 50% outpatient attendances across all specialities], Patients can be repeatedly investigated and referred but in only 5-10% of cases will an organic cause be found for the symptoms. Invasive investigations increase morbidity and mortality and presentation with MUS is associated with twice the standardised mortality ratio for cancer, accidents and suicide. This proposal is for a Stepped care model for recognition, assessment and treatment of MUS.
Strategic Review of emotional health and wellbeing pathways for children and young people	We spend £2.4 million on CAHMS and most of this in the more intensive treatment end and comparatively little in terms of prevention. The CCG spend on CAMHS is about 5% of the mental health spend on adults. The proposal is to under-take a multi-agency review of child and adolescent mental health services to inform a new model of care for emotional health and mental wellbeing support to children and young people.
Extension of the Mental Health Liaison Team to Children and Young People	The 24/7 Liaison Team at the County Hospital is for adults only and there is not psychological support available for children and young people who attend A&E and/ or are admitted in a crisis. Within RSCH approximately 300 under 18 year olds who are admitted with a mental health issue each year. We have recently seen an increase in the number of young people presenting with self-harm, eating disorder and conversion disorder. There has been an increase of 40% in rate of self-harm among young people presenting at A&E from 2010 until 2013 with increased acuity

4.3.Urgent Care

We recognise that to have a resilient urgent care system we need to significantly change our models of care, particularly, for older people from a reactive bed based service to one that is more proactive, integrated and responsive to what people want. The key mechanism for delivering this change will be the Better Care Programme.

We will continue to focus on urgent care, working as a system to reduce the numbers of people attending A&E, supporting the delivery of the 4 hour standard and streamlining pathways into, within and out of hospital.

In particular, we will continue to work with the trust to deliver significant reductions in ambulance handover delays and to sustain consistent achievement of the 4 hour standard beyond March 2015 onwards following successful implementation of the Operational Resilience and Capacity Plan. The table below outlines the key components of that plan:

Table 4.3.1:Urgent Care Work Stream

Work stream	Description
Supporting patients and the public to access care	We will continue to develop and implement our local communications strategy building on the work already started via the We could be heroes campaign.
Delivering the 4 hour A&E standard	We will continue to work in collaboration with our local acute hospital to achieve sustainable improvement in the 4 hour A&E standard and in ambulance handover delays.
Reducing ambulance conveyance	We will develop our local approach to contracting and commissioning of ambulance services that is much more responsive to local need and priorities.
Integrated Urgent Care model	We intend to accelerate work already commenced in 2014/15 to develop an integrated primary care led service as the entry point to urgent care in the city. Urgent care provision in Brighton and Hove is complex and difficult for patients and professionals to navigate, with the default position often being ringing 999 or attending A&E. With the implementation of NHS 111 and further changes to GP opening times, the time is right to look at this resource as a whole and seek to develop and implement an integrated urgent care model that makes sense for patients and clinicians. We will be conducting an option appraisal towards the end of 2014/15 aiming for implementation of the agreed model in 2016/17.
Acute Assessment Pathways	Building on the work commenced in 2014 we will expect to see further expansion in ambulatory care and acute assessment pathways and will seek to formalise a local tariff for non-admitted activity.

4.4.Planned Care (including Cancer)

We will be seeking to implement a number of planned care pathways changes or service developments over the coming year including:

- The development of a Community Irritable Bowel Syndrome (IBS) service
- The development of new direct access diagnostics pathways e.g. 24hr ECG, endoscopy etc.
- We will seek to commission repeat chest x-rays following abnormal results without the referral going back to the GP
- A review of the use of direct access diagnostics by primary care
- Implementation of ae neurology virtual clinic including direct to diagnostic and one-stop services

Cancer is a priority in Brighton and Hove CCG's 2 year Operating Plan. The CCG has established a Cancer Action Group and are in the process of developing a detailed work plan. The CCG priorities are aligned to the Cancer Strategic Clinical Network's (SCN) strategy for improving cancer detection and care. The CCG are also working with the SCN to reconnect the cancer commissioning pathway which has become fragmented since the NHS reorganisation of 2013 when Sussex Cancer Network ceased to operate.

The programme of work will be structured around the following key themes:

- Promoting the uptake of cancer screening programmes
- Early diagnosis in primary care including 2 week wait referrals and conversion rates and improved

access to diagnostics
- Reducing diagnosis in A&E and other emergency settings
- Pathway redesign work with secondary care (particularly for colorectal and lung cancers) to reduce the possibility of avoidable delays in care and treatment
- Education of GPs, health professionals, patients and carers about cancer risks, early diagnosis and survivorship

A summary of the potential workstreams is contained in the table below:

Table 4.4.1: Planned Care Work Streams

Workstream	Description
Irritable Bowel Syndrome	The main purposes are: - to support people with IBS without referring them to hospital - release capacity in secondary care for patients who need acute services - to support primary care by proving a more specialist service for those patients who need more time and/or a higher level of clinical knowledge of IBS The service will provide dietary and lifestye advice and will support patients in informed self-management, providing a range of information and resources. The service will signpost patients to psychological support if needed. The service will provide a patient helpline.
Direct Access Diagnostics	The CCG is working with stake holders to review current Lung, Colorectal, Breast Prostate pathway for patients who need CT in line with the Cancer Outcomes Strategy 2011 which recommended GPs have direct access to chest x-rays; brain MRIs; abdominal/pelvic ultrasound
Increase endoscopy capacity	Explore increased awareness and use of the iron deficiency anaemia (IDA) clinic and redesign the CCG anaemia pathway to take into account the positive predictive value of IDA in over 65s
Screening	Improved uptake of breast screening across all demographics with an impact on diagnostics
Living Beyond Cancer Survivorship	we will work with the trust to improve the percentage of patients offered a treatment summary completed at the end of each acute treatment phase, sent to the patient and GP

4.5.Children and Young People

Earlier this year the CCG took back commissioning responsibility for children and young people's community paediatric and therapy services from Brighton and Hove City Council. The table below outlines the areas where we need to focus in 15/16.

Table 4.5.1: Children and Young People Commissioning

Supporting Primary Care	• Children's urgent care pathways, to embed local and national guidelines and best practice, cascading training to all members of the team and to ensure prioritisation of reassurance to families of under 5s;

	• Children with disabilities and complex needs – ensuring these children and young people can easily access appointments that recognise their individual needs; holding a register of these children and providing input to their transition to adult services; • Multi-disciplined working around children and young people with complex needs, ensuring agreed identification of cases with other professionals: e.g. Mid Wives; Health Visitors and School Nurses; Paediatricians; CAMHs and proactive approaches to working as part of a team around these children and young people.
Supporting Communities Therapies	Development of therapeutic support and pathways for children with medically unexplained symptoms and chronic pain management all of whom require input from OT, Clinical Psychology and physiotherapy. There is currently no such service available and we need to undertake a scoping exercise to understand the level of need.

4.6.Maternity

Maternity services in Brighton and Hove are provided by Brighton and Sussex University Hospitals Trust; there is an Obstetric Led Unit at the Royal Sussex County Hospital site or women can choose to have a home birth which accounts for about 5% of local births. Brighton does not provide full choice of birth place as it does not have a midwifery-led unit. Following initial delays there are now plans being developed for such a service that will provide for increased capacity, a co-located birth centre and a women's health centre for both ante natal and gynaecology outpatients. The current timescale for the completion of all this work is 2015.

We will be working with neighbouring CCGs on the development of the Maternity Dashboard with regular informative narrative. We also expect to work closely with maternity services on a realistic plan to improve the numbers of normal births. We intend to develop a service specification for maternity services and work with key stakeholders to ensure that the Birthing Unit is developed to reflect the needs of the local population.

4.7.Medicines Management

Moving into 2015-16, we will continue to work with partner commissioners, providers and other organisations to optimise medicines use in all care settings for our population, to ensure that patients get the best possible health outcomes from the investment that we make in medicines and other prescribed items.

We will continue our current work plan by consolidating the roll out of governance systems for high cost drugs (Blueteq) and continue at pace the delivery of system-wide and online formularies. We will also focus on the implementation of NICE Guidance and on prescribing in key therapeutic areas such as for those with long-term conditions.

We will continue with the managed entry of new drugs via the Brighton Area Prescribing Committee as a governance structure to reflect the needs of the local health economy. We will engage with neighbouring

CCGs and providers to ensure that medicines which are evidence based and affordable are made available to the general public whilst delivering value for money when committing the use of public funds.

5. Reducing Inequalities

In order to address the gap in life expectancy and improve mortality and morbidity in the City overall, the CCG plans to commission a range of high impact, evidence based interventions to improve health outcomes in 2015/16 based on the outcomes of the premature mortality audit.

6. Primary Care Development

In July 2014 the CCG Governing Body approved the Primary Care Strategy, which set out the CCG vision for Primary Care and General Practice in Brighton and Hove.

"We see high quality primary care as the foundation on which to build the very best healthcare for the population of Brighton and Hove. In order to achieve this we will need to 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".

We have established a Primary Care Transformation Board to oversee this significant area of development in 2014/15. Key to the Board's areas of responsibility will be to:

- Commission a range of services in Primary Care via a new offer to General Practice, an appropriately costed city-wide Locally Commissioned Service (LCS) that addresses key areas of health inequality, improves clinical outcomes and shifts the model of care to one that is more proactive and preventative for our most frail population;
- Oversee the development of a collaborative model of primary care in order to respond to the City wide LCS and build a more resilient and sustainable model of provision in the City;
- Manage the process for receiving primary care commissioning responsibilities back from NHS England, ensuring the governance around this is robust;
- Strengthen the mechanisms for reporting on and addressing issues relating to the quality of care in general practice.

7. Quality and Safety

Quality and safety in the delivery of health services, is the fundamental core to the roles and responsibilities of every commissioning and provider organisation. Within Brighton & Hove Clinical Commissioning Group (CCG), quality is defined as clinical effectiveness, patient experience and patient safety. We are committed to ensuring patient focussed outcomes arising from the standards should be embedded in service redesign, planning and commissioning and that all contracts are robustly monitored , in order to provide assurance that the quality standards and outcomes are being met.

8. Sustainability

8.1.Commissioning for Sustainability:

- 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.
- Fully utilising contractual levers to ensure sustainable practice within commissioned services.

8.2.Being Sustainable as an Organisation

- Ensuring we have energy efficient business processes;
- Paying our staff the City's living wage;
- Providing a workplace which facilitates health and wellbeing.

8.3.Leading our Member Practices

- Supporting general practice with energy audits and top 10 high impact actions;
- Addressing areas such as medicines wastage;
- Facilitating enablers such as the roll out of electronic prescriptions;
- Agreeing a programme of work with member practices and developing a "sustainability pledge" for members.

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Early Help and the Stronger Families, Stronger Communities programme

1.1 The contents of this paper can be seen by the general public.

1.2 This paper is for the Health & Wellbeing Board on the 9th December 2014

1.3 This paper was written by:

Steve Barton, Assistant Director, Stronger Families, Youth & Communities
steve.barton@brighton-hove.gov.uk

2. Summary

2.1 To seek agreement to proceed with the next stage of the children's Early Help Partnership Strategy and the expanded national Troubled Families programme.

2.2 In January 2014 the council and our partners published a Partnership Early Help Strategy setting out 5 priorities to improve Early Help services for families.

2.3 Since then we have worked with the Local Safeguarding Children's Board (LSCB) to publish a 'Thresholds document' which describes when to refer a child or family to child protection or early help services. We have set up a new Multi-Agency Safeguarding Hub (MASH) and an Early Help Hub (EHH) to deal with those referrals.

2.4 We have also successfully delivered a Stronger Families, Stronger Communities (SFSC) programme - our local version of the national Troubled Families programme. The national Troubled Families Unit has therefore offered us the opportunity to become an 'early starter' for the new expanded national programme from January 2015.

2.5 This report summarises the changes we have made to our local infrastructure and makes recommendations about the next stage of the Early Help Partnership strategy and the expanded troubled families programme.

3. Decisions, recommendations and any options

That the Board:

3.1 Gives agreement to proceed with the next stage of the strategy to inform the re-design, commissioning or de-commissioning of future early help services for families. Some of these services sit within the council and some are delivered externally.

3.2 Supports the council's decision to become from January 2015 an 'Early Starter' for the expanded national Troubled Families programme (commencing April 2015).

3.3 Gives agreement to hold local discussions about the opportunities presented by the new 'health offer' developed by the national Troubled Families Unit to support the expanded programme.

4. Relevant information

4.1 The strategy sets out 5 priorities:

1. Via the establishment of an Early Help Hub, to improve the assessment of problems facing children and families and to ensure prompt access to the right support services.

2. To deliver evidence-based Early Help of high quality and value for money.

3. To implement a workforce development strategy to support the delivery of priorities in the Early Help Partnership Strategy, focussing on building capacity and skills of the children's workforce to deliver effective Early Help.

4. To develop parenting capacity across the city and increase the engagement of all parents and carers.

5. To improve services around key issues for parents and families which impact on outcomes for children and young people.

4.2 Following publication of the strategy we have improved our local infrastructure i.e.

4.21 A Threshold document:

The LSCB published Brighton and Hove's Inter-Agency Threshold of Need and Intervention Criteria in July 2014. The document provides guidance for both professionals and services to:

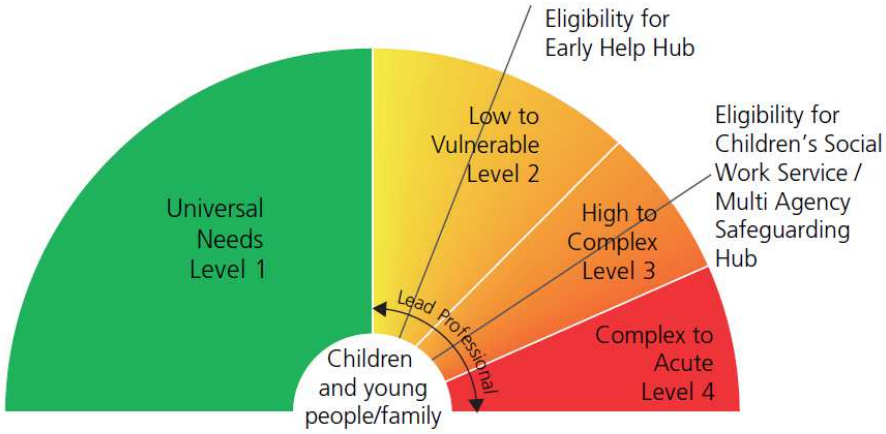
- Identify and assess levels of individual need;

- Clarify the circumstances in which to refer a child to the Multi-Agency Safeguarding Hub (MASH), the Early Help Hub (EHH) or to a specific agency to address an individual need

The document's describes thresholds in the following way:

'Most children and young people have a number of basic needs that can be supported through a range of universal services (Level 1). These services include education, early years, health, housing, youth services, leisure facilities and services provided by voluntary and community organisations. However, some children have additional needs (Level 2) or complex needs (Level 2 and 3) or require specialist services to support them (Level 4).

This can be represented diagrammatically as:



4.22 A Multi-Agency Safeguarding Hub:

Located in the east of the city the Multi-Agency Safeguarding Hub (MASH) consists of: social work staff; police officers; staff from Housing; Education; Youth Offending and Probation; a range of Health providers, and members of the Early Help Hub. Team members continue to be employed by their own agencies but are co-located in one office to offer an integrated service.

The hub deals with all notifications relating to safeguarding or the welfare of children. Staff work together jointly to assess all referrals sharing information and working to an agreed process for analysing and assessing risk.

4.23 An Early Help Hub:

Staff in the Early Help Hub provide professionals in universal services with a new route for advice and referral about families that do not meet the threshold for the council's social work service. The EHH coordinates information about each family and, through weekly multi-agency meetings, identifies the most appropriate response. The purpose of the EHH is to improve our understanding and management of need, enabling the right support to be provided earlier to prevent families' problems from becoming more serious.

4.3 Stronger Families, Stronger Communities (SFSC) is Brighton & Hove's version of the national Troubled Families programme. The first phase of the national programme began in April 2012 and was

originally scheduled to end in April 2015. It reflected significant cross-agency work to understand and address the effects of multiple-deprivation on vulnerable families and communities in the city. Building on the council's successful Family Intervention Project we used Payment by Results income, and generous secondments from partner agencies, to set up a new Integrated Team for Families (ITF) to work with partners to provide a 'tiered' service i.e. intensive, supportive, mentoring and monitoring interventions based on the Troubled Families Unit family intervention model.

4.4. SFSC has been integral to the development of the Early Help Strategy and the Early Help Hub, and is overseen by the Early Help Partnership Board, chaired by the Director of Children's Services.

The programme is funded by a payment by results model in which a fixed maximum amount of money is paid to the Local Authority for each eligible family that achieves two or more proscribed outcomes. Brighton and Hove is on track to meet the target of 'turning around' 675 families during Phase 1 of the programme (by April 2015).

4.5 As a result of this success the council has been asked to become an 'Early Starter' in January for the expanded national programme which is due to commence in April 2015 for 5 years (funding beyond 2015/16 is subject to the next Spending Review). We are seeking the Board's support to deliver an even more challenging Payment by Result scheme across an expanded set of eligibility criteria, directly relevant to the remit of the Health and Well Being Board i.e.

- Parents and children involved in crime or anti-social behaviour;
- Children who have not been attending school regularly;
- Children who need help;
- Adults out of work or at risk of financial exclusion and young people at risk of worklessness;
- Families affected by domestic violence and abuse;
- Parents and children with a range of health problems.

4.6 As part of building the expanded national programme the Troubled Families Unit published a new 'health offer' on November 5th 2014. Agreed with Public Health England, the Department of Health, the Local Government Association and NHS England the offer includes:

- a leadership statement from the Department of Health, Public Health England and NHS England setting out for health partners the importance of working with the programme;
- a practical data sharing protocol with a working example of how families can be identified for the expanded programme. This was developed with the Department of Health, Public Health England and, crucially, with advice from Dame Fiona Caldicott (Chair of the Independent Information Governance Oversight Panel);
- access to specialist health training.

4.7 As well as providing support to individual families, the strategic purpose of SFSC is to evaluate our impact to support whole systems change, including:

- Working with partners, including Public Health, to maximise our learning from the participation in the national Troubled Families evaluation and the local multi-agency research pilot 'Beating the Odds' led by the University of Sussex.
- Organising a multi-agency workforce conference in May 2014 focussing on the Family Coaching intervention promoted by Troubled Families Unit and developed locally by the council based multi-agency Integrated Team for Families (the key delivery arm for SFSC).
- Developing the SFSC Partnership into the city's Early Help Partnership.
- Transferring staff from the ITF into the new Early Help Hub to provide expertise in performance and data collection, and to provide mentoring support to other agencies.
- Developing the secondment arrangements with our partners which underpin the ITF and EHH, including with: Police; Probation; Housing; Adult Social Care; the Youth Offending Service, and the Children's Services Children In Need Team.

4.8 As part of the partnership approach set out in Connected City, the council's Corporate Plan and the Children's Services Plan, including the work of the newly formed Children's Partnership Forum and the Health and Well-Being Board itself, we are seeking the Board's agreement to proceed with four initiatives:

4.8.1 The next stage of the Early Help Partnership Strategy, i.e.: Priority 2 "To deliver evidence based Early Help of high quality and value for money". Activity will include a partnership approach to the mapping of relevant service pathways; the assessment of need; and the evaluation of the impact and outcomes of interventions

leading to the re-design of commissioning or de-commissioning of early help services for families.

4.8.2 In liaison with the SEN and disability review, one theme that is emerging that we will need to consider is our emotional wellbeing and mental health pathway. It's likely that we will need to make some changes to the services that we deliver and commission.

4.8.3 Preparation to become a national Troubled Families 'Early Starter' for the expanded national programme commencing in April 2015. This will include agreeing a local 'outcomes plan' to track and meet the eligibility criteria set out in paragraph 4.5. This work will be overseen by the Early Help Partnership Board.

4.8.4 Local discussions with relevant local health organisations to take forward the opportunities in the new 'health offer' described in paragraph 4.6.

5. Important considerations and implications

5.1 Legal

5.1.1 The Early Help Partnership Strategy aims to improve the assessment of problems facing children and families and to ensure prompt access to the right support services, and develop parenting capacity across the city. The expanded Troubled Families programme works with families where children are not attending school, young people are committing crime, families are involved in antisocial behaviour and adults are out of work. As a matter of statutory duty local authorities are in any event obligated to work with families to offer services which address these issues, and to promote the wellbeing of young people in partnership alongside other agencies (Children Act 1989, and Children Act 2004). The strategy identified in this paper offers a methodology of promoting the well-being of adults and children, addressing a range of different needs which are understood to contribute to a risk of family breakdown. In offering early help it is to be hoped that the numbers of adults and children who may otherwise by required to be offered a higher level of statutory intervention will be reduced, so promoting the European Convention Article 8 right to family life.

Legal comments from Natasha Watson, 28/11/14

5.2 **Finance**

5.2.1 The Early help Strategy is underpinned by funding through the national Troubled Families Programme grant. The funding received for phase 1 of this programme covered the period April 2012 – March 2015 and is anticipated to total £1,425,600 (attachment funding) + £826,400 (results funding, based on a 65% success rate) + £300,000 (for co-ordinator's post) = £2,552,000. The estimated grant for Phase 2 is £4,320,000 over the 5 year period from 2016 and is broken down into £1000 attachment fee per family and £800 payment by results per family.

5.2.2 There are a number of services encompassed within the Early Help Strategy. The key areas identified within the report are the Multi-Agency Safeguarding Hub (MASH), The Early Help Hub (EHH) and the Integrated Team for Families (ITF). The funding arrangements for these services are shown in the table below:

Service	Gross Budget	BHCC contribution	Grant	Other funding
M.A.S.H.	£0.423m	£0.423m	n/a	
E.H.H.	£0.811m	£0.532m	£0.204m	£0.075m (via the Dedicated Schools Grant)
I.T.F	£0.840m	£0.347m	£0.223m	£0.270m (carry forward of 2014-15 SFSC grant)

5.2.3 The MASH and EHH have agreed funding for 2015-16 and, as such, no significant financial risk is anticipated in respect of these components of the overall programme. It is expected that through a combination of Payment by Results income, carry forward of unspent grant from 2014-15 and the core council funding, the ITF will secure the level of budget required for the financial year in order to deliver against the expanded Trouble Families programme (TF2) and sustain the team in advance of the new grant funding coming on stream in late 2016. Pending confirmation of the carry forward of un-ringfenced grant to 2015-16 no significant financial risk is anticipated against the ITF element of the overall programme.

Finance comments from David Ellis, 18/11/14

5.3 **Equalities**

5.3.1 The Early Help Partnership Strategy and the SFSC programme work within a current Equalities Impact Assessment.

5.4 **Sustainability**

5.4.1 Ensuring the sustainability of the Early Help Partnership Strategy and the SFSC programme with its proven results in supporting successful outcomes for families with complex problems, contributes strongly to the following sustainability areas:

- Culture and Community
- Equity and the Local Economy
- Health and happiness

5.5 **Health, social care, children's services and public health**

5.5.1 Many of the families supported through the Early Help Partnership Strategy have physical and mental health issues alongside a range of other needs. Whole family working promotes health and wellbeing by addressing the complex interplay of issues that prevent families functioning well. Phase 2 of the Troubled Families programme will bring a specific new eligibility for adults and children with health problems. A representative from Public Health is on the Early Help Partnership Board to ensure all implications are fully recognised.

6. Supporting documents and information

Documents in Members' Rooms

1. None

Background Documents

1. None

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Brighton and Hove Winter Preparedness and NHS Capacity Planning Arrangements 2014.

1.1 The contents of this paper can be shared with the general public.

1.2 This paper is for the Health & Wellbeing Board meeting on the 9th December 2014

1.3 This paper was written by:

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2. Summary

2.1 Provide a short summary of the paper
The HWB has requested a paper on City Winter Preparedness. This report is split into 2 sections (City Winter Preparedness and NHS LHE 'Operational Resilience & Capacity Plan). Together the report details the arrangements that the NHS and Local Authority and other partners have ensured are in place to meet the coming challenges of this winter.

The paper seeks to assure the HWB that the City and its partner agencies are prepared for 'Winter'.

3. Decisions, recommendations and any options

3.1 That the Health and Wellbeing Board note the plans in place to ensure that Brighton and Hove is prepared for 'winter'.

4. Relevant information

4.1 The 'Winter Service Report' to the HWB dated Nov 27th, 2013[1] agreed that the BHCC Winter Service Plan Review Scrutiny panel in 2010 [2] identified a range of improvements needed, including the need for greater coordination within BHCC and with partners, more streamlined chains of command, better linkages with schools & better communication. A debriefing of staff involved in winter planning in 2012/13 identified improvements in local resilience over recent years, but also noted the need for improved strategic direction and oversight of such issues. In particular, the more integrated planning approach in the NHS is perceived to have significant benefits in ensuring business continuity. These issues have been recognised as resenting aims for service improvement, over last winter and preparedness arrangements for this coming winter.

4.2 This report addresses these issues in 2 sections. The first details general cold weather planning arrangements for Brighton and Hove, (B&H) and the second contextualises current local NHS Operational Capacity planning.

Section A - Brighton and Hove Arrangements in support of the National Cold weather Plan 2014.

4.3 Cold weather planning requirements are set out by the national Cold Weather Plan for England 2014. [3] The plan aims to prevent avoidable harm to health, by alerting people to the negative health effects of cold weather, and enabling them to prepare and respond appropriately. The CWP also aims to reduce pressure on the health and social care system during winter through improved anticipatory actions with vulnerable people.

4.4 Cold weather increases the risk of heart attacks, strokes, lung illnesses, flu and other diseases, resulting in an average of 25,000 'excess winter deaths' each year in England. 'EWDs' are the

[1] http://present.brighton-hove.gov.uk/Published/C00000826/M00004778/AI00037460/$Item35WinterServicePressuresv6cover.docA.ps.pdf

[2] http://www.brighton-hove.gov.uk/content/council-and-democracy/councillors-and-committees/winter-service-scrutiny-review-panel-2010

[3] https://www.gov.uk/government/publications/cold-weather-plan-for-england-2014

observed total number of deaths in winter (December to March) compared to the average of the number of deaths over the rest of the year. These winter deaths are related to cold temperatures and living in cold homes, as well as infectious diseases such as influenza. Older people, very young children, and people with serious medical conditions are most vulnerable.

4.5 The national CWP contains five key messages:

1. All local organisations should consider the document and satisfy themselves that the suggested actions and Cold Weather Alerts are understood across the system, and that local plans are adapted as appropriate to the local context.
2. NHS and local authority commissioners should satisfy themselves that the distribution of Cold Weather Alerts will reach those that need to take action, especially in light of recent structural changes.
3. NHS and local authority commissioners should satisfy themselves that providers and stakeholders will take appropriate action according to the Cold Weather Alert level in place and their professional judgements.
4. Opportunities should be taken for closer partnership working with the voluntary and community sector to help reduce vulnerability and to support the planning and response to cold weather.
5. Long-term planning and commissioning to reduce cold-related harm is considered core business by health and wellbeing boards and should be included in joint strategic needs assessments and joint health and wellbeing strategies.

4.6 The City Council has held planning meetings with NHS and other local partners to agree City arrangements to support the health of the local population during winter, and to reduce EWDs, (which have averaged 135 p.a. in recent years), and fuel poverty. These local arrangements are fully detailed in the 'Brighton & Hove Local Health Economy Cold Weather Plan 2014'.[4]

4.7 The aim of the local plan is to set out the procedures and work-streams to be implemented within the Local Health Economy (LHE), which comprises all health providers across the city. It acknowledges that arrangements are in place between NHS, local authority services, the Voluntary sector and others. These agencies have engaged in year-round planning, and are ready to receive and implement the alerts.

[4] Arrangements are being made to have this plan available electronically, meanwhile it can be obtained from kevin.claxton@nhs.net

4.8 The objectives of the local plan are to:

- Define the partners engaged within the LHE
- Ensure the requirements of the national plan care complied with locally, by clearly stating the work-streams agreed to be relevant and those partners engaged in their delivery.
- Set out the coordination and oversight / assurance arrangements.
- Mitigate as far as possible the impact of cold weather on the health of the local population.

4.9 The key issues for the City resulting from this year's National CWP and other known circumstances are:

- The need for strong local leadership and partnership working to tackle the range of causes and reduce the number of EWDs and fuel-poor households.
- That B&H planning arrangements support the nationally-recognised importance of long-term and strategic planning and commissioning to reduce cold-related harm, and that this is considered 'core business' by the HWB and joint strategic needs assessments (JSNA). (This is evidenced by the linking of these winter planning arrangements to the Health Protection Forum, which is now active and which reports to the HWB.
- Ensuring the appropriateness and effectiveness of arrangements which ensure that the CWP's Action Cards (which correspond to the Cold Weather Alerts), are disseminated widely to all City stakeholders as appropriate for:

  Commissioners & LA

  GP's & Practice Staff

  Community & Voluntary Sector

  Frontline health & Social Care staff in community & care facilities

  NHS Provider Organisations

  Individuals.

4.10 Whilst these arrangements are further bolstered by links to the City's Vulnerable People plan, and an acknowledgement that the Public Health Outcomes Framework includes indicators to reduce excess winter deaths and address fuel poverty, there are also challenges. Not the least of these is that there is no longer a nationally provided Warm Homes / Healthy People Fund.

4.11 The health, social, economic and environmental risks associated with a Severe Cold Weather spell have been assessed by the multi-

agency Sussex Local Resilience Forum (SRF) and included on the Sussex Community Risk Register. A risk description can be found on the Sussex Local Resilience Forum website.[5]

4.12 'Sussex' major incident and emergency plans recognise multi-agency command and control arrangements, and wide response to such incidents would be coordinated by Sussex Police, who would also lead on communications issues. More local incidents may not result in the declaration of an 'emergency', and agreed plans state that BHCC and the CCG will lead the response and communication arrangements.

4.13 The Director of Public Health (DPH) for Brighton and Hove has ensured that effective local plans are in place within the B&H LHE. Coordination arrangements are in place with NHS Trusts and NHS-funded providers, and other stakeholders, to ensure that all partners understand their responsibilities and have organisational plans in place in line with the 'Action Cards contained within the National Plan. Oversight of these arrangements will be provided by the B&H Health Protection Forum, which reports to the Health & Wellbeing Board, in line with the national plan.

4.14 The DPH, CCG and the NHE England Surrey & Sussex Area Team (NHS E S&S AT) have together ensured that all providers are formally linked to 'health' strategic planning for Sussex via the Local Health Resilience partnership (LHRP), as also to the SRF. In this way, local winter planning arrangements are compatible and link with wider 'Sussex' multi-agency contingency plans.

4.15 B&H LHE partners include:

BHCC (Public Health, Adult Social Care, Children's Services, Highways, Communications, Housing, Parks, Sea Front and Emergencies & Resilience Team)
B&H CCG (Commissioning Teams / Winter Pressures, Communications)
NHS E S&S AT (the primary care commissioner)
Brighton and Sussex University Hospitals Trust (BSUHT - secondary care provider)
Sussex community Trust (SCT - community services provider)
Sussex Partnership Foundation Trust (SPFT - mental health services provider)
South East Coast Ambulance (SECAmb - is also the NHS 111 provider).
IC24 (Out of Hours (OoH) provider).
British red Cross (BRC)

[5] http://www.sussexemergency.info/media/srf/severe%20weather.pdf

'Community Works' (B&H community sector forum).

4.16 Cold weather alerts are issued at:

Level 0 - Long-term planning (all year round planning)
Level 1 - Winter preparedness programme (1 November–31 March)
Level 2 - Severe winter weather is forecast
Level 3 - Response to severe winter weather
Level 4 - Major incident – emergency response

4.16.1 Level 2 is issued when a mean temperature of 2 deg C and/or widespread ice and heavy snow are predicted within 48 hours, with 60% confidence. Level 3 is issued when widespread ice and heavy snow occur.

4.17 Local cascading of cold weather alerts within the B&H LHE is as per indicative national arrangements above except that:

- All category 1 providers (incl SCT / hospital trusts / SECAmb etc) also receive alerts directly from the Met office
- The NHS E S&S AT have now confirmed that they are able to cascade to pharmacies, as well as to GP practices.
- BHCC Adult Social care (ASC) have provided assurance that they would inform all B&H care & rest homes.
- The CCG / Public Health (PH) Resilience Manager disseminates alerts to Public Health, CCG staff (on-call managers, agreed primary care staff and Communications), IC24 (the LHE Out Of Hour's provider), Sussex Partnership Foundation Trust, (SPFT) and British Red Cross.

4.18 It is therefore confirmed that systems are in place to ensure that all who need to receive cold weather alerts are doing so within the LHE.

Consolidation of previous work.

4.19 The following work has been consolidated into winter planning in B&H through 2014, and since last winter (2013 / 14):

- (Further to the ending of the national Warm Homes Healthy People (WHHP), this work-stream now receives funding from the PH budget, enabling an annual programme to reduce the prevention of EWD's and fuel poverty.
- Liaison with Community Development team at BHCC and with CCG re GP practice PPG's regarding enhancing B&H Community Resilience via the commencement of a project lead by Local Area Teams across the City.

- Clarity agreed regarding who a lead on B&H comms messages that this will be BHCC or CCG comms.
- CCG development of a smartphone 'app' which signposts GP's and others towards a range of available services for use of practices and frontline staff.
- A draft B&H Vulnerable People Plan has been agreed. This defines vulnerabilities which may make people vulnerable, and contains a 'list of lists' of agencies who are likely to hold data reading peoples vulnerabilities, and which may assist to contact them during an emergency, so that they have be evacuated or otherwise assisted and protected. This links to an 'information sharing protocol'.

Winter Planning Group / Areas of City winter planning

4.20 A winter planning group has been re-established, and a meeting was held on 21st October 14. A wide-ranging attendance gave an update on issues linked to winter preparedness for 14/15 as follows:

Brighton and Sussex University Hospitals Trust.

4.21 Plans have been reviewed at BSUHT, and whilst there is little change to comment on, the Trust has fully participated in the NHS 'OCRP' (see B), and has a director in place who manages system capacity of a daily basis. It is recognised that the Trust is often at a higher state of response, but the issues are being actively managed with the support of other organisations.

4.22 The Trust will ensure that any changes in procedures requires by the 2014 Cold weather plan are put in place, and is committed to raising staff flu vaccination levels etc. BCP's are also being updated, and the Head of EPRR also has a new director who seems keen and interested in addressing EPRR issues. A supply of thermometer cards for waiting areas etc would be useful if available.

Sussex Community Trust.

4.23 SCT provides out-patient clinics on-site and teams of healthcare staff who deliver frontline community health services to patients in the community, across B&H and in W Sussex. The Trust maintains 130 BCP's and has 4 4x4 vehicles to deliver its role during severe weather. Staff are directed towards a severe weather page on the Trust intranet, and staff and patients are asked to "Keep warm – keep well".

BHCC Adult Social care

4.24 Both Domiciliary and bed-based services are delivered by the directorate, which has well-rehearsed BCP's. It also has service level agreements with both the Seafront Team and City Parks at BHCC, who will assist with 4x4 vehicles and drivers when necessary. The whole team also works closely with IC24. All are working hard to raise levels of flu vaccine uptake amongst staff.

BHCC Public Health

4.25 Reduction of excess winter deaths and fuel poverty are PH priorities and the annual WHHP winter program is a partnership between Public Health, Housing, NHS and the local Community and Voluntary Sector. The 2014/15 WHHP programme includes:

- Leaflets and room thermometer cards, providing information on the health risks of living in a cold home, keep warm advice and local and national helpline numbers. These will be disseminated widely across the city, including direct delivery by all LHE partners to people most at risk.
- Small emergency grants administered by local community and voluntary sector organisations. These will be distributed to those most at risk of winter death and illness in order to maintain a warm home (e.g. for a boiler repair)
- 'Warm packs' for vulnerable householders and rough sleepers, distributed by BRC and CRI. The packs contain items for emergency warmth (e.g. blanket, thermal hat, flask of hot soup)
- Pilot project (currently in developmental stages) to provide year round advice sessions in selected GP practices for patients at risk of winter death and illness. Sessions will include personalised, in-depth income maximisation, advice and support, care navigation and signposting for further support. GP practices will be selected for the pilot according to deprivation profiles.

4.26 The Public Health Team will also consider whether CityCamp may be approached to engage in winter or general community resilience planning. CityCamp Brighton is a local network of people and events working to accelerate social innovation projects within the City, through providing support, funding and resource. [6]

BHCC Seafront Team

4.27 The City recognises that numbers of rough-sleepers across the city have risen, and this is a particular problem for the seafront area. The team is liaising with the Police, CRI and various other stakeholders across a number of for a. It was acknowledged that

[6] See website is at http://citycampbtn.org/

advice to traders re flood defences etc can be obtained from the Gov.UK website. [7] A number of products such as flood sacks etc can be locally obtained from local stores. Events such as the Christmas Day Swim are acknowledged. The team put out public safety signage, and the event can be cancelled if weather forecasts warrant it. Following good experience in recent years, the team now has a productive relationship with the swimming club.

IC24 (NHS Out of Hours Provider).

4.28 IC24 provides GP services to B&H and to E Sussex, as well as a GP at BSUHT, a walk-in service and other facilities. The organisations fleet has been updated, but no longer includes 4x4 vehicles. (This is being looked into, and is recognised as a risk.) The organisation has good links with Adult Social care and other providers.

Cityclean

4.29 Cityclean staff working for BHCC become the gritting team during inclement or severe weather, and operate under the direction of the BHCC 'Winter Duty Officer' who will advise on weather and road conditions, and on action required by the team. There are 4 priority areas of work which do include primary routes, city centre and hospital entrances. Gritters (including a pavement gritter) have been serviced and are ready for winter. Up to 6 gritters will be in use at any one time. A labour dispute involving a work to rule by CityClean staff is a potential risk, which is being actively monitored, and contingencies will be considered if appropriate.

The BHCC Highways Winter Service Plan 2014-15

4.30 This plan states the Councils roads gritting and monitoring arrangements, as agreed at Committee. It is available on the council's public website.[8]

4.31 The Local Authority also maintains an information page on the council's public website, which provides advice on driving and 'what you can do' as well as on 'what the Council does'.[9]

4.32 The highways plan ensures that roads to NHS hospitals are gritted, as well as ambulance stations. Clearance of pavements which lead to those hospitals are also on the 'Priority 1' list.

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[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/292943/geho1009brdl-e-e.pdf

[8] http://present.brighton-hove.gov.uk/Published/C00000823/M00005176/AI00041438/$20140926115311_006148_0026144_CommitteeReportTemplate100614newsavedformat.docx.pdf

[9] http://www.brighton-hove.gov.uk/content/parking-and-travel/roads-highway-structures/gritting-roads-winter-maintenance-service

4.33 All B&H Bus Company routes are on City 'primary routes'. It was acknowledged that grit and salt is good at combating ice but that the addition of the buses and other heavy transport is needed to make the grit work in snow. It was important to keep the buses running where possible to break up snow, but that is an operational decision for the bus company.

BHCC Flood Engineer

4.34 The City's focus is on groundwater, (as the Environment Agency retains responsibility for other areas). The approach is to reduce (not eliminate) risk. Groundwater levels are currently higher than in recent years, but the situation is being closely monitored. There has been preliminary discussion regarding a Patcham flood defence scheme, following receipt of money from an Environment Agency grant. Patcham residents are in contact with BHCC staff, and developments are being monitored.

BHCC Housing

4.35 The team has responsibility for the City's stock of social and sheltered housing, and a shelter under the Severe Weather Emergency Protocol (SWEP – temperature below minimum for 48 hours). Recently this has been extended to include heavy rain, and includes the notion of 'No 2nd night out'.

BHCC Children's Services

4.36 The importance of involving Children's services in preparedness and health protection is (particularly in order to reach City schools) is recognised. Schools closures have a clear impact on the city, and support to business continuity planning in educational settings is available. Very recently, a departmental representative has been identified to attend the Health Protection Forum and it is hoped this will result in further opportunities to coordinate city winter planning.

Brighton & Hove Energy Services Co-operative

4.37 BHESCo is planning to improve resident's thermal comfort this winter by providing information and taking action, especially targeting vulnerable people in hard to treat homes, thereby reducing the potential for EWD's.

4.38 They will be delivering outreach to consumers to help them reduce their energy costs through action on tariffs, switching energy supplier and take up of energy efficiency offers. Targets involve

delivery of training sessions and advice sessions. They are working with local councillors in their constituencies to arrange energy advice clinics where they will review people's energy bills, ensure that people who qualify are listed on the priority services register and speaking to them about draughts and the thermal comfort of their homes. They have some funding to pay for simple measures like weather stripping, secondary glazing film, energy meters and radiator reflectors. If opportunities for loft insulation top ups are identified or where they can get more funding, they will do that as well.

4.39 Other Areas of housing-related concern include the elderly, vulnerable and socially isolated. There are good links to other BHCC departments and other stakeholders. There is also a temporary accommodation and homeless team. In times of severe weather etc, the team is committed stop non-urgent work and to re-deploy housing officers to other services who need extra support. The BHCC contractors Mears & PH Jones run out of hours services. They maintain winter contingency stock including heaters etc. Out of hours the duty housing officer is contactable via the Emergencies and Resilience Team or via Carelink.

BHCC Emergencies and Resilience Team / Public Health resilience

4.40 BHCC has sold the Hove Park Depot and stocks of winter grit etc are likely to be located at the Stanmer Park depot. Transport hub arrangements have been reviewed.

4.41 The B&H Transport Hub results from an agreed arrangement between partners to support BHCC in running a hub facility during periods of severe weather. This will:

- Ensure an overview is maintained on weather conditions.
- Liaise with the BHCC Highways department and media sources to understand the impacts of the severe weather on the cities road's.
- Understand the implications of the weather falling on roads on transport providers including buses and taxis.
- Coordinate available 4 x 4 resources (including via the NHS MOU with Sussex 4x4 Response), from partner organisations (incl BRC as below) and local community volunteers and
- Match local prioritised tasking's for 4x4's against 4x4 availability.

4.42 The transport hub is managed and staffed via the agreement, and by an operational document. Both of these have been updated for this coming winter, and the BHCC list of 'I can help' volunteers will also be updated.

NHS Brighton & Hove CCG and NHS Providers

4.43 The primary care team at BH CCG have been asked to urge GP practices to obtain a stock of grit / salt if not already held, via 'Primary Care News'.

Seasonal Flu - Immunisation of at risk groups

4.44 The CCG is engaged with all key agencies to ensure preparedness for the 2014/15 flu season, and to improve the local uptake of the flu vaccine. Last year Brighton and Hove achieved an uptake in rates but an improvement is still needed. The responsibility for commissioning flu vaccination programmes has passed to the NHS Area Team, and we maintain close contact with them through our public health links.

4.45 The CCG has recognised that the efforts or previous years were not as successful as were wished, and has now agreed to fund further investment through enhancement of the Directly Enhanced Service which should provide additional nursing staff to target people who are housebound and who are most likely to miss out through their mobility problems.

4.46 Building on work from last year, the NHS England Area team is maintaining the vaccination programme in key hospital settings for patients with long term conditions. Monitoring of vaccine ordering in primary care is being carried out, and we are looking for their assurance that the process is working successfully.

4.47 Flu publicity will be led by Public Health England and Brighton and Hove City Council with a national campaign being distributed locally.

Immunisation of frontline staff

4.48 Main providers with the system are expected to deliver a significant improvement in staff vaccination rates this year moving towards a compliance rate of 75% for 2014.

4.49 Last year's rates were not at these levels, and every provider in the LHE is aware of the need to do more in this area, as having staff vaccinated reduces their own vulnerability, increases the resilience of the provider, and reduces the threat of transmission to patients. Staff vaccination programmes are in place across local provider organisations. Although uptake will be monitored by NHS England, we are also planning to monitor local providers via the Urgent Care Task Forces and Performance and Quality Boards.

4.50 Working in partnership with the local authority, we are also encouraging all Care Homes with Nursing to vaccinate their residents this year. The City Council has made arrangements with the Healthy Living Pharmacies for their directly employed frontline staff to be offered vaccination. The negotiated rate per vaccine will also be available for staff of other private health and social care organisations if their employers chose to use the service.

British Red Cross

4.51 BRC has agreed to link with BHCC and other local services and support them during periods of bad weather over winter. BRC has a dedicated hove based 4x4 land rover. This is to ensure delivery of warm packs and has been used over the last couple of years to provide the ability to reach all areas of Brighton and Hove, no matter how much snow there is.

4.52 BRC have agreed that IC24 Adult Social Care and other existing B&H support services could make use of it if needed. This could be accessed direct, or via the BHCC run transport hub, when operating.

4.53 Other BRC Provision Winter Provision available in B&H:

- At any time day or night for emergency response, call the 24 Emergency Response Messaging service. This will mobilise staff and volunteers as required, 24/7/365 to support people in crisis and depending on what the situation is, if BRC can help, they will respond.
- In addition to the 4x4 land-rover (see above), BRC can also call on (slightly further afield) a variety of support / welfare vehicles for catering and emotional support.
- The basic "offer" to B&H is to provide practical and emotional support, work in Rest Centres, providing transportation during bad weather and home welfare checks on vulnerable individuals.
- BRC can also provide blankets, hot drinks etc and man power.
- If made aware of a longer term failure of infrastructure or facilities, then we may be able to call in our dedicated communications or catering units to provide operational support to large groups of people.

Section B - Brighton and Hove NHS / LHE Operational Resilience & Capacity Planning.

4.54 The Operational Resilience and Capacity Plan (ORCP) is a detailed plan for the local health and social care system around the Brighton

and Sussex University Hospitals NHS Trust (BSUHT) and the City's health and social care system. Whilst it focuses primarily on Brighton and Hove, it is also cross referenced with plans developed by our neighbouring CCGs in Horsham and Mid Sussex and High Weald Lewes Havens.

4.55 It replaces what where previously known as surge or winter plans and has been developed in response to national guidance. The aim of the plan is to ensure planned or elective as well as urgent care services operate as effectively as possibly in delivering year round services for patients.

4.56 The plan is structured in two parts – urgent care and planned care and describes for each area the issues affecting those areas and plans to address them informed by expected changes in demand or levels of pressure throughout the year. The key objectives of the plan are to ensure sustainable delivery of the two national NHS service standards i.e. the 4 hour A&E standard and 18 weeks for referral to treatment for planned care.

4.57 It has been informed by national good practice guidance but also local reviews and improvement plans including a whole system review facilitated by the Emergency Care Intensive Support Team (ECIST) in July and the recent Care Quality Commission (CQC) visit to BSUH.

4.58 The plan also makes reference to cold weather and flu plans described above.

4.59 With regard to urgent care, the plan recognises that to build a sustainable system we need to significantly change our models of care consequently much of the work is aligned to the Better Care Programme. The plan also recognises however, that whilst transformation is underway, we will need some extra capacity in the short-term. This is built into the plan, for example, in the form of additional acute and community bed capacity over the winter period.

4.60 The local system has a strong record of achieving the national 18 week referral to treatment standard. Last year 96% of non-admitted and 93% of admitted patients waited less than 18 weeks from referral to treatment.

4.61 Recently however performance has deteriorated and a backlog of patients waiting has developed. In September performance was at 90.5% of non-admitted and 85.7% of admitted patients waiting less than 18 weeks.

4.62 The planned care element of the ORCP describes how BSUH will achieve the required 18 weeks standard from 1st December. This includes running additional elective activity internally i.e. at weekends within BSUH and the outsourcing of some activity to local independent sector providers during October and November.

4.63 The local system has been allocated non recurrent resilience funding to support delivery of the ORCP for planned and urgent care. This includes the following:

Funding Source	**£m**
1st Tranche Urgent Care Resilience Funding	1.8
2nd Tranche Urgent Care Resilience Funding	3.8
Referral to Treatment Times funding	1.97
Total	**7.57**

4.64 Alongside this resilience allocation, a number of other sources of funding have been used to support the plan including funds generated from the application of contractual rules to the acute contract, and other CCG non recurrent funds. A more detailed breakdown of the how the resilience funding and other sources as described above are being used to deliver the plan is attached as a supporting document to this report.

4.65 Delivery of the ORCP is supported by a revised governance structure. As required by national guidance, the current Urgent Care Working Group (UCWG), a chief officers group with oversight of the urgent care system, has changed its terms of reference to become a System Resilience Group (SRG). This group now has oversight of planned and urgent care services and ensuring appropriate links with Better Care programmes.

4.66 The SRG will be more strategic in its approach and have expanded membership including more clinical leaders and provider representatives across the system e.g. the independent care home sector. It will also be supported by a Project Management Office to ensure that all plans are on track and are delivering the required benefits.

4.67 A number of high level risks to delivery of the plan have been highlighted and these are monitored at the SRG. They include:

Risk	Mitigation
Delivery of the overall plan given its scale and complexity	Revised terms of reference for SRG and robust support governance structure including Project Management Office (PMO) approach to delivery of work streams
Workforce – inability to recruit additional staffing to deliver required additional/new services and/or detrimental effect on existing services	Development of a workforce map of new additional staffing and mitigation plans to ensure that we are able to deliver the commitments in the plan HEKSS Partnership Council to support medium to longer term workforce planning across transformation programmes in Sussex
Impact – that the plan will not have the desired impact in terms of system resilience and improvement in service standards such as 4 hour wait in A&E	Development of KPIs and outcomes for each work stream Rigorous monitoring of the impact of each work stream to ensure they are achieving required impact. Escalation route to SRG if work streams not delivering
Insufficient focus on the transformational programmes	SRG explicit commitment to maintain focus and pace on initiatives that deliver sustainable improvement All work streams subject to same governance progress

4.68 Whilst it is early days, we have seen improvement in the acute trusts performance against the 4 hour standard i.e. for the week ending 23rd November it achieved 91.9% against a trajectory of 89.1%.

Report Conclusions.

4.69 Taken together, the City's winter planning arrangements and NHS ORCP develop preparedness arrangements following the 2009 / 10 winter scrutiny report, and ensure that agreed arrangements are in place to prepare the City and Local health Economy for 'winter'. These arrangements are in line with the national CWP and are supported by Sussex multi-agency contingency resilience arrangements under the Civil Contingencies Act and other legislation.

4.70 The Health Protection Forum and the health and Wellbeing Board are asked to note this report.

5. Important considerations and implications

5.1 Legal

5.1.1 The Civil Contingencies Act 2004 governs UK resilience. It places duties on NGS Providers and the City Council as 'category 1 responders' under the Act. The CCG is a category 2 responder, with duties to share information with other responders. The CCG is also required by NHS England EPRR framework, to 'support' its 'Area Teams' in managing 'local' EPRR matters.

5.1.2 The Local Authority has a range of relevant legal duties for instance in the provision of Highways gritting services.

5.1.3 The Public Health England national Cold Weather Plan 2014[10] contains details of guidance and expectations of health and other systems in order to prevent and reduce numbers of EWD's.

Legal comments from Elizabeth Culbert 28.11.14

5.2 Finance

5.2.1 Financial Costs incurred in connections with the arrangements detailed within this paper are drawn from existing budgetary arrangements agreed by the City Council and NHS Commissioners and providers.

5.3 Equalities

5.3.1 There are no equalities implications envisaged in connection with the implementation of these arrangements, which have been drawn up planned and implemented with the aims of protecting the community and reducing cold weather related threats to vulnerable people.

5.4 Sustainability

5.4.1 Both the City Council and partners from the Local Health Economy are keenly aware of sustainability issues. There are no perceived negative sustainability implications associated with this report and the documents and plans it draws from.

5.5 Health, social care, children's services and public health

5.5.1 These areas are covered within the above sections.

[10] https://www.gov.uk/government/publications/cold-weather-plan-for-england-2014

6. Supporting documents and information

1. Brighton & Hove Local Health Economy Cold Weather Plan 2014 (Not attached);

2. BSUH LHE Operational Resilience and Capacity Plan (Not attached);

3. Summary of ORCP Resilience Funding (Attached).

Proactive Care	
A&E Liaison Worker for club drug use	40,000
Urgent Communications Plan - We can be heroes	50,000
Extension of Safe Space service on West Street	40,000
Nursing support to homeless hostels	98,000
Community Rapid Response Service additional capacity	286,000
Late shift for Integrated Primary Care Team	111,383
SCT In reach Frailty Co-ordinator	100,000
GP in Ambulance Despatch Centrre	155,000
2 Band 6 mental health nurses to inreach to care homes	81,266
Alamac system - local system dashboard to manage pressures in the system	90,000
	1,051,649
Acute Assessment Pathways within BSUH	
Additional handover nurses in Emergency Department	1,000,000
Continuation of additional beds on Overton Ward	250,000
Surgical Assessment and surgical Ambulatory care	53,999
72 hour short stay capacity and frailty unit	500,000
Additional emergency registrar cover in the ED	163,000
Cardiac Assessment Unit	300,000
Additional modular pod ward	815,000
Improved site management	745,000
Additional onsite capacity by reconfiguring existing non clinical space	1,220,000
Relocation of CIRU to extend Acute Floor	900,000
	5,946,999
Supported Discharge	
Frailty Pathway	295000
7 day social work coverage in HRDT	60,000
BSUH Care home liason post	75,000
3 dedicated ambulance vehicles	50,000
10 additional CSTS beds - Nov-March	350,000
SCT Admission and Discharge Co-ordination Team.	220,000
Block contract of care workers	99,000
Urgent home care linked with specialist end of life care	200,000
Extension of Integrated Community Equipment Store	50,000
Discharge to assess pilot	477,104
Hurstwood Park Step Down beds	240000
0.5 WTE Social work post for Millview	23,000
	2,139,104
RTT	
To fund capacity to reduce the backlogs across Gynae, T&O, DDS and neurology to a sustainable level	1,970,000
Increase in Surgical bed capacity (modular ward to support RTT and decompress RSCH site)	750,000
	2,720,000

Grand Total	**9,718,648**

Alongside the resilience allocation; the plan is funded from a number of other sources including funds generated from the application of contractual rules to the acute contract, and other CCG non recurrent funds. This is why they total value of the plan exceeds the resilience allocation.

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Better Care Fund Plan update

1.1 The contents of this paper can be shared with the general public.

1.2 This paper is for the Health & Wellbeing Board meeting the 9th December 2014.

1.3 This paper was written by:

Mark Hourston
Better Care Interim Programme Manager, Brighton and Hove Clinical Commissioning Group and Brighton and Hove City Council
Tel: 01273 574608
m.hourston@nhs.net

2. Summary

2.1 Brighton and Hove City Council and the CCG have received confirmation of the status of its revised Better Care Plan following the National Assurance Review Process:

- Brighton and Hove's plan was recognised as strong and has been "approved with support."
- There are a few, relatively minor changes to be made before the plan moves to "approved" status. We expect this confirmation in early December.

- An action plan has been developed and will be completed by the 28th November, when it will be submitted to NHS England, together with the revised plan, for sign off.

- In the meantime, we have been given approval to begin implementing our plan and this has commenced.

3. Decisions, recommendations and any options

3.1. That the Health & Wellbeing Board notes the progress made to approve the Better Care Fund Plan following the original re-submission in September 2014.

4. Relevant information

Background

4.1. Every council and CCG is required to develop a Better Care Fund Plan in line with the national guidance. Each area is expected to identify local priorities for inclusion and demonstrate how the plan meets the following six national conditions:

- Plans to be developed jointly
- Protection for social care services
- 7 day services to support patients being discharged and prevent unnecessary hospital admissions at weekends
- Better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessment and care planning
- Agreement on the impact in the acute sector

4.2. The Better Care Plan for Brighton & Hove was previously approved by the Health and Wellbeing Board on 5th February 2014 & sent to NHS England for approval.

4.3. Following amendments to national guidance for the Better Care plan, each area was required to update their plan submission by 19th September in line with updated national guidance. Brighton and Hove's revised submission was greatly improved and made clearer the underpinning programmes of work which will deliver our 5 high level outcome measures. The revised plan was sent to members following the submission on the 19th September.

4.4. This reports updates the Health and Wellbeing Board on National Assurance process on all BCF plans and the actions being taken to achieved "approved" status.

Update on Better Care Plan

4.5. All resubmitted plans were subject to a Nationally Consistent Assurance Review (NCAR) process. The outcome of the NCAR process was announced on 29th October and Brighton and Hove's BCF Plan has been classified as "Approved with Support". Our Plan was recognised as strong but a few relatively minor areas for improvement were identified which once addressed will enable us to move to a fully approved status. Out of a total of 149 areas that submitted plans in September, 6 areas were "Approved", 90 "Approved with Support", 48 "Approved with conditions" and 5 were "Not approved".

4.6. A timetable has been agreed with NHS England to make those changes to the plan and reach "approved" status. We expect our plan to be formally "approved" in early December. In the meantime we have been given approval to proceed with implementing our plan. A full copy of the letter with recommended improvements is attached as Appendix 1.

4.7. Better Care is a large scale change programme jointly led by the City Council that has very significant buy-in from partners across the health system. A strengthened Programme Management Office approach has been initiated to oversee delivery of the Better Care Fund programme. Every project under the Better Care programme will shortly have a detailed implementation plan, level of investment required, quantified impact and KPIs and risk score, all aligned to one or more of the high level outcome metrics. Weekly PMO meetings, chaired by the Brighton and Hove CCG Accountable Officer, are held to oversee delivery and monthly highlight reports discussed at the Better Care Programme Board. A regular report will also be submitted to the H&WB.

4.8. The programmes of work under the Better Care Fund are summarised and attached as Appendix 2.

5. Important considerations and implications

5.1 Legal

5.1.1 The Health and Wellbeing Board has responsibility to oversee and monitor the implementation of local Better Care Fund Plan and the Board itself is required to sign off the Plan.

Legal comments from Elizabeth Culbert 28.11.14

5.2 Finance

5.2.1 The measurement for the performance related payment element will be based on total emergency admissions. This will be measured quarter by quarter. The first quarter measurement is May 2015, based on the period January to March 2015. If the target is not achieved then the payment will instead go directly to the CCG to pay for the over-performance in the acute trust.

- There are risks therefore attached to this, although a cautious approach has been taken to forecasting the likely value of savings; ensuring plans are not overly ambitious. Therefore total planned savings are a relatively modest £1.3m in 14/15 and £2.1m in 15/16. The payments will reward part achievement against the target, so it is not an all or nothing approach e.g. achieving 30% of the planned reduction in emergency admissions will release 30% of the funding.

- There is a joint commitment to spending the Better Care Fund in the most effective way. If future payments are withheld because of a delay in realising the benefits of a particular scheme, but it is agreed that the scheme will still deliver the benefit, then the CCG will continue to fund that scheme.

- The CCG has built a contingency into their financial plans which will mitigate against over performance in the Acute sector relating to Quality Innovation Productivity and Prevention (QIPP) or Better Care. There is also a history of joint working across the local health and social care economy which will help to reduce this risk.

5.2.2 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.

5.3 Equalities

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

5.3.2 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.

5.4 Sustainability

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

5.4.2 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.

6. Supporting documents and information

Appendix 1: Letter from NHS England
Appendix 2: Summary of BCF programme

Appendix 1

Publications Gateway Ref. No. 02396

Quarry House

Quarry Hill
Leeds
LS2 7UE
E-mail: england.coo@nhs.net

To:
Brighton and Hove Health and Wellbeing Board
NHS Brighton and Hove CCG

Copy to:
Brighton & Hove City Council

29th October 2014

Dear colleague,

Thank you for submitting your revised Better Care Fund (BCF) plan. We know that the BCF is an ambitious programme and preparing the plans at pace has proved an immensely challenging task. However, your plan is now part of an ongoing process to transform local services and improve the lives of people in your community.

It is clear that your team and partners have worked very hard over the summer, testing out ways of working and finding innovative solutions to some of the challenges our services face in order to improve people's care.

NHS England is able to finally approve plans once the 2015/16 Mandate is published. I am pleased to let you know that, following the Nationally Consistent Assurance Review (NCAR) process, provided there is no material change in circumstance and the 15/16 Mandate is published as expected, your plan will be classified as 'Approved with Support' once the 15/16 Mandate has been published. This recognises that whilst your plan is strong the review process identified a number of areas for improvement which once addressed will enable you to move to a fully approved status. This category means that your plan will be approved and your BCF funding will be made available to you subject to the following standard conditions which apply to all BCF plans:

- That you complete the agreed actions from the NCAR in the timescales agreed with NHS England;
- The Fund being used in accordance with your final approved plan and through a section 75 agreement;
- The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as

detailed in the BCF Technical Guidance1. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance.

The conditions are being imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These allow NHS England to make payment of the BCF allocation subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG that it be spent in a particular way.

Appended to this letter is your NCAR Outcome Report which documents the agreed actions. Please work with your Area Team Lead Sarah Creamer (sarahcreamer@nhs.net) to agree a timetable for when you will submit the additional information/evidence required on the back of the NCAR report.

We are confident that there were no areas of high risk in your plan and as such you should progress with your plans for implementation. Although the areas of support the review identified are essential to successful delivery in the medium term we do not consider them as material at this stage.

Any ongoing support and oversight with your BCF plan will be led by NHS England Regional/Area Team along with your Local Government Regional peer rather than the BCF Taskforce from this point onwards.

Non-elective (general and acute) admissions reductions ambition

As there is a considerable amount of time between the submission of BCF plans and their implementation from April 2015, we recognise that some areas may want to revisit their ambitions for the level of reduction of non-elective admissions, in light of their experience of actual performance over the winter, and as they become more confident of the 2014/15 outturn, and firm-up their plans to inform the 2015/16 contracting round. Any such review should include appropriate involvement from local authorities and be approved by HWBs. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition, as part of its assurance of CCGs' operational plans.

Once again, thank you for your work and we look forward to the next stage.

Yours sincerely,

Dame Barbara Hakin
National Director: Commissioning Operations

Health & Wellbeing

NHS England

1 http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

Appendix 2

Better Care Fund

Our vision for our frail and vulnerable population is to help them stay healthy and well by providing more pro-active preventative services that promote independence and enable people to fulfil their potential

Programmes	Description	Outcomes 15/16
• Integrated Frailty Model	• multiagency/disciplinary teams working around clusters of GP practices	• Emergency Admissions reduced by 3.5%/920/£1.4m
• Integrated Homeless Model	• multidisciplinary teams working with Morley Street Practice	• Care Home Admissions reduced by 13%/32/£800k
• Proactive Care	• Case finding frail and vulnerable people providing co-ordinated care	
• Personalised Care	• care planning and pilot of personal health budgets	• Reablement and Rehabilitation increased by 5%/38
• Keeping People Well	• Enhanced information and advice and signposting, promoting self management	
• Supporting Carers	• Support carers to achieve positive changes in their lives	• Delayed Transfers of Care reduced by 5%/320 days
• Protecting Social Care	• maintaining and improving access to social care support	
• Dementia	• proactive assessment and identification and support	• Improved User Experience
• Supported Discharge	• enhanced community support to enable early discharge	• Dementia Diagnosis Rates increased to 67%
• 7 Day Working	• ensuring system is responsive 7 days a week	

Health & Wellbeing

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1. Housing Adaptations Update – Extract from the Proceedings of the Housing Committee meeting held on 10 September 2014

1.2 This paper is to be made available to the general public.

1.3 Health & Wellbeing Board meeting on 9th December 2014

1.4 Caroline De Marco, Democratic Services Officer, 01273291063.
caroline.demarco@brighton-hove.gov.uk

2. Summary

2.1 To receive a recommendation from the Housing Committee held on 10th September 2014.. An extract of proceedings is attached.

