Who are we?

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

Where and when is the Board meeting?

This next meeting will be held in the Council Chamber, Hove Town Hall on Tuesday 11th July, 2017, starting at 4.00pm. It will last about two and a half hours.
There is limited public seating available for those who wish to observe the meeting. Board meetings are also available to view on the council's website.

What is being discussed?

There are eight main items on the agenda:

- Caring Together: July Update
- Brighton & Hove Caring Together: Communication and Engagement Strategy
- Working Together to Support Parents with a Learning Disability, Learning Difficulty and Autism
- Food Poverty Action Plan Progress Update:
- Joint Strategic Needs Assessment review
- Weight Management Tier 2 procurement
- Annual Report of the Director of Public Health 2016/17
- Bon Accord Nursing Home

What decisions are being made?

- To consider the request from the NCE Committee in relation to food poverty and community meals
- To consider the JNSA review and recommendations
- To approve the procurement of the weight management contract

Health & Wellbeing Board

Geoff Raw BHCC Chief Executive	**Daniel Yates** **Councillor** Chair	**Elizabeth Culbert** Legal Adviser	**Mark Wall** Secretary to the Board

Adam Doyle
CCG
(Voting member)

Nick Taylor
Councillor
(Voting member)

Dawn Barnett
Councillor
(Voting member)

Peter Wilkinson
(Non-voting Statutory member)

Lola BanJoko
CCG
(Voting member)

Dr Manas Sikdar
CCG
(Voting member)

Graham Bartlett
(Safeguarding Boards Adults & Children
(Non-voting co-optee**)**

Pinaki Ghoshal
(Non-voting Statutory member)

Caroline Penn
Councillor
(Non-voting invitee)

Karen Barford
Councillor
(Voting member)

Dr George Mack
CCG – Lay member
(Voting member)

Dick Page
Councillor
(Voting member)

Rob Persey
(Non-voting Statutory member)

Dr David Supple
CCG
(Voting member)

David Liley
Healthwatch
(Non-voting Statutory member**)**

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

Public Speaker	**Public Speaker**

Public Seating
For those with public items on the agenda

Press table

Health & Wellbeing Board
11th July 2017
4.00pm
Hove Town Hall, Council Chamber

Who is invited:

Voting Members: Cllrs Daniel Yates (Chair), Karen Barford, Dawn Barnett, Dick Page and Nick Taylor; LolaBanjoko, Adam Doyle, Dr George Mack, Dr David Supple and Dr Manas Sikdar (Brighton & Hove Clinical Commissioning Group).

Non-Voting Members: Geoff Raw, Chief Executive; Rob Persey, Statutory Director of Adult Services; Pinaki Ghoshal, Statutory Director of Children's Services; Peter Wilkinson, Acting Director of Public Health; Cllr Caroline Penn (BHCC); Graham Bartlett (Brighton & Hove Local Safeguarding Adults and Children's Boards); Pennie Ford (NHS England); and David Liley (Brighton & Hove Healthwatch).

Contact: **Mark Wall**
Secretary to the Board
01273 291006
mark.wall@brighton-hove.gov.uk

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Date of Publication - Monday, 3 July 2017

AGENDA

Formal matters of procedure

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

Page

10 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.

11 MINUTES **1 - 12**

The Board will review the minutes of the last meeting held on the 13th June 2017, decide whether these are accurate and if so agree them (copy attached).

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

12 CHAIR'S COMMUNICATIONS

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

13 FORMAL PUBLIC INVOLVEMENT **13 - 18**

This is the part of the meeting when members of the public can formally ask questions of the Board or present a petition. These need to be notified to the Board in advance of the meeting. Ring the Secretary to the Board, Mark Wall on 01273 291006 or send an email to mark.wall@brighton-hove.gov.uk

Note: Attached is a record of the public questions and supplementary questions asked at the last meeting on the 13th June, 2017; together with the responses given at the meeting and following the meeting.

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

The main agenda

Health & Wellbeing

Papers for Discussion at the Health & Wellbeing Board

14 CARING TOGETHER - JULY UPDATE

Verbal update from the Executive Director for Health & Adult Social Care and the Accountable Officer for the CCG.

Contact: *Rob Persey* *Tel: 01273 295032*
Ward Affected: *All Wards*

15 BRIGHTON & HOVE CARING TOGETHER: COMMUNICATION AND ENGAGEMENT STRATEGY **19 - 32**

Report of the Executive Director for Health & Adult Social Care (copy attached).

Contact: *Barbara Deacon* *Tel: 01273 296805*
Ward Affected: *All Wards*

16 WORKING TOGETHER TO SUPPORT PARENTS WITH A LEARNING DISABILITY, LEARNING DIFFICULTY AND AUTISM **33 - 66**

Report of the Executive Director for Families, Children & Learning (copy attached).

Contact: *Paul Lavery* *Tel: 01273 290760*
Ward Affected: *All Wards*

Papers for Decision at the Health & Wellbeing Board

17 FOOD POVERTY ACTION PLAN PROGRESS UPDATE **67 - 70**

Extract from the proceedings of the Neighbourhoods, Communities & Equalities Committee meeting held on the 13th March, 2017 (copy attached).

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

18 JOINT STRATEGIC NEEDS ASSESSMENT REVIEW **71 - 92**

Report of the Executive Director for Health & Adult Social Care (copy attached).

Contact: *Alistair Hill* *Tel: 01273 296560*
Ward Affected: *All Wards*

19 WEIGHT MANAGEMENT TIER 2 PROCUREMENT **93 - 104**

Health & Wellbeing

Report of the Executive Director for Health & Adult Social Care (copy attached).

Contact: *Victoria Lawrence* *Tel: 01273 296558*
Ward Affected: *All Wards*

Papers to Note at the Health & Wellbeing Board

20 ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2016/17 **105 - 108**

Report of the Director of Public Health (copy circulated separately with the agenda).

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

21 BON ACCORD NURSING HOME **109 - 118**

Report of the Executive Director for Health & Adult Social Care (copy attached).

Contact: *Andy Witham* *Tel: 01273 291498*
Ward Affected: *All Wards*

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Electronic agendas can also be accessed through our meetings app available through www.moderngov.co.uk

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.

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

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

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- 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 13 June 2017
Council Chamber, Hove Town Hall

Minutes

Present: Councillors Yates (Chair), Barford, Taylor (Opposition Spokesperson), Page (Group Spokesperson), Barnett and Penn. Lola BanJoko, Dr. George Mack; Dr. Manas Sikdar, Dr. David Supple, Clinical Commissioning Group.

Other Members present: David Liley Health Watch, Mia Brown (Safeguarding Business Manager), Pinaki Ghoshal, Statutory Director of Children's Services Rob Persey, Statutory Director for Adult Care, Peter Wilkinson Acting Director of Public Health.

Apologies: Adam Doyle – CCG, Pennie Ford – NHS England, Geoff Raw – BHCC, Graham Bartlett (Independent Chair of Safeguarding Boards) and Jennie Oates.

Part One

1 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

1.1 Prior to taking the formal items on the agenda, the Chair welcomed everyone to the meeting and stated that there had been some changes in people attending from the CCG. He therefore wished to welcome Lola BanJoko the Director of Performance, Planning and Informatics who would be attending the Board in place of John Child. John had gone on temporary secondment to the SPFT to oversee the mental health commissioning.

1.2 The Chair then asked for any declarations of substitutes.

1.3 Mia Brown stated that she was attending as a substitute for Graham Bartlett, Chair of the Adult and Children's Safeguarding Boards.

1.4 There were no other declarations of substitutes.

2 MINUTES

2.1 The minutes of the last Board meeting held on the 31st January 2017 were approved and signed by the Chair as a correct record of the meeting.

3 APPOINTMENT OF DEPUTY CHAIRS

3.1 The Chair noted that the Board's terms of reference allowed for the appointment of two Deputy Chairs, one from the City Council and one from the CCG. He therefore sought nominations for the two roles.

3.2 Councillor Barford proposed Dr. David Supple as the Deputy Chair from the CCG.

3.3 Dr. David Supple proposed Councillor Barford as the Deputy Chair from the City Council.

3.4 Councillor Taylor formally seconded both nominations.

3.5 The Chair noted that there were no other nominations and put the motion to the vote which was carried unanimously.

3.6 **RESOLVED:** That Councillor Barford and Dr. David Supple be appointed as Deputy Chairs of the Health & Wellbeing Board for the 2017/18 municipal year.

4 CHAIR'S COMMUNICATIONS

4.1 The Chair gave the following communications:

4.2 It is a very small agenda today. As many of you will be aware the recent General Elections meant that the purdah period has restricted our agenda but we did wish to proceed.

4.3 There are a number of members of the public here, which is good to see. Clearly there are issues on today's agenda which people feel passionate about. Please do note that you are here as observers, not as participants in the meeting. The council has a number of ways for people to ask questions or present petitions to committee meetings – and we have members of the public here today with a deputation. However, we cannot have the meeting disrupted by people shouting out from the public gallery, and I'm sure everyone here today will respect this.

4.4 At each Annual Council membership of the various council committees is reviewed. I would therefore like to welcome Councillors Dawn Barnett and Nick Taylor to the Board and in addition I would like to thank the following people; Councillors Vanessa Brown and Ken Norman who are no longer sitting with us today. In particular I would like to thank Councillor Ken Norman who was part of the Board since it was first established in shadow form. He also noted that Councillor Norman would now be chairing the Health Overview & Scrutiny Committee and hoped that the Board would be able to work closely with the committee on a number of matters that would be coming up in the future.

4.5 There have also been changes in attendance with the CCG and I note that this is the last meeting for George Mack. George will be leaving the area to relocate to London. George has been involved with Board again from the early days and I am sure we would like to thank him and wish him well in the future. John Child has been asked to go on secondment to Sussex Partnership Foundation Trust for a short period of time. John has been a regular contributor to the Board and we thank him. Lola BanJoko will be attending in his place. Thank you Lola.

4.6 HOSC are continuing to track the quality and improvement progress of a number of health bodies in the local area. This includes:

- Brighton and Sussex University Hospital Trust
- South East Coast Ambulance NHS Foundation Trust

4.7 HOSC will shortly be talking to Sussex Partnership Foundation Trust about their recent CQC inspection and post inspection improvement action plan. HOSC will be also continuing to look at GP sustainability within our city. HOSC have also established a working group to look at the Sustainability and Transformation Partnership (STP).

4.8 I'm also aware that the CQC have recently inspected the Bon Accord nursing home in the city and have rated it inadequate. The council is working with the new management team and an update report will be provided at the next Board meeting.

4.9 The Chair also offered to write to the previous members of the Board to thank them for their time and contribution to the Board's meetings.

5 FORMAL PUBLIC INVOLVEMENT

5.1 The Chair noted that there were a number of public items on the agenda, which included a petition and public question on the same matter. He was therefore inclined to take both items before responding to them.

5.2 He also stated that given the number of written questions and new members to the Board, he intended to respond to the initial question but would provide written responses to any supplementary questions. The written responses would be sent to the individual questioners and reported to the next meeting of the Board for information.

5.3 The Chair then invited Ms. Walker to come forward to present her petition in relation to the service of a breastfeeding support worker.

5.4 Ms. Walker thanked the Chair and presented the petition which had been signed by over 500 people and called for the reinstatement of a breastfeeding support worker.

"My breastfeeding support worker is having her role removed by the NHS. Without her so many mums in the area will not receive the support needed and may fail to breastfeed their babies. Please sign this petition in the hopes that we can save Donna's breastfeeding support role."

5.5 Ms. Walker sated that the service provided was essential and meant that she and other new mothers had been able to cope and develop a bond with their babies and breast feed. She was therefore seeking support for the reinstatement of their support worker whose role had been changed by the NHS.

5.6 The Board Members acknowledged that the petition raised an important question in relation to the importance of breastfeeding for children and the loss of dedicated support workers. It was noted that the service provision was a matter for Sussex Community Foundation Trust and it was felt that a report on the change of provision to the Board would be helpful.

5.7 The Acting Director for Public Health noted that the SCFT service was performing well and wished to reassure the Board that the aim was to provide a broader service across the city. The challenge was to duplicate the excellent service that had been provided at a local level. He also noted that breastfeeding figures for 6-8 weeks for South Portslade were at 77% and North Portslade 73%.

5.8 The Chair thanked Ms. Walker for the petition and invited Valerie Mainstone to come forward and put her question on the subject to the Board.

5.9 Ms. Mainstone thanked the Chair and asked the following question, "Will the Board prevail upon Sussex Community Foundation NHS Trust to re-instate the post of Breastfeeding Support Worker for Hangleton and Portslade while a full impact and equality assessment is conducted, including a meaningful consultation with the service users, and then brought to the Board?"

5.10 The Chair replied to the petition and the question, “Thank you both for your petition and for your question about the breastfeeding support worker.

As the Board is aware in the past 15 months we have had several reports on the Public Health Community Nursing 0-19 service which includes the breastfeeding service. The current provider of these services is Sussex Community Foundation Trust.

Within the Healthy Child Programme the Department of Health has identified breastfeeding as one of the six high impact areas where the work of the 0-19 teams is expected to have a significant impact on health and wellbeing and improve outcomes for children, families and communities. The breastfeeding rate is one of the key performance indicators for the new public health community nursing service 0-19 years.

In Brighton & Hove the breastfeeding rates are amongst the highest in the country. In 2016, the breastfeeding rate in Brighton & Hove at 6-8 weeks was 72% compared with the England rate of 43%. The local rates at ward level varied from 85% to 55% with Hangleton and Knoll at 67%.

The Health and Wellbeing Board does not have the authority to reinstate the breastfeeding support worker post. This is a matter for the Trust. Having spoken with Sussex Community Foundation NHS Trust their strategy is to develop the public health

nursing workforce to be able to provide the type of additional support being provided in Hangleton and Portslade for breastfeeding mothers living everywhere in the city."

5.11 Ms. Mainstone asked the following supplementary question, "Could I have any information relating to the figures for Portslade and could the Chair explain how the revised service would support the most vulnerable people in regard to breast feeding."

5.12 The Chair thanked Ms. Mainstone for her questions and invited Mr. Kapp to come forward to put his question to the Board.

5.13 Mr. Kapp thanked the Chair and asked the following question, "Will you please report on the number of vulnerable people who have been treated under the Better Care Fund (BCF) giving recovery rates and future plans to treat addicts and homeless people in the light of the Council's policy of ending the need for rough sleeping by 2020?"

5.14 The Chair replied, "In 2014, the Homeless Integrated Health and Care Board was established under the Better Care Programme with the aim to: "Improve the health and wellbeing of homeless people by providing integrated and responsive services that place people at the centre of their own care, promote independence and support them to fulfil their potential."

"As a result of the work of the Homeless Board during 2016 the CCG commissioned a new extended homeless GP practice to improve the health care offer to homeless people. The GP practice serves as a hub with an engagement outreach team working across the city. In addition the GP practice provides in reach support to homeless patients admitted to the Royal Sussex County Hospital and Millview Hospital. The service involved an additional investment in the service.

The contract for the new GP practice started in February 2017 and has been positively received.

The next phase of work is to ensure a broader range of health and care services are integrated to create a full Hub and spoke model. The aim is to change the way care is accessed, increasing utilisation of primary and community services and reducing reliance on unscheduled and emergency care."

5.15 Mr. Kapp asked the following supplementary question, "What are you doing about dead doctors and nurses walking (not working) in the toxic NHS?"

5.16 The Chair thanked Mr. Kapp for his questions and invited Ms. Gee to come forward to put her question to the Board.

5.17 Ms. Gee asked the following question, "What is the HWB doing to support the self-management of the large number of primary care patients with medically unexplained symptoms yet who tend to reject psychological therapy (CBT) due to their explanatory model being physical and the stigma of mental health services?

There is a research-informed approach based on substantial evidence which has been designed with service users and piloted at the University of Hertfordshire. This service promotes self-care for this patient population with strikingly positive outcomes for patients, substantial increased GP capacity as well as huge savings in the NHS.

5.18 The Chair replied, The CCG has commissioned the GP Persistent Symptoms service to provide a multidisciplinary care pathway for people with medically unexplained symptoms. The service started in April 2017 at the following surgeries:

- Matlock Road Surgery
- Hove Park Villas Surgery
- Trinity Medical Centre
- Charter Medical Centre
- Brighton Health & Wellbeing
- Benfield Valley Healthcare Hub

This is a 12 month pilot which will be fully evaluated using a range of evidence based clinical outcome measures. The GP, Psychiatrist and Psychologist providing this service have all received specialist training the treatment of medically unexplained symptoms, and have provided training to Primary Care Clinicians within the cluster.

We will be reviewing every 3 months and depending on demand / capacity will roll out to other Clusters over the course of the pilot."

5.19 Ms. Gee asked the following supplementary question, "Will the pilot be focusing on self-management of symptoms?"

5.20 The Chair thanked Ms. Gee for her questions and invited Mr. Kirk to come forward and put his question to the Board.

5.21 Mr. Kirk asked the following question, "I can see the approach you collectively take to the STP is to make the best of it. To try and minimise the effect of the reduced budget and redefine services to fit the diminished funding and at the same time account for the deficit; yes and integration health and social care. The approach I think that would best serve the interests of B&H patients, and surely the message the general election result conveys, is for you to say 'No, enough of this pretence. We had at one time a comprehensive health service and now you expect us to destroy it, we will not be part of the Conservative party's pursuit of small government. What the government expects us to do is just plain immoral. Can you not see this?"

5.22 The Chair replied, "Thank you for your opinions around the STP. We understand the concerns you have raised about the national context of the STP. One of the priorities of all STP is, of course, to ensure that we are getting the most out tax payer's money for the residents we cover and maximise the resources available, including the workforce. However, it is not right to say that the STP is just a cost cutting exercise.

The Sussex and East Surrey Sustainability and Transformation Partnership (STP) outlines how the NHS and social care will work together to improve and join-up services

to meet the changing needs of all of the people who live in our area. There are 23 organisations in our partnership – local authorities, providers and clinical commissioning groups. It is the first time that we have all worked together in this way and it gives us an opportunity to bring about significant improvements in health and social care over the next five years. The STP aims to ensure that no part of the health and care system operates in isolation. For example, we know that what happens in GP surgeries, impacts on social care, which also impacts on hospital wards, and so on. The STP aims to make practical improvements – like making it easier to see a GP, speeding up the diagnosis of cancer, and offering help faster to people with a mental illness. It also aims to support people to take more responsibility for their own health and wellbeing.

The STP is not one single separate plan. It is a way of making sure that all the plans being developed by the partners across the area are joined up and working together. The STP's overarching approach is to ensure that there are local 'place-based plans' so that people can get the care they need as close to home as possible. The place-based plans are being developed locally, led by the CCGs and local authorities, and are being incorporated into the STP, rather than the other way around. Much of the work that underpins the place-based plans would be going on already even if it were not for the STP; the STP ensures that it is joined-up.

Caring Together is Brighton and Hove's response to the STP and is part of the local place-based plans to improve health and social care across the city. The programme builds on work that has already been underway in Brighton and Hove and sets out how the city can improve and transform adult and children's services, physical and mental health, social care, public health, GPs, pharmacies, community, voluntary sector and hospital services. It is a joint programme led by Brighton and Hove CCG and Brighton & Hove City Council. The two organisations have already engaged with the public about the aims and objectives and a programme description was approved by the CCG's governing body in March. More detailed plans will now be developed alongside significant engagement with the public, patients, the community sector, Healthwatch and GPs in the coming months. A comprehensive engagement plan is being developed and the next public engagement event is planned for 4 July."

5.23 Mr. Kirk asked the following supplementary question, "Do you agree that the best approach for residents would be for the Health & Wellbeing Board to say no and not be part of the Government's proposals?"

5.24 The Chair thanked Mr. Kirk for his questions and invited Ms. Kehoe to come forward and put her question to the Board.

5.25 Ms. Kehoe asked the following question, "What impact assessments (ia) have been undertaken by Mr Persey, his department, council employees, Councillors or sub-contractors, of our STP/place-based plan relating to Brighton and Hove (B&H). A written report on its implications for health and care service changes/provision for B&H, including a financial breakdown of implementing these changes is essential. Consultation on same, with awareness of the impact of these changes to our health and social care provision, can then take place. Therefore, if not already available, when will a

full ia report on these changes be available? A time-table of public consultations would also be appreciated."

5.26 The Chair replied, "Impact assessments are done at service level as changes are made. People who come to the Board regularly will know that as service are retendered or services reviewed a full impact assessment has to be undertaken as part of the process and this will continue.

With regard to public consultation and engagement. The council and CCG have had a series of events last year, which many of the people here attended. Now more information is becoming clear we are starting a programme of conversations about out health and care across the city, the first will be on 4th July. We are currently planning out the heath and care conversations and a communications strategy should be coming to the Board on 11 July.

5.27 Ms. Kehoe asked the following supplementary question, "Who will provide replacement financial implications of the changes being proposed and can you provide details of that information?"

5.28 The Chair thanked Ms. Kehoe for her questions and invited Ms. Dickens to come forward and put her question to the Board.

5.29 Ms. Dickens asked the following question, "Given Councillor Yates February statement refusing to cooperate with the STP Board how have the STP proposals relating to Primary and Social Care been passed into CCG operational plans for 2017-2019 with no public consultation no impact assessments? Given the council's crucial role in the provision of social care did the HWB or another council committee sign off on this?

Will the HWB agree to demand urgent answers from the CCG on these matters of crucial public interest citywide; and in particular ask for urgent clarification of the true level of cuts entailed in the main STP and the Place-based plan and their consequences?"

5.30 The Chair replied, "Caring Together is the strategy for the future of health and care in the City. It is jointly owned by the CCG and Local Authority and approved by the Health & Wellbeing Board. The Operating Plan describes the actions required to deliver Caring Together. The Operating Plan indicates where our local plans align to the STP but does not commit us to any proposals for primary care which are over and above those set out in Caring Together.

The HWB has this item as a standard item. We are continuing to work with our partners on this and will provide further updates at each meeting. "

5.31 Ms. Dickens asked the following supplementary question, "There still appears to be a miss-match of the figures relating to the cuts, could a true figure be provided on the level of cuts that are anticipated?"

5.32 The Chair thanked Ms. Dickens for her questions and noted that brought the public questions item to an end. He confirmed that the written responses to the supplementary questions would be included in the minutes and sent to the questioners. He then invited Ms. Aston to come forward to present her deputation to the Board.

5.33 Ms. Aston thanked the Chair and outlined the deputation that had been submitted in relation to the findings of a survey of GPs and their views on the proposals relating to the STP.

5.34 The Chair thanked Ms. Aston and responded by stating that the Board was aware of the challenges currently being faced in General Practice. One of the key areas of Caring Together is to find ways to address these to help ensure we have general practice across the city that is sustainable, more resilient and works efficiently and effectively for the years ahead. This will include integrating services, with other clinical specialists like pharmacists better supporting GPs, and to have a model of care that sees GPs working more collaboratively and at a larger scale.

Our GPs recognise the need for change and they can identify the benefits of working in this way. We have been engaging with them to help us shape a new model of care that works best for them and local people and work is currently being done to develop how this will look like. Our GPs are already working within groups, or 'clusters', caring for between 30,000-50,000 people and we already have some services that work across these clusters, such as pharmacists.

He also noted that a full response to the questions had been prepared and would be issued with the written response to the deputation and appended to the minutes for information.

5.35 Councillor Page stated that he had found the information given in the deputation to be very informative and that it gave a clear message that GPs were concerned about the implications of the STP. He was also aware that the HOSC had a Working Group looking at the STP process and hoped their findings could be considered in the future.

5.36 Dr. Supple stated that to date the engagement process with GPs in regard to the STP had been minimal and noted that things had been changing rapidly over the last few months, which may well have prevented any meaningful engagement until now. However, now that it was becoming clearer he was hopeful that an engagement process would be taking place across the city.

5.37 Councillor Barford stated that there had been a lack of information around the STP, but she had been reassured with the intention to take the Caring Together consultation process forward. She also welcomed the opportunity for a bottom-up approach to developing the provision of services across the city and feeding into the STP on a regional level.

5.38 David Liley stated from Healthwatch's perspective it was important to have a meaningful engagement process and he was encouraged by the intention to have a 'Caring Conversation.' He noted that a recent survey that Healthwatch had put online had

gained 90 responses within the first 48 hours, which showed the level of interest across the city and stated that he would share the results with the Board in due course.

5.39 The Chair noted the comments and proposed that the Board should note the petition and note the deputation and that the information provided by the deputation be shared with the HOSC Working Group.

5.40 **RESOLVED:**

(1) That the petition be noted and a report detailing the changes to the service provided by SCFT in relation to breastfeeding and support to mothers be requested for the Board in the autumn;

(2) That the deputation be noted and referred to the HOSC Working Group for information.

6 BRIGHTON & HOVE CARING TOGETHER - JUNE UPDATE

6.1 The Chair invited the Executive Director for Health and Adult Social Care and Dr. Supple to update the Board on the Caring Together project.

6.2 The Executive Director for Health and Adult Social Care and Dr. Supple gave a short presentation on Caring Together, (a copy of the slides can be found in the supporting papers to the meeting of the Board -). The Executive Director stated that the STP was now being referred to as the Sustainability and Transformation Partnership, which included East and West Sussex and part of Surrey as well as Brighton & Hove. It meant that Brighton & Hove were part of 23 organisations that formed the partnership and it now had the opportunity to develop service provision for the City and then feed into the STP.

6.3 Dr. Supple noted that the first engagement event was scheduled for the 4th July and that others were being planned across the city.

6.4 The Board welcomed the presentation and asked for regular updated to future meetings on the matter. Members of the Board also welcomed the approach and stated that they felt more positive about the joint working and hoped that in having conversations across the city that they would be taken on board and information considered in relation to developing how services could be provided within the city.

6.5 The Chair noted the comments and moved that the information be noted.

6.6 **RESOLVED:** That the information given in the presentation be noted.

7 COMMUNITY MEALS - POST TRANSITIONS USER SURVEY

7.1 The Commissioning Manager, Adult Social Care introduced the report which outlined the findings from a survey undertaken by Brighton and Hove Impetus in relation to the decision to end the contracted Community Meals Service on the 31st March 2016. She

noted that the results had shown a number of people had opted to provide for themselves or find alternative provision to meet their needs. She also noted that the decision to cease the service had meant a loss in terms of welfare checks for those people who had been in receipt of a community meal.

7.2 The Board welcomed the report and queried whether there was any concern in regard to the loss of a welfare check and the lack of a suitable diet or people going hungry as a result of choosing to feed themselves. Members of the Board also queried whether additional providers could be added to the Approved Provider List and noted that whilst the decision to cease the service had been reported to the Board, it would have been helpful to have received a report on the matter before that decision was taken.

7.3 Councillor Page stated that he remained concerned that some isolated elderly and disabled people may fall through the safety net, now that nutritious home-delivered meals were no longer subsidised, and few users of the previous RVS service had taken up with the new approved providers, hence missing out on the welfare check. He noted that the Board had not received any report on this change of service until now, and hoped that in future it would be involved in such decisions.

7.4 The Commissioning Manager, Adult Social Care stated that it was possible for additional providers to be added to the Approved Provider list as long as they met the set criteria. She also noted that it was felt that in exercising their own choice for their provision of meals, people were more in control over what they were eating. They were also able to decide where and when they would eat and choosing to share meals or eat with friends and families. She also drew the Board's attention to a leaflet produced by the Food Poverty Partnership about eating well that was available and had been included with the supporting papers on the council's website for the current Board meeting.

7.5 The Chair noted the comments and asked whether any issues had been raised in regard to people's welfare and nutrition that Board Members were aware of.

7.6 David Liley stated that he was not aware of anything being brought to the attention of Healthwatch and Mia Brown confirmed that she was not aware of any matters being raised at the Adult Safeguarding Board.

7.7 The Chair noted the comments and moved that the report be noted.

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

8 UPDATE ON THE VOLUNTARY SMOKING BAN

8.1 The Environmental Health Manager introduced the report which provided the Board with an update on the progress made in relation to the recommendations approved in December 2015 to extend smoke-free areas to outdoor spaces. He noted that it was intended to launch a voluntary outdoor dining scheme in mid-June with local businesses signing up to it.

8.2 The Board welcomed the report and thanked the officers involved for the work that had been undertaken to encourage local businesses to sign-up to the voluntary scheme. It was noted that as a voluntary scheme it would need to be monitored to see how effective it was; however it was accepted that any action to encourage the cessation of smoking was to be welcomed.

8.3 The Chair noted that a report on tobacco reduction was due to be considered by the Children, Young People & Skills Committee at its meeting on the 19th June, 2017. He then moved that the report be noted.

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

9 PHARMACEUTICAL NEEDS ASSESSMENT 2017/18

9.1 The Public Health Consultant introduced the report which detailed the revised Pharmaceutical Needs Assessment (PNA) that was due to be published in April 2018. She stated that a revised PNA had to be published every 3 years and as part of the process, consultation had to take place with neighbouring Health & Wellbeing Boards. As such, a formal response to the East Sussex PNA had been made and the Board were asked to note the process for the PNA in Brighton and Hove prior to its publication in April 2018.

9.2 Councillor Page noted that reference was made to the closing of a local pharmacy in the report and asked it its location could be made known.

9.3 The Public Health Consultant stated that a Boots Pharmacy in Boundary Road, Portslade was due to close; but noted that another pharmacy existed close-by.

9.4 The Chair noted the information and moved that report be noted.

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

The meeting concluded at 6.40pm

Signed Chair

Dated this day of 2017

PUBLIC INVOLVEMENT

WRITTEN QUESTIONS FROM MEMBERS OF THE PUBLIC

The following written questions were received for the Health & Wellbeing Board meeting held on the 13th June, 2017; and are included along with the supplementary questions asked at the meeting and the written responses that were provided following the meeting:

PQ 1. Valerie Mainstone

"Will the Board prevail upon Sussex Community Foundation NHS Trust to re-instate the post of Breastfeeding Support Worker for Hangleton and Portslade while a full impact and equality assessment is conducted, including a meaningful consultation with the service users, and then brought to the Board?"

Response:

“Thank you both for your petition and for your question about the breastfeeding support worker.

As the Board is aware in the past 15 months we have had several reports on the Public Health Community Nursing 0-19 service which includes the breastfeeding service. The current provider of these services is Sussex Community Foundation Trust.

Within the Healthy Child Programme the Department of Health has identified breastfeeding as one of the six high impact areas where the work of the 0-19 teams is expected to have a significant impact on health and wellbeing and improve outcomes for children, families and communities. The breastfeeding rate is one of the key performance indicators for the new public health community nursing service 0-19 years.

In Brighton & Hove the breastfeeding rates are amongst the highest in the country. In 2016, the breastfeeding rate in Brighton & Hove at 6-8 weeks was 72% compared with the England rate of 43%. The local rates at ward level varied from 85% to 55% with Hangleton and Knoll at 67%.

The Health and Wellbeing Board does not have the authority to reinstate the breastfeeding support worker post. This is a matter for the Trust. Having spoken with Sussex Community Foundation NHS Trust their strategy is to develop the public health nursing workforce to be able to provide the type of additional support being provided in Hangleton and Portslade for breastfeeding mothers living everywhere in the city.

Ms. Mainstone asked the following supplementary question, “Could I have any information relating to the figures for Portslade and could the Chair explain how the revised service would support the most vulnerable people in regard to breast feeding.”

Supplementary Question

"Could I have any information relating to the figures for Portslade and could the Chair explain how the revised service would support the most vulnerable people in regard to breast feeding."

Response:

The Board will request an update item to cover:

- The breastfeeding rates across the city by ward – if possible
- The outcomes that SCT are working towards in the contract and if the there is any specific targeting within the contract that reflects need
- Any information about impacts of the change of contract – although this may be not apparent within this timeline.

PQ 2. Mr. Kapp

"Will you please report on the number of vulnerable people who have been treated under the Better Care Fund (BCF) giving recovery rates and future plans to treat addicts and homeless people in the light of the Council's policy of ending the need for rough sleeping by 2020?"

Response:

In 2014, the Homeless Integrated Health and Care Board was established under the Better Care Programme with the aim to: "Improve the health and wellbeing of homeless people by providing integrated and responsive services that place people at the centre of their own care, promote independence and support them to fulfil their potential"

As a result of the work of the Homeless Board during 2016 the CCG commissioned a new extended homeless GP practice to improve the health care offer to homeless people. The GP practice serves as a hub with an engagement outreach team working across the city. In addition the GP practice provides in reach support to homeless patients admitted to the Royal Sussex County Hospital and Millview Hospital. The service involved an additional investment in the service.

The contract for the new GP practice started in February 2017 and has been positively received.

The next phase of work is to ensure a broader range of health and care services are integrated to create a full Hub and spoke model. The aim is to change the way care is accessed, increasing utilisation of primary and community services and reducing reliance on unscheduled and emergency care.

Supplementary Question

"What are you doing about dead doctors and nurses walking (not working) in the toxic NHS?"

Response:

The supplementary question was in a 4 page summary report presented by Mr Kapp and could not be responded to given it is an opinion rather than a formal public question.

PQ 3. Sandy Gee

"What is the HWB doing to support the self-management of the large number of primary care patients with medically unexplained symptoms yet who tend to reject psychological therapy (CBT) due to their explanatory model being physical and the stigma of mental health services?"

Response:

"The CCG has commissioned the GP Persistent Symptoms service to provide a multidisciplinary care pathway for people with medically unexplained symptoms. The service started in April 2017 at the following surgeries:

- Matlock Road Surgery
- Hove Park Villas Surgery
- Trinity Medical Centre
- Charter Medical Centre
- Brighton Health & Wellbeing
- Benfield Valley Healthcare Hub

This is a 12 month pilot which will be fully evaluated using a range of evidence based clinical outcome measures. The GP, Psychiatrist and Psychologist providing this service have all received specialist training the treatment of medically unexplained symptoms, and have provided training to Primary Care Clinicians within the cluster.

We will be reviewing every 3 months and depending on demand / capacity will roll out to other Clusters over the course of the pilot."

Supplementary Question

"Will the pilot be focusing on self-management of symptoms?"

Response:

The treatment pathway involves an initial formulation which will be shared with the GP and patient and include advice regarding self-management. A proportion of patients will have evidence based one to one treatment form a Psychologist and will be discharged with a full self-management / relapse prevention plan. We plan to introduce ongoing rolling groups by the end of the Pilot and these will be co-facilitated with patients and focus on self-management

PQ 4. Ken Kirk

"I can see the approach you collectively take to the STP is to make the best of it. To try and minimise the effect of the reduced budget and redefine services to fit the diminished funding and at the same time account for the deficit; yes and integration health and social care. The approach I think that would best serve the interests of B&H patients, and surely the message the general election result conveys, is for you to say 'No, enough of this pretence. We had at one time a comprehensive

health service and now you expect us to destroy it, we will not be part of the Conservative party's pursuit of small government. What the government expects us to do is just plain immoral. Can you not see this?"

Response:

"Thank you for your opinions around the STP. We understand the concerns you have raised about the national context of the STP. One of the priorities of all STP is, of course, to ensure that we are getting the most out tax payer's money for the residents we cover and maximise the resources available, including the workforce . However, it is not right to say that the STP is just a cost cutting exercise.

The Sussex and East Surrey Sustainability and Transformation Partnership (STP) outlines how the NHS and social care will work together to improve and join-up services to meet the changing needs of all of the people who live in our area. There are 23 organisations in our partnership – local authorities, providers and clinical commissioning groups. It is the first time that we have all worked together in this way and it gives us an opportunity to bring about significant improvements in health and social care over the next five years. The STP aims to ensure that no part of the health and care system operates in isolation. For example, we know that what happens in GP surgeries, impacts on social care, which also impacts on hospital wards, and so on. The STP aims to make practical improvements – like making it easier to see a GP, speeding up the diagnosis of cancer, and offering help faster to people with a mental illness. It also aims to support people to take more responsibility for their own health and wellbeing.

The STP is not one single separate plan. It is a way of making sure that all the plans being developed by the partners across the area are joined up and working together. The STP's overarching approach is to ensure that there are local 'place-based plans' so that people can get the care they need as close to home as possible. The place-based plans are being developed locally, led by the CCGs and local authorities, and are being incorporated into the STP, rather than the other way around. Much of the work that underpins the place-based plans would be going on already even if it were not for the STP; the STP ensures that it is joined-up.

Caring Together is Brighton and Hove's response to the STP and is part of the local place-based plans to improve health and social care across the city. The programme builds on work that has already been underway in Brighton and Hove and sets out how the city can improve and transform adult and children's services, physical and mental health, social care, public health, GPs, pharmacies, community, voluntary sector and hospital services. It is a joint programme led by Brighton and Hove CCG and Brighton & Hove City Council. The two organisations have already engaged with the public about the aims and objectives and a programme description was approved by the CCG's governing body in March. More detailed plans will now be developed alongside significant engagement with the public, patients, the community sector, Healthwatch and GPs in the coming months. A comprehensive engagement plan is being developed and the next public engagement event is planned for 4 July."

Supplementary Question

"Do you agree that the best approach for residents would be for the Health & Wellbeing Board to say no and not be part of the Government's proposals?"

Response:

The Board has previously had presentations about the Sustainability and Transformation Partnership (STP). These have clearly stated that the do nothing approach is not viable. We will continue to work for the best outcome for our residents and will provide ongoing reports to the Board.

In the Board the Chair did say he would do a personal response which is below

While I appreciate the strong feelings and the depth of admiration and love that all residents feel for the ongoing secure future of our National Health Service and its principles, the lesson of the General Election is that over 80% of voters supported the development of integrated Health and Social Care services which were features of both current Conservative government policy and the Labour party manifesto. While integration is a desirable and rational ambition for the city we will of course continue to closely monitor developments and ensure that our city's health and wellbeing outcomes are our highest priority and are the focus of all future changes and challenges. The financial challenge and staffing challenge that our cities health and care services face would not be helped by delaying, deferring or ignoring the benefits of integration. The nature of the integration will be subject of public engagement to find out the needs, preferences and ideas that our broad communities hold. The NHS is not ours merely to control. It is everyone's responsibility to nurture it and give it the strength and support to flourish.

PQ 5. Pat Kehoe

"What impact assessments (ia) have been undertaken by Mr Persey, his department, council employees, Councillors or sub-contractors, of our STP/place-based plan relating to Brighton and Hove (B&H). A written ia report on its implications for health and care service changes/provision for B&H, including a financial breakdown of implementing these changes is essential. Consultation on same, with awareness of the impact of these changes to our health and social care provision, can then take place. Therefore, if not already available, when will a full ia report on these changes be available? A time-table of public consultations would also be appreciated."

Response:

"Impact assessments are done at service level as changes are made. People who come to the Board regularly will know that as service are retendered or services reviewed a full impact assessment has to be undertaken as part of the process and this will continue.

With regard to public consultation and engagement. The council and CCG have had a series of events last year, which many of the people here attended. Now more information is becoming clear we are starting a programme of conversations about out health and care across the city, the first will be on 4th July. We are currently planning out the heath and care conversations and a communications strategy should be coming to the Board on 11 July."

Supplementary Question

"Who will provide replacement financial implications of the changes being proposed and can you provide details of that information?"

Response:

A number of organisations across our STP have been financially challenged for some time and have, individually, been trying to find ways to address the situation, which they have found difficult. We also know that we have systems and processes in place currently across the STP that are not as efficient as they could be for our patients and this is something we have to look at improving locally and across the STP area. Work is going on across the STP area as well as with our CCG and Council. We will continue to share information when it is available but we do not have the detail yet. A comprehensive engagement plan is being developed and the next public engagement event is planned for 4 July.

PQ 6. Madeleine Dickens

"Given Councillor Yates February statement refusing to cooperate with the STP Board how have the STP proposals relating to Primary and Social Care been passed into CCG operational plans for 2017-2019 with no public consultation no impact assessments? Given the council's crucial role in the provision of social care did the HWB or another council committee sign off on this?

Will the HWB agree to demand urgent answers from the CCG on these matters of crucial public interest citywide; and in particular ask for urgent clarification of the true level of cuts entailed in the main STP and the Place-based plan and their consequences?"

Response:

"Caring Together is the strategy for the future of health and care in the City. It is jointly owned by the CCG and Local Authority and approved by the Health & Wellbeing Board. The Operating Plan describes the actions required to deliver Caring Together. The Operating Plan indicates where our local plans align to the STP but does not commit us to any proposals for primary care which are over and above those set out in Caring Together.

The HWB has this item as a standard item. We are continuing to work with our partners on this and will provide further updates at each meeting."

Supplementary Question

"There still appears to be a miss-match of the figures relating to the cuts, could a true figure be provided on the level of cuts that are anticipated?"

Response:

Please see the response to PQ5.

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 Adults as well as Healthwatch. 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 & Hove Caring Together: Communication and Engagement Strategy

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 4th July 2017.

1.3 Authors:

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2. Summary

2.1 The Health & Wellbeing Board has a standing agenda item on Brighton & Hove Caring Together. This is the Communications and Engagement strategy that supports Caring Together.

2.2 This is not a static strategy but one that will be reviewed and refined as work progresses,

3. Decisions, recommendations and any options

3.1 That the Board notes the strategy.

3.2 That the Board will receive regular updates on the communications and engagement strategy, any updates and progress.

4. Relevant information

4.1 Caring Together is a programme that builds on work already underway in Brighton & Hove to improve local health and social care for the entire population.

It involves looking at the health and care needs of everyone in the city and sets out how we can improve and transform adult and children's services, physical and mental health, social care, public health, GPs, pharmacies, community, voluntary sector and hospital services.

4.2 Caring Together is led by NHS Brighton and Hove Clinical Commissioning Group (CCG) and Brighton & Hove City Council, alongside the local hospital, community and mental health Trusts, working in partnership with Brighton and Hove Healthwatch and representatives from the local community and voluntary sector.

4.3 Caring Together supports wider plans to transform health and care services across Sussex and will help us respond to the rising demand on services, whilst managing a restricted budget.

4.4 Some engagement with local people took place at the end of 2016 about the aims and objectives of Caring Together and a programme description was approved by the CCG's governing body in March.

More detailed plans are now being developed and this needs to be done alongside engagement with the public, patients, the community sector, Healthwatch, GPs and other key stakeholders in the coming months.

4.5 This strategy sets out how this engagement will be carried out by both the CCG and local authority. It sets out five high-level communications and engagement objectives and the actions that will be taken throughout the rest of 2017 and early 2018.

The strategy (which is in Appendix 1) is presented in three sections:

Where we are now – reviewing the background and context of the current levels of public engagement and what we now need to do

What we want to achieve – identifying our objectives, what success looks like and the audiences we want to engage with

What we are going to do – identifying the actions that will be taken to achieve the objectives of this strategy

4.6.1 This strategy will be updated and adapted regularly as a result of feedback and evaluation of the communications and engagement methods and channels being used.

5. Important considerations and implications

Legal:

5.1 There are no direct legal implications arising from the strategy.

Lawyer consulted: Natasha Watson Date: 3.07.17

Finance:

5.2 There are no direct financial implications at this stage and the strategy will be delivered within the overall budget resources available.

Finance Officer consulted: Sophie Warburton Date: 3.07.17

Equalities:

5.3 The strategy is aimed at ensuring all protected characteristics groups are involved in the Big Conversation.

Sustainability:

5.4 There are no implications within the strategy.

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

5.5 These are all included within the strategy.

6. Supporting documents and information

6.1 The Communications and Engagement Strategy is attached.

Brighton & Hove City Council

NHS
Brighton and Hove
Clinical Commissioning Group

Communications and Engagement Strategy

Caring Together

June 2017

Contents

Introduction

Caring Together is a new programme that builds on work that is already underway in Brighton and Hove to improve local health and social care for the entire population. It involves looking at the health and care needs of everyone in the city and sets out how we can improve and transform adult and children's services, physical and mental health, social care, public health, GPs, pharmacies, community, voluntary sector and hospital services.

It is led by NHS Brighton and Hove Clinical Commissioning Group (CCG) and Brighton & Hove City Council, alongside the local hospital, community and mental health Trusts, working in partnership with Brighton and Hove Healthwatch and representatives from the local community and voluntary sector.

Caring Together supports wider plans to transform health and care services across Sussex and will help us respond to the rising demand on services, whilst managing a restricted budget.

Some engagement with local people took place at the end of 2016 about the aims and objectives of Caring Together and a programme description was approved by the CCG's governing body in March. More detailed plans are now being developed and this needs to be done alongside engagement with the public, patients, the community sector, Healthwatch, GPs and other key stakeholders in the coming months.

This strategy sets out how this engagement will be carried out by both the CCG and local authority. It sets out five high-level communications and engagement objectives and the actions that will be taken throughout the rest of 2017 and early 2018. The strategy is presented in three sections:

Where we are now – reviewing the background and context of the current levels of public engagement and what we now need to do.

What we want to achieve – identifying our objectives, what success looks like and the audiences we want to engage with.

What we are going to do – identifying the actions that will be taken to achieve the objectives of this strategy.

This strategy will be updated and adapted regularly as a result of feedback and evaluation of the communications and engagement methods and channels being used.

Communication and engagement principles

All the communications and engagement actions described in this strategy will be underpinned by the following principles:

- We will identify and understand our public and stakeholders.
- We will be open and transparent in everything we do.
- We will provide clear, meaningful and timely communication.
- We will be clear about why we are engaging patients and the public.
- We will work in partnership with all our local stakeholders.
- We will promote a culture of equality across all work carried out in Caring Together.

1. Where we are now

The CCG and local authority held three joint public engagement events about Caring Together at the end of 2016. At the time, there was limited information about the programme and the events were focused on its aspirations and objectives. As a result, these events were not as effective as we would have wanted.

Since this time, there has been very little public engagement around Caring Together and it is clear that the current level of awareness of the programme among the public, stakeholders and staff is very limited.

The programme has now been developed to a point where there is more detailed information about what it wants to achieve and it is now the right time for a sustained period of engagement with the public and stakeholders to take place to help develop and deliver the plans.

Engagement challenges

Previous communications and engagement around Caring Together has been made difficult for the CCG and local authority by the programme's connection to the Sussex and East Surrey Sustainability and Transformation Partnership (STP).

Up until recently, the STP has not had stable or consistent communications and engagement direction or ownership. This has meant it has been unclear as to who should engage with the public, what they should be saying, when they should be saying it, and how this should be done. Individual organisations have been uncertain as to the extent they should be engaging, which has led to many not engaging at all. This lack of engagement has led to growing dissatisfaction and distrust among some sections of the public in the STP, particularly those within local campaign groups.

Caring Together is Brighton and Hove's contribution to the STP and, as such, it has meant that the CCG and local authority has been unable to communicate clearly to the public about the programme without referring to the STP. Due to the unpopularity of the STP, this has made it difficult to engage the public effectively in Caring Together.

Public meetings have been dominated by individual members of the public voicing concerns around the STP, which has been largely due to the lack of alternative channels in which these people can raise their concerns, ask questions and express how they feel about the future of health services.

In order to allay some of the fears among the public, the CCG and local authority have now decided to try to engage more effectively and openly about the STP where appropriate, alongside the engagement with Caring Together.

2. What we want to achieve

Aim of this strategy

The aim of this strategy is to set out how communications and engagement will be developed, delivered and maintained throughout 2017-18 so that, by April 2018, our public feel they have been engaged in, informed about and have influenced the work taking place within Caring Together.

Communications and engagement objectives

To achieve our aim, we have set ourselves five communications and engagement objectives:

1. To build and maintain public and external stakeholder awareness, knowledge and confidence in the vision, objectives and priorities of Caring Together and the STP.

2. To establish and publicise mechanisms by which the public can be engaged with Caring Together and the STP and feel assured that their views are being listened to and taken into account.

3. To obtain feedback, insight and patients' views and experiences about services and their health needs, and engaging patients in decision-making.

4. To ensure staff, CCG members and councillors are fully informed and engaged with Caring Together and the STP.

5. To ensure all information about the Caring Together programme and the STP is readily accessible to different population groups, including those with protected characteristics.

What success looks like

By April 2018:

- We want our public and stakeholders to feel they have been informed and engaged in the plans and work of Caring Together and the wider STP.

- We want our public and stakeholders to feel they have been given enough opportunities to provide feedback around the work of Caring Together.

- We want our public and stakeholders to feel their feedback has been listened to and they have played a part in influencing and shaping the work within Caring Together.

- We want to ensure that our public and stakeholders fully understand the reasons why any feedback has not been taken forward or incorporated within the work of Caring Together.

- We want our public and stakeholders to feel we have engaged in an open and transparent way and have confident that the engagement that has taken place has been meaningful.

- We want to have developed an open and transparent relationship with our residents and local campaign groups, where they recognise we are working in the best interests of the public.

Who we want to engage with

“The public” - patients, carers, residents
The public are at the heart of everything we do and, as such, they are the primary focus for this campaign. We will use all of our ‘tried and tested’ methods to engage effectively with patients, carers and residents, as well as developing new methods which will focus on “going to where people are” as much as possible. We are aiming to reach individuals who we have not engaged with in the past and to go to communities that we have historically not had regular contact with.

We will give particular focus to ensuring our communications and engagement is inclusive, by using targeted channels that reach those individuals and communities who may be marginalised and/or those who experience health inequalities.

Our staff
Our staff are often our biggest champions and biggest critics and the messages they give out to external audiences can influence how others perceive the work and reputation of the organisation. Our staff are also responsible for driving forward much of the work within Caring Together and their continued commitment and productivity to the programme will be vital in ensuring it is delivered as effectively as possible. It is, therefore, essential that staff are informed, engaged, understand and advocate the aims and ambitions of Caring Together and the wider STP and see themselves as important cogs in the wheel of delivery. We will do this by running specific staff-focused engagement events under the banner “The Big Staff Conversation”.

CCG Membership
The membership will be at the heart of much of the clinical work within Caring Together and will need to drive forward and advocate the transformation of services. The success of much of the programme will largely depend on the level of engagement of GPs and their commitment to new models of care. This makes members one of the key audiences and we will ensure they are fully informed and understand every area of the programme. A bespoke communications and engagement strategy has been developed for the membership and this will support and feed into this strategy.

Campaign groups
The local campaign groups are made up of residents who are concerned about the future of health and social care. They have become increasingly frustrated with the lack of engagement around the STP. We will, therefore, give specific attention to these groups to ensure their concerns and issues are heard and addressed. We will offer them a number of opportunities for discussion in an open and transparent environment, with the aim of creating a better working relationship and understanding.

Media
As key opinion-makers, the media will be given particular focus within this strategy. Engagement activities will be proactively promoted in the local media and they will also be invited to attend engagement events. Regular interviews and briefings will be made available and will be done in an open and transparent way.

Provider staff
Staff working for the wide range of different providers will play an important role in helping to shape future service transformation. They also represent a large proportion of the “general public”. We will, therefore, give them specific attention to ensure their views are listened to and they are fully informed and engaged in work we are carrying out.

Councillors
Lead councillors can act as champions for programmes, providing effective spokespeople and advocates. All councillors benefit from updates and inclusion to shared key messages; one of the main topics of queries from local councillors are health-related issues.

Partners
The CCG and local authority works alongside a complex mix of partners, all of which will have different levels of influence over, and interest in, Caring Together. This group includes: Commissioning Support Unit; Brighton and Hove Healthwatch; clinical networks; local community and neighbourhood groups, condition specific groups and associations.

Key decision-makers
These include Health Overview and Scrutiny Committee; Health and Wellbeing Board, Brighton & Hove City Council, Lead committee members, councillors and officers.

Opinion-formers
The reputation of work carried out by the CCG and local authority within the city is influenced by the views of a number of local stakeholders and commentators. These include politicians, campaigners and community and voluntary sector leaders. We recognise these influencers may have a political role, with the responsibility of being answerable to constituents. It is important, therefore, that we make sure they are fully informed about our priorities and progress around every area of Caring Together so they are in a position to provide and reflect accurate information about us and our work to local residents. We will also ask for their help in ensuring wide ranging engagement with our work.

3. What we are going to do

The 'Big Health and Care Conversation'

Our communications and engagement approach and actions for the rest of 2017 will come under a campaign called the 'Big Health and Care Conversation'. The campaign represents a recognisable brand for engagement that is clearly identifiable with the public and will provide more opportunities for us to listen to our residents and stakeholders and act on their feedback.

It gives us an opportunity to discuss a broad range of issues under one engagement banner, which makes it easier for the public to recognise how their feedback is influencing the larger strategic plans. The feedback collected from the campaign will be collated as it progresses and this will be used to shape the development of the Caring Together programme.

Campaign logo
The logo involves two speech bubbles which reinforces the message that we want a two-way conversation with our public. It uses two distinct colours – aqua green and pink. The aqua green symbolises the sea that is associated with Brighton and Hove. Pink is proven to be associated with sensitivity, tenderness and softness and is, therefore, used to represent health and care services. The logo will be included on all communications and promotional material related to the campaign.

Communication and engagement approaches and channels
We will use a number of different communication and engagement approaches and channels within the campaign. These will include established approaches, and those that were already scheduled, as well as new methods specifically tailored for the campaign. The key theme that will be emphasised in all approaches will be openness and transparency and the public will be encouraged to be active participants, and not merely spectators.

1. **Events/groups**
   We will hold two large public engagement events, one to launch the campaign on 4 July 2017 and another three months after.

2. **Group discussions**
   We will hold public group discussions on strategic issues, with open access, bi-monthly in a range of localities and at different times of the day.

3. **Open forums**
   At least four question and answer forums will be held which will be open to all to attend. The public will be encouraged to ask any questions they wish and they will be fielded by relevant members of CCG staff. At least one of these forums will involve the members of the Governing Body. Some of these forums will be dedicated to discussing the STP.

4. **"Big health and care survey"**
   We will carry out the "Big health and care survey" to ask the public and stakeholders to outline their health priorities, gauge their level of understanding of current and future challenges, and to gain their feedback and ideas on how they think services should be shaped. This will be done throughout August 2017, both electronically and through hard copies that will be distributed at engagement events.

5. **Roadshows - “Go to where people are”**
   We will go to different locations across the city to speak to local residents and gain their views and feedback. This will be in the form of “pop up chats” and will include the use of props to signify the conversation element, such as blow up sofas, folding chairs and tables. These will be done at, for example, Tesco in Hove, Asda Marina, Churchill Square shopping centre, Gala Bingo, Fitness First gym and at identified street open air locations.

6. **Social Media**
   We will run a number of social media initiatives throughout the campaign that encourages the public to comment on key issues and to give feedback. This will include live Tweeting from engagement events and holding Q&A sessions on Facebook live.

7. **Targeted engagement – subject**
   We will carry out targeted work where we want to hear about a key patient experience or clinical area. This will comprise bespoke focus groups and online discussions/feedback. For example “our hospital discharge conversation”, “your GP practice conversation”.

8. **Targeted engagement - people**
   Where we know we want to talk to particular groups, we will carry out targeted work in certain locations. This will include reaching staff working for providers and may be in conjunction with key partners such as the Community and Voluntary Sector. CCG commissioners will be supported to take part. For example, visiting baby groups to talk to mothers, visiting the deaf café in Queens Park, visiting the Macmillan Horizon centre to speak with patients living with cancer.

9. **Attending existing meetings and forums**
   We will attend existing meetings, forums and groups to discuss our plans or key areas, and gather feedback from those present. These will include, for example, the Hangleton and Knoll forum and PPG Network.

10. **Existing initiatives**
    Engagement work that is carried out as part of a work programme or specific commission will feed into the campaign. For example, Maternity Services Liaison Committee, engagement with seldom heard groups through the CVS.

Digital Communications

The campaign will have a presence on both the CCG and local authority websites to ensure it has a constant platform to host up-to-date information and to gain feedback. A bespoke webpage will be created, as well as feedback forms and an email address that can be used specifically for people to make contact with any concerns, issues or feedback they have. The webpage will be referred to in all communications and engagement around the campaign.

Use of community researchers

We have a number of groups of trained community researchers in the city, which include older people, BME people, young men and cancer survivors, and we will offer the opportunity to these individuals, and any other local people who would like to support this work, to help us with our conversations. It is suggested that the co-ordination of this work could be commissioned locally (e.g. Trust for Developing Communities, who have experience in this area) with support from the CCG Engagement Team.

Timeframe
The campaign will be launched at an engagement event on 4 July 2017 and will run for six months throughout the rest of the calendar year. We will carry out at least two engagement activities per month, along with ongoing digital/virtual communication and engagement throughout the period.

At the end of the campaign, a series of engagement events will be held in the first three months of 2018 to demonstrate how the feedback from the campaign has influenced and shaped our future plans. These will include a 'marquee' event, as well as smaller focused discussions.

4. Feedback and Evaluation

Feedback
We will collect and collate both formal and informal feedback from all the engagement activity carried out during the Big Health and Care Conversation campaign, which will be clearly recorded in one place. This will help to inform and influence the Caring Together programme during the campaign and after its completion.

At the end of the campaign, the feedback will be analysed and published in a public document that clearly articulates how the feedback has helped to shape service transformation and, where this has not happened, the reasons will be explained in an open and transparent way. Likewise, any common feedback themes which have not been taken forward will be described and justified with clear reasoning.

The feedback will be collected through a number of mechanisms, including verbal face-to-face, paper and digital surveys, through social media, emails and web feedback forms.

An engagement event will be held in January 2018 that clearly demonstrates how the feedback collected as part of the Big Health and Care Conversation has influenced the work within Caring Together.

Evaluation
The campaign will be assessed and evaluated on a monthly basis. This will be done by looking at inputs, outputs, outcomes and resource of each engagement activity to gauge the level of success. A monthly evaluation report will be produced and reported to the appropriate committees and senior management meetings for reference and comment. Where engagement activity has been regarded a particular success or failure, key learning will be identified and taken forward and any repeat of similar activity will be amended and adapted.

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 Adults as well as Healthwatch. 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. Working Together to Support Parents with a Learning Disability.

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 11th July 2017.

1.3 Author of the Paper and contact details

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2. Summary

The purpose of this report is to provide an update, on the development of joint work between Children and Adult Services to support parents in Brighton and Hove who have a learning disability.

The report follows on from the challenge raised within the 2016 Fairness Commission regarding the ability of Adults and Children Services to work together to provide a needs led service to families to

help support them to keep children safe and well and for families to remain living together. This stated:

'The Council needs to change its approach to working with parents with learning disabilities to support the safety and security of the family and avoid children being taken into care by:

a) Establishing a joint protocol between Adults and Children's Services for referrals, assessment and support for parents with learning disabilities (as set out in DH Good Practice Guidance on working with a parent with learning disability, 2007).

b) Work with experts from the University of Bristol Norah Fry Centre for Disability Studies to conduct an independent evaluation of current practice in supporting parents with learning disabilities in Brighton and Hove, and to develop specialist support for parents with a learning disability.

c) Providing parents with learning disabilities with a choice of how they wish to live and be supported. This could involve extending Shared Lives, to parents with learning Disabilities (currently available in Brighton and Hove to adults with learning disabilities), as well as specialist support as outlined above.
Ensuring all staff are aware of how the Care Act 2014 applies to parents with a learning disability, at all relevant stages'.

In October 2016 the Community Learning Disability Team moved into the Families, Children and Learning Directorate which has brought a closer partnership between Learning Disability Services and Childrens Safeguarding and Care.

Definitions:

Learning disability and learning difficulty can sometimes get confused and it is worth noting that there is no overall single interpretation or consensual definition of the terms 'learning difficulty' and 'learning disability'.

In general terms the difference is highlighted as**:**

Difficulty = obstacle
Disability = something that incapacitates

Learning difficulty: Any learning or emotional problem that affects, or substantially affects, a person's ability to learn, get along with others and follow convention.

Learning disability: A lifelong condition that can range across a spectrum of ability and starts before adulthood affects development and leads to help being required to:

- Understand information
- Learn skills
- Cope independently

For the purposes of this report we will be covering working with parents with a learning disability but it is fair to say that the principles do apply more broadly to parents who might experience a range of problems in relation to parenting.

3. Decisions, recommendations and any options

3.1 That the Board accept this report and agrees that the content fulfils the response to the Fairness Commission

3.2 That the Board notes the joint protocol now established between Children and Adult's Services with regards services to parents with learning disabilities. The Protocol is awaiting feedback from a key stakeholder and we plan to go live as of the week ending 14th July.

See Draft Protocol in Appendix 1.

3.3 That the Board notes the services and support provided to parents who have learning disabilities to enable their parenting.

4. Relevant information

4.1 Good practice is that the provision of services and support from all agencies to parents with a learning disability must include:

- Information that is accessible and communication that is clear.
- Early help and intervention.
- Eligibility criteria and assessment pathways and processes that are coordinated and clear.
- Access to independent advocacy.
- Parental engagement in learning and education and planning for a family.

- Supports designed to meet the needs of parents and children that are based on assessment of needs and strengths.
- Flexible funding and coordinated packages of support.
- Long term support where necessary.
- Support provided for parents who are unable to care for their child.

4.2 The way we all learn can be very different and for parents who are vulnerable individuals it is very important that we understand the best approach to enable learning and change. Becoming a new parent is a challenge for all parents. For parents the importance of having support available at an early stage in order to prevent unnecessary difficulties arising is key. For parents with learning disabilities how to communicate and aid understanding and achieve the assimilation of new skills is essential to enable individuals and couples. In addition a multi- agency understanding of the issues which inhibit the ability to be a good parent and how to support each individual and create a supportive 'Team around the Child' which enables 'good enough' parenting is essential.

4.3 The reality for many parents with learning disabilities is that many are subject to structural inequalities and experience poverty, unemployment, poor housing, lack of information, harassment, bullying and sometimes violence and financial or sexual exploitation. All of which can impact upon a parent's capacity to parent their child or children safely. The majority of concerns with regards care by parents with learning disabilities arise as a result of inadequate levels of childcare and supervision and are recorded under the risk of neglect and emotional harm categories Cleaver and Nicolson, 2005). Where children are removed from the care of their families there are usually other difficulties faced by those parents, in addition to the learning disability (SCIE, 2005).

4.4 Fear can be a real barrier to working with any parent who believes that they have little chance of parenting their children due to stigma or prejudicial attitudes. For all parents a sensitive and enabling approach based on trusting relationships is the core of achieving good outcomes for children and parents. Each individual parent will have different strengths and weaknesses. The challenge is to support parents to be 'good enough' and to identify what support may be required to enable this to be the case. A further issue can be that families may struggle for a long time with a high level of stress, delaying seeking help until a crisis situation; thus leaving little opportunity for preventative intervention.

4.5 Balancing the rights and needs of both children and adults in families can pose difficult dilemmas that need to be owned, articulