Who are we?

The Health and Wellbeing Board is a joint board of the Council and CCG which provides the strategic leadership for the health and social care in the city. 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 **Auditorium - The Brighthelm Centre** on **Tuesday, 2 February 2016**, starting at **4.00pm**. 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 six main items on the agenda

- Personal Medical Services GP Contract Review
- Multiple Births – Notice of Motion
- Brighton and Hove Clinical Commissioning Group Commissioning Intentions 2016/17
- Fees to Providers 2016
- Annual Review of Adult Social Care Charging Policy 2016-2017
- Better Care Finance & Performance Report December 2015

What decisions are being made?

- The Board will consider a revised charging policy for both residential and non-residential care
- The Board will consider fees to be paid to the independent sector care providers

Health & Wellbeing Board

Geoff Raw
Chief Executive - BHCC
(Non-voting)

Cllr Yates
Chair
(Voting member)

Natasha Watson
Lawyer BHCC

Mark Wall
Secretary - BHCC

Dr. Christa Beesley
CCG
(Voting member)

Cllr K. Norman
(Voting member)

Cllr G. Theobald
(Voting member)

Tom Scanlon
Director of Public Health - BHCC
(Non-voting Statutory member)

John Childs
CCG
(Voting member)

Dr. Manas Sikdar
CCG
(Voting member)

Graham Bartlett
Safeguarding Children's & Adults
(Non-voting co-optee)

Pinaki Ghoshal
Director Children's Services - BHCC
(Non-voting Statutory Member)

Lead Member
(In attendance - Non-voting)

Denise D'Souza
Director Adult Services - BHCC
(Non-voting Statutory member)

Dr. Xavier Nalletamby
CCG
(Voting member)

Cllr Mac Cafferty
(Voting member)

Dr. George Mack
CCG – Lay Member
(Voting member)

Frances McCabe
Healthwatch
(Non-voting Statutory member)

Pennie Ford
NHS England
(Non-voting co-optee)

Cllr Barford
Lead Member for Adult Services
(Voting member)

Cllr Penn
Lead Member for Mental Health
(In attendance – Non-voting)

Claire Holloway
CCG
(Non-voting member)

Presenting Officer
or
Public Speaker

Presenting Officer
or
Public Speaker

Public Seating

Press

Officers and Representatives
attending

Health & Wellbeing Board
2nd February 2016
4.00pm
Brighthelm Church & Community Centre
Auditorium - The Brighthelm Centre

Who is invited:

Councillors Yates (Chair),K Norman (Opposition Spokesperson), Mac Cafferty (Group Spokesperson), Barford and G Theobald, Dr Christa Beesley (Brighton and Hove Clinical Commissioning Group), Claire Holloway (Brighton and Hove Clinical Commissioning Group), Dr George Mack (Brighton and Hove Clinical Commissioning Group), Dr Xavier Nalletamby (Brighton and Hove Clinical Commissioning Group) and Dr. Manas Sikdar (Brighton and Hove Clinical Commissioning Group), Denise D'Souza (Statutory Director of Adult Services), Pinaki Ghoshal (Statutory Director of Children's Services), Dr Tom Scanlon (Director of Public Health), Graham Bartlett (Brighton & Hove Local Safeguarding Children's Board & Adult Safeguarding (Combined Role)), Pennie Ford (NHS England) and Frances McCabe (Healthwatch)

Who is unable to attend:

Contact: **Mark Wall**
Head of Democratic Services
01273 29100606
mark.wall@brighton-hove.gov.uk

This Agenda and all accompanying reports are printed on recycled paper

Date of Publication - Monday, 25 January 2016

AGENDA

Formal matters of procedure

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

Page

49 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

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.

50 MINUTES **1 - 16**

The Board will review the minutes of the last meeting held on the 15th December 2015, decide whether these are accurate and if so agree them.

Contact: *Mark Wall* *Tel: 01273 291006*
Ward Affected: *All Wards*

51 CHAIR'S COMMUNICATIONS

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

52 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 3 working days in advance of the meeting. Ring the Secretary to the Board, Mark Wall on 01273 291006 or send an email to mark.wall@brighton-hove.gov.uk

Health & Wellbeing

The main agenda

Papers for Discussion at the Health & Wellbeing Board

53 PERSONAL MEDICAL SERVICES GP CONTRACT REVIEW **17 - 22**

Report of the Chief Operating Officer of the Clinical Commissioning Group (copy attached).

Please note this report was written prior to the announcement that the Practice Group would be withdrawing from the 5 surgeries highlighted in the report.

A presentation will be provided to the Board by NHS England and the CCG to ensure the Board has the latest information.

Also attached to the report are copies of the Stakeholder Letter and Patient Letter that have been sent out from NHS England.

Ward Affected: *All Wards*

54 MULTIPLE BIRTHS - NOTICE OF MOTION **23 - 30**

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

Contact:	*Alistair Hill,*	*Tel: 01273 296560,*
	Kathy Felton	*Tel: 01273 574658*
Ward Affected:	*All Wards*	

55 BRIGHTON AND HOVE CLINICAL COMMISSIONING GROUP COMMISSIONING INTENTIONS 2016/17 **31 - 54**

Report of the Chief Operating Officer of the Clinical Commissioning Group (copy attached).

Contact:	*Claire Holloway,*	*Tel: 01273 574863,*
	Ramona Booth	
Ward Affected:	*All Wards*	

Papers for Decision at the Health & Wellbeing Board

56 FEES TO PROVIDERS 2016 **55 - 68**

Report of the Executive Director for Adult Services (copy attached).

Contact:	*Jane MacDonald*	*Tel: 01273 295038*
Ward Affected:	*All Wards*	

Health & Wellbeing

57 **ANNUAL REVIEW OF ADULT SOCIAL CARE CHARGING POLICY 2016** 69 - 94

Report of the Executive Director for Adult Services (copy attached).

Contact: *Angie Emerson* *Tel: 01273 295666*
Ward Affected: *All Wards*

Papers for Noting at the Health & Wellbeing Board

58 **BETTER CARE FINANCE AND PERFORMANCE REPORT DECEMBER 2015** 95 - 102

Report of the Chief Operating Officer of the Clinical Commissioning Group (copy attached).

Contact: *Claire Holloway* *Tel: 01273 574863*
Ward Affected: *All Wards*

WEBCASTING NOTICE

This meeting may be filmed for live or subsequent broadcast via the Council's website. At the start of the meeting the Chair will confirm if all or part of the meeting is being filmed. You should be aware that the Council is a Data Controller under the Data Protection Act 1988. Data collected during this web cast will be retained in accordance with the Council's published policy (Guidance for Employees' on the BHCC website).

For further details and general enquiries about this meeting contact Democratic Services, 01273 2910066 or email democratic.services@brighton-hove.gov.uk

Health & Wellbeing

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.

Brighthelm 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
(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 15 December 2015

Auditorium - The Brighthelm Centre

Minutes

Present: Councillors Yates (Chair), K. Norman (Opposition Spokesperson), Mac Cafferty (Group Spokesperson), Barford and G Theobald Dr. Xavier Nalletamby, Dr. Christa Beasley, Claire Holloway, Dr. Manas Sikdar and Jenny Oates; Clinical Commissioning Group.

Other Members present: Karin Janson Health Watch, Graham Bartlett, Pennie Ford, NHS England, Regan Delf, Assistant Director Children's and Adult Service, Denise D'Souza, Statutory Director of Adult Social Care Dr. Tom Scanlon, Statutory Director of Public Health.

Also in attendance: Councillor Penn and Mrs. Kate Parkin, Director Armed Forces Network, Business Manager Public Health, Public Health Programme Manager, Head of Commissioning & Contracts Adult Social Care, Environmental Health Manager and Head of Public Health Intelligence.

Apologies: Dr. Mack, Pinaki Ghoshal and Frances McCabe.

Part One

36 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

36.1 The Chair noted that the following were attending the meeting as substitutes for their respective colleagues:

J. Oates for Dr. Mack
R. Delf for Pinaki Ghoshal
K. Janson for F. McCabe.

36.2 The Chair noted that there were no declarations of interest and that there were no items listed in Part 2 of the agenda and therefore sought agreement that the meeting should remain open to the press and public.

36.3 **RESOLVED:** That the press and public be not excluded from the meeting.

37 MINUTES

37.1 The minutes of the last Board meeting held on the 20th October 2015 were agreed and signed by the Chair as a correct record.

37.2 The minutes of the Joint meeting of the Children, Young People & Skills Committee and the Board held on the 10th November 2015 were agreed and signed by the Chair as a correct record.

37.3 The Chair noted that the minutes from the joint meeting would be referred to the Children, Young People & Skills Committee on the 11th January for approval.

38 CHAIR'S COMMUNICATIONS

38.1 The Chair welcomed Dr. Manas Sikdar, to the meeting and noted that he had taken over from Dr Darren Emilianous as one of our CCG Board members.

South East Coast Ambulance Service

38.2 The Cahir stated that SECAMB had been in the local and national press as a result of significant concern about governance and decision making and the subsequent impact on resident's health outcomes. He noted that there were reports available that provide the detail.

38.3 SECAMB covers 6 upper tier authorities. Each authority has their own Health and Wellbeing Board, Scrutiny arrangements and Healthwatch.

38.4 In an effort to try and reduce duplication contact has been made with lead officers from the different authorities. Various meetings have been taking place across the 6 authorities to try and get a deeper understanding as to what happened, how it happened and next steps. I know OSC will be looking at this across the areas concerned.

38.5 One of the key responsibilities of the HWB is to sign off the **pharmaceutical needs assessment**. This was done in March 2015 and will next be formally refreshed by March 2018. I have been notified through the PNA steering group (which oversees and monitors changes on our behalf) that one chemist in the city has closed, Boots in Preston Drove. However considering the number of alternative chemists in the area and supported by the views of NHSE there is no need for further action at this time.

Children and Young Peoples Mental Health Transformation Plan

38.6 This plan has come to the Board several times so I now pleased to be able to report that we have received the Transformation Plan funds of £373,000 into the CCG budget, although have yet had any formal response from NHS England. The plan is now published on the CCG website' The next steps are:

- Update the project plans and actions plans (Dec 2015)
- Start implementation (Dec 2015 onwards)
- Report back to HWB

38.7 To note that a Transformation Plan will need to be updated and re-published each year on the CCG website (autumn 2016).

Rough Sleeping Strategy Scoping Consultation

38.8 The council has begun the scoping consultation to develop the city's new Rough Sleeping Strategy.

38.9 If the city does not reduce rough sleeping there will be:

More health problems and early deaths
More suffering and hardship
Crisis pressure on the Police, hospital accident and emergency and other services
Crime and anti-social behaviour associated with rough sleeping and street drinking
Increased costs to the local authority, Police and NHS
Reputation damage as a caring city
Tourism impact from street begging

38.10 A Position Paper has been produced to help frame the consultation that summarises the city's current approach to rough sleeping and existing plans as well as highlighting the challenges we face which has a number of questions for stakeholders about our approach.

38.11 I also had the pleasure of attending a summit on 4 December to hear first-hand about ideas for improving the way the city works in partnership together to tackle rough sleeping.

38.12 The summit endorsed a winter campaign to raise awareness of how residents can help rough sleepers. The campaign provides two actions people can take straight away:

38.13 Firstly, people are encouraged to use Streetlink, a website and mobile app to share information about the location of rough sleepers so details can be given to outreach workers for action.

38.14 Secondly, donations can be made through a JustGiving page to St Mungo's Broadway, the charity which provides outreach care in Brighton & Hove for people sleeping rough. The money raised is dedicated for the city.

38.15 I urge you all to respond to the consultation and share your thoughts and those of your constituents about how we can deliver our vision "To make sure no-one has the need to sleep rough in Brighton & Hove by 2020."

38.16 Comments on this initial stage are welcome throughout December and will be used to help develop the city's draft Rough Sleeping Strategy which will be ready in spring 2016.

HIV testing week

38.17 The high profile **'Its starts with me'** campaign this year was obvious in the city. The posters promoting testing were displayed on buses and also in bus shelters. The Terrace Higgins Trust opened their office for HIV testing from 10am – 5pm each day and city GP's promoted safe sex as well as offering HIV testing to all men and all African women who were having any blood test that week. Public Health England have launched a free HIV sample service and key risk groups can go on line and order a free blood sampling kit. The results will be returned to them with details of local services within 5 days. We do not have any data about impact or take up yet.

38.18 The **Sugar debate** has engaged more than 1100 people across the city. The online debate closed on November 30th. We thank you for your contributions and are currently analysing the quantitative and qualitative results. A report summarising the results and sugar smart action plan will come to the Health and Wellbeing Board in the New Year.

38.19 **Brighton & Hove Impetus** is convening a round table discussion on the 20th of January to consider the current experiences of parents with learning disabilities in BHCC, their right to access long-term support with parenting, appropriate assessments, and how this could work in theory and in practice in our City.

38.20 A panel of experts from other local authority areas, national and local charities and the legal profession will present on these topics and be available for discussion throughout the day. Members of the Health & Wellbeing Board, key Officers and local professionals will be invited to attend.

38.21 **Matthew Kershaw**, the Chief Executive of Brighton and Sussex University Hospitals (BSUH), which runs the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath, will be leaving at Christmas to take up the role of Chief Executive of East Kent Hospitals University NHS Foundation Trust. Matthew has been Chief Executive of BSUH for three years. Following Matthew's departure the Deputy Chief Executive Amanda Fadero will act as interim Chief Executive whilst the Board and Trust Development Authority

undertake a full recruitment process for a substantive successor. I know Board members will want to give our thanks to Matthew as well wish him every success in his new role.

38.22 **John Child** will be starting as the Chief Operating Officer of the CCG on 1st February. I am sure we will all welcome him on his second day in his new role at our next Board meeting.

38.23 **NHS England has awarded 11 Celebrating Participation in Healthcare grants**, to community groups and organisations that have developed innovative and creative ways to get patients and the public involved in shaping healthcare services. Two of the grants have been awarded to Brighton and Hove projects.

38.24 One of them is Mind in Brighton and Hove's LiVE Project which aims to support people with lived experience of mental health issues to develop diverse and varied approaches to engagement to help shape local services. The other is a joint project between Healthwatch Brighton & Hove and the Jaffa Panel (run by Brighton & Sussex University Hospitals Trust) which will be used to film work showing how patients and the public have contributed to shaping new health research ideas across the Trust.

39 FORMAL PUBLIC INVOLVEMENT

39.1 The Chair noted that three public questions had been received and invited Mr. McKenna to put his question to the Board.

39.2 Mr. McKenna thanked the Chair and asked the following question:

"With Neighbourhood Hubs being discussed by the City Council and the new Council leadership wanting to find new cost effective and community involving ways to tackling issues such as health inequalities, does the Health and Wellbeing Board agree that working with grassroots organisations such as DueEast Neighbourhood Council could provide innovative ways to look to join up health and adult social care services from the patients' street level perspective at a local level with local people involved at their heart ?"

39.3 The Chair replied: "Brighton & Hove City Council are committed to building on our approach to community development to recognise that it is the capacities of local people and their community and voluntary activity builds powerful communities.

The Communities, Equality and Third Sector Team and Public Health jointly commission a range of neighbourhood and equalities based community development support across the city including the areas covered by Due East Neighbourhood Council - Whitehawk, Bristol Estate and Manor Farm. In this area the Community Development support is commission to Serendipity Enterprise Solutions

The Community Development is specially commissioned to provide support to communities to work with public services, to find solutions to local issues and to develop their capacity to support themselves. This includes the delivery of a small grants approach to community health initiatives and is open to the provision of flexible support for small pockets of the city.

At a time with reducing public spending and changes to the welfare state we recognise that individuals and communities (particularly those facing most disadvantages) will face additional pressures over the coming years. Subsequently, there is a greater need to increase and strengthen communities and individual well-being and resilience. This includes supporting all communities to be empowered and proactive in the development of community groups, services and activities in the city and increasing social networks and individual skills and knowledge.

I am also happy to provide you with a more detailed response in writing.

39.4 Mr. McKenna then asked the following supplementary question; "Would you like more information on DueEast and its activities and invited members of the Board to attend meetings in the future."

39.5 The Chair replied, "Thank you for the offer and yes he would welcome as much information as possible an given sufficient prior warning would endeavour to attend a future session."

39.6 The Chair then invited Mr. Kirk to come forward and to put his question to the Board;

39.7 Mr. Kirk thanked the Chair and asked the following question;

"At the July meeting of the HWB board a paper and strategy was agreed for the Public Health Commissioning for the Healthy Child Programme 0-19. In the paper was a proposal to 'test the market' for potential providers of this service in November 2015. Can the board ….

1. Publish the strategy paper, and
2. Report which providers have expressed an interest in this contract?

In the minutes of that meeting it was noted that a Transition Board would be established. What exactly are the terms of reference of the Transition Board, and if it has reported, what has it recommended?"

39.8 The Chair replied; "Thank you for your question Mr. McKenna. Following the transfer of the commissioning responsibility for the health visiting service in October 2015 the NHS England Healthy Child Programme Transition Board, set

up to ensure the safe commissioning transition of the service, was replaced by a Health Visiting Transformation Group, led by Public Health. The purpose of the group is to inform the model of delivery for the future health visiting service. This group reports to the Public Health Modernisation Board as part of the wider work for the commissioning of the Healthy Child Programme 0-19 years. The market testing, which was slightly delayed, is now underway. The results of the market testing will be available at the end of January and will be reported to the Public Health Modernisation Board and to the March meeting of the Health and Wellbeing Board. We will be able to say how many organisations have expressed an interest; however it will not be possible to provide the details of any individual provider.

The Terms of Reference for the Health Visiting Transformation Group dated the 14th October 2015 are available and I will ensure a copy is sent to you."

39.9 Mr. Kirk then asked the following question; "Are the Council and the Board responsible to the residents of the city as they should be transparent in their decision-making and if people did not want to bid then they would choose not to do so."

39.10 The Chair asked the Lawyer to the Board to respond.

39.11 The Lawyer to the Board stated that in any bidding process there was an element of commercial sensitivity which had to be respected and could not be shared publicly. All such matters would be considered by the Board on their merits and it was perfectly usual to have a degree of confidentiality in order to obtain the best deal for residents.

39.12 The Chair then invited Mr. Kapp to come forward and to put his question to the Board;

"My question relates to Item 47 on the agenda, Enhanced Health and Wellbeing GP service update. Will the third sector be invited to bid for these Locally Commissioned Services, and if so, when will the invitations be issued?"

39.13 The Chair replied; "The new Locally Commissioned Services contract is a contract available only to GP practices working together in a cluster. Clusters of practices are required to develop action plans to outline how they want to deliver services. In the future clusters of GP practices may want to work with, or possibly commission voluntary sector providers to support delivery of particular services but this will be decided by the GP cluster."

39.14 Mr. Kapp asked the following supplementary question; "Would the Chair confirm that as the start date was not until April 2016 that invitations would be issued nearer the time?"

39.15 Dr. Beesley replied; "All practices cover the whole population and would not spend the whole budget from day one and she expected the GP Clusters would seek to work with groups from all sectors."

39.16 The Chair noted that there were no further questions and prior to taking the formal items listed in the agenda noted that it was now intended to split the agenda into items for decision, items for discussion and items to note. In this regard it was hoped that it would make it clearer to those attending the meeting. He also noted that those items listed as being to note, would not usually be considered but simply taken as read. The reports would be included with the agenda so that the information was made publicly available.

40 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE

40.1 The Head of Public Health Intelligence introduced the report which detailed the Joint Strategic Needs Assessment (JNSA) update and sought approval of the summary updates for their publication and approval of the planned needs assessments for 2016/17. She noted that following consultations with various partner organisations it was proposed to conduct needs assessments for vulnerable migrants, the management of mental health and wellbeing in primary care in adults, sensory impairment and acquired brain injury. She also noted that the updated assessments to date were all available online.

40.2 Councillor Mac Cafferty stated that the update provided a good insight into what was happening in the city and queried whether the proposed savings in Public Health Intelligence would impact on the JNSA.

40.3 The Public Health Consultant stated that the Public Health Intelligence and Corporate Intelligence teams had recently merged and it was anticipated that this would provide a more effective and efficient service. The officers were working closely with other partners and he did not expect it to impact on the work associated with the JNSA and needs assessments.

40.4 The Director of Public Health stated that it was a larger team overall having been merged and was now part of the council, which he felt would have a positive effect.

40.5 The Chair noted the comments and that a notice of motion was due to be presented at the forthcoming full Council meeting which may result in an issue being brought to the Board. In the meantime however, he put the recommendations to the Board for approval.

40.6 **RESOLVED:**

(1) That the following needs assessments be approved and conducted in 2016/17, based on discussions with, members, officers, partners and commissioners:

- Vulnerable migrants (to expand on the brief assessment that is in place)
- the management of mental health and wellbeing in primary care in adults (rapid needs assessment)
- Sensory impairment (new JSNA summary- all ages)
- Acquired brain injury (JSNA profile - adults).

(2) That the 2015 JSNA summary section updates be approved for publication; and

(3) That the 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 be noted.

41 JOINT HEALTH AND WELLBEING STRATEGY 2015

41.1 The Deputy Director of Public Health introduced the report which detailed the Board's second Joint Health & Wellbeing Strategy and reflected the Board's a broader remit since its first published strategy in 2012/13. He stated that the proposed strategy included input from across the council and the CCG and was aimed at improving the health and wellbeing of the population and reducing inequalities. There were five key themes within the strategy which it was hoped would be a dynamic document that developed over the period.

41.2 Dr. Beesley stated that the CCG fully endorsed the strategy and had welcomed the opportunity to develop it and hoped that it would lead to outcomes that were the best possible in Europe.

41.3 Councillor Mac Cafferty thanked everyone involved in the development of the strategy and welcomed the intent that it would be a living document. However, he was concerned about the deliverability of the aims such as removing rough sleeping from the city by 2020 and reducing unemployment when there were a number of disabled people who could not work. He believed the aspirations listed were commendable but was concerned about how they could be delivered and the impact of budget reductions.

41.4 Councillor K. Norman stated that there were a number of challenges to be faced and it was unlikely that all the aspirations listed would be achieved fully, but the intention was to improve the quality of life for residents and that had to be supported.

41.5 The Chair of the Adult Safeguarding Board welcomed the report and stated that the strategy complimented a number of activities that had been undertaken and were planned around safeguarding and inclusion.

41.6 Councillor G. Theobald noted that a number of older people suffered falls and queried how they would be dealt with in the future. He was unsure whether the necessary links

amongst providers were in place or that it would result in a number of people delivering help in different ways.

41.7 The Chair stated that there were a number of challenges to be tackled in regard to the delivery of the strategy and it would require people to work differently and together. However, he felt that even if only a partial amount of the strategy was delivered, it would have a positive impact within the city.

41.8 Karin Janson informed the Board that in relation to falls there were different levels of support and noted that other countries had introduced the use of rolling walking aids which might be something that could be looked at as part of developing the strategy.

41.9 The Head of Commissioning and Contracts noted that Public Health had recently held a workshop on how to support people at risk of a fall and an action plan was currently being drawn up that would then be shared.

41.10 The Deputy Chair stated that she wished to thank everyone involved in developing the strategy and welcomed the intention that it would be a living document. She also noted that there were adults who were not older people but were in need of support and an understanding of healthy living that could be owned by everyone in the city. She looked forward to being able to see how things progressed.

41.11 **RESOLVED:** That the Joint Health and Wellbeing Strategy as set out in appendix 1 to the report be approved and published.

42 CHILDREN'S HEALTH & WELLBEING COMMISSIONING STRATEGY

42.1 The Public Health Programme Manager introduced the paper which set out the shared ambition of commissioners in the council and NHS for the children and young people of the city. She stated that the strategy set out at a high level the way partner organisations intended to work together to achieve the ambition by 2020.

42.2 Councillor Mac Cafferty welcomed the report and asked whether in drawing up the strategy any consideration had been made to national changes and their impact in a local context e.g. local authority rules in relation to schools and joint commissioning as outlined on page 85 of the report. He queried whether there was any duplication currently and suggested that it would help to reference the challenges ahead.

42.3 The Public Health Programme Manager stated that the national picture had been taken into account and in real terms council and public health budgets would be used as the drivers for change and improvement. The need for better and more integrated services was recognised and this would address any duplication.

42.4 The Assistant Director (Children's and Adult Service) noted that it was a new role for the local authority and was sure that the health and attainment of young

people would be considered. However, overall she felt it was a positive approach and would bring about changes.

42.5 Councillor Penn stated that she wished to thank the officers involved in bringing the report forward and stated that it appeared that service users had been taken into account in the formulation of the strategy. She believed that when service users were engaged in a process it was more likely that better outcomes would be achieved.

42.6 Dr. Beesley stated that as a GP it was important to meet children and families and she was aware that at present it was not possible to work with all service providers. She believed that the new strategy would help to join things up and provide advantages for those children and families in the future.

42.7 The Assistant Director (Stronger Families Youth and Communities) welcomed the comments and noted that it was intended to provide an on-line system which would link to the Early Help team and the multi-agency hubs.

42.8 The Chair thanked the officers and welcomed the recognition that working together and sharing information was important and would lead to better service provision and outcomes.

42.9 **RESOLVED:** That the Children's Health and Wellbeing Commissioning Strategy as set out in appendix 1 to the report be approved and published.

43 BRIGHTON AND HOVE ARMED FORCES COMMUNITY

43.1 The Director Sussex Collaborative, Lead, Sussex Armed Forces Network introduced the report which concerned the obligation to meet the requirements of the Armed Forces Covenant. She thanked the Chair and Board for the opportunity to attend the meeting and to outline the work of the Armed Forces Network and the Civil Military Partnership Board that had been established by the Council. She noted that the armed forces community was a hard to reach sector and that there was a genuine need to provide help and assistance to that community in order to enable veterans, families, reservists and regulars to integrate into society and the local community.

43.2 She noted that both groups worked together to avoid duplication and that the Civil Military Partnership Board was held in high regard nationally as an example of how things should work at a local level. She hoped that the Board would support the efforts of both groups and would be happy to receive regular updates.

43.3 The Chair thanked the Director for attending the meeting and outlining the report.

43.4 Councillor Mac Cafferty welcomed the report and the work of both groups. He then referred to the issue of mental health and any correlation with the available support from disability groups such as the FED and others.

43.5 The Director stated that this matter had been raised and was one that the groups intended to take forward. However, they were still at an early stage and needed to build relations and publicise their roles, hence the report to the Board.

43.6 The Chair of the Children's Safeguarding Board queried whether any provision had been made in relation to street homelessness and children in the area. He was happy to have further discussions with the Armed Forces Network and to look at how matters could be taken forward.

43.7 The Director welcomed the offer and noted that a small number of trained champions had been established within the organisation to help in this area, but felt that better relations with the Local Safeguarding Board and Children's Services would be beneficial.

43.8 The Director of Adult Services referred to paragraph 4.44 of the report and suggested that more work could be done as the rate was higher than expected.

43.9 The Director welcomed the proposal and noted that the data on the number of veterans going through areas was only just being collected; and any help would be welcome.

43.10 Councillor Penn referred to paragraph 3.39 in the report and asked if action was being taken to help in terms of housing.

43.11 The Director stated that Brighton was ahead of most other councils in this respect, but noted that there were others within the armed forces community who required assistance with housing matters.

43.12 Councillor K. Norman noted that his wife, Councillor Ann Norman had been involved with the Network and the Civil Military Partnership Board since its inception. There had been some real progress made but the key point that kept coming up was integration of services to meet the needs. He hoped this would develop and applauded everyone involved in the work to date.

43.13 The Chair thanked everyone for their comments and put the recommendations to the Board.

43.14 **RESOLVED:**

(1) That the progress made to date by the Civil Partnership Board, Sussex Armed Forces Network and services and partners within Health and Social Care be noted; .

(2) That Board's support for the continuation of the way the groups and systems are working to deliver the needs for this community be agreed;

(3) That the recommendations from the local JSNA 2015 be noted and agreed:

(i) To continue joint working across Sussex through the Sussex Armed Forces Network; and

(ii) Where possible, implement recommendations from the Sussex needs assessment.

44 THE PUBLIC CONSULTATION ON EXTENDING SMOKE FREE SPACES

44.1 The Environmental Health Manager introduced the report which presented the results of the recent public consultation on extending smoke free spaces, to include outdoor areas such as the parks and beaches. He stated that it had been a very successful consultation process and whilst overall there had been little support to extend to parks and beaches, there had been support for areas where children tended to be, i.e. children's centres, outside of schools, play parks and outside seating areas at restaurants.

44.2 Councillor Mac Cafferty noted the report and queried why there was no reference to smoke-free zones and whether they had led to a reduction in smoking and whether there was any impact from second-hand smoke.

44.3 The Environmental Health Manager stated that there was evidence to show that second-hand smoke did exist in out-door open spaces although its impact could not be confirmed.

44.4 The Director of Public Health noted that where notices had been used in countries to encourage smoke-free spaces they had had an impact and set a tone, which was something that was worth considering.

44.5 Councillor K. Norman agreed with the view but noted that it would be very difficult to enforce in an open space; and whilst notices could be used he was not sure that they would have an impact.

44.6 The Chair agreed that voluntary bans could not be enforced but felt that having notices in areas such as outside school entrances may result in a smoke-free area being established. It would be helpful to highlight the outcomes of the consultation in conjunction with the placement of notices and he believed it had raised awareness levels.

44.7 **RESOLVED:**

(1) That the Board agrees that the Council, through the Public Health Schools programme should encourage smoke free school gates to all primary schools on a voluntary basis;

(2) That the Board agrees that the Council continue to promote smoke free spaces in children's play parks and the Council through the Public Directorate works with children's centres to encourage smoke free entrances on a voluntary basis;

(3) That the board agrees that the Council's Public Health Directorate works with restaurants and pubs to encourage smoke-free outdoor areas on a voluntary basis; and

(4) That the board agrees that the council does not extend smoke free places to all parks and beaches.

45 TRANS NEEDS ASSESSMENT FINDINGS AND RECOMMENDATIONS

45.1 The Board considered a request from the Neighbourhoods, Communities and Equalities Committee to raise the issue of the concerns and frustrations identified in the Trans needs assessment, in relation to waiting lists and access to pathways, especially in relation to specialist services with NHS England.

45.2 Pennie Ford informed the Board that NHS England were aware of matter and that she intended to bring a report to the Board in the New Year. She noted that specialist services were commissioned by NHS England and asked that the request from the committee be noted and that the Board await the report. She also noted that Brighton & Hove had been invited to participate in a task and finish group set up by the Regional Director for NHS England that would influence National Policy.

45.3 Councillor Mac Cafferty stated that he had chaired the Trans Scrutiny Panel and it was concerning that access to services for the Trans community were not easily accessible. He hoped that the forthcoming report would give some positive news and that action could be taken to support this community.

45.4 The Chair noted the comments and suggested that the request and report be noted.

45.5 **RESOLVED:** That the request from the Neighbourhoods, Communities & Equalities Committee and the intention that a report would be brought to a future meeting on the matter from NHS England be noted.

46 IMPACT OF THE IN-YEAR REDUCTION TO THE LOCAL AUTHORITY PUBLIC HEALTH GRANT ALLOCATION 2015/16

46.1 The Business Manager for Public Health introduced the report which outlined the impact of the recent government announcements on public health budgets and the savings identified in order to come within budget. She stated that further discussions were being held with providers and services in order to identify savings across all the various contracts and to see way budgets could be pooled to provide better provision.

46.2 Councillor Mac Cafferty stated that the reduction in public health budgets was not good news and expressed his concern on how services would be maintained and vulnerable communities protected. He noted that throughout the meeting there had been mention of integrating services and provision and hoped that this would result in an ability to meet the savings required, but again expressed his concern as to how such reductions would enable the delivery of the Health & Wellbeing Strategy.

46.3 The Director of Public Health stated that it was a difficult situation and that all proposals would need to be carefully scrutinised to ensure that services could be maintained.

46.4 Dr. Beesley stated that there was a need to look at budgets in the round and not just in Public Health and hoped that this would be something that could be taken forward as part of the process. There was a need to look across the whole of the city and health pathways in the required savings were to be achieved and services provided to those in need.

46.5 The Chair noted the comments and stated that money spent in Public Health was a good investment, however reductions had been made on a national basis and these needed to be tackled.

46.6 **RESOLVED:** That the report be noted.

47 ENHANCED HEALTH AND WELLBEING GP SERVICES: UPDATE

47.1 **RESOLVED:** That the report be noted.

48 MENTAL HEALTH CRISIS CARE CONCORDAT - PROGRESS UPDATE DECEMBER 2015

47.1 **RESOLVED:** That the report be noted.

The meeting concluded at 6.05pm

Signed Chair

Dated this day of 2016

WRITTEN QUESTIONS FROM MEMBERS OF THE PUBLIC

The following written questions for the Health & Wellbeing Board meeting to be held on the 2nd February, 2016 have been received:

(i) Ms. Valerie Knight

"A significant factor leading to closure of Promenade Ward at Mill View Hospital was the transfer of Substance Misuse Services from Sussex Partnership NHS Foundation Trust to Cranstoun/Surrey and Borders Partnership Foundation Trust. SPFT's loss of funding means it cannot support in-patient doctors on Promenade Ward. The short term "gain" in outsourcing SMS has resulted in:

- a dramatic decline in local SMS services
- the loss of many experienced staff
- B&H no longer having its own detox ward

Please explain:
Why your initial impact assessment did not identify these outcomes and how you will repair these dangerous and unacceptable negative outcomes?"

Relevant supporting references:

- *Council's 2016 document on Licensing (1) "..alcohol related death rates are twice the national average in Brighton & Hove"*
- *Argus 2013 "Alcohol abuse is costing Brighton and Hove taxpayers more than £100 million a year".*

(ii) Ms. P. Morley, Older People's Council

"Would the Board advise us what urgent steps it intends to take to ensure the continuity of all the current health services provided for patients at the 5 GP surgeries in Brighton and Hove covered by The Practice Group contract."

1. Review of General Practice Personal Medical Services (PMS)

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 2nd February 2016.

1.3 Author of the paper and contact details:

Natasha Cooper – Head of Commissioning Primary & Community Care
natasha.cooper4@nhs.net

2. Summary

2.1 This Report has been prepared to summarise the key findings emerging from a review of all General Practice Personal Medical Services (PMS) contracts across England undertaken by NHS England during Feb 2014 and March 2016.

2.2 In 2014 NHS England launched a national review of PMS contracts. In Brighton and Hove City there are 5 GP practice sites that operate under a PMS Contract.

2.3 PMS contracts are locally negotiated contracts compared to the nationally negotiated General Medical Services (GMS) contract and were used to allow for commissioning of services which more closely reflected local need, the financial arrangements for those services and the provider structure.

2.4 NHS England has written to the practices operating under a PMS contact outlining the approach to the review in accordance with the National guidance. These reviews need to be completed and any proposal implemented by March 2016.

2.5 The CCG has a role in working with NHS England to review the current provision of these practices where they provide services above core General Medical Services to ensure it is in line with our local strategic plans and determine how any funding released will be reinvested locally in primary care.

2.6 Conclusion, The aim of the PMS contract review is to ensure any extra funding above and beyond what an equivalent practice on a GMS Contract would receive is linked to providing extra services. This will ensure that every GP Practice in the country will receive the same core funding for undertaking core work, and that any additional funding for additional services is agreed with local commissioners, against a set of consistent principles and criteria.

2.7 Next Steps, Following the conclusion of the review NHS England will notify The Practice Group of the outcome, the pace of change for any "premium" removal and arrange contract variations as appropriate.

3. Decisions, recommendations and any options

3.1 The Health and Wellbeing Board is recommended to note the information provided in this report and agree to accept future update papers regarding the outcome of the review

4. Relevant information

4.1 Brighton and Hove have 5 General Practices who hold a PMS contract under review and managed by The Practice PLC. These practices are located within the centre on the city and more remote practices to the east and west of the city.

4.2 One of the centre located practices provides services to our homeless population; this weighting has been included within the information provided by The Practice PLC to NHS England and the CCG.

4.3 The CCG have carried out initial discussions with NHS England and The Practice PLC to establish which options are strategically appropriate and affordable.

4.4 These will be assessed as appropriate for commissioning at a practice level to align with CCG Primary Care Commissioning intensions and Proactive care model.

5. Background and context

Background:

5.1 Personal Medical Services (PMS) agreements were introduce in 2008 in advance of changes to the national General Medical Services (GMS) contract in 2004.

5.2 The key aims of PMS were to:

- Provide greater freedoms to address the primary care needs of patients
- Enable flexible and innovative ways of working
- Address recruitment problems by providing roles for salaried GP and supporting enhanced roles for nurses

5.3 Many practices received premium funding as part of the PMS contract that is now seen as potentially inequitable in relation to the amount paid to GMS contractor for an equivalent contract. Following a data collection exercise in 2013 it was identified that services commissioned nationally through PMS premium funding may not offer added value beyond that of a standard GMS contract or may duplicate other service or payment mechanisms.

5.4 In 2014 NHS England launched a national review of PMS contracts and Local Area Teams were informed that they should:

- Begin a programme of reviews from April 2014 and to complete this process by March 2016 at the latest
- Seek to secure best value from future investment of the "premium" element of PMS funding by ensuring available resources for investment are deployed in line with the following criteria:

    - Reflect joint Area Team/CCG strategic plans
    - Secure services or outcomes that go beyond what is expected of core general practice
    - Help reduce health inequalities
    - Give equality of opportunity to all GP practices
    - Support fairer distribution of funding at a locality level

- Decide on an appropriate pace of change for any "premium" removal that takes into account the impact on services to patients and the individual practices affected

CCGs are expected to work alongside NHS E during the review to identify the priorities for reinvestment that will support delivery of the local primary care strategy.

Context - Current local situation

5.5 The Practice Group was advised in September 2015 by NHS England that, in line with national guidance, a review would be undertaken of their funding and service provision over and above that of practices operating under GMS contracts.

5.6 Practices sites would be review on a case-by-case basis to ensure that they are not serving special populations that might merit continued additional funding, and that they would not be unfairly disadvantaged by the changes.

5.7 The following General Practice sites within Brighton and Hove operate under a PMS Contract held by The Practice Group:

Provider	**Patient Population**
Boots North St	2,082
Brighton Homeless Healthcare	1,138
Whitehawk Medical Practice	3,339
Willow House	1,959
Hangleton Manor Surgery	2,010
Total	**10,528**

5.8 In line with national guidance PMS practices were given three options to consider

- Option 1 – remain as PMS and if appropriate make a case for retaining part or all of the PMS premium or a phased reduction of the PMS premium
- Option 2 – Revert to GMS
- Option 3 – Revert to GMS with phased reduction of PMS premium

5.9 If premium funding is reduced or removed a transitional period until 2020 has been agreed, with 20% reduction in the current PMS Premium each year over this time. Any funds released by the PMS reviews will be available for the CCG to reinvest in primary care services.

5.10 Practice sites were given the opportunity to provide information on what the PMS premium was currently used for, any specific populations they serve, what impact the removal of the PMS premium would have and any other specific issues.

5.11 This information is intended to enable the CCG to understand the services provided and whether those over core GMS services should continue to be funded or if monies will be released for local reinvestment and the timescales for this.

5.12 Locally it is anticipated the review will highlight existing variation and the vulnerability of these practice sites, and it is likely there would be a significant impact if premium funding is removed. Meetings between The Practice Group, NHS England and the CCG are being held to discuss the implications in detail.

6. Supporting documents and information

6.1 Stake holder and patient letters issued by NHS England.

Supporting sustainable GP services

Addressing the current challenges

2 February 2016

The key issues and challenges facing General Practice

- How to care for an ageing population and an increasing number of patients with complex care needs and long term conditions
- Significant workforce issues
- Infrastructure
- Complex operating environment
- Greater professional and organisational accountability including CQC registration and inspection process

How these issues and challenges are manifesting

- Many practices are struggling to recruit to vacant partnership and salaried positions
- Some practices do not have the operational capacity to register new patients
- Some practices are closing branch surgeries and are looking to consolidate services on fewer sites
- Some practices are merging and coming together
- Some practices are handing back their contracts.

What is being done about this?

- National programmes to stabilise GP practices and support GPs
- Fairer and more secure funding
- 10 point plan around workforce
- Primary Care Transformation Fund – investment in premises & IT
- New models of care; 5 Year Forward View and pilots
- Shift towards Place Based Services – integration and localism, including movement towards co-commissioning.

Personal Medical Services Review

Review of PMS Agreements

2 February 2016

About the PMS review

- Forms part of the wider approach to equitable funding of GP practices.
- Personal Medical Services (PMS) contracts provide additional funding to GP practices above the standard national General Medical Services (GMS) contract.
- PMS contracts and the services and the funding attached to them are negotiated locally. However this extra investment has historically not always been clearly linked to extra or higher quality patient services.
- Where GP practices are receiving extra funding per patient, this has to be fairly and transparently linked to the quality of care they provide in meeting the diverse needs of the local community in accordance with our legal obligation to address health inequalities.

About the PMS review

- Nationally PMS expenditure (as of April 2013) was £325m in excess of GMS equivalent or £13.52 per weighted patient. (“The PMS premium”)
- Only £67m was linked to extra services or Key Performance Indicators (KPIs). The remaining £258m was not clearly defined.
- We need to ensure every GP practice is paid equitably for the services they provide to patients, regardless of contract type, and gives value for money.
- All PMS contracts are being reviewed across NHS England to ensure we make the best possible use of NHS resources and where any funding is not being used to maximum effect, it is to be reinvested into other GP services in the local area.
- This represents a redistribution of resources based on the principles of fairness and meeting patient need across the totality of GMS and PMS contracts. There will be no reduction in the overall level of GP funding in each area as a result of this review.

In the South East

- The difference in funding between GMS and PMS practices across the South East equates to £9.9m as of April 2015 but will reduce through national increases to GMS "core" funding, so that by April 2020 this difference will be reduced to £6.6m if we do nothing.

- We wrote to all PMS practices (there are 135 PMS contractors in the South East) asking them to provide information on any additional and 'non core' services they provide and any other factors or special populations they serve which they would like to be considered as part of the review.

- This information is being used to consider each contract on a case-by-case basis and discussions with local GP practices are ongoing as part of the review in the South East. As part of the review process we have also had discussions with CCGs and representatives of the Local Medical Committees to provide local input into the review.

- We have now extended existing PMS contracts for a further three month period to the end of June 2016 as there has been a delay in receiving the information required in some cases. The extension to the timetable will allow sufficient time to fully consider each case in order to reach the best solutions we can for patients.

In the South East

- We recognise the need to manage the pace of change to best balance any reinvestment of funding with the need to manage this in a way that doesn't adversely impact on practices and patients.

- As part of the local PMS review, any decisions made to reallocate funding to other local services will be introduced in a phased way over a transitional 4 year period, so as not to destabilise practices

- Any funds released by the removal of PMS premium payments will be re-invested by CCGs in GP primary care services for the benefit of the wider local population.

In Brighton and Hove

- In Brighton and Hove, The Practice Group holds the only PMS contract.
- The group provides services across 5 GP surgeries .
- Across 4 of these GP surgeries, The Practice Group receive almost 20% over and above what other comparable local GP surgeries receive for the same services under the General Medical Services (GMS) contract. We were discussing this funding for the services provided by these four surgeries with the Practice Group.
- The Practice Group also provides a specific service to local homeless people at Morley Street. It is recognised this provides a valuable service to these patients.
- No decisions had been made about any future funding arrangements for these services at the point The Practice Group gave notice on their contract.
- Any proposed changes to these funding arrangements would have been subject to final agreement between us and the Practice Group.

Future care of patients

Ensuring ongoing care for patients who use The Practice Group surgeries

Current position

- The Practice Group gave notice to NHS England just before Christmas that they would be bringing their PMS contract to an end. We have subsequently informed patients and stakeholders of this.

- In response to the provider's decision, NHS England is working to identify alternative options to guarantee ongoing care for all affected patients before the current arrangements end.

- No decisions have yet been made about this. We need to carefully consider our options and seek the views of patients and stakeholders in advance of taking any commissioning decision.

- We are in ongoing discussions with The Practice Group to ensure that we have as much time as possible to secure ongoing care arrangements for patients before current arrangements come to an end.

- **Patients do not need to take any action at this point and can continue to receive care at their surgery as normal.**

Next steps

- We have written to affected patients advising them of the situation and to provide them with an opportunity to provide any feedback about arrangements for their future care

- We are working closely with NHS Brighton & Hove Clinical Commissioning Group (CCG), existing local GP practices and the Local Medical Committee in considering the available options.

- This includes working to ensure the needs of any vulnerable patients continue to be met, including those who are homeless and who currently use services provided by the Practice Group.

- All feedback will be taken into account in reaching a final decision about how to ensure ongoing access to care for affected patients.

- We will update all patients as soon as we are in a position to do so

NHS England
18-20 Massetts Road
York House
Horley
RH6 7DE
england.primarycare.southeast@nhs.net
Tel: 01293 729298

13 January 2016

Dear Sir/Madam

Re: Changes affecting your care at [insert name and address of surgery]

I am writing to inform you of planned changes at **[insert name of surgery]**.

What has happened?

The healthcare provider, The Practice Group, has informed NHS England that they wish to stop providing GP services at the surgery.

What should you do?

Please note that you do not have to take any action at this point. [insert name of surgery] will continue to provide services to you at the current time. We will write to update you as soon as possible about future arrangements for your care.

What are we doing about it?

Our priority is to make sure that you can continue to see a doctor when you need to. We are exploring the available options to achieve this but wanted to make sure you were informed straight away about the situation.

We are working to ensure we can give you as much notice as possible about the future arrangements for your care and will send you further information as soon as we are in a position to do so.

We may need to ask you to register with a new GP practice in order to make sure you can continue to get medical care when you need it, but no decisions have yet been made about this. You will be given as much notice and support as possible to register at a new GP practice if this is the case.

How can I give my views?

The purpose of this letter is to invite you to provide us with any feedback you wish to give about arrangements for your future care, including any issues you want us to consider in making a decision about this or any concerns you may have.

All feedback will be considered by NHS England in reaching a final decision about

how to ensure your ongoing care.

Please contact us with any feedback about your future care by Friday 19 February. You can contact us in the following ways:

Email: england.primarycare.southeast@nhs.net

Post: Primary Care Team
NHS England
18 – 20 Massetts Road
York House
Horley
RH6 7DE

Telephone: 01293 729298

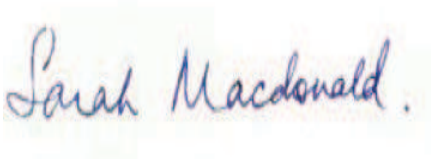
What will happen next?

We will write to update you again as soon as we can, once we have taken into account all patient feedback, reviewed all options and have made a final decision.

We understand this may be an uncertain time for you and that you may be concerned about your ongoing care. Please be assured that we are exploring all options to make sure you can continue to get care from a doctor locally, when you need it in the future.

In the meantime if you have any queries about the process, you can contact us using the contact details above. If you have any queries about your individual care, please contact **[insert name of surgery]** direct.

Yours sincerely,



Sarah Macdonald
Director of Commissioning
NHS England South (South East)

This information can be made available in formats such as easy read, or large print and may be available in alternative languages on request. Please contact NHS England on 01293 729298 or email england.primarycare.southeast@nhs.net, or speak to reception staff at the surgery.

Our Ref: SM/sm

NHS England
18-20 Massetts Road
York House
Horley
RH6 7DE

england.primarycare.southeast@nhs.net
Tel: 01293 729298

13 January 2016

Dear colleague,

Re: Provision of services by the Practice Group in Brighton and Hove

I am writing to inform you that the Practice Group has told NHS England that they wish to bring to an end current arrangements for them to provide GP services at five GP surgeries in Brighton and Hove.

The healthcare group currently manages services at the following GP surgeries:

- The Practice Whitehawk Road, Wellsbourne Health Centre (around 3,969 patients)
- The Practice Hangleton Manor, Northease Drive, Hove (recently placed into special measures (around 1,986 patients)
- The Practice North Street, c/o Boots, North Street, Brighton (around 2,134 patients)
- The Practice Willow House, Heath Hill Avenue, Lower Bevendean (around 1,977 patients)
- Brighton Homeless Healthcare, Morley Street, Brighton (around 1,354 patients)

In response to the provider's decision, NHS England is now working to identify alternative options to guarantee ongoing care for all affected patients before the current arrangements end.

We are currently in discussions with The Practice Group to ensure that we have as much time as possible to agree continued patient care. We will update patients with further information as soon as we are in a position to do so, but they do not need to take any action at this point and can continue to receive care at their surgery in the same way at the present time.

We are working closely with NHS Brighton and Hove Clinical Commissioning Group (CCG) to ensure that we consider any options which will ensure the delivery of continued and sustainable local GP services to all those patients affected. This includes working to ensure the needs any vulnerable patients continue to be met, including those who are homeless and who currently use services provided by the Practice Group.

We will be liaising with other local GP practices to determine their current individual capacity to register new patients, as well as assessing whether there is the opportunity to take a different approach in order to support the best possible long-term care for affected patients. No decisions have yet been made about this. We need to identify and assess all available options, but wanted to ensure patients and other members of the local community were informed straight away about these developments.

General practice services have a vital role to play in caring for people in our communities, but as you will be aware GP services across the country are currently facing a number of challenges. This includes workforce challenges, as well as the challenge of how to care for an ageing population and an increasing number of patients with complex care needs and long term conditions and the need to address variation in the quality and performance of different services.

We must therefore transform the way we deliver care to patients in order to meet these challenges and ensure that services deliver quality care, both now and in the future, and make the maximum use of NHS resources for the benefit of people in our local community.

At a local level, NHS England and NHS Brighton and Hove CCG are continuing to work closely together to address these challenges and to ensure the on-going development of sustainable local GP services.

We will therefore need to consider how we can ensure the long-term sustainability of services that will meet the needs of all patients (including any vulnerable patients) in determining how to guarantee ongoing care for those currently cared for by the Practice Group.

We appreciate that colleagues may be concerned about the provider's decision to end current arrangements for the provision of services at these surgeries, following the closure of Eaton Place Surgery and Goodwood Court Surgery last year. Please be assured that in responding to this development, we will ensure patients can continue to access local GP services, as we have done previously.

We are writing to all affected patients from each practice advising them of the situation and to provide them with an opportunity to provide any feedback about arrangements for their future care, including any specific concerns they may have or any issues they think we should be mindful of in reaching a decision about this. A copy of the patient letter is attached.

Your views

We would also like to invite you to provide any feedback you may have about this. Should you wish to comment please email england.primarycare.southeast@nhs.net by Friday 19 February, or write to the postal address above by so we can ensure your feedback is considered as part of the final decision making process.

All feedback from patients and other members of the local community will be taken

into account in reaching a final decision about how to ensure ongoing access to care for affected patients.

We will write to patients again as soon as we can, once we have completed our review and are in a position to confirm new care arrangements for them. We will also update you at this point.

We understand that this is an uncertain time for patients and that they may be concerned about their future access to local GP services.

We have reassured them that The Practice Group will continue to provide services to them while work takes place to determine alternative arrangements for their care.

In the meantime, if you have any queries, please do not hesitate to contact me.

Yours sincerely,

Sarah Macdonald
Director of Commissioning
NHS England South (South East)

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. Multiple Births – Notice of Motion

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 2nd February 2016.

1.3 Author of the Paper and contact details:

Kathy Felton
Commissioning Manager – Maternity, Acute & Community Paediatrics,
NHS Brighton and Hove CCG
Tel. 01273 574658
kathy.felton@nhs.net

Alistair Hill
Public Health Consultant
Brighton & Hove City Council
Tel. 01273 296560
alistair.hill@brighton-hove.gov.uk

2. Summary

2.1 To consider the notice of motion referred from the full Council meeting held on the 17th December 2015 (as detailed in paragraph 4 below), and the response from the Clinical Commissioning Group;

3. Decisions, recommendations and any options

3.1 To determine whether any action should be taken in light of the notice of motion and information provided by the CCG and Public Health.

4. Relevant information

4.1 **Notice of Motion – Multiple Births**

"This Council notes with regret figures from the Twins & Multiple Births Association (Tamba) which state that multiple pregnancies make up 3% of all births but account for more than 7% of stillbirths and 14% of neonatal deaths.

This Council notes the £3.8bn of additional funding for the NHS allocated for 2016/17 announced by the Chancellor of the Exchequer and resolves to:

1. Call on NHS England to consider the allocation of funds for further assistance to parents who have experienced multiple births and investigate improvements in care to reduce the number of stillbirths and neonatal deaths.
2. Request the Chief Executive to write to Brighton and Hove CCG to ask to what degree the clinical guidance and quality standards published by the National Institute for Health and Care Excellence (NICE) have been implemented in Brighton and Hove.
3. Request the Health and Wellbeing Board ensure that a Joint Strategic Needs Assessment on Multiple Births is added to the work programme."

5. Supporting documents and information

5.1. <u>Multiple pregnancies – an overview</u>

5.1.1 The incidence of multiple births has risen in the last 30 years. In 1980, 10 women per 1000 had multiple births in England and Wales compared with 16 per 1000 in 2011. This increase in multiple births is due mainly to the use of assisted reproduction techniques, including in vitro fertilisation (IVF). Older women are more likely to have a multiple pregnancy and, because the average age at which women give birth is rising, this is also a contributory factor. Multiple births currently account for 3% of live births.

5.1.2 Many women pregnant with twins or triplets will have an uncomplicated pregnancy which will result in a good outcome for both mother and babies. However multiple pregnancies have higher risks compared with a singleton pregnancy. For the mother, there is an increased risk of miscarriage, anaemia, hypertension, vaginal bleeding, preterm delivery, and an assisted birth or caesarean. Risks to babies include low birth weight and prematurity which can result in admission to a neonatal intensive care unit, congenital malformations, cerebral palsy, and impaired physical and cognitive development. The stillbirth rate for twin births is also 2.5 times that for singleton births. It is therefore important for health professionals to be vigilant for complications to help manage these risks and provide the best possible outcome for mother and babies.

5.2 National statistics on perinatal mortality (including stillbirths)

5.2.1 Every year in the UK over 6,500 babies die just before, during or soon after birth (including 3,600 stillbirths). While other countries have succeeded in reducing their rates of stillbirth, the UK's figure is still largely unchanged from a decade ago.

5.2.2 39 percent of all stillbirths (approximately 1,400 per year) are now known to be the result of fetal growth restriction (babies who are not growing as well as they should be in the womb). It is estimated that 800 of these could be saved every year, an overall reduction of stillbirth rates by 22 percent.

5.3 Multiple births, and stillbirths, in Brighton & Hove

Number of multiple births and outcomes

5.3.1 For Brighton & Hove residents for the ten year period 2005-2014:

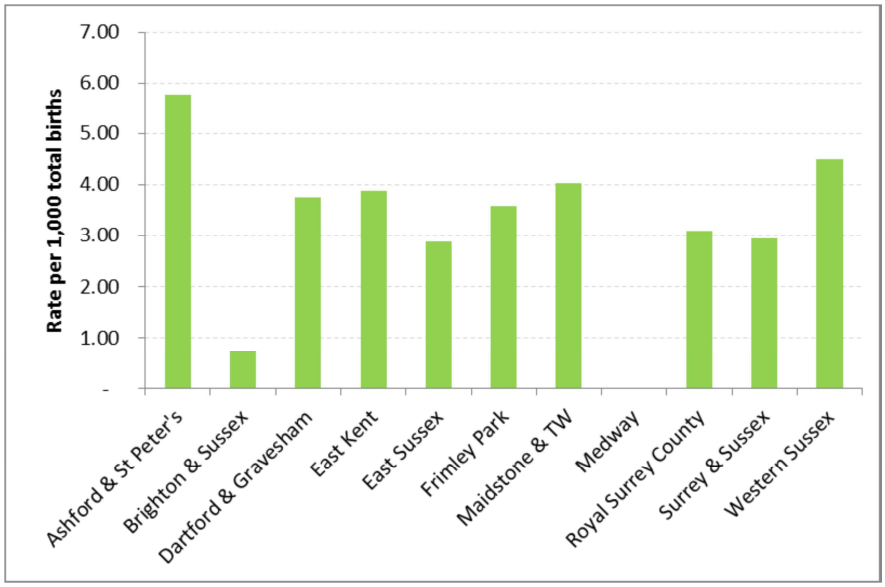
- There were 34,733 live births and 153 still births. 4% of all births were multiples.
- Of the 153 stillbirths, 18 (12%) were multiples and 135 singletons.
- In terms of still birth rates, the stillbirth rate for singletons is 4.0 still births per 1,000 live and still births (95% confidence interval 3.4-4.8) and the still birth rate for multiples is 13.9 per 1,000 live and stillbirths (95% confidence interval 8.8-21.8). The higher rate in multiple births reflects the picture nationally.
- Comparable data for neonatal deaths in multiple births for Brighton & Hove residents is not available. Nationally, to identify neonatal deaths which are babies from multiple births the Office for National Statistics (ONS) link births and deaths registration data through NHS number. The ONS have legal authority to link these two sources but this authority is not the

same for Local Authorities. The Head of Public Health Intelligence has emailed the births and deaths registration lead at ONS to check if permission can be granted for this local linkage in order to include the information in future Joint Strategic Needs Assessment updates.

Comparative rates of stillbirths by NHS Trust

5.3.2 Data from 2013/14 indicates that the local provider, Brighton & Sussex University Hospital NHS Trust, had a lower rate of stillbirths in the South East than other Trusts. This provides a relatively positive picture for Brighton & Hove, although the data relates to one year only.

Figure 1: Stillbirths by South East NHS Trust per 1,000 total births, April 2013 to March 2014.



Source: South East Coast Quality Observatory. NB* Still birth indicator (and a range of other data items) on the birth record were not being recorded fully in Medway at the time of data collection

5.4 National Institute of Clinical Excellence (NICE) guidelines on multiple pregnancy and local implementation

5.4.1 Because of the increased risk of complications, women with multiple pregnancies need more monitoring and increased contact with healthcare professionals during their pregnancy than women with singleton pregnancies. This coupled with a considerable variation in antenatal care and outcomes for multiple pregnancies led to the publication by NICE of: *Multiple pregnancy: antenatal care for twin and triplet pregnancies guidelines [CG129]* in September 2011 and

Multiple pregnancy: twin and triplet pregnancies quality standard [QS46] in September 2013.

5.4.2 These clinical guidelines and standards provide evidence-based advice on the care of women with multiple pregnancies in the antenatal period and are intended to drive measureable quality improvements in care.

5.4.3 In summary, they recommend and outline in detail the following: a specialist team made up of obstetricians, midwives and ultrasonographers, with previous experience of caring for women with multiple pregnancies; increased frequency and timing of antenatal care visits for women with multiple pregnancies and what should be done at each visit; clear recommendations on when elective birth should be offered to pregnant women expecting twins or triplets.

5.4.4 In Brighton and Hove, Brighton & Sussex Universities Hospitals NHS Trust have a very clear protocol for care of mums with multiple pregnancies and this is consistent with NICE and best practice guidelines.

5.5 National and regional initiatives on stillbirth

5.5.1 Reducing stillbirth is being brought to the top of the NHS agenda. On 13 November 2015, the Health Secretary, Jeremy Hunt, announced a new ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2030.

5.5.2 Under the plan to make England one of the safest places in the world to give birth, maternity safety champions could be introduced to report to senior NHS executives. From a £4m total pot of money, NHS trusts will be able to buy new digital equipment for monitoring or training, such as cardiotocography equipment to monitor a baby's heartbeat, which has been shown to save lives.

5.5.3 There is currently a wide range of initiatives at a number of levels:

(i) The ***Each Baby Counts*** project, set up by the Royal College of Obstetricians and Gynecologists (RCOG) aims to reduce avoidable incidents during labour at term resulting in stillbirth, early neonatal death or severe brain injury by 50 per cent by 2020.

(ii) NHS England are leading a major programme, called ***Saving Babies' Lives***, with the involvement of the Strategic Clinical Networks. The programme has developed a 'care bundle' for tackling stillbirth with four elements that, if implemented as

a package of care to all pregnant women, has huge potential to significantly reduce stillbirth rates. These are:

1. Smoking cessation
2. Identification of fetal growth restriction
3. Raising awareness of reduced fetal movements
4. Effective fetal monitoring in labour

(iii) A wider **independent review of NHS maternity services** is currently underway and will assess how best to respond to England's growing birth rate, and the need for well-staffed and safe services that give mums more say over their care.

(iv) More locally, the South East Strategic Clinical Network has produced two papers[1] to promote high quality maternity care in the South East: The Reduction of Stillbirth and The Reduction of Pre-term Birth both contain a number of useful recommendations for commissioners and providers that will be implemented over the next two years .

Other services commissioned by NHS England

5.5.4 Specialist baby care and neonatal activity is largely commissioned by NHS England. BSUH have the Trevor Mann Baby Unit (TMBU) at the Royal Sussex County Hospital and the Special Care Baby Unit at Princess Royal Hospital.

5.5.5 TMBU is one of three intensive care units in the Kent, Surrey and Sussex Neonatal Network. It provides a tertiary, neonatal medical and surgical service for Brighton, East and West Sussex and a special care service for Brighton and Mid-Sussex. There are 27 cots on the TMBU.

5.6 **Health visitor services**

5.6.1 All parents have a family health assessment carried out by the Health Visitor (HV) at an antenatal visit around 30 - 34 weeks of pregnancy and are all seen routinely at 10 - 14 days and 6 weeks postnatally. HV and children's centre support is offered to all parents whether they have a single or a multiple birth as part of the HV core programme.

5.6.2 Having a multiple pregnancy/birth is a criteria for offering a Universal Plus (UP) or Partnership Plus (UPP) HV service. This will provide them with extra support from the HV in terms of home visits, referral to Community Nursery Nurses etc depending on

[1] http://www.secscn.nhs.uk/our-networks/maternity-children-and-young-people/maternity/programmes-of-work/reduction-of-stillbirth-and-reduction-preterm-birth/

their specific needs. Not all clients with a multiple pregnancy/birth will require a UP or UPP service. Provision of this service will depend on the conversation with the client and identification of their needs and any other risk factors that they may have.

5.6.3 The breastfeeding team in Brighton & Hove currently provide peer supporters on the postnatal ward at the Royal Sussex County Hospital to provide support to all breastfeeding parents.

5.6.4 In addition all clients with a multiple pregnancy / birth will be offered information about multiple births such as TAMBA, NHS Choices website etc. and invited to children's centre groups such as Baby and You, breastfeeding drop-ins, Healthy Child Clinics etc. They will also be invited to the city-wide multiple birth group at Hangleton Children's Centre which is run by parents of multiple births and is well attended.

5.7 Brighton & Hove Joint Strategic Needs Assessment

5.7.1 The topics of multiple births and still births / neonatal deaths are particularly relevant within three sections of the Brighton and Hove JSNA

3.2.4 Population groups: Pregnancy and maternity
7.1.2 Starting well: Maternal & Infant Health
8.3 Health services: Maternity care
http://www.bhconnected.org.uk/content/needs-assessments

5.7.2 Following the decision at Full Council the Public Health Directorate will, as part of the annual JSNA programme, ensure that a review of the latest data related to multiple births and still births / neonatal deaths takes place in 2016 and that the relevant sections of the JSNA are revised accordingly.

5.8 Summary

5.8.1 Multiple pregnancies have higher risks compared with a singleton pregnancy, including for still birth and neonatal deaths. BSUH NHS Trust have a very clear protocol for care of mums with multiple pregnancies and this is consistent with NICE and best practice guidelines.

5.8.2 National initiatives, some supported by new funding, are underway to reduce the rate of stillbirths (for both single and multiple pregnancies). Locally the focus for the CCG is mainly around antenatal care, where the identification of risk and clinically evidenced approaches is key to improving outcomes. During 2016 the CCG plans to work with the Trust and the Maternity Services

Liaison Committee (a parent led group with parent representation from across the City) to use all of the national and regional initiatives available to continue to drive improvements forward as outlined above.

5.8.3 The local JSNA will be reviewed in 2016 to ensure that it highlights needs related to multiple pregnancy, and stillbirths / neonatal deaths.

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 2016/17

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 2nd February 2016

1.3 Author of the Paper and contact details:

Ramona Booth, Head of Planning and Delivery, Brighton and Hove CCG.
Email: ramona.booth@nhs.net

Claire Holloway, Acting Chief Operating Officer, Brighton and Hove CCG
Email: claire.holloway@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 2016-17 will come back to a future meeting of the Health and Wellbeing Board for final sign off and will subsequently be published in April 2016.

2.3 This paper also sets out the requirements for the development of a longer term plan covering the period between October 2016 and March 2021, which will be subject to formal assessment in July 2016 following submission in June 2016. The finalised Plan for 2016-21 will come back to a future meeting of the Health and Wellbeing Board for final sign off and will subsequently be published in September 2016.

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 2016-2017.

3.2 That the Health and Wellbeing Board gives its opinion on whether the draft commissioning intentions 2016-1017 take proper account of the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment.

3.3 That the Health and Wellbeing Board note the requirement and timetable for the development of a longer term plan covering the period October 20161 to March 2021.

4. Relevant information

Background and Context

4.1 The CCG's exisiting 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 2015 the CCG developed an operating plan which outlined how, over the period 2015/16, the CCG planned to deliver its strategic goals.

4.3 The operating plan and the five year plan were approved by the Health and Wellbeing Board.

Refreshing the Plans

4.4 The Planning Guidance "Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21" published on 22nd December 2015 asks every health and care system to come together, to create its own ambitious local blueprint for accelerating its

implementation of the Forward View. These plans are referred to as Sustainability and Transformation Plans (STP).

4.5 STPs will cover the period between October 20161 and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016.

4.6 Whilst developing long-term plans for 2020/21, the CCG must also produce a one year operating plan outlining its priorities for 2016/17 and aligned to the emerging themes from the STP.

4.7 The operating plan for 2016/17 should include the following must do's:

4.8 Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.

4.9 Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

4.10 Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.

4.11 Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

4.12 Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.

4.13 Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

4.14 Achieve and maintain the two new mental health access standards: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

4.15 Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

4.16 Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.

Consulting and Developing

4.17 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 System Resilience Plans, developed in conjunction with other NHS commissioners and overseen by the System Resilience Group;

4.18 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 events in January 2016 and February 2016.

5. Important considerations and implications

Legal

5.1 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.

Lawyer Consulted:

Finance

5.2 Commissioning Intentions are required to include broad financial assumptions for the CCG only. These are included in section 3. The amount of funding required of the CCG in relation to the Better Care Fund (2016/17) is not currently known.

Finance Officer Consulted:

Equalities

5.3 Equality Impact Assessments will be conducted on specific commissioning plans.

Sustainability

5.4 Section 16 in the attached document deals with sustainability.

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

5.5 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 Commissioning Intentions 2016/17 Document

NHS
Brighton and Hove
Clinical Commissioning Group

Commissioning Intentions

2016/17

Contents

1. Purpose of this document

This document sets out the CCGs initial plans for the coming year (2016/17). This should be read alongside The Five Year Forward View (NHS England, 2014). The proposals contained here will form the basis of further engagement with our clinical community through the Clinical Strategy Group and Locality Member Groups, with provider organisations through the contract negotiation process and with patients and public at events scheduled for January 2016 and February 2016.

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 System 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 2016 and February 2016.

3. National Financial context

NHS England and independent analysts have calculated that a combination of growing demand and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21.

The NHS has a track record for delivering efficiency of 0.8% annually, but this has increased to 1.5%-2% in recent years. For the NHS to continue to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade would represent a strong performance -compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems.

This scale of challenge cannot be met by efficiencies alone. Delivery of the transformation described in the FYFV is essential to ensure future financial balance for the NHS.

4. Local Financial and planning context

The final CCG allocations are due to be published in Janaury 2016. For the purposes of this document we have the most up-to-date planning assumptions available. These numbers are therefore a guide and will be subject to change.

Table: Initial Planning Assumptions

	2016/17
Growth on CCG Opening Allocations	1.80%
Tariff (Mandatory)	0.40%
Non Mandatory (Non-PbR, Tariff)	0.40%
Activity Growth	2.25%
CQUIN	2.50%
Prescribing Inflation (before new drugs)	5.00%
Contingency	0.50%
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 16/17, which will become clearer in the next few months once the financial framework is published and the roll forward position becomes clearer.

5. Health Needs of Brighton and Hove

Brighton and Hove Joint Strategic Needs Assessment has recently been refreshed and has been used to inform the development of the commissioning intentions alongside Right Care and Atlas of variation. The below provides a high level summary of the health needs of Brighton and Hove:

- All-age all-cause mortality is slightly elevated from the England mean.
- There is a higher level of deprivation in Brighton and Hove compared to the England mean, although this is lower than some neighbouring CCGs.
- Inequalities in male and female life expectancies are both worse than the England mean.
- The mental health spend per weighted head of the population is higher than the England mean, with favourable outcomes which are better than those of most neighbouring CCGs.
- The directly standardised mortality rate from suicide and undetermined injury is higher than the England mean and exhibits worse outcomes.
- The musculoskeletal spend per weighted head of the population is much higher than the England mean, however the Patient Reported Outcome Measures EQ-5D Hips Health Gain scores worse in comparison to the England mean.
- The cancer spend per weighted head of the population is higher than the England mean, and a higher percentage cancer patients receiving treatment within 2 months of diagnosis.

However, there are worse cancer outcomes in terms of mortality from all cancers in those under 75 years old.

- The gastrointestinal disease spend per weighted head of the population is similar to the England mean, however we have a higher mortality rate for gastrointestinal disease than average.
- The spend per weighted head of the population for circulation is higher than average, mortality from circulatory diseases is lower, and the number of patients with CHD whose last blood pressure was more than 150/90 is slightly lower.
- The respiratory spend per weighted head of population is also similar to the England mean, but mortality from respiratory diseases such as COPD is slightly higher than average.
  The percentage of patients with CRF and hypertension on ACE/ARB therapy is 1% higher than average.

The sections below outline the draft commissioning intentions for 2016/17.

6. Community Services

Significant changes are required to community services, primary care and acute care if we are to respond effectively to local and national drivers for change. Our strategic plans for Better Care are to develop more planned and integrated care for our frail and vulnerable populations. Phase 1 of the Brighton and Hove Better Care Plan is focused on testing out the new frailty model of care through the development of integrated multi-disciplinary teams based around two clusters of GP practices. During Q3 and Q4 of 2015-16 we expect that this will increasingly integrate with the proactive care model to provide a joined up, proactive approach with SCT working in partnership with General practice and other providers to support our most vulnerable and frail to remain well and living at home. We see this as building on the work SCT has already implemented and the services provided, in particular by the integrated primary care teams.

The roll out of Better Care across the city will continue in 2016-17. We will continue to work collaboratively with all local providers and other stakeholders through the agreed Better Care Programme structures to focus on prevention, self management, integrated care and care closer to home. SCT are an integral part of the Better Care Plan and will be a key partner in the delivery of integrated care across the City.

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:

Commissioning Intention	Description
Discharge to Assess	**Discharge to Assess** - In support of the Discharge to Assess programme the CCG will invest in community health services that facilitate the timely discharge of patients from hospital for the

Commissioning Intention	Description
	assessment of their long term care and therapy needs. This investment will fund extra therapists and health care assistants within the Community Rapid Response Service delivered by Sussex Community Trust. The CCG will also commission a Social Prescribing service from the voluntary sector to support people discharged from hospital to access community resources and reduce social isolation.
Intermediate care beds	**Intermediate care beds –** The Ernst and Young work completed in 2015/16 has key recommendations that include a review of community beds. We intend to redesign our intermediate care bed provision, to support both urgent and step up care as well as step down care, and with reduced average length of stay, which will include re-procurement. We give 12 months' notice on the existing contract for this element of community short term services, with the expectation of a new service being in place for 01/10/16.
Improving outcomes for people living in Care homes	**Improving outcomes for people living in Care homes** - To explore joint health and social care approach to support quality and practice for residents in Residential and Nursing Homes promoting a holistic approach to quality improvement. In particular expanding the support to Care Homes around end of life care support and resources.
Neurology	**Neurology** - To develop integrated multi-disciplinary teams to support people with neurological conditions. We want to ensure the service has sufficient capacity and is resilient, fit for the future and to further embed principles of self-management and preventative approach.
Diabetes	**Diabetes** - We are in the final stages of the Community Diabetes Hub procurement. In line with this commissioners will work with the new provider to ensure appropriate transition to the new community service hub, including the transfer of current outpatient diabetes services.
Single Point of Access	**Single Point of Access** – We would like to work with you to scope, develop and implement a single point of access hub. This will be a stepping stone to improving access to services across urgent and routine care in the City, and will be a key element of wider system change over the next few years.
Respiratory –	**Respiratory –** we want to continue to work with you to develop and deliver an integrated respiratory care service, including case finding and providing consultant support to primary care to reduce COPD related admissions.
Self-management	**Self-management** - The CCG is currently mapping the availability of commissioned self-management/self-care services across Brighton and Hove. This will inform the development of a local Self-management strategy in spring 2016. The aim is to facilitate access to a broad of a range of self-management support (including digital technology such as telecare or telehealth). This is considered an important part of the Better Care Personalisation programme and the CCG wishes to work with SCT and other partners to introduce options for self-care/self-management into individual care planning through both cluster multi-disciplinary and specialist city-wide community health services during 2016-17.
Personal Health Budgets (PHBs)	**Personal Health Budgets (PHBs) –** NHSE expects CCGs to lead a major expansion of PHBs from 2016-17 with a particular focus on children with complex needs and people with multiple long term conditions. During 2016-17 the CCG aims to build a partnership with local NHS providers and voluntary sector and user led/community organisations to develop its offer of locally available PHBs. The

Commissioning Intention	Description
	offer would sit within a broader programme of commissioning personalised community based services alongside robust case management, care planning, and self-care options for individuals. The CCG will therefore look to enter into discussions with SCT to develop the operational management of PHBs (including assessment and care provision). Much of 2016-17 is likely to explore identifying population cohorts/individuals who might benefit, and developing budget setting and sustainable funding models. This would include how best to build the PHB offer into the work of cluster integrated delivery teams as part of broader personalisation initiatives.
Person Centred Outcomes Measure	**Person Centred Outcomes Measure** (PCOM) – The CCG is currently working with providers to develop an approach to support person centred care planning to support better outcomes at an individual level and drive local service improvements. We expect to work with you to introduce this approach in community health services.
The Integrated Homeless model	**The Integrated Homeless model** is a key focus for the CCG this year and will continue to be over the coming year. SCT is a key partner in ensuring the health needs of homeless people are met and we want to continue to work with you, and other providers, to design and deliver the model.

7. Mental Health

Mental health remains a key commissioning priority for the CCG. In collaboration with Brighton and Hove City Council the Happiness Strategy was launched in the summer of 2014. We have now set out our plans for the next 2 years. The strategy sets out the framework for improving Mental Health and Wellbeing in the City.

The Happiness Strategy takes an all-round approach to mental health and wellbeing and as well as the inclusion of specific actions around mental health services it also provides a framework to make mental health part of everyone's business. It includes a broader set of actions, for example around employment, training, and working with schools.

Huge change has taken place in adult mental health services in Brighton and Hove over the last few years and the CCG intend to continue to work collaboratively with SPFT to ensure that wherever possible care is delivered outside hospital. The CCG is also committed to working with a wide range of providers across the City, including the community and voluntary sector, to provide services across a range of needs.

As part of our commitment to Parity of Esteem, in addition to our planned improvements to improve mental health services, we will continue to ensure mental health becomes an integral part of all relevant care pathways. Where appropriate, the CCG will look at commissioning all age pathways to ensure that individuals at the point of transition (between children's and adult services) get the most appropriate care to meet their needs.

We will continue to monitor performance against existing service standards and the new standards for EIP in force from April 2016. We intend to increase our focus on quality and support SPFT in developing services in line with evidence of best practice and outcomes, including the programme of work arising from recommendations made following the Care Quality Commission inspections earlier this year.

In addition, we will continue to work with the trust to secure sustainable improvement in delayed transfers of care, and expect the trust to remain a core member of the wider health economy System Resilience Group, and associated sub groups to ensure the health and social care system is sufficiently resilient to meet demand.

The CCG will also work with other mental health providers to ensure that there is continuous service improvement, and that new and emerging national standards around access to mental health services are met.

Our draft priorities for 2016/17 are:

Commissioning Intention	Description
complex trauma pathway	Develop a **complex trauma pathway** that will support young people over the age of 14yrs and adults who have experienced severe trauma. The focus will be on developing a network of providers with SPFT as the lead agency. The plans for this are well worked up and additional investment has been secured.
urgent care pathway	Review the **urgent care pathway**, including the Mental Health Liaison Team, to ensure that the level of investment/capacity can adequately meet the needs of those in mental health crisis in the city. This continues the work done in 2015/16 on the **Crisis Care Concordat**. We will further reduce the numbers of people detained under section 136, and continue to reduce the numbers of people being detained to custody.
rehabilitation pathway	The **rehabilitation pathway** across the city will be reviewed to better meet the changing needs of our population and a new model of care developed as a result of the re-investment of resource from the closure of Hanover Crescent.
Transformation Plan for children and young people's mental health services	The **Transformation Plan for children and young people's mental health services** that is currently being developed gives us an opportunity to work with you to ensure that we have appropriate and responsive services across the City. We want to work with you to ensure that the additional investment allocated to the plan supports the transformation of children and young people's mental health service in Brighton & Hove. This will include looking at how services are accessed and the timeliness of response, and clarity on the workforce in LD CAMHS, neurodevelopmental and ASD services and the capacity to meet the demand.
Eating disorder services for children and young people	**Eating disorder services for children and young people** have also attracted additional investment over the next 5 years. We want to work with you to look at how we further strengthen ED services for children and young people, and how we work with adult services to ensure an age appropriate pathway without the 'cliff edge' of transition. We will also continue to monitor the capacity within the **BHED Service** against demand. B&H CCG will look to other CCGs across Sussex, as well as SPFT, to support the development and implementation of better ED services.
children and young people's mental health liaison team	The **children and young people's mental health liaison team** at the Royal Alex Children's Hospital (RACH) will further enhance the crisis response service to children and young people in a mental health crisis. We want to ensure that SPFT and BSUH work together to provide a responsive crisis pathway within RACH. SPFT will also engage BSUH staff in a programme of training and development around mental health issues.
Integrated Homeless model	The **Integrated Homeless model** is a key focus for the CCG this year and will continue to be over the coming year. SPFT is a key partner in ensuring the mental health needs of homeless people are met and we want to continue to work with you, and other providers, to deliver the model.
Recovery College	We will work with SPFT and other community providers to continue to develop the **Recovery College** in Brighton & Hove. We also want to explore the development of a **Discovery College for young people**.
Community and Voluntary Sector	The community and voluntary sector deliver a wide range of services that a vital part of the mental health provision across the City. The CCG will be reviewing all the contracts we have

Commissioning Intention	Description
	with the C&VS to ensure that we are commissioning the right services, that duplication and gaps are identified and plans in place to manage these, and that we maximise the contribution of our community and voluntary sector partners in the mental health and wellbeing of our population.
Wellbeing Services	The contract for the provision of Wellbeing services, which includes IAPT and a primary care mental health service, expire in March 2017. Throughout 2016/17 we will be re-procuring these services to ensure that they meet the needs of our City's population, are effective and represent good value for money. The work will include talking to patients, the public and other stakeholders about what a primary care mental health service needs to look like.
Autism pathway	We will work with Brighton and Hove city Council to ensure that we review services offered to those individuals who have a diagnosis of autism or other autistic spectrum disorders. This will include scoping the need for additional support services for both children and young people and adults.
Dementia	We will work with SPFT to continue to ensure that people with **Dementia** have access to high quality care through the specialist dementia teams. We also want SPFT to continue to work with partners across the system to ensure people have access to timely diagnosis and follow up support as necessary. In addition we want to ensure that there is equity of access to crisis and urgent care services for those with dementia, specifically looking at access to **dementia crisis services**.

8. Hospital Care

The CCGs expect the trust to work closely with commissioners in the proposed collaborative commissioning alliance around the BSUH catchment area. Building on the findings of the recent Ernst and Young capacity review, it is essential that the trust and the wider system engage in a more radical programme of transformation in order to manage demand more effectively outside of the hospital and optimise capacity within BSUH. We expect this to include the following programme areas:

- *Keeping people well* – including the establishment of a more collaborative model of General Practice and aligning/integrating community resources to deliver more joined up care
- *Responsive services* – including a system–wide frailty pathway and a single integrated model for community geriatrics and the extension of sub-acute community care via Hospital at Home and Discharge to Assess schemes;
- *Safe and effective hospital care* including good practice such as the SAFER flow bundle and assessment at home/hospital at home models being business as usual across all wards areas on both sites;
- *Short Term Reablement Services* - a more responsive and appropriate model of care for step up/step down and rehabilitative care that is consistent and streamlined across the LHE.

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 secure sustainable improvement in handover delays and consistent achievement of the 4 hour standard beyond March 2016 onwards following successful implementation of the current Urgent Care Improvement Plan.

We expect the trust to be a core member of the local health economy System Resilience Group, and associated sub groups thus ensuring the health and social care system is sufficiently resilient to meet demand.

We expect the trust to achieve sustainable delivery of the 18 week wait service standard during 16/17 as per local improvement trajectories. We also expect historic data quality issues to have been

addressed and will be seeking assurance that robust internal data quality processes are in place on an on-going basis to ensure that patients' constitutional rights are met.

In order to achieve a sustainable 18 week position across the system, we will work to increase the range of choice of provider that is available to patients. We will also continue to work with acute colleagues to identify any referrals that could be better met in primary care and support peer review in primary care to benchmark best practice in referrals.

Where service standards are not met it is our intention to apply fines and penalties in 2016/17 and re-invest them in recovery where they will have most impact.

Commissioning Intention	Description
7 day services	We expect the trust to be compliant with a minimum of 5 of the 10 7 days a Week Forum Clinical Standards by April 2016 with a plan articulating how compliance with all 10 standards will be achieved by March 2017. In particular, the CCGs expect the trust to prioritise implementation of Service Standard 8 On-going Review at PRH which requires consultant wards rounds 7 days a week.
Stroke Services	We expect the trust to implement the findings of the Sussex Stroke Collaborative programme. We will expect acute stroke services to meet the SEC CVD Strategic Clinical Network Stroke Clinical Advisory Group quality standards for hyper acute stroke and TIA services. Community rehabilitation of stroke survivors will be provided in collaboration between health and social care and will meet the service outcomes set in the South East Stroke Service Specification. Review of stroke survivors at between 4 and 8 months post stroke will be integral to the proactive prevention of readmission; this will be undertaken to the recommendations of the South East Cardiovascular Strategic Clinical Network. Community services should report to SSNAP in a timely manner and with data completeness. We would expect continued improvements in performance ahead of any reconfiguration and plan to work collaboratively to create a world class stroke service for the CCGs by implementing the best option highlighted by the exhaustive pan Sussex stroke service review.

9. Planned Care and Cancer Care

The CCGs expect to work with the trust to respond to the implications of the Independent Cancer Taskforce and the NHS England implementation plan which is expected later in 2015/6 and to implement the new NICE 2WW guidance issued in June 2015.

Our cancer programme is structured around the three following priority areas and specific programmes of work. Work streams relevant to the trust are included below.

Commissioning Intention	Description
Raising awareness and earlier diagnosis of cancer	Reducing premature mortality- Key to improving cancer outcomes and delivery of nationally mandated cancer standards including improving 1 year cancer survival rates, reducing diagnosis in A&E Work with the trust to Implement best practice pathway for patients with suspected Lung Cancer (ACE) including, working with the trust to support a pathway for walk in service (no appointment necessary) for patients requiring a Lung/ Chest X-ray for suspected cancer Promoting the uptake of cancer screening programmes

Commissioning Intention	Description
	Improve uptake of breast screening across all demographics with an impact on diagnostics Review current Lung, Colorectal, Upper GI, Breast, Prostate pathways in line with the Cancer Outcomes Strategy which recommended GPs have direct access to Upper GI Endoscopy, chest x-rays; brain MRIs; abdominal/pelvic ultrasound
Improve cancer waiting times so that all providers meet national mandated standards	Delivery of cancer mandated standards Implementation of National Institute of Clinical Excellence (NICE) guidance for suspect cancer referrals Pathway redesign work with secondary care (particularly for colorectal, lung Prostate (PSA), Urology cancers) to reduce the possibility of avoidable delays in care and treatment Work with the trust to establish demand and capacity need for upper GI endoscopy Work with the trust to explore direct to test colonoscopy Work with the trust to explore proposals for a Vague Bowel Symptoms hub Work in partnership with secondary care to enable effective communication with primary care regarding patient treatments and late effects of treatments
Enhanced Survival	Improving patient experience and self-management, reducing premature mortality Work with the trust to establish a Sussex-wide Pelvic Toxicity Service to support cancer patients who have been treated with radical radiotherapy to the pelvis area. A significant proportion of this cohort of patients develops long-lasting side effects, and there is no local service that can offer them support. Work with the trust to develop a remote clinic for patients with Indolent haematological malignancies Increased implementation of the SE SCN Cancer Recovery Package comprising of 4 main elements - Holistic needs assessment (HNA) and care planning, treatment summaries, cancer reviews and patient education and support events Work with the trust to improve percentage of patients offered a treatment summary completed at the end of treatment and sent to patient and GP Work with the trust to improve percentage of patients offered a Holistic Needs Assessment during and at the end of treatment Work collaboratively with the trust and third sector and other partners to deliver aspects of the Recovery Package including psychological Support.

10. Children and Young People

Children's physical health care services in Brighton and Hove are provided by Brighton and Sussex University Hospitals Trust (BSUH), with the more community based therapy services provided by Sussex Community Trust (SCT).

The majority of health care for children and young people is provided by GPs in primary care and is in the context of looking after the family as a whole. Children in the pre-school tend to see their GP 6 times a year on average, with school age children seeing their GP 2 to 3 times per year. The CCG wants to ensure that primary care has the capacity and capability to offer high quality health care to children and young people. We will do this through the Locally Commissioned Service (LCS)

outcomes contract, building on the work done throughout 2015-16. Having happy healthy children in our city will lead to happy healthy adults and less reliance on the health and social care system.

The CCG are also committed to bringing care for children and young people, particularly those with the most complex needs, closer to home and away from hospital based settings. This is reflected in the work we will do to review and re-design children's community nursing and other therapies. We will be working closely with our ley partners, BSUH and SCT, to achieve this.

We will continue to work collaboratively with all local providers and other stakeholders to focus on prevention, self-management, integrated care and care closer to home.

The CCG will continue to work with BSUH and SCT to develop a performance reporting dashboard for paediatric and community based therapy services, building on the progress made throughout this year.

Commissioning Intention	Description
Medically Unexplained Symptoms	The CCG wants to commission an all-age pathway to support those children, young people and adults who experience medially unexplained symptoms. During this year we have been scoping the need and looking at models of delivery for the pathway.
Children's Community Nursing	A particular element of the re-alignment of community health services outlined in the Better Care paragraph above is to take forward a review of local Children's Community Nursing services. The CCG wishes to work with SCT and other partners to ensure that there is access to sufficient community-based generic and specialist Children's nursing to support the provision of care close to home for children and families.
Speech and Language Therapy	The CCG wishes to undertake a review with Brighton and Hove Children's services and SCT into the current levels of demand for local Speech and Language Therapy services, and future capacity requirements to respond to this. This will include looking at the needs of those young people between 16 and 25 years, in light of the SEND reforms (see below).
special educational needs and disability	In light of the recent SEND (special educational needs and disability) review we want to work with providers and other strategic partners, in particular the local authority, to ensure that children and young people with SEND have access to integrated, high quality care that meets needs in a personalised way and takes a whole family approach.

11. 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 timescales

for this development are still being worked through but it is hoped that 2017-17 will see some progress.

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.

The CCG will also ensure that the recommendations from the national maternity review, which is currently underway and due to report in early 2016, will be taken into account in all its maternity commissioning plans.

The CCG will continue to work with BSUH and neighbouring CCGs to develop a performance reporting dashboard for maternity services, building on the progress made throughout this year.

The development of commissioning intentions for maternity services will be heavily influenced by the outcomes and recommendations form the national Maternity Review and therefore have not been worked through.

The Review will develop proposals for the future shape of modern, high quality and sustainable maternity services across England. The proposals should, in particular, seek to achieve three complementary objectives:

- first, review the UK and international evidence and make recommendations on safe and efficient models of maternity services, including midwife-led units
- second, ensure that the NHS supports and enables women to make safe and appropriate choices of maternity care for them and their babies
- third, support NHS staff including midwives to provide responsive care. (Maternity Review Terms of reference, NHSE March 2015)

12. Medicines Management

Moving into 2016-17, 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.

This section sets out the expectations for 2016/17 with regard to high cost drugs for the Coordinating Commissioner on behalf of itself and Associate Commissioners.
Adherence to all medicines management specification documents, i.e. The Interface Prescribing Policy (IPP) and the CCG 2016/17 Payment by Results excluded drugs Commissioning Intentions for PbRe Drugs document.

All existing, and new drugs and technologies should be provided within the scope of National Tariff guidance unless:

- Explicitly excluded through the National Tariff 2016/17 and funding agreed with commissioners, or
- As part of excluded services or
- Through local arrangement agreed with the commissioners
- The 2016/17 Payment by Results excluded drugs Commissioning Intentions document will contain all drugs and indications that are expected to be prescribed in 2016/17 in line with the scoping horizon work undertaken between November 2015 and January 2017. Horizon scanning of drugs and respective business cases to support their use must be submitted to commissioners by 31 December 2015 in order that decisions and finances are aligned for 2016/17. Business cases will not be accepted in-year except for drugs which get a positive NICE Technology Appraisal in-year.
- A full data set will be submitted for all drug charges and any subsequent challenges

We will continue to monitor prescribing spend against budgets set for GP practices and other providers. We will use our prescribing monitoring dashboards to identify outliers with prescribing and work with partners to address any problems or learning needs.

We have set KPIs for all our projects and will be monitoring performance against KPIs on a regular basis.

For the high cost drugs we have a CQUIN with our main provider and will be monitoring achievement against target for that.

Commissioning Intention	Description
Drug charges	Drug charges must be for the drug only and at acquisition cost or at local Procurement Partnership (LPP) agreed price, whichever is lower. There will be no additional charges automatically added to drug prices without prior discussion and agreement with commissioners and in accordance with National Tariff rules.
patient access schemes	It is the responsibility of the Provider to ensure that all national/regional agreed patient access schemes (PAS) are in put in place within the provider and all such drugs will be charged as per the detail of the PAS.
minimises the potential for waste	Providers will be expected to prescribe and supply in a manner that minimises the potential for waste: examples of prescribing practices that could lead to financial waste include dispensing very large supplies of drugs in particular high cost drugs with each issue.
biosimilar PBRe drugs	Where biosimilar PBRe drugs are available, new patients should be initiated on the

Commissioning Intention	Description
	biosimilar product in preference to the branded originator product.
Challenges to drug interventions	Challenges to drug interventions will be responded to within the prescribed timeframe for all challenges
specialized services/chemotherapy	If specialized services/chemotherapy commissioning is transferred back to CCGs, robust systems and processes will be put in place to manage the entry of new drugs/chemotherapy protocols onto formularies to ensure that there is appropriate governance in place and that evidence based, clinically safe, cost-effective decisions are made.
procurement	The Provider will work with the commissioner when contracts are negotiated for the procurement or supply of items such as continence or stoma devices, glucose monitoring devices or feeds which may require ongoing prescription in primary care.
Oral Nutritional Supplements	In the case of Oral Nutritional Supplements (ONS) the Provider should only supply enteral feeds on discharge if accompanied with a nutritional management plan including a MUST score.
professional standards	The Provider will work with commissioners to fully implement the Hackett report and the professional standards issued by the Royal Pharmaceutical Society of Great Britain including clinical and cost effectiveness review and audit of home care medicines.
blister pack of medicines	A two week blister pack of medicines should be supplied on discharge for patients who require such a medication compliance aid. This is in-line with Section 6.1 of the IPP which states that 'patients should be discharged from hospital with a supply of medication in line with local policy, minimum 14 days.'
Stoma	We will undertake reviews of prescribed stoma appliances to ensure choices and quantities are aligned to our local guidance. We hope to work with specialist stoma nurses to achieve medicines optimization and reduced waste in this area.
Wound Care	We will continue to improve uptake of ONPOS for the provision of wound care to our residents. We will be looking at the appropriateness of quantities being ordered and rationalizing the choices on our formulary. This will help reduce waste and encourage better use of NHS resources. We will work to include optimal prescribing and be part of the Wound Care LCS.
Specials	We will work with providers to ensure that 'specials' are only prescribed and dispensed where there is no suitable licensed alternative.
Nursing Home Project	We will continue to deliver a nursing home medication review service to encourage safe and appropriate medicines management in care home and nursing home settings. We will continue to work towards a model of one GP practice per home to ensure consistency and to also align the homes to the cluster model of working within the city.
Better Care Pharmacist Model	We will continue with our cluster based pharmacist work building a case for more pharmacists working in GP surgeries across the city.
Prescribing Work as part of the LCS	We will move the prescribing incentive scheme to become an integral part of the primary care LCS this will ensure greater engagement and the achievement of medicines optimisation objectives.

13. Information Management and Technology

The CCG intends, in line with national ambition for electronic (paperless), interoperable and real-time health records by 2020 (NHS England, 2015), to begin the implementation of the CCGs Digital

Roadmap during 2016-17. The CCGs Digital Roadmaps will be published by April 2016 following consultation with Local Authorities, NHS providers and the Health & Wellbeing Boards. The CCG intends to embed technology and use of information in core CCG decision making in order to use them much more fundamentally to improve productivity and quality. It will develop a vision and roadmap that consists of:

- A view only portal for professionals across organisations to access patient records held in multiple organisations.
    - A shared working space where professionals can record and work together on a subset of care plans for patients with complex needs or a high level of risk.
    - A portal for patients/potential patients, with a view of records, ability to record, and access to relevant evidence.
    - An effective management / intervention planning toolset.
    - Effective use of specialist clinical expertise through teleworking initiatives.
    - Streamlined care delivery making effective use of information and technology wherever there is a benefit.

The CCG has identified the following prerequisites to successfully deliver the roadmap:

- The agreement of a CCG commissioning vision and strategy. Informatics is an enabler and cannot enable from within a silo separate from the commissioning agenda, neither can informatics lead development of the commissioning strategy. It must be integrated with the commissioning agenda.
- An effective means of leading this agenda, in terms of expertise, seniority, and time.
- Appropriate resources and skills to develop and deliver projects.
- Governance and coordination mechanisms, particularly across organisations.
- Provider strategy, scrutiny and challenge.
- Business cases for the future products starting with identification and quantification of benefit expected.
- Identification of critical clinical data to be required, with a focus then to drive up its quality, consistency and timeliness.
- Supporting strategies for information governance, management information, knowledge and skills, and programme control.

We will work with providers to develop consistent service improvement development plans to underpin the delivery of the digital roadmap.

The items below out the key performance and quality indicators relating to informatics:

a. All discharge summaries to be send electronically
b. Full implementation of the 2015/16 priority digital standards
c. Implementation plan for pipeline digital standards 2016-2020
d. Improved use of available shared records such as SCR
e. Full engagement with development of the Digital Footprint and dedicated resource to support delivery.

Commissioning Intention	Description
Risk stratification	Risk stratification – (commissioners need to define how the tool may be used to support their

Commissioning Intention	Description
	requirements. Link needs to be considered with LCS audit tools. Need to consider implications for data collected by GPs – coding and summarising, management of information received by the practice from other providers.)
Shared Care Record	Shared Care Record – (Care records exist. The digital roadmap will need to define how these will be shared in the medium and long term.)
Share My Care	Share My Care (See my note above. This is a short term solution for sharing Care Records, specifically the Contingency Plan) deployment is this year -see my note above. It may become the tool of choice to share Care Records but that decision has not been made yet).
Summary Care Record	Summary Care Record - Increase benefits realisation of SCR additional information through requirements on providers to increase viewing of SCRs.
GP Records Sharing	GP Records Sharing –Commission options appraisal of viewing portal solutions (including ROCI) as part of digital roadmap development.
-	- Develop and implement Records Sharing Charter proposal to ensure patients are supported to make informed decisions about the use and sharing of their electronic patient records, in line with the requirements for Personalised Health and Care 2020
-	- Undertake Electronic Patient Record reviews underpins GP records sharing by providing assurance that practices meet the standards for information management, data quality and information governance.

14. 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".

In 2015/16 we established a Primary Care Committee to oversee this significant area of development. Key to the Committee'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.

15. 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.

16. Sustainability

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.

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.

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. Fees to Providers 2016

1.1. The contents of this paper can be seen by the general public

1.2. This paper is for the Health & Wellbeing Board meeting on the 2nd February 2016.

1.3. Author of the Paper and contact details:

Jane MacDonald, Commissioning Manager, Brighton & Hove City Council
Jane.macdonald@brighton-hove.gov.uk
Tel: 01273 295038

2. Summary

2.1 This paper outlines current fees paid to independent, voluntary and community care providers. It makes recommendations for fees to be paid from April 2016 and dates when fees are reviewed. Services affected are care providers and potentially vulnerable adults for whom they provide care and support.

3. Decisions, recommendations and any options

3.1 The recommendations for fees uplifts are set out below in Table One. There is a new rate system being introduced in September 2016 when fees will be reviewed to cover additional costs such as living wage and to ensure sustainability. Following this all will be reviewed annually for implementation in April.

Table One Recommendations

	Implementation Date			
Fee area	**April 2016**	**Sept 2016**	**April 2017**	**April 2018**
Care Homes in city set rates	2% uplift	Implement new rate system	To be reviewed	To be reviewed
Care Homes in negotiated rates	No uplift			
Care Homes out of city set rates	Match host Authority	To be determined		
Care Homes out of city negotiated rates	No change	To be determined		
Home Care	2% uplift	Implement new rate system	To be reviewed	To be reviewed
Shared Lives	2% uplift	No uplift	To be reviewed	To be reviewed
Direct payments	2% uplift	Alignment with core home care	To be reviewed	To be reviewed
Other service areas	No change	no	To be reviewed	To be reviewed

Note: These uplifts are high-lighted in the report

3.2 If the above recommendations are not agreed, or if the board wishes to amend the recommendations, then the item will need to be referred to the Policy & Resources Committee meeting on 11th February to be dealt with as part of the overall budget. This is because the budget is being developed on the assumption that the fees and charges are agreed as recommended and any failure to agree, or a proposal to agree different fees and charges, will have an impact on the overall budget, which means it needs to be dealt with by the Policy & Resources Committee as per the requirements of the constitution. This will not stop the board from making recommendations to P&R

4 Relevant information

4.1 This paper sets out the issues concerning fee levels and makes recommendations on fee uplifts. Fees are those paid to independent and voluntary sector providers that supply care services on behalf of Brighton and Hove City Council Adult Social Care and Brighton and Hove Clinical Commissioning Group.

4.2 It includes fees paid to providers of care services for older people, adults with a learning disability, adults with mental health needs and people

with physical disabilities. Service providers include registered care homes, supported accommodation, home care and community support, community service and direct payments. Terminology used in this Paper is detailed in Appendix One

4.3 Overview of the market

- Hospitals are discharging people earlier and care providers are increasingly caring for people with complex and multiple needs.
- The community struggles more than ever to respond to demand. Recruitment in both the home care and care home sector is difficult for a large number of providers.
- The care market in the city is changing at a pace that accelerates year on year. Care homes with nursing are closing or changing their business model and new care homes are opening. It is now a challenge to purchase care home places at the set fee rate.
- Two contracted home care providers have left the market in the last year.
- The home care contract is being re-tendered and a new contract will be in place from September 2016.
- Following recent legislation employers will be required to pay a minimum of £7.20 from April 2016 rising to £9 an hour by 2020. Locally there is a commitment to the Living Wage Foundation which currently requires a minimum £8.25 per hour.

4.4 Finances

4.4.1 The Council has developed draft 4 year budget proposals which will be considered by Budget Council on 25 February 2016. The Council faces a significant financial challenge over the medium term and has to balance the predicted gaps arising from reducing government grant support against projected growth in service demands and complexity(mainly social care) and cost increases (inflation) alongside encouraging good practice by ensuring proposed fee rates reflect living wage and other recommendations.

Fees paid to providers

4.5. Overview of how fees are paid

4.5.1 For a number of years there has been an issue about the costs of delivering decent quality care versus the prices which such care attracts. This is particularly true of care delivered in registered care homes where the council pays set rates for a placement ie care homes for older people and older people with mental health needs. Some providers have expressed

concern that prices paid by councils do not reflect the real cost of care. The debate has tended be different in care homes where fees are individually negotiated e.g. those for people with a learning disability. In these homes fees tend to be higher, sometimes significantly higher.

4.5.2 Currently both set fees paid to care home and home care providers are constructed in a way that has developed over a number of years. Stakeholders generally agree there is little transparency, which makes determining whether or not they are reasonable, a difficult task. See Appendix Two for 2015-6 In-city care home fees paid to providers

4.6 Projects to determine fee levels and implementation dates

4.6.1 In order to get a better understanding of the cost of care the Council and Health commissioners are working with stakeholders to construct a methodology for fee calculation. This has been complex and included analysing national rates and the 'real' rate. A local overlay to the information will be added which has included use of a survey and a focus group is informing this process. This work is currently in progress and the outcome will be known in the summer of 2016. .

4.6.2 The new, simpler fee structure will require a system overhaul that will include a different use of the Care Matching Service and the introduction of a new 'micro commissioning' system, also known as a Dynamic Purchasing System. This is a web based procurement route used to award contracts for specific individual packages of care or placements. The new fee structure will be used for all new adult home care and care home packages of care and placements. The same intelligence will be used to inform both the new care home and new home care rates.

4.6.3 The new home care contract will be in place by September 2016. This will include the new home care fee. New care home rates will be will be ready for implementation in September 2016. The recommendation to the Health and Wellbeing Board April / May 2016 will be for a further uplift.

4.6.4 As some parts of the market are struggling financially it is recommended that some care home and home care fees are uplifted in April 2016, before the new fees system is introduced in September 2016.

4.6.5 The recommendation is for in city care homes and home care to be reviewed:

- April 2016 uplift
- September 2016 new fees system
- April 2017 and April 2018 fee reviews

Proposals for fee increases in April 2016

4.7 Learning Disability services and Dynamic Purchasing

4.7.1 Fees for learning disability care homes have no set rates and can vary significantly according to provider and individual users' needs. Generally the fees paid are higher than in care homes where set fee rates apply, arguably though many of the 'hotel' costs are similar. Although these services have not received any uplift to fees for several consecutive years, the sector broadly understands and accepts the need for continued efficiency.

4.7.2 In the future learning disability care home fees will be considered as part of the broader work taking place. Placements for these services will be included for consideration on the Dynamic Purchasing System.

4.8 Care homes

4.8.1 Fees for care homes where no set fee rates apply vary significantly according to provider and individual users' needs. They include providers where the primary need is learning disability and younger adults with mental health needs and physical health needs. Generally the fees paid are higher than in care homes where set fee rates apply, arguably though many of the 'hotel' costs are similar. Although these services have not received any uplift to fees for several consecutive years, the sector generally understands the reasons for this. **It is recommended therefore, that there is no uplift to providers of care homes where there are no set fee rates**

4.8.2 Residential and nursing homes in the city that accept set rates are under pressure. A number of smaller providers have left the market and others are seeking to do so. The new fee structure from September 2016 will help providers. It is likely to include an uplift that is greater than 2%. Action to support providers is needed before the new structure is implemented. The Brighton and Hove Registered Care Association (RCA) has been lobbying the Council, Elected members and this Board to make the point that, 'The fees are well below the true cost of providing care for vulnerable older people'. **It is recommended that there is an uplift of 2.0 % for all registered care homes where set rates apply. This would apply to both residential and nursing homes from April 2016 through to September 2016**

4.8.3 It has long been recognised that each local area best understand their market. **It is recommended that Brighton and Hove match the applicable**

host authority set fee rates for new and existing registered care home placements out of the city where these rates apply. It is also recommended that any adjustment to these rates is reflected in any third party payments which apply.

4.8.4 With regard to supported living out of the city, if appropriate owners will be requested to contact the council to discuss future rates. This includes supported living and community support for people with learning disabilities and accommodation services for people with mental health needs.

4.8.5 It is also recommended that any adjustment to rates for registered care homes in the city is reflected in any third party payments which apply.

4.9 Home care

4.9.1 The current home care fee is outlined below.

AGENCY	***Standard Care***	***Special Care***
60mins	*£15.10*	*£17.14*
45 & 30 mins.	*Pro-rata*	*pro- rata*
15mins	*£6.22*	*£7.24*
Beyond 8pm		
60 mins	*£15.61*	*£17.65*
45& 30min	*Pro-rata*	*pro- rata*
15 mins	*£6.73*	*£7.85*

4.9.2 The current standard rate fee is £15.10 per hour for Brighton & Hove main providers with an enhanced rate of £17.14 per hour.

4.9.3 Overall the percentage uplift from September 2016 is likely to be greater than 2%, but will be agreed as part of the Permission to Tender for Home care report coming to the Health and Wellbeing Board also in February 2016. Further to this fees will again be reviewed for adjustment in April 2017.

4.9.4 **An uplift of 2% on the current fee is recommended April 2016 through to September 2016**

Note for system reasons percentage uplift figures need to be divisible by four - see Appendix Three

4.10 Direct payments

4.10.1 The commissioning intention is to align direct payments that are used to purchase home care from an approved home care agency, to the new home care core rate. This will make direct payments attractive to potential users and simple to administer. Currently there is a small variation between rates which has the potential to deter potential users taking up direct payments. It also causes significant administrative problems. **The recommendation is an uplift of 2% on the current fee in April 2016 through to September 2016, then an alignment with the core home care rate.**

4.10.2 This recommendation is supported by the general manager with responsibility for Self-Directed Support.

4.11 Shared Lives

4.11.1 A key area of growth is Shared Lives. In order for this service to continue expanding **it is recommended a 2% paid to providers of this service April 2016-7.**

4.12 Service contracts

4.12.1 Service contracts are funding arrangements for services provided in the community generally by voluntary and community groups. This category includes day activities and community meals. The prospectus approach to commissioning was used for many funding arrangements. This includes the facility for a bidder to set their price for overall delivery of service, including management and operations costs. Thus any relevant cost of living or uplift within the scope of the available funding would be built into the bid. This would be agreed for the length of the funding agreement. Both council and NHS commissioners are continuing to work with providers to make efficiencies on an individual basis. **There is no recommendation for a change of fee rate for service contracts.**

4.13 Additional benefits

4.13.1 It is recommended that the current systems of additional benefits paid to providers remain in place. This includes Brighton & Hove City Council continuing to fund and provide a range of training and targeted advice sessions eg fire evaluations that are free to access and which are much appreciated by providers. The council also provides advice and support relating to fire compliance and health and safety. There is also funding for flu vaccines for front line care workers.

4.14 Providers experiencing financial difficulty

4.14.1 Any provider experiencing financial difficulty is urged to contact the council. If the council cannot assist directly, business support partners might be able to help, information is available on the council website.

4.15 Other Areas

4.15.1 Other local areas are also modelling rates that they will set. The early indication is that this is a more complex picture than in previous years and a number of areas continue to consider their offer.

5. Important considerations and implications

Legal

5.1 It is a function of the Health and Well Being Board to oversee and make decisions concerning Adult Social Care in the City. The Local Authority has a duty pursuant to Section 5 of the Care Act 2014 to ensure there is a varied and sustainable market available to meet the needs of all persons in its are with care and support needs both now and in to the future. In securing adequate and quality provision to meet care and support needs the responsible public bodies must have regard to individuals' Human Rights in accordance with the Human Rights Act 1998

Lawyer: Sandra O'Brien Date 30.12.2015

Finance

5.2 The proposed increases in Home Care rates are discussed in the 'Permission to Tender for Home Care' report presented at this meeting and include the financial impact. The fee uplifts of 2% proposed for Direct Payments and Shared Lives are within the proposed 2016/17 budget assumptions

5.3 The proposed increases in Care Home rates will initially be covered by inflationary uplifts applied to budgets until new rates are set from September 2016. Collaborative working with Care Home providers across the city is on-going to determine a sustainable fee model, which will incorporate the UK living wage, for an implementation date of September 2016. Care Homes who are not on set rates will receive no uplift until the new rating system is implemented in September 2016, the savings that result will be used to alleviate the budget pressures from the increasing number of placements.

5.4 The recommendations for new rates from September will be the subject of a further report which will include an assessment of the financial impact.

Finance Officer Consulted Anne Silley Date 22/12/15

Equalities

5.5 An Equalities Impact Assessment has been completed.

Sustainability

5.6 This paper recommends fees that recognise Council and NJHS budget pressures and keep providers sustainable.

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

5.7 There has been engagement with Commissioners in the Clinical Commissioning Group and Public Health Commissioners - see below

5.8 This paper has minimal impact on Children's Services

6 Supporting documents and information

Engagement

6.1 This report has been shared:

6.1.1 The **Clinical Commissioning Group** is broadly in support of the recommendations in this report

6.1.2 The **Public Health** Business Manager confirmed that Public Health does not intend to provide uplift to its service contracts in 2016.

6.1.3 **Corporate Policy, Performance and Communities** indicated that it is important that Adult Social Care and CCG Commissioners continue to work with users of services and providers to make efficiencies on an individual basis. They highlighted the importance of balancing efficiencies with quality, social value and overhead costs being taken into account in future reviews.

6.1.4 This report has been shared with **Healthwatch Brighton and Hove**. Their comments are below:

6.1.4.1 The proposals to uplift set rates by 2 % from April 2016 to Sept 2016 should address any pressures arising from inflation (projected to be

below 2%). However, service users are expressing concerns about quality of care and it is difficult to comment on whether the fees will be sufficient to ensure quality care, particularly where needs are complex. Healthwatch Brighton and Hove therefore welcome the further work the Council and Health Commissioners are undertaking with stakeholders to construct a methodology for fee calculation with a view to further revisions to the fee structure from September 2016, and will be happy to comment on this in due course.

6.1.5 The **East Sussex, Brighton & Hove Registered Care Association** broadly supports the recommendations in the Fees to Providers 2016 Report. They welcome the collaborative approach taken to determine a sustainable fee model and they are keen to ensure that the increase in September 2016 reflects the living wage of £8.25 as set by the Living Wage Foundation. However, to enable care home providers to pay this, a very substantial increase in fees would be required. For the record the Laing Buisson report "Fair Price for Care" 6th edition, Oct 2014 to Sept 2015, states that the lowest fair fees are £554 per week for residential care, older people and £591 per week for residential care, dementia. The highest set rates currently paid by Brighton & Hove City Council are £474.70 per week and £529.38 per week respectively.

Appendix One

Terminology

- *Dynamic Purchasing System* is the procurement route used to award contracts for specific individual packages of care or placements.
- *Care homes* and care homes with nursing; care homes are also known as rest or residential homes and care homes with nursing are known as nursing homes. In this report the term registered care home is used to mean both care homes and care homes with nursing, all of which are registered with the Care Quality Commission.
- *Set fee rates* are usually used for placements in homes for people needing physical support and people needing memory/mental health support. These tend to be older people. Fees for adults aged 18 - 65 generally are individually negotiated ie 'non set fee rates'.
- Supported living and *supported accommodation* refer to services where a person has a tenancy or licence agreement for their accommodation, with separate agreements for care and support.
- *Third party payments* are 'top ups' paid by a third party, usually a family to secure a placement at a price that is greater than the council would fund.
- *Service contracts* are funding arrangements for services, such as advocacy and day services that are provided in the community generally by voluntary and community groups.

Appendix Two

2015-6 In-city care home fees paid to providers

Residential Care Homes for Physical Support 65-74, 75-84, 85+ Negotiated rates and Memory/Mental Health 65-74, 75-84, 85+ Negotiated rates

Residential Care Homes for Physical Support 65-74, 75-84, 85+	Weekly Rate 2014/2015	% increase	Weekly Rate 2015/2016
Low need - single room	£347.00	1	£350.47
Low need - shared room	£312.00	1	£315.12
Medium need - single room	£422.00	1	£426.22
Medium need - shared room	£384.00	1	£387.84
High need - single room	£470.00	1	£474.70
High need - shared room	£431.00	1	£435.31

Residential Care Homes for Memory/Mental Health 65-74, 75-84, 85+ Negotiated rates	Weekly Rate 2014/2015	% increase	Weekly Rate 2015/2016
Single room	£519.00	2	£529.38
Shared room	£481.00	2	£490.62

Nursing Homes for Physical Support 65-74, 75-84, 85+ Negotiated rates and Memory/Mental Health 65-74, 75-84, 85+ Negotiated rates

Weekly rate including social care rate for FNC

Care homes with Nursing for Physical Support 65-74, 75-84, 85+ Negotiated Rates	Weekly Rate 2014/2015	% increase	Weekly Rate 2015/2016
Shared room	£539.89	1	£545.29
Single room	£577.89	1	£583.67
Care homes with Nursing for Memory/Mental Health 65-74, 75-84, 85+ Negotiated Rates	Weekly Rate 2014/2015	% increase	Weekly Rate 2015/2016
Shared room	£590.89	1	£596.80
Single room	£628.89	1	£635.18

FNC	Weekly Rate 2014/2015	% increase	Weekly Rate 2015/2016
Single Nursing Band	£110.89	1	£112.00
Continence Payment	£6.90		£6.90

Weekly continuing health care base line fee rates for 2015/2016 for in city nursing homes for physical support 65-74, 75-84, 85+ Negotiated rates and memory/mental health 65-74, 75-84 and 85+ negotiated rates

Care homes with Nursing for Physical Support 65-74, 75-84, 85+ Negotiated Rates	Weekly Rate 2014/2015	% increase	Weekly Rate 2015/2016
Shared room	£581.20	1	£587.02
Single room	£619.20	1	£625.40
Care homes with Nursing for Memory/Mental Health 65-74, 75-84, 85+ Negotiated Rates	Weekly Rate 2014/2015	% increase	Weekly Rate 2015/2016
Shared room	£632.20	2	£643.33
Single room	£670.20	2	£682.09

Block (38 beds): Partridge House	Memory and mental health 65-74, 75-84, 85+ negotiated rates NH	£811.97 (continence payments are included in the above price)

Appendix Three

System Demands

The Adult Social Care database (Carefirst) and the Electronic Call Monitoring System and Payment system (CM2000 and Finance Manager) need to match in order to pay the home care providers in a timely manner. Currently Carefirst rounds down to the nearest pence and ECMS rounds up. In order to resolve this, the standard and special homecare rates need to be divisible by four (to two decimal places) for the hour, half hour, quarter hour and three quarter hour calls. This means that if a percentage fee increase is agreed, the actual home care rates need to be adjusted up to the nearest figure that is divisible by four.

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. Annual Review of Adult Social Care Charging Policy 2016

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 2nd February 2016

1.3 Author of the Paper and contact details:

Angie Emerson, Head of Financial Assessments and Welfare Rights
Tel: 01273 295666
angie.emerson@brighton-hove.gcsx.gov.uk

2. Summary

2.1 People eligible for adult social care services are means tested to establish whether they are required to contribute towards the cost. There are around 2500 service users with non-residential care and around 1300 in residential care homes. This includes older people, working age adults with physical disabilities, learning disabilities and mental health difficulties and charges are determined by legislation and policy.

2.2 Under the Care Act 2014 charging policies are discretionary but subject to certain regulations and limitations. This report seeks approval of the council's charging policy which is compliant with the requirements of the Care Act 2014.

2.3 Most social care services, funded by the council, are provided by private organisations and the maximum charge a person may have to pay depends on the fees charged by them. However, where the council

provides in-house services there are set maximum charges which are reviewed in April of each year. Most charges are subject to a financial assessment to determine affordability but the charging policy also includes several, low cost, fixed rate charges. This report provides recommendations to uprate our maximum and fixed rate charges.

3. Decisions, recommendations and any options

With effect from 11th April 2016

3.1 That the council continues with the current charging policies for residential care and non-residential care services which are compliant with the requirements of Section 17 of the Care Act 2014, (subject to 3.2). The policy is attached at Annexe 2.

3.2 To amend the charging policy to stop providing an income disregard for the night rate element of Attendance Allowance and DLA(care) for new service users see 4.6.7 below

3.3 To continue with the current decision that no charges should apply to carers for any direct provision of care and support to them.

3.4 The fee charged for setting up Deferred Payment Agreements should be increased by 2% to £485 plus any additional costs for property valuations.

3.5 The council continues to charge the maximum interest rate as set by the government for loans provided under the mandatory Deferred Payment Scheme. (See 4.5 below).

3.6 That the table of charges below are agreed with effect from 11th April 2016

Maximum Charges	**2015/16**	**Proposed for 2016/17**
Means Tested Charges		
In-house home care/support	£21 per hour	**£22 per hour**
In – house day care	£34 per day	**£35 per day**
Fixed Rate Charges		
Fixed Rate Transport	£3.50 per return	**£3.60 per return**
Fixed Meal Charge /Day Care	£4.30 per meal	**£4.40 per meal**

CareLink Plus

2015/16	**Proposed 2016/17**
	New Service Users
£16.00 month – with 2 key holders,	**Band 1 - £18.50 - Two key holders ***
£18.50 month – with 1 key holder	**Band 1 - £18.50 - One key holder ***
£22.17 month – with key safe	**Band 2 - £22.17 - No key holders, ***
	Existing service users
£16.00 month – with 2 key holders,	***£17 per month (protected charge)**
	*See details 4.7.3 and in Annex 1.

Please note:
If the above recommendations are not agreed, or if the board wishes to amend the recommendations, then the item will need to be referred to the Policy & Resources Committee meeting on 11th February to be dealt with as part of the overall budget. This is because the budget is being developed on the assumption that the fees and charges are agreed as recommended and any failure to agree, or a proposal to agree different fees and charges, will have an impact on the overall budget, which means it needs to be dealt with by the Policy & Resources Committee as per the requirements of the constitution. This will not stop the board from making recommendations to P&R.

4. Relevant information

4.1 Where the council has determined that a person is eligible for care and support under sections 18 to 20 of the Care Act, the Council can charge the service user subject to the financial assessment set out in Section 17 of the Act.

4.2 Financial assessments determine a fair contribution towards care costs and are subject to an appeals procedure for exceptional circumstances.

4.3 **Charging for Carer's services**
The Act empowers councils to charge for the direct provision of care and support to carers. The recommendation above is not to charge carers in recognition of the value of care provided to vulnerable people. During the first year of the Act referral numbers have not increased but will be monitored.

4.4 **Residential Care:**
The Care Act repealed the national mandatory means test for residential care creating a new, but almost identical, discretionary framework for charging. The council continue to charge for services taking account of the new regulations.

4.5 **Deferred Payment Agreements: (DPA)**
Under current legislation, the council has discretion to "loan fund" care home fees, where the resident owns a property and does not want to sell it during their lifetime or where they are not immediately able or willing to sell. The Care Act requires the council to operate this mandatory scheme, subject to some discretionary conditions, including compound interest on the loan from the start date. The government have set a maximum interest rate which is currently 2.25% and will be reviewed in April 2016. The council could charge a lower interest rate or none at all but cannot charge more than this. It is recommended that the council continues to charge the maximum interest rate on the debts that accrue.

The administration costs for setting up and managing a Deferred Payment were set in 2015/16 at £475 and it is proposed that this fee is increased by 2% to £485. This is based on the estimated average administrative cost for a DPA during the lifetime of an agreement including ongoing invoicing costs and termination costs.

4.6. **Non-residential Services,** including direct payments, personal care at home, community support, day activities, adaptations, money management and other support.

4.6.1 **Charging for people with eligible needs for care in their own home.**
There are around 2500 service users in their own homes with eligible needs and around 45% of them, who have minimal savings and limited income from state benefits, will continue to receive **free** means tested care services. They will only be affected by the fixed rate charges in the list above at 3.6.

4.6.2 Around 45% of service users are assessed to contribute an average of around £50-£60 per week, usually based on their entitlement to disability benefits.
The proposed new maximum charges in the list at 3.6 will not affect the assessed charge for these people but they may be affected by the fixed rate charges.

4.6.3 Most people receive home care services from the independent sector where lower fee rates are set and agreed under the council's contracted

terms and conditions. The unit cost for in-house home care is £67 per hour. The current 2015/2016 fee for standard home care with an approved agency is £15.10 per hour but rates can vary with other agencies. People who have over £23,250 in savings will be required to pay the full fees charged by private agencies.

4.6.4 Around 10% of service users pay the maximum charge for in-house home care and day care. This affects people with savings over the threshold of £23,250 and also affects a small minority of people with very high income, and those with a very small care package, e.g. One day centre attendance per week.

4.6.5 The council provides intermediate care and reablement home care and residential care services free of charge for up to 6 weeks. If, in exceptional circumstances, the home care service continues beyond 6 weeks then the service user is means tested and may be charged up to £22 per hour. Most people use private agencies where fees are generally lower.

4.6.6 The averaged actual cost of council provided day care is £94 per day. The maximum charge is now £34 per day and it is recommended to increase the maximum to £35 per day. Many councils have more recently reduced or removed their subsidy for day care and now charge the actual cost. Any increase in charge will only affect people who are assessed as able to pay this amount as set out in para 4.6.4.

4.6.7 **Proposed change to the financial assessment policy:**

Attendance Allowance and DLA (Care) are income benefits provided by the DWP for people with disabilities. The highest rate of payment is £82.30 per week which includes a payable element of £27.20 per week for night time needs. These benefits are taken into account when calculating the amount a person can pay towards the cost of their care package but with the exception, in some cases, of the extra £27.20 per week. Previous regulations required us to disregard this £27.20 for night time needs where the council does not provide any night services. However, under the Care Act, it is no longer a requirement to disregard this sum, other than protecting those people who already have this allowance. The Department of Health say that DLA(care) has been replaced by PIP (Personal Independence Payment) which does not have night rate element. It does still have a rate of £82.30 per week which can be taken fully into account in the calculations. It is therefore recommended that the charging policy for new service users is amended to take full account of all 3 disability benefits where the

rate of £82.30 is in payment. (AA, DLA(care) and PIP). This means that charges will be higher for new service users who receive this benefit than under the current policy.

4.7 **Fixed Rate Charges – (not means tested)**

4.7.1 Flat rate charges for transport to day centres or other activities have fallen behind inflationary increases in travel costs. It is, therefore, recommended that the return journey charge is increased from £3.50 to £3.60 in April 2016.

4.7.2 It is recommended that the fixed charge for meals provided in the council's day centres should be increased from £4.30 per meal to £4.40. This charge includes beverages and small snacks during the day.

4.8 **CareLink Plus Services:**

- There are almost 3000 carelink plus service users in the city, excluding sheltered housing. Almost 2500 people pay the charges listed in this report whilst a minority get a free service as explained below.

- The CareLink Plus net budget for 2015/16, after charges and revenue generated from out of hours, contractual work and better care funding is only £10,000. It is expected that further funding from better care bids for 16/17 to support further delivery of the telecare living well programme will result in all operating costs being financially self sufficient.

4.8.1 Under the Care Act charges made for preventive services must be reasonable and must not exceed the actual cost. Where someone has eligible care needs under Sections 18-20 of the Care Act, they will have a mainstream financial assessment to determine any charges and if this shows a nil contribution they will be eligible for a free Carelink Plus service. Otherwise, everyone will pay a reasonable flat rate charge for CareLink Plus services unless they appeal against the charge if they feel they are in hardship.

4.8.2 **Comparator information**

- CareLink Plus charges have historically been low compared to other councils but over several years, increases have placed us about midway in the country and the proposed pricing points are in line with national averages. The largest service in Sussex

"Welbeing" costs £15.96 per month, with an additional one off set up fee of £37 and extra telecare devices are chargeable.

The largest national service Age UK costs £15.03 per month+£129 setup fee.

There is a vast range of different charging policies with no national standard approach e.g. Hillingdon has a free service for people over 80 and Merton's charges exceed £30 per month.

4.8.3 A review of our current charging policy has taken into account:

- The ability of CareLink Plus services to provide cost effective (and preventative) social care and support
- Telecare devices have so far been free of charge. However, given the growth in the range of telecare, the number of people who use this and the cost, this position has become unsustainable.
- People may cancel and face greater risks if the service becomes unaffordable
- The recent evaluation of the telecare living well programme showed preventative savings of £5-6k per year per person, in line with similar studies.
- CareLink Plus has a business plan which seeks to become financially self sufficient. The proposed charges will generate more income which represents progress towards this aim.

4.8.4 **The proposal for 16/17 is:**

a) To continue providing a 4 week free trial for hospital discharge, carers and the living well project.
b) To provide a free service for those with eligible needs under S.18 of the Care Act and a financial assessment of nil contribution.
c) **New customers** (or following a change in need) who are required to pay to be charged one of the 2 new bandings as described in Annex 1.
d) **Existing customers** who pay £16.00 per month will have an element of protection for one year against the new bandings and it is proposed to increase their charge to £17.00 per month.
e) Existing customers who currently receive a free service under the old Supporting People policy should be reviewed and brought into line with these proposals (see further details below*).

*There are still 450 people receiving a free service under the old Supporting People funding policy and they will be reviewed during the first 6 months of 2016/17. They may still be eligible for a free service under the new policy but if not they will be charged under the new bandings proposed here. This may lead to cancellations and risk assessments will be carried out to encourage access to welfare benefits (to help pay for the service) and to review ASC support.

5. Important considerations and implications

Legal

5.1 It is a function of the Health and Wellbeing Board to oversee and make decisions concerning Adult Social Care. Within the body of this report references are made to the relevant powers and duties in relation to Charging contained in the Care Act 2014. Duties must be adhered to. Where the exercises of Powers are recommended the Board must make a decision as to whether the Power should be exercised.

Sandra O'Brien 12/1/2016

Finance

5.2 Charges for Adult Social Care services are reviewed annually in line with the Corporate Fees and Charges policy. The annual income from charging for in-house non residential services is approximately £1 million, out of the estimated total for non-residential services fees across Adult Social Care of £4.9million. It is anticipated that the proposed charges will deliver the level of income assumed in the 2016/17 budget strategy including an inflationary increase.

5.3 The costs of providing in house services are higher than the proposed charges. The 2014/15unit costs are:

- Home Care £67 per hour compared to the proposed charge of £22 per hour
- Day Care (Older People) £94 per day compared to the proposed charge of £35 per day

5.4 The proposed charges take into account the cost of running the services (albeit with subsidy) and are benchmarked against other local authorities

Finance Officer consulted: Anne Silley Date 15/01/16

Equalities

5.5 All service users are subject to the same means test and will only be affected by this revised policy if they are able to pay. People will not be treated in any way less favourably on the grounds of personal differences such as age, race, ethnicity, mobility of lifestyle, religion, marital status, gender, sexual orientation, physical or mental impairment, caring responsibilities and political or other personal beliefs.

Sustainability

5.6 There are no sustainability issues.

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

5.7 There are No identified issues

6. Supporting documents and information

6.1 The proposed Charging Policy is attached as appendix 1 and it is intended to update the Board at its meeting in relation to the information that is awaited from the Department of Health.

Proposed new charging bands for new customers from April 2016:

Band 1: £18.50 per month for a Standard CareLink Plus package with:

a) Two key holders
b) One key holder plus key safe (No change to the charge for key safes at £50.00)

This includes pendant alarm button, 24/7 monitoring, installation costs, 24/7 response to NSR (if key holders can't respond), service and maintenance and standard telecare devices following assessment, as follows:

Medication prompt / well-being check (initiated by unit)
Pendant or IVI pendant
Smoke detector
Co2 detector
One from: Shower pendant/skirting trigger/bogus caller/pull cord

Band 2: £22.17 per month for an Enhanced telecare package with:

No key holders, key safe only (No change to the charge for key safes at £50.00)

This includes all the standard options for Band 1 (as assessed) and in addition specialised telecare devices such as:

Carelink unit via mobile network (GSM),
GPS locator unit
PIR
Chair sensor
Bed sensor, with or without X10 lamp
Epilepsy sensor
Pressure mat
Pillow shaker
On site carer system
Door entry/exit sensor
Heat sensor
Flood detector
If 2 or more required: Shower pendant/skirting trigger/bogus caller/pull cord

(The phoned based Anywhere service at £12.50 to remain the same)

Health & Wellbeing

BRIGHTON AND HOVE CITY COUNCIL

CHARGING POLICY For Care Services – APRIL 2016 - 2017

Effective from 11th April 2016

CONTENTS

1. Introduction and Legal basis for charging for Care and Support

1.1 This policy is approved by Brighton and Hove City Council and is compliant with The Care Act 2014, Care Act Regulations and Guidance. The aim is to provide a consistent and fair framework for assessing and charging all service users following an assessment of individual needs, and individual financial circumstances. It applies to all service users equitably.
Section 14 of The Care Act 2014 provides councils with a power to charge for meeting a person's eligible needs in a single legal framework. Section 17 of The Care Act permits local authorities to undertake an assessment of financial resources. This will determine the amount a person should pay to meet the cost of providing for their needs for care and support.

The policy for non-residential services was originally formulated in December 2002 under consultation with service users and their carers. This has been revised to take account of the requirements of the Care Act 2014. For the purposes of this policy, an adult is a service user aged 18 and above.

1.2 The services **included** for this financial assessment policy are:

Residential Care including Nursing Homes
Supported Accommodation*
Shared Lives Schemes*
Home Care
Day Care, Day Activities
Community Support / outreach services
Money Advice and money management services
Direct Payments / Personal Budgets for any services
Tenancy Support (Supporting People) including Carelink alarm systems
Adaptations over £1,000

*People in Shared Lives and Supported Accommodation schemes, in addition to any assessed care and support charge, will also be responsible for paying for rent, food and utilities from their own income, usually including Housing Benefit or universal credit.

1.3 Services **excluded** from charges are:

All Daily Living Equipment
Adaptations under £1000
Services provided under Section 117 of the Mental Health Act, "after care" services.
Intermediate Care and Reablement Services for the first 6 weeks
Any Care funded under Continuing Health Care by the Health Authority
Care and support provided to people with Creutzfeldt-Jacob Disease;
Assessment of needs and care planning

1.4 **No Charge for Direct Support to Carers**

There is no charge carers for any services provided directly to them during 2016/2017. This policy will be kept under review. Where services are provided directly to the service user to meet their eligible care needs, in order to provide the carer with support, the service user will be charged in accordance with this policy.

2. From April 2016 the maximum charges for non-residential services are:

2.1 Home Care provided by the council, including all forms of support at home
£22.00 per hour
(Please note that the charge is double where two carers are provided)
The maximum charge for care provided by an independent agency will depend upon the fees set by them. This can vary between providers but is usually less than £22 per hour.

2.2 Day Care / Day Activity provided by the council (for any time period)
£35.00 per day

The maximum charge for care provided by an independent agency will depend upon the fees set by them. This can vary between providers but is usually less than £20 per hour.

2.3 Additional Fixed Rate charges

Any meals provided at a Day Centre and any transport costs will not form part of the assessed charge as they substitute for ordinary daily living costs.
These charges are payable in addition to assessed contributions.

Meals at a day centre	**£4.40 per meal**
Transport to day centres	**£3.60 per return journey**

3 The Financial Assessment Process

3.1 The financial assessment follows the care needs assessment. When care needs have been assessed, details are passed to the Financial Assessment team who will usually make arrangements for a personal visit to the service user or their representative. In some cases it may be possible to complete an assessment over the telephone or by post or email but information will be subject to full verification. Where a person lacks mental capacity to complete a financial assessment we will consult someone with Enduring Power of Attorney (EPA), Lasting Power of Attorney (LPA) for Property and Affairs or a Deputy under the Court of Protection. If there is no person with a formal authority we can discuss with someone who has been given Appointeeship by the Department of Work and Pensions (DWP) or any other person who is dealing with that person's affairs.
We will:

(a) Gather financial information from the service user or their representative and have sight of relevant documentation for verification purposes e.g. Bank statements, property valuations, completion statements etc.

(b) Assist with the completion of the Financial Assessment Form which is signed as a correct statement by the service user or their representative
(c) Arrange for "Forms of Authority" to be signed if any information needs further written verification from the asset holders, building societies etc.
(d) Complete postal assessments and any further financial enquiries and verification
(e) Undertake a Welfare benefits check and help with claims if applicable.
(f) Provide written notifications to service users of the chargeable amount
(g) Notify the care provider of the charge for their collection (in most cases).

4. The Financial Assessment Calculation for all services

First we take account of Capital and Savings (see "tariff income" at 4.1)
Then we take account of income
Then we make allowances for various types of expenditure
The difference between the income calculation and the expenditure allowances is the amount charged for care services.
The amount charged will depend upon whether the service user needs a Residential Care Home service or other services while remaining in their own home (known as "non-residential services".

4.1 Treatment of Capital and Savings

People with over £23,250 in capital and savings pay the full cost of any service from the start date of the service.
People who do not want to disclose full financial information may opt to pay the full cost without going through this assessment.
People who are unable to show that they do not have £23,250 will pay the full cost from the start of the service.

For people needing permanent care and support in a residential care home or nursing home, the net value of their former home, where owned by them, will be taken into account when calculating their level of savings.

Where care needs are met in a person's own home, the main residence occupied by the service user will not be taken into account but the value of all other forms of capital and savings will be taken into account, including any other property, eg second homes, holiday homes, whether or not they are rented out and whether they are located in this country or abroad. Where a property is not occupied as a main home, for example where the person has moved out to live with other family members or to move into rented accommodation, the property value will be taken into account for charging purposes. The only exception to this rule is where the person is taking steps to occupy that home. In this case the value will be disregarded for a maximum of 26 weeks.

We will take into account any form of savings irrespective of where and how they are invested (with the exception of special complex rules regarding capital held in a trust and capital held in investment bonds with Life Assurance). (Note that, where funds are held in trust, or in a disregarded savings bond, the financial assessment will seek to determine whether any income received should be included or disregarded. Copies of trust documents (e.g. Trust Deeds, Will Settlements etc.) must be provided for verification.

The capital limits are currently £23,250 upper limit and £14,250 lower limit with effect from **11/04/2016.** Any capital above £14,250 is calculated as "tariff income" which is calculated as £1.00 per week for every complete £250 or part).

People with more than £23,250 held in their own name, or held in their share of joint accounts, or in accounts held by another person on their behalf, will pay the full cost of the care service. **This charge applies from the start date of the service.**

Notional assets, savings or income included in the financial assessment:
If a person has gifted any savings, investments, income or property to another person, prior to, or whilst receiving any care services, any such amounts will usually be included in the financial assessment as though they remain in their own possession. This is called "notional capital or notional income". This may also apply where a person has spent down their capital more significantly than would usually be the case. Consideration will be given to exceptional circumstances.
This is sometimes referred to as deprivation of assets and can include transfer of ownership or conversion from one kind of asset to one that would otherwise be disregarded. In all cases, it is up to the person to prove to the council that they no longer possess the income or asset and the council will determine whether to conduct an investigation into whether deprivation has occurred. Where notional assets are included in the assessment and the person is unable to pay the charges, the council may charge the person who received the gift to pay for the costs of care services.
Notional capital or income will also be taken into account if a person is not claiming monies to which they are entitled.

4.2 Income to be taken fully into account

Income includes **most state benefits** means tested and non-means tested, including State Retirement Pension, Pension Credit, Employment and Support Allowance, Tax Credits, Child Benefit, Statutory Sick Pay, Income Support (including all premiums for age, family and disability), Job Seekers Allowance, Personal Independence Payments (PIP)for care, Universal credit etc. **(see exceptions in 4.3)**

Income also includes:
Attendance Allowance, Disability Living Allowance and PIP (care components only)

All other income is included eg.
Occupational Pensions
Private Pensions
Income from annuities

Trust Income
Income from charitable or voluntary sources (subject to £20 per week disregard)
Rental Income / lodging payments (including other persons in the household)
All other income except where it derives from capital that has been taken into account (**subject to exceptions below in 4.3)**

Where another person, who is not a spouse or partner or civil partner or a dependent child, lives in the household of the service user (e.g. A relative, a friend, a lodger) the payments they make towards the household expenses will be taken into account as income.
Where no actual payments are made by the person living in the household there will be an assumed income of one third of the basic Income Support allowance as a contribution towards general household living costs.

4.3 Income to be disregarded

Earnings are disregarded.
(Earnings consist of any remuneration or profit derived from employment or self-employment, including bonus or commission and holiday pay but excluding re-imbursement of expenses and any occupational pension)

DLA (Mobility Allowance)
War Pensioners Mobility Supplement
War Widow(er) Special Payments
Tax credit income (related to earnings)
Pension Credit "**Savings Credit**" Payments are disregarded for non-residential services but there are other special rules for residential care with a partial disregard

5. Assessment for non-residential services

5.1 **General Living Allowance** – known as MIG (Minimum Income Guarantee)

The standard living allowance for people who live in their own home is intended to cover general living expenses including food, utilities, fuel, transport, leisure, insurances and other miscellaneous living costs and including any debts relating to these expenses. In accordance with Government guidance, the minimum allowance is calculated by reference to basic Income Support Rates plus a 25% buffer and these rates differ according to age and other circumstances. However, irrespective of the age of the service user, the weekly allowance in this policy has been aligned to pension credit rates which are more generous than for other age groups. These allowances for 2016/17 are **£195 per week** for single people and **£297 per week** for couples or **£149 per week** for one person in a couple (the rates are reviewed by the Department of Health every April).

Where there are dependent children in the household, the general allowance will be calculated by taking basic Income Support rates for the adult(s) and the dependent children, multiplying the total by 125% and rounding up the total to the nearest whole pound. (Note that basic income support rates do not include

SDP for adults but extra allowances may apply in the case of enhancements for dependent disabled children).

5.2 The Disability Related Expenditure assessment (DRE)

Service Users will be asked to list any additional expenses, extra to the standard allowances explained in 5.1 that arise specifically as a consequence of disability. Examples of such expenditure and verification methods are set out in **Appendix A.**

5.3 Housing Costs

Allowances are given for the following housing costs:

- Rent (net of Housing Benefit - or Universal Credit)
- Council Tax (net of Council Tax Reduction and discounts)
- Minimum mortgage repayments (as a substitute for rent) excluding enhanced mortgage payments.
  Ground Rent and Maintenance (except costs already allowed in the standard living allowance eg.Lighting, heating, Hot water, etc.
- Water Rates / Metered Water Costs

No Allowance for rent will be made where the service user lives in another person's household and there is no legal liability for rent payments. This is because any charge made for living in the other person's household will be deemed to be covered by the general living allowance of at least £**195** per week. Where the person is not liable for these costs, but contributes towards them through a private board agreement or similar, then the service user will be expected to meet this expenditure from their general living allowance.

5.4 Method of Calculation for non-residential services

a) Income less expenditure and allowances equals "assessable income"

b) Assessable income is rounded down to the nearest whole pound.

c) There is no charge if this is below £3.00 per week

d) Note that where the actual service costs are less than the assessed charge, the lower amount will be charged.

5.5 Assessing Couples

a) Financial assessments will usually be carried out for couples by reference to all income, savings and expenditure of the household. Where means tested benefits are being paid, this will be a similar process to Income Support / ESA / JSA/ Guarantee Pension Credit, Housing Benefit / Universal Credit.

b) Where no means tested benefits are in payment the income and savings of both partners will usually be considered in order to determine individual ownership including any beneficial interest of the service user.* (see below)

c) Where the total savings and assets of the service user are over £23,250, including any interest in savings held by their partner, the full cost of care services will apply.

d) Councils may consider whether a service user could reasonably have access to, or legal entitlement to, resources held by another person, including a partner. For example, where there are savings in joint bank accounts or where savings and assets are held in one partner's name and can reasonably be assumed to be shared, particularly where the service user's monies have been saved in that account. In such cases it is reasonable to seek disclosure from the partner and refusal will allow the council to decide that the user has not shown they are unable to pay and therefore the full cost will be charged.

e) Where income and savings are held in the partner's name an assessment may be made of the history of this arrangement and the extent to which the service user has some access to the resources held by the partner. Savings held in joint accounts will be treated as 50% ownership unless there is specific evidence as to a different percentage. The actual position regarding payments for rent, mortgage, water rates etc will be considered and the general living allowance will be amended accordingly.

6. Residential Care: Charging for care homes for permanent residents

6.1 Only where a person has been assessed as having an eligible care and support need will a financial assessment be necessary to determine whether or not they must pay the full fees.

6.2. Charges for residential care are payable from the date care commences.

6.3 Property will usually be taken into account for charging purposes unless the resident is taking steps to occupy that home. In this case the value will be disregarded for a maximum of 26 weeks. Property is disregarded where it is occupied by a spouse or partner or another relative aged over 60 or disabled.

6.4 The Financial Assessment will take into account income, capital and the value of any assets. The charging calculation will take into consideration any mandatory disregards of income, capital and property as defined in the Charging for Care and Support Statutory Guidance.

6.5 The Assessment will allow the prescribed minimum personal allowance known as the 'Personal Expenditure Allowance' (PEA). This is £24.90 per week from April 2015. Some people may also qualify for an additional Savings Credit Disregard depending upon the level of their income and state benefits.

6.6 People will be advised of the maximum amount of funding the council will pay towards the fees and this is known as 'The Local Authority Rate'. This rate is inclusive of any assessed contribution from the resident's resources, and in the case of nursing care, includes the free nursing care element (FNC) paid by the NHS.

6.7 Where a person decides to reside in another local authority area the council will match the local authority rate for the area where the person decides to live.

6.8 Where a person chooses to live in a care home charging more than The Local Authority Rate they must identify a person, known as a third party, to meet the additional cost. This additional cost (known as a 'top-up') must be sustainable and the local authority has the right to refuse a customer using their assets for this purpose, if the costs cannot be met over a sustained length of time.

6.9 The third party must confirm they are able to meet the costs of the top-up for the duration of the agreement, including any price changes that may occur. Both they and the resident will be made aware of the cost and the consequences of failing to maintain payment. The third party will be asked to enter into an agreement.

6.10 People who own a property or other valuable asset, over which security can be taken, may be eligible to defer care costs against the value of the property/asset. This is known as a Deferred Payment Agreement. Details of this scheme can be found within the council's separate Deferred Payment Agreement policy.

7. Charging for Residential and Nursing Home care on a TEMPORARY basis

7.1 The council will financially assess and charge people having a temporary stay in a care home from the start date of the service.

7.2 A temporary resident is defined as a person whose need to stay in a care home is intended to last for a limited period of time and where there is a plan to return home. The person's stay should be unlikely to exceed 52 weeks, or in exceptional circumstances, unlikely to substantially exceed 52 weeks.

7.3 Where a person's stay is intended to be permanent, but circumstances change and the stay is temporary, the council will charge on the basis of a temporary stay.

7.4 The financial assessment for temporary stays will disregard the person's main or only home where they intend to return to that home.

7.5 The financial assessment for a temporary stay will treat income and capital in the same way as for permanent residential care with the following exceptions:

- Disability Living Allowance or Attendance Allowance will be disregarded from the financial assessment.
- Where Severe Disability Premium or Enhanced Disability Premium are in payment, these will be included in the assessment.

7.6 If Housing benefit is paid, this will be disregarded.

7.7 Liabilities for rent, mortgage interest and water rates are taken into account.

8. Financial re-assessments for all Services

Financial assessments will be reviewed in the following circumstances:

a) Where someone receives a new or backdated state benefit, such as Attendance Allowance, Severe Disability Premium etc. Note that charges will be backdated to the date of the DWP award for the additional benefit. (actual payments from DWP may be later).

b) At any time where the council discover an amendment to the financial information previously provided: e.g. Inheritance, previously undisclosed property, savings or income, including benefits (this can lead to additional charges being backdated).

c) Where a person notifies the council that their circumstances have changed:

d) Where there is a significant change to Government regulations, state benefit entitlements or charging policy revisions

e) Benefit Uprates for residential care in April of each year.

f) Otherwise, financial reviews will take place over a period of time.

9. Backdating charges

Charges will usually date from the start of the service where the service user has been provided with appropriate charging information.

Backdated charges will apply where additional benefits have been successfully claimed. People will be advised of this policy in writing and will be required to pay the additional charge from the date they are found to be eligible for the benefit. This may include a period of backdated payment from the DWP.

Where people have not provided correct financial information, backdated assessments and charges will usually apply from the start of the service or from the date any additional assets were acquired.

Where it is found, at any time, that a person still has, or did have, over £23,250 the maximum charge will be backdated to the start date of the service costs.

10. Notification of Charges

The outcome of the financial assessment and charge information will be confirmed in writing. This might provide a provisional charge pending the production of evidence of income, capital, costs of disability, or awaiting the outcome of additional benefit claims. If all information is complete the notification will provide details of the final assessment.

11. Paying the contributions

11.1 Care Agencies: Where the service is provided by an independent care agency, the service user will usually pay them direct, upon receipt of an invoice from them or by standing order. If the service user fails to pay the provider further action will be taken.

11.2 Council Services: Where the service is provided directly by the Council the service user will receive an invoice, monthly in arrears, from the Council's Central Collections Team.

11.3 Direct Payments for care services

Where the service user receives Direct Payments in order to purchase their own care services, they will be required to pay their contribution into their Direct Payments account. The preferred method is for the service user to set up a standing order from their personal bank account into the Direct Payments account. Where a charge applies, the service user must pay this into the account first, to cover the first part of the care costs, and the council will pay the remainder of the agreed eligible care costs into the account on a 4 weekly basis.

12. Recovery of Debt

a. The Care Act 2014 provides powers to recover money owed for arranging care and support where a person fails to pay the amount they have been assessed to pay.

b. The powers for recovery of debt extend to the service user and their representative, where they have misrepresented or have failed to disclose (whether fraudulently or otherwise), information relevant to the financial assessment.

c. The council will only proceed with Court action where alternatives have been exhausted. At this stage the council will proceed with action through the County Court.

d. The council will deal with each case of debt on an individual basis and all circumstances will be carefully considered.

13. Appeals and Complaints

Service users have the right to ask the Council for a review of the assessed charge if they consider it to be unreasonable.
The appeal will involve the following checks:-

That income included in the assessment is correct
That the standard disregards/allowances are correct
That all eligible additional disability costs have been included
That any further exceptional circumstance has been considered which may warrant special discretion.

The Appeal Decision is initially made by the Head of Financial Assessments to ensure consistency and equity with other service users and provides an information base of exceptional decisions.

The appeal should be completed within 4 weeks of referral including written notification of the outcome. If the service user is still dissatisfied they can use the complaints procedure.

Diversity and equality

a. The council is committed to the broad principles of social justice and is opposed to any form of discrimination. It therefore embraces best practice in order to secure equality of both treatment and outcome.

b. The council is committed to ensuring that no one is treated in any way less favourably on the grounds of personal differences such as age, race, ethnicity, mobility of lifestyle, religion, marital status, gender, sexual orientation, physical or mental impairment, caring responsibilities and political or other personal beliefs.

Summary of Publications

The following publications have been referred to in the compilation of this policy

- The Care Act 2014
- The Care Act 2014 Regulations Part 1
- The Care Act 2014 Care and Support Statutory Guidance
- Mental Health Act 1983
- The Local Authority Social Services and NHS Complaints Regulations 2009

APPENDIX A - Assessing the costs of disability for non-residential care

Evidence of actual expenditure may be requested at the Council's discretion. Where receipts have not been kept, a council may request that this be done for future expenditure. It is legitimate for Councils to verify that items claimed have actually been purchased, particularly for unusual items or heavy expenditure.

Generally the items allowed for should be based on actual past expenditure; though in some cases estimates of annual spending based on available evidence will need to be made. Spending not yet incurred should not be allowed. It is not practicable for assessments to take account of expenditure users would incur if they had more income.

If, despite a request to keep future receipts, users fail to do so, it may be reasonable for Councils not to include this in the assessment.

The following allowances may be agreed but is not an exhaustive list of disability-related costs. It is reasonable to expect that most people would not qualify for the full range of allowances. These allowances should align with information gathered during the care assessment and should be identified in the Care Plan.

The council has the right not to allow costs that should be met by other agencies, such as the NHS. This applies to therapies such as physiotherapy, chiropody and incontinence pads

DISABILITY EXPENDITURE ALLOWANCES 2015-16

Item	Average Fuel Costs - 2014-2015			Evidence
All fuel.	Single in flat and terraced Couple in flat and terraced Single in semi-detached Couple in semi-detached Single in detached Couple in detached	£1,203 £1,587 £1,278 £1,684 £1,555 £2,049		Last 4 bills for all types of fuel. Allowance = difference between the sums listed here and the average of **actual bills** (divided by 52.) (not the sums paid by DD)

Notes - consideration will be made for additional householders contributing to household costs.

- if bills not retained, copies to be provided within 28 days. If not provided within this timescale the allowance will apply from the date that the evidence is provided.
- Winter Fuel and Cold Weather Payments are disregarded.

ITEM	AMOUNT	EVIDENCE
Community Alarm System	Actual cost to service user	Bills from provider
Privately	Where Social Worker confirms as part of the Care Plan and Council funded	Signed receipts for at least 4 weeks using a proper

arranged care Including domestic help	care is reduced accordingly. (does not usually allow payment to immediate family members)	receipt book Maximum £12 per week if no receipts
Laundry/Washing Powder	£3.61 per week	Care Plan identified an incontinence problem. Allowance applies where more than 4 loads per week
Dietary	Discretionary as special dietary needs may not be more expensive than normal	Details of special purchases – Max £6 per week
Gardening	Discretionary based on individual costs of garden maintenance	Signed receipts for at least 4 weeks using a proper receipt book Maximum £12 per week if no receipts
Wheelchair	£3.75 per week manual £9.12 per week powered	Evidence of purchase. No allowance if equipment provided free of charge
Powered bed	Actual cost divided by 500 (10 yr life) up to a maximum of £4.20 per week	Evidence of purchase if available
Turning bed	Actual cost divided by 500 up to a maximum of £7.27 per week	Evidence of purchase if available
Powered reclining chair	Actual cost divided by 500 up to a maximum of £3.30 per week	Evidence of purchase if available
Stair-lift	Actual cost divided by 500 up to a maximum of £5.88 per week	Evidence of purchase without DFG input
Hoist	Actual cost divided by 500 up to a maximum of £2.88 per week	Evidence of purchase without DFG input
Chiropody	Where paid privately	Signed receipts for at least 4 weeks using a receipt book Maximum £2.00 per week
Hair Hygiene	Only applies where hygiene is not already included in care package and disability prevents personal care	Max £6.00 per week
Prescription Charges.	Cost of an annual season ticket divided by 52 or actual cost of prescriptions whichever is less.	For those not eligible for free prescriptions
Transport.	Discretionary based on costs that are greater than those incurred by the general public.	Evidence in the Care Plan for transport needs where person cannot use public transport – max £12 per week

Note: - Mobility Allowance cannot be included in the normal financial assessment as an income but the statutory guidance states that transport costs should be allowed where necessitated by illness or disability, over and above the mobility component of DLA if in payment. Therefore no further transport costs are allowed if Mobility Allowance covers them.

Awaiting information from DH for updates AE Jan 2016

1. Better Care Finance and Performance Report December 2015

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 2nd February 2016.
2 February 2016

1.3 Author of the Paper and contact details:

Claire Holloway, Interim Chief Operating Officer, Brighton and Hove CCG
Email: Claire.Holloway@nhs.net

2. Summary

2.1 This report provides the Better Care Board and the Health and Wellbeing Board with an overview of the Better Care programme.

3. Decisions, recommendations and any options

3.1 That the Health and Wellbeing Board note the report.

4. Relevant information

4.1 The report is in three sections; finance, performance and programme delivery as detailed below:

Better Care
Delivering Better Care in Brighton & Hove

NHS
Brighton and Hove
Clinical Commissioning Group

Better Care Finance and Performance Report December 2015

Introduction

This report provides the Better Care Board and the Health and Wellbeing Board with an overview of the Better Care programme. The report is in three sections; finance, performance and programme delivery.

Finance Overview

2.1 Section 75 Pooled Budget

At month 8 the budgets are underspending by £1,239k, with an underspend of £633k expected by the year end. The key points to note are below and a summary table is contained in Appendix 1.

The Integrated Delivery workstream is currently underspent by £559k, with a forecast year end underspend of £501k. Progress against plans continues to be reviewed to establish whether in-year delays will result in additional underspends at the end of the year.

The Personalisation workstream is also underspent at month 8 (£267k), and is now forecast to underspend by £167k. Lower than anticipated savings on equipment, under the councils current contract for community equipment (a 30% reduction was expected) are generating an expected cost pressure of £55k, but this has been offset by forecast savings against some of the carers budgets (£222k). There remains a risk that the overspend on community equipment will increase as we progress through the year and transition to the new service provider.

At month 8 the Protecting Social Care workstream is overspending by £71k, with a forecast overspend for the year of £195k, due to significant pressures on the Disabled facilities grant budget. The position is under close review with a cost reduction program being put in place to bring costs back in line with the budget.

Plans within the Keeping People Well workstream are in the process of being finalised and therefore there is an underspend of £484k at Month 8. Currently we are reporting a forecast underspend of £160k in relation to Dementia projects, but other plans are currently being reviewed to assess the impact of delays on the outturn position.

The overall forecast underspend currently being reported should be considered with some caution, however, the Better Care Board is asked to consider principals for the treatment of any surplus budget, should this become available.

2.2 Better Care Fund Enablers

The schedule contained in Appendix 2 details the funding earmarked in CCG budgets (outside of the pooled fund) to support of the establishment of Better Care schemes and the position at Month 8. The total amount available to support workstreams is £1,971k.

Following a thorough review of the progress in the implementation of work programmes, we are now anticipating slippage across a number of budgets, totalling £1,037k. The Finance &

Performance group as part of the ongoing review of performance of projects and the resulting achievement of targets will consider whether any funds should be diverted to alternative use.

2.3 Payment for Performance

Nationally £1bn of the total Better Care Fund was tagged as being a payment for performance – the achievement of planned Non-Elective activity levels.

CCGs were able to set their own target reduction in Non-Elective activity and for Brighton & Hove this was a reduction of 469, with an associated value of £699k.

Where performance was not achieved it was intended that the performance payment, rather than being available for the pooled fund would be withheld by the CCG to be spent outside of the pool as necessary either to fund the additional Non-Elective activity or assist with improving future performance .

In setting up their pooled fund some areas initially withheld this element of the funding, in order that it could either be directed into the pooled fund if performance was achieved or spent elsewhere as needed to support improved performance. Brighton & Hove however, took the decision to include the Payment for Performance in the pooled fund, and instead deal with any non-achievement of performance outside of the fund where possible, should it be necessary.

Currently we are on track to achieve our target for Non-Elective activity levels.

Performance Overview

3.1 National Targets

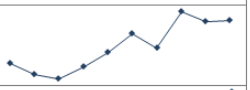
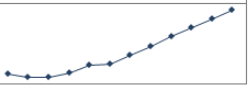
There are 5 national metrics which relate to the Better Care programme. The delivery of the Brighton and Hove Better Care Plan anticipates the following improvements in the 5 national metrics:

1. Reduce non elective admissions by 1.9% (478)
2. Reduce permanent admissions to care homes by 13.3% (32)
3. Proportion of older people who were still at home 91 days after discharge from hospital into reablement services to be 89.1%
4. Reduce delayed transfers of care by 5.2% (308)
5. Increase dementia diagnosis rate to 67%

There are 4 programmes of work, supported by 3 enabling workstreams, which collectively will deliver these improvements.

3.2 Performance against the national targets

The current performance against the national targets is contained in the table below and summarised in the following narrative:

Measure	Target	Actual	Period	RAG	Trend
Total non-elective admissions in to hospital (general & acute), all ages	-1.9%	-4.6%	Q2 15/16 YTD	G	
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000	545.9	855.6	Q2 15/16 YTD	R	
Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	85%	82%	2014/15	G	
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+)	610.3	1187.8	Q2 15/16 YTD	R	
Dementia diagnosis rates	67%	65%	Aug-15	G	

Please note the table above shows performance in the nationally mandated format. The sections below describe the targets in more detail.

3.2.1 Non elective admissions:

- Emergency admissions in October 2015 decreased from last month as well as the same period last year by 68 admissions.
- Admissions are forecasted to be -4% against plan by the end of Q3 2015/16.

3.2.2 Care home admissions:

- In Q2 2015/16, there were 68 admissions against a target of 52. Provisional figures for September showed a small decrease against last month from 26 to 23. For Brighton and Hove to meet the annual target, there should be on average 17 admissions each month.
- The number of care home admissions is forecasted to be 320 in 2015/16, with a target of 208. Based on the forecast, Brighton and Hove would have breached the target by November. This could amount to a financial pressure of £1.8m.

3.2.3 Reablement:

- Due to this indicator being measured only in Q4, it is difficult to provide an accurate forecast. The commissioner anticipates performance will not deteriorate against last year and therefore forecast it to be 82%.

3.2.4 Delayed Transfers for care:

- There was a continual drop in delays for September 2015 over the last two months. It's difficult to predict whether this can be sustained due to the fluctuations in the last 18 months. Historically, delays usually increase over winter, so performance is expected to get worse.
- Patients awaiting residential/nursing home placements continue to account for almost half of all delays.
- For 2015/16, days delayed forecasted to be 11,030 against a target of 5,644.

3.2.5 Dementia diagnosis:

- Performance is forecasted to be 68% by the end of 2015/16.

Local Programme Delivery

4.1 Integrated Care Update

	Target	Actual	Period	RAG
Integrated Care				
Patients contacted within 1 week of identification	95%	100%	Nov-15	G
Patients receive F2F assessment within 4 weeks of identification	95%	100%	Nov-15	G
MDT meetings include a GP from the patient's GP practice	95%	75%	Nov-15	R
Patients see an improvement in their wellbeing and independence	90%	-	-	-

i. **Milestones** - Implementation of the proactive care model across General Practice clusters on-going; patient centred outcome measure being pilot within an MDT. Work to include Young People's outcome measure at risk of delay.
ii. **Metrics –** A number of metrics are being reported via Excel, but the overall goal is to have it reported via the risk stratification tool. Discussions have started with Sollis on how it can be achieved.
iii. **Risk** - Risk to delivery is a delay in the start of care coach roles; initial delay due to recruitment but this is now complete
iv. **Finance** - The Integrated Delivery workstream is currently underspent by £262k, with a forecast year end underspend of £388k.

4.2 Homeless Update

	Target	Actual	Period	RAG
Homeless				
Reduction in homeless A&E attendances	<448	545	Q2 15/16	R
Reduction in homeless **total** admissions	-5	-11	Q2 15/16	G

i. **Milestones** - Homeless 'Hub & Spoke' service model has been agreed. Contracting and procurement work is being initiated to define service delivery options
ii. **Metrics –** Awaiting reply from BSUH to only include data for emergency admissions. A&E attendances increased considerably in August.
iii. **Risk** - Current risk resulting from a reduction in funding for homeless services in city, which could result in increased pressure on the Better Care homeless model
iv. **Finance** - Actual vs. planned spend is on track

4.3 Personalisation Update

	Target	Actual	Period	RAG
Personalisation				
PHB – number of active CHC PHBs	3	7	Q2 15/16	G

i. **Milestones** – Future expansion of Personal Health Budgets (PHBs) agreed. Roll-out to homeless and integrated care patient cohorts underway. Mapping of existing self-management services and a future strategy is on track
ii. **Metrics** - The number of active Personal Health Budgets (PHBs) for CHC patients is on track with a target of 12 by the end of the year, and the first PHB within the Homeless cohort established
iii. **Risk** - Current risk around access to patient activity data in order to monitor the impact of Personal Health Budgets being reviewed against Information Governance advice
iv. **Finance** - The Personalisation workstream is also underspent at month 6 (£255k), but is currently forecast to overspend by £55k.

4.4 Protecting Social Care Update

i. **Milestones** – Compliance elements of the Care Act delivered; remaining on-going including assessment redesign and market shaping. Homecare Hospital Discharge and Additional Social Workers in Access Point fully delivered and reporting positive impact
ii. **Risk** – Key risk associated with budget restrictions on-going; awaiting Government assessment to determine financial position
iii. **Finance -** At month 6 the Protecting Social Care workstream is overspending by £170k, with a forecast overspend for the year of £176k, due to significant pressures on the Disabled facilities grant budget.

4.5 Dementia Update

	Target	Actual	Period	RAG
Dementia				
Dementia diagnosis rates	67%	65%	Mar-15	G

i. **Milestones –** Current work regarding Dementia service development not in scope of the Better Care programme; primary care diagnosis and audit work complete early 2015.
ii. **Risk** – Planned improvements to the MAS are unlikely to deliver target diagnosis rates therefore further actions are required to improve performance.
iii. **Finance** - Currently we are reporting a forecast underspend of £160k in relation to Dementia projects, but other plans are currently being reviewed to assess the impact of delays on the outturn position.

Recommendation

The Better Care Board is asked to note current performance and to advise on the principals for the treatment of any surplus budget, should this become available.

Appendix 1 – Section 75 Pooled Budget Month 8

			Annual	Month 8			Year End	
			Budget £	Budget £	Actual £	Variance £	Forecast £	Variance £
1	Integrated Delivery Workstream							
	Natasha Cooper (CCG)							
	1.2	Integrated Care (Sarah Bartholomew)						
		Proactive Care (Primary Care)	1,500,000	780,581	498,963	(281,618)	1,385,000	(115,000)
		Additional Care Managers working across the City localities 7 days per week	145,000	96,667	86,473	(10,194)	131,060	(13,940)
		Additional Mental Health nurses (IPCT)	100,000	66,665	66,666	1	100,000	0
		Additional therapy capacity (IPCT)	150,000	100,000	0	(100,000)	0	(150,000)
		Additional nursing capacity (IPCT)	160,000	106,667	0	(106,667)	0	(160,000)
		Additional therapy in Integrated Primary Care Teams	283,392	188,928	188,928	0	283,392	0
		3 Social Workers in IPCT's	120,000	80,000	68,922	(11,078)	108,120	(11,880)
		Baseline IPCTs	7,076,532	4,717,688	4,717,688	0	7,076,532	0
		SCT increase in IPCT late shift nursing to support Collaborative working with CCRS	111,000	74,000	44,000	(30,000)	66,000	(45,000)
		SCT in-reach IPCT Frailty Co-ordinator £100K	100,000	66,667	63,333	(3,333)	95,000	(5,000)
		Incentivising care homes and homecare providers to respond 7 days per week	69,000	46,000	40,000	(6,000)	69,000	0
		Pharmacy (IPCT)	105,288	70,192	70,192	0	105,288	0
	1.3	Homeless Model (Linda Harrington)	607,000	404,667	394,835	(9,832)	607,000	0
2	Personalisation Workstream							
	Neil Francis							
	2.3	Integrated Comm. Equipment (Anne Richardson-Locke)	1,338,784	892,523	796,536	(95,987)	1,393,784	55,000
	2.4	Supporting Carers (Gemma Scambler)						
		Carers Reablement Project (previously known as Carers Befriending)	40,000	26,667	26,667	0	40,000	0
		Alzheimer's Society – Information, Advice and Support for Carers	50,000	33,333	33,333	0	50,000	0
		Alzheimer's Society – Dementia Training for Carers	10,000	6,667	6,667	0	10,000	0
		Sussex Community Trust – Carers Back Care Advisor - SLA ???	34,000	22,667		(22,667)	34,000	0
		Amaze – Carers Card Development	10,000	6,667	6,667	0	10,000	0
		Carers Centre – Adult Carers Support	128,000	85,333	85,333	0	128,000	0
		Carers Centre – Young Carers Support	32,000	21,333	21,333	0	32,000	0
		Crossroads – Carers Support Children and Adults	47,000	31,333	31,333	0	47,000	0
		Carers SDS Breaks and Services – spot purchase budget	25,000	16,667	15,485	(1,182)	25,000	0
		Carers Centre – End of Life Support	18,000	12,000	12,000	0	18,000	0
		Amaze – Parent Carers Survey	1,000	667	667	0	1,000	0
		Dementia	22,000	14,667	14,667	0	22,000	0
		Carers SDS Breaks and Services – spot purchase budget	100,000	66,667	66,667	0	100,000	0
		Crossroads – Carers Health Appointments (previously known as Carers Prescriptions)	75,000	50,000	50,000	0	75,000	0
		Working Carers Project - ASC Supported Employment Team	60,000	40,000	40,000	0	60,000	0
		Hospital Carers Support – IPCT Carers Support Service	54,000	36,000	36,000	0	54,000	0
		Carers Support Service - Integrated Primary Care Team (ASC Staff)	185,000	123,333	123,333	0	185,000	0
		Carers	554,000	369,333	222,160	(147,173)	331,855	(222,145)
3	Protecting Social Care Workstream							
	Anne Hagan							
	3.1	Protection for Social Care						
		Maintaining eligibility criteria	2,904,000	1,936,000	1,936,000	0	2,904,000	0
		Protection for Social Care (Capital grants)	484,000	322,667	109,520	(213,147)	484,000	0
		Disabled facilities grant (Capital grants)	911,000	607,333	987,757	380,424	1,115,000	204,000
		Additional social workers for Access Point	70,000	46,667	41,581	(5,086)	68,960	(1,040)
		Telecare and Telehealth (Capital grants)	200,000	133,333	128,572	(4,761)	200,000	0
		Additional call handling resource for CareLink out of hours	35,000	23,333	15,429	(7,904)	26,600	(8,400)
		Additional Telecare and Telehealth resource	200,000	133,333	54,500	(78,833)	200,000	0
		Care Act Implementation (Philip Letchfield)	1,189,000	792,667	792,667	0	1,189,000	0
4	Keeping People Well							
	Annie Alexander							
		Retention of preventative services	300,000	200,000	0	(200,000)	300,000	0
		EMBRACE	50,000	33,333	0	(33,333)	50,000	0
		Information Prescriptions	100,000	66,667	0	(66,667)	100,000	0
	4.X	Dementia						
		Dementia Plan	250,000	166,667	36,667	(130,000)	90,000	(160,000)
		2 Band 6 RMNS for care home in reach / Dementia Patients	81,000	54,000	**0**	(54,000)	81,000	0
		TOTAL	**20,084,996**	**13,170,576**	**11,931,540**	**(1,239,037)**	**19,451,591**	**(633,405)**

Supporting Workstreams 2015/16

Comms	Recurrent	Non recurrent	Total	Committed	TBC	Surplus
Programme Support		£ 70,000	£ 70,000	£ 21,000		£ 49,000
Total	**£ -**	**£ 70,000**	**£ 70,000**	**£ 21,000**	**£ -**	**£ 49,000**

Enagagement	Recurrent	Non recurrent	Total	Committed	TBC	Surplus
Community development support	£ 75,000		£ 75,000	£ 45,000		£ 30,000
Case studies	£ 10,000		£ 10,000			£ 10,000
Community navigator	£ 135,000		£ 135,000	£ 38,856		£ 96,144
Experience led commissioning		£ 60,000	£ 60,000	£ 60,000		
Brefriending expansion	£ 137,000		£ 137,000			£ 137,000
Total	**£ 357,000**	**£ 60,000**	**£ 417,000**	**£ 143,856**	**£ -**	**£ 273,144**

Business Intelligence	Recurrent	Non recurrent	Total	Committed	TBC	Surplus
DMIC data collection - system build		£ 180,000	£ 180,000			£ 180,000
DMIC data collection - maintenance	£ 70,000		£ 70,000			£ 70,000
Associated hardware		£ 40,000	£ 40,000			£ 40,000
Total	**£ 70,000**	**£ 220,000**	**£ 290,000**	**£ -**	**£ -**	**£ 290,000**

IM&T	Recurrent	Non recurrent	Total	Committed	TBC	Surplus
Project Managers - IM&T Implementation		£ 110,000	£ 110,000	£ 110,000		
Programme Co-ordinator		£ 40,000	£ 40,000	£ 40,000		
Business Process Analysis		£ 40,000	£ 40,000	£ 40,000		
Data Cleansing / NHS No - BHCC	£ 8,000		£ 8,000			£ 8,000
Data Cleansing - SECAMB	£ 30,000		£ 30,000			£ 30,000
Data Cleansing - SPFT / SCT	£ 20,000		£ 20,000			£ 20,000
Specialist Support	£ 20,000		£ 20,000	£ 13,875	£ 6,125	£ -
Primary Care Pro-active Frailty Risk Strat	£ 60,000		£ 60,000	£ 60,000		
BH Ph1 Social Care (to NHS and NHS to Social Care)	£ 186,000		£ 186,000	£ 7,772	£ 62,628	£ 115,600
BH Ph2 SPFT	£ 115,000		£ 115,000		£ 25,000	£ 90,000
BH Ph3 SCT / BICS	£ 100,000		£ 100,000		£ 30,000	£ 70,000
BH Ph4 BSUH - Royal Sussex	£ 115,000		£ 115,000		£ 25,000	£ 90,000
Total	**£ 654,000**	**£ 190,000**	**£ 844,000**	**£ 271,647**	**£ 148,753**	**£ 423,600**

Frailty / PHB	Recurrent	Non recurrent	Total	Committed	TBC	Surplus
Integrated Service Delivery - Project Manager		£ 80,000	£ 80,000	£ 80,000		
Proj Admin (assume will be extended 6mth to end of FY)		£ 27,000	£ 27,000	£ 27,000		
PHB Project Manager - 1yr (NF)		£ 70,000	£ 70,000	£ 70,000		
Total	**£ -**	**£ 177,000**	**£ 177,000**	**£ 177,000**	**£ -**	**£ -**

	Recurrent	Non recurrent	Total	Committed	TBC	Surplus
Clinical Support to Pharmacists		£ 116,778	£ 116,778	£ 64,000	£ 52,778	
Voluntary & Community Post for Better Care		£ 46,400	£ 46,400	£ 45,321		£ 1,079
Project Support to developing premises for Homeless team		£ 10,000	£ 10,000		£ 10,000	
Total	**£ -**	**£ 173,178**	**£ 173,178**	**£ 109,321**	**£ 62,778**	**£ 1,079**

Total	**£ 1,081,000**	**£ 890,178**	**£ 1,971,178**	**£ 722,824**	**£ 211,531**	**£ 1,036,823**