3. Decisions, recommendations and any options

Action Required of the Health & Wellbeing Board:

To consider the recommendation referred from the Housing Committee for approval:

'That the Health & Wellbeing Board be recommended to agree that the allocation for the Disabled Facilities Grant will be monitored as part of the governance arrangements for all schemes in the Better Care Fund.'

BRIGHTON & HOVE CITY COUNCIL

HOUSING COMMITTEE

4.00pm 10 SEPTEMBER 2014

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Randall (Chair), Councillor Phillips (Deputy Chair), Councillor Barnett, Daniel, Littman, Meadows, Mears, Peltzer Dunn (Opposition Spokesperson), Wakefield and Wilson (Group Spokesperson).

PART ONE

21 HOUSING ADAPTATIONS UPDATE

21.1 The Committee considered the report of the Executive Director Environment, Development and Housing in which Members were asked to consider the capital funding pressures this year and going forward in light of the end of the Private Sector Housing capital programme and the options for managing the demand for and expenditure on major housing adaptations where this is forecast to exceed the capital funding available. The report was presented by the Head of Housing Strategy & Development – Private Sector Housing and the Operational Manager, Housing Adaptations.

21.2 Councillor Barnett referred the Adaption Panel. Sheltered blocks had not been considered by the Panel. Nothing had been done to help the older blocks. She mentioned Churchill House, an older sheltered block in Hove. She stressed that stair lifts should be provided in this older block as many older people were finding it difficult to use the stairs and were becoming isolated in their flats. The back of these buildings had stairs and should have slopes. Post boxes on back of doors would help prevent the elderly people having to bend. Electronic doors that opened would be expensive but would be a great help. The current doors were very heavy safety doors. The Operational Manager, Housing Adaptations replied that work had been carried out in the past on sheltered housing refurbishment. She agreed that proactive work would increase the supply of successful homes. The Chair promised to look at this request.

21.3 Councillor Mears referred to the graph in paragraph 3.14. She raised concern about the significant HRA contribution compared to the contribution of other departments. Contributions were low compared to saving made by people staying in their own homes.

21.4 The Chair concurred and stressed that some of the savings were made by the NHS rather than the council. The Health and Wellbeing Board were involved in this issue and the situation needed to be monitored.

21.5 Councillor Meadows stated that she was pleased to see that housing associations would be asked to contribute to the cost of adaptations. She asked if the same framework was being used to keep their costs down. Councillor Meadows stressed that the Better Care Fund was not new money and was concerned that the £0.911m which was the indicative allocation for the DFG from the Better Care Fund might be used to support savings in the Better Care Fund.

21.6 Councillor Meadows stressed the need for more wheelchair adapted homes and was concerned that all the best sites were taken for student accommodation.

21.7 **RESOLVED:**

(1) That housing adaptations capital expenditure commitments in 2014/15 and beyond be noted.

(2) That the potential options outlined in paragraphs 3.18 to 3.29 in the report to mitigate pressures identified be noted, and that the actions identified in the resolutions below be agreed subject to report back to a future Housing Committee on progress & outcomes.

(3) That the Health & Wellbeing Board be recommended to agree that the allocation for the Disabled Facilities Grant will be monitored as part of the governance arrangements for all schemes in the Better Care Fund.

(4) That consultation be approved with housing associations to encourage tenant rather than landlord applications for Disabled Facilities Grant and a greater contribution from housing associations toward the overall cost of adaptations to their homes.

(5) That the use of the Adaptations Framework for adaptations in the private housing sector be approved.

(6) That the consultation with council tenants and key stakeholders on the introduction of an Adaptations Policy for council tenants be approved.

From: Warren Morgan
Sent: 27 October 2014 14:07
To: Giles Rossington
Cc: Gill Mitchell; Chaun Wilson
Subject: GP Surgery provision issue for HWB

Dear Giles,

I'd like to table something for inclusion on the HWB agenda for December please regarding GP surgery provision. It is partly related to a closure in my ward but also to the broader issue of GP retirements.

We have written to the CCG regarding the closure of the Eaton Place surgery and what will happen to its c.5k patient list spread across Kemp Town and East Brighton. We want to know what capacity other surgeries have and whether GPs have been consulted on the potential increase in patients. We would like to know if anonymised postcode-based information as to where those patients are is available.

We would also like to know about other GP retirements across the city, any other surgery closures, what is projected in the next four years in terms of meeting demand (in a similar way to the pharmacy needs report to the last HWB) and whether the number of GPs is likely to meet the demands of a growing/ageing population.

Regards,

Warren.

Councillor Warren Morgan
Leader of the Labour and Co-operative Group
Councillor for East Brighton
Brighton and Hove City Council

@warrenmorgan | http://warrenmorgan.wordpress.com/

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1. Response from NHS England to the letter from Councillor Morgan

Having been informed that the current surgery premises would no longer be available for NHS use after this date, we were unable to secure the use of an appropriate, alternative local building large enough to accommodate all the patients from Eaton Place Surgery.

Without the immediate, guaranteed use of an alternative building we could not run a procurement exercise to appoint a new provider in time to deliver GP services to the practice's patients from 1 March 2015.

NHS England therefore had no choice but to ask patients from Eaton Place Surgery to register at another local practice. There are 15 other practices within a two mile radius of Eaton Place that are ready to welcome new patients and which collectively have capacity to accommodate all the patients from Eaton Place Surgery.

The patients currently registered at Eaton Place Surgery live in different areas across Brighton and Hove and we believe that patients will have a choice of other good local surgeries.

We know the unavoidable action we have had to take in asking patients to register with an alternative practice is a disappointment to some people, but we hope they will understand that we have had to act promptly in order to protect the health and welfare of all Dr Mockett and Dr Stalker's patients and to ensure alternative arrangements for their care are in place by 28 February

NHS England is working with the surgery to identify any patients who may need additional support registering with a new practice, so that they can be provided with help to do this as necessary. This includes requesting help from community nursing teams to monitor and support any elderly and vulnerable patients who may need extra help registering with a new surgery.

Patient information drop in sessions are being held at the practice on Wednesday 26 and Friday 28 November, where patients will be able to find out more information and ask any questions they may have about registering with another local practice.

We will continue to monitor the provision of local GP services to ensure services are meeting the needs of local people and we are continuing to discuss with local practices how we can further increase capacity to treat patients.

NHS England will also be working alongside the Brighton and Hove Clinical Commissioning Group (CCG) to determine how we can transform the way local GP services are delivered, in order to address some of the growing challenges faced by general practice (including workforce issues) and to ensure care is provided in a sustainable way over the coming years, based around patient needs.

Eaton Place Surgery (located at 24 Eaton Place, Brighton BN2 1EX) is managed by two GP partners, Dr Mockett and Dr Stalker. Dr Mockett and Dr Stalker hold a General Medical Services (GMS) contract with NHS England for the provision of services to patients registered with Eaton Road Surgery and they are the sole signatories to the contract.

NHS England was informed by Dr Mockett and Dr Stalker of their intention to retire and the GPs subsequently gave notice on their contract to provide services at Eaton Place Surgery, in line with the required notice period.

In accordance with parliamentary regulations, their contract must come to an end at the point of their retirement from the surgery and therefore the current contract to provide services at the practice has to legally end on 28 February 2015.

Since receiving notice of Dr Mockett and Dr Stalker's planned retirement, NHS England's priority has been to ensure that alternative arrangements are in place for the treatment of their patients after this date.

Surgery premises

In September 2014, NHS England was first informed that the current surgery premises (which are privately owned) would not be available for NHS use after 28 February 2015 and that the site was being put up for sale.

A rapid options appraisal was therefore undertaken by NHS England during September and October 2014 in order to determine how we could guarantee ongoing care for the surgery's patients after the retirement of Dr Stalker and Dr Mockett and to ensure that all potential solutions were considered. We wrote to patients registered at Eaton Place Surgery as soon as possible to inform them of this development and the actions we were taking to guarantee their future care.

This included determining whether there were appropriate, alternative premises available within the local area that were large enough to accommodate services to care for all the patients from Eaton Road Surgery and which were both readily available for use as a GP surgery and within NHS England's gift to secure for use.

As a commissioner of GP services (rather than a provider), NHS England does not own any GP surgery buildings, rather it is responsible for funding costs associated with their use (such as rental costs which are reimbursed to GP practices).

NHS Property Services was established under the Health and Social Care Act 2012 and was the organisation given responsibility for owning and managing most of the NHS premises which were owned previously by the former primary care trusts (PCTs), including some local GP surgeries. Other GP surgeries are owned privately and this often includes ownership by GPs themselves.

NHS England is therefore not legally able to purchase the Eaton Place Surgery building itself and NHS Property Services is not in a position to purchase alternative premises on behalf of the NHS at the immediate

time. Any proposed significant investment by the NHS in healthcare facilities has to be subject to the proper processes of scrutiny and review given our duty to make the best possible use of finite NHS resources, for the ultimate benefit of patients in our local communities. Even if funding was available for the NHS to purchase another surgery building, which it is not at the current time, it would not be possible to complete such a purchase before 28 February 2015 – by which time we have to have alternative arrangements in place to care for the patients currently registered at Eaton Place Surgery.

Some local people have indicated that they understand there are some empty spaces in commercial units at Brighton Marina and have asked whether it would be possible to relocate Eaton Place Surgery there, or for alternative local premises to be rented for use as a surgery.

Any vacant local properties would need to meet appropriate standards and be a suitable environment to deliver patient care from before they could be designated for use as a GP surgery. NHS England also has a duty to make the best possible use of NHS resources and so would need to follow due process to make sure that the premises would be affordable to the NHS over the long term, as we would be responsible for reimbursing any GP practice that used the space for the cost of their rent.

Even were a local building to be identified that would be affordable and suitable for immediate use as a GP practice, we would still be required by law to run a procurement process to award a new contract to another provider to deliver services to the patients from Eaton Place Surgery. We are not legally permitted to transfer Dr Mockett and Dr Stalker's existing contract to another group of GPs.

At this point in the process, without guaranteed immediate use of affordable and appropriate alternative premises, there is no longer sufficient time to appoint a new provider of services through a procurement process before Dr Mockett and Dr Stalker's contract comes to an end on 28 February. We are also not aware of any potential providers of services who already have access to a suitable building and who would be interested in bidding for the contract or taking on the lease of a vacant property.

Nor could we directly employ GPs to deliver care to patients to allow further time for a procurement process to take place, because NHS England is a commissioner of services, rather than a provider. This means NHS England does not itself have the legal authority to directly employ GPs, only to contract GPs, or providers who employ GPs, to deliver care to patients.

On 20 November, the owners of the existing Eaton Place Surgery premises indicated that their position had changed and that they would now be able to make the premises available for continued use as a GP surgery after 28 February.

While this is a welcome suggestion that is now being made, unfortunately there is no longer sufficient time to enable NHS England to hold a procurement process to appoint a new provider to deliver services to patients from the existing premises from 1 March 2015, once the current contract with Dr Mockett and Dr Stalker ends.

We will however actively consider proposals from any other local practice if they wish to open a branch surgery within the current Eaton Place Surgery premises at a future date and this is agreeable to the owners of the site.

In summary, we could not secure the guaranteed use of an appropriate, alternative local building to house Eaton Place Surgery in time to run a procurement exercise to appoint a new provider to deliver GP services to the practice's patients.

I am afraid that it is not possible for us to consider this further because, as confirmed above, we can't guarantee securing alternative premises for the practice, procure a new provider to deliver care and have these services up and running within the 13 weeks we now have available to make sure all the practice's patients have access to GP services from 1 March 2015.

Support for patients to register at another local practice

NHS England therefore had no choice but to ask patients from Eaton Place Surgery to register at another local practice. Before confirming this to patients, NHS England spoke to other local practices to determine the extent to which they were able to welcome new patients and to ensure that all patients from Eaton Place Practice could be accommodated at alternative surgeries.

Following discussions with other local practices we determined that there are 15 other practices within a two mile radius of Eaton Place that are ready to welcome new patients (six of which are located less than a mile away). These practices collectively have capacity to register in excess of 5,600 new patients and we therefore believe that they have sufficient capacity to accommodate all the patients from Eaton Place Surgery (who live in different areas across Brighton and Hove) and that patients will have a choice of other good local surgeries.

NHS England is aware that 404 patients (7% of the total patient population registered at Eaton Place) have already registered with other local GP practices since we wrote to patients earlier this month to explain that they would need to do so before 28 February and how to go about this.

We do recognise however that some patients are anxious about the closure of Eaton Place Surgery and we are doing everything we can to support them at this time.

NHS England is working with the surgery to identify any patients who may need additional support registering with a new practice, so that they can be provided with help to do this as necessary. We have adapted the letter that was sent to patients explaining the action they need to take to register with a new practice in order to provide a bespoke version for any patients with learning disabilities. This further letter is due to be sent to affected patients this week. We will also be working with community nursing teams to request their help in monitoring and supporting any elderly and vulnerable patients who may need extra help registering with a new practice. Local pharmacies will also be asked to help identify any patients who have particular medication needs that they may need help with in registering with a new practice.

We are also working to ensure that if any patients have particular health needs they can be supported to register at other practices which will be able to provide them with the appropriate treatment. For example we have provided Eaton Place Surgery with information on other local GP surgeries that specialise in the treatment of patients with HIV so that they can make this available to their patients as appropriate.

Patient information drop in sessions are being held at the practice on Wednesday 26 and Friday 28 November, where patients will be able to find out more information and ask any questions they may have about registering with another local practice.

We will continue to monitor the situation to ensure that any vulnerable patients identified have been supported to register with an alternative practice before 28 February.

Work to improve longer term access to services in Brighton and Hove

While we know that there is the capacity within the 15 other local practices located closest to Eaton Place to accommodate all the surgery's patients, we are continuing to work with practices and NHS Brighton and Hove Clinical Commissioning Group to determine how we can improve access to GP services within the city and ensure care is provided in a sustainable way to patients in the area over the coming years. This includes determining how we can further

increase the capacity of local practices to treat patients and any proposals which would facilitate this will continue to be fully explored by NHS England.

Work is also taking place locally to explore new ways in which care can be delivered to patients in the most effective way. Across Brighton and Hove 16 GP practices have benefited from around £1.8 million of money from the Prime Minister's Challenge Fund in order to pilot a project aimed at improving patient access to care and support from local services. The project brings together local GP practices and pharmacies, to provide patients with a more flexible appointments service, including same day appointments, seven days a week. Specially trained care navigators have also been appointed to help provide health advice and guidance to patients, particularly those with complex needs or elderly patients who live on their own for example.

We will use the learning from this local scheme and the other pilot schemes that are
taking place across the country to inform the development of GP services in Brighton and Hove.

Questions raised by Cllr Warren Morgan

NHS England has set out below answers to the questions raised by Councillor Warren Morgan about this issue:

- ***We want to know what capacity other surgeries have and whether GPs have been consulted on the potential increase in patients. We would like to know if anonymised postcode-based information is available as to where those patients are.***

NHS England met with each of the 15 local practices that are located within a 2 mile radius of Eaton Place Surgery in investigating how future care for the practice's patents could be secured. These local practices confirmed that between them, they had sufficient capacity to register around 8,700 patients (Eaton Place Surgery had around 5,600 patients as at the beginning of October, before patients began to register elsewhere).

The attached map shows that a number of the patients registered at Eaton Place Surgery live outside the immediate Kemptown area at other locations across Brighton and Hove.

We therefore believe that patients will have a choice of other good local surgeries, but as confirmed above we are continuing to explore ways in which we can support practices by further increasing capacity within the area to

treat patients.

- ***We would also like to know about other GP retirements across the city, any other surgery closures, what is projected in the next four years in terms of meeting demand and whether the number of GPs is likely to meet the demands of a growing/ageing population.***

NHS England is not currently aware of any other impending retirements by local GPs.

Nationally, the ageing GP workforce is one of the challenges that the NHS is working to address in order to ensure the delivery of sustainable care to patients, as more members of the existing GP workforce approach retirement age and fewer medical students choose to enter general practice.

Feedback to NHS England from local practices indicates that at this point in time, this is having less of an impact on services within Brighton and Hove than it is in some other areas and local practices have continued to be able to recruit new GPs.

Nonetheless, when GPs retire and they are the sole holders of a contract to provide services to patients at their surgery (as in the case of Eaton Place Practice) then NHS England does have to work at pace to secure future services for a practice's patients. Under the standard national General Medical Services (GMS) contract that many GPs hold, they only have to give six months' notice of their intention to retire if the impact of their retirement will result in their contract to provide services having to end (because they are the sole holders of the contract). When a GP retires but they have other GP partners who jointly manage the contract to provide services at their surgery and who will continue to deliver care to patients after their departure, the retiring GP partner only has to give 28 days' notice of their intention to leave a practice.

As confirmed above, NHS England will continue to work with the Brighton and Hove Clinical Commissioning Group (CCG) to determine how we can transform the way local GP services are delivered, in order to address some of the growing challenges faced by general practice (including workforce issues) and to ensure care is provided in a sustainable way over the coming years, based around individual patient needs.

We have an ageing population and an increasing number of patients with complex care needs and multiple long-term conditions, who are likely to

require more intensive support from their GP, coupled with the need to recruit and retain more doctors to meet the rising demand for services and patient expectations.

We need to consider how we will meet these challenges so that GP services are fit for purpose, both now and in the future. This includes exploring the potential for delivering care in a more integrated way and strengthening the services that are available to patients within the community outside of a hospital setting. We believe GPs have a vital role to play in supporting patients to remain well by linking in with other local health services and delivering care to patients in a personalised and joined up way, which can help avoid patients being admitted to hospital unnecessarily.

The Five Year Forward View that has just been published by NHS England and other national health partners sets out some of the potential future models of care that could be adopted by local communities in order to achieve this and to meet the health needs of their populations (http://www.england.nhs.uk/ourwork/futurenhs/).

This might for example include supporting groups of GP practices to join forces and provide a broader range of services to patients (including those traditionally provided in hospital) or creating new organisations that provide both GP and hospital services together with mental health, community and social care.

We want all patients in Brighton and Hove to have good access to high quality, GP services and we will continue to work to support the development of local services to achieve this.

- ***Eaton Place surgery is in close proximity to the Royal Sussex County Hospital, so there are worries about the potential impact of former Eaton Place patients using hospital A&E rather than travelling to an alternative GP***

NHS England will continue to monitor the situation as patients register with alternative local practices. As confirmed above, 404 patients from Eaton Place Surgery have already re-registered with other practices. Due to the widespread local area that patients who are currently registered with Eat Place live across and the fact that not all patients live in the immediate area surrounding the practice we do not believe that patients will opt to use A&E rather than attending another surgery according to where they live.

- ***There are a very large number of vulnerable older people close to Eaton Place surgery (particularly from council and RSL-owned sheltered housing schemes around Edward Street). Again worries that some of these patients will not register with an alternative GP and will therefore not receive the support they need to continue living good quality independent lives.***

We are committed to ensuring that all vulnerable patients currently registered with Eaton Place Surgery are supported to register with an alternative local practice.

We are working with Eaton Place Surgery to identify any vulnerable patients so that we can support them to re-register with another practice.

As confirmed above, we will be working with local community nursing teams to support elderly and vulnerable patients to re-register with other local surgeries. We are also providing an adapted version of the patient letter with information about how to register with another local practice for patients with learning disabilities.

We will continue to monitor the situation to ensure any vulnerable patients have been supported to re-register with another local practice before 28 February.

We would encourage any patient, or carers, who are worried about their individual circumstances and ability to access alternative care suitable for their needs to speak to their existing GP or reception staff at Eaton Place for initial advice, given that they know the needs of their current patients the best and can escalate any concerns to NHS England as appropriate.

Patients can visit the NHS Choices website at www.nhs.uk to find out more about other local practices in their area, or call the Primary Care Support Service on 01903 756800 to determine which surgeries are nearest to them.

- *East Brighton suffers significant health inequalities and has relatively poor access to primary care. Worries that the closure of Eaton Place will exacerbate access issues for the East Brighton patients on its list (i.e. issue is not that there are plenty of alternative surgeries within 2m of Eaton Place, but access from where patients actually live)*

NHS England is committed to ensuring that all patients, including those living in the east of Brighton, can access high quality, local GP services.

Brighton and Hove is a relatively compact city with good local transport links and we are confident that patients will have a choice of other good local surgeries to choose from.

Patients currently registered at Eaton Place Surgery live across different areas of Brighton and Hove. We will however continue to keep the needs of patients in the east Brighton area under review to ensure that local GP services are meeting their needs and we are continuing to discuss with local practices how we can further increase local capacity to treat patients.

Any proposals which would facilitate this, such as considering any applications from local practices to open new branch surgeries in the local area, will continue to be fully explored by NHS England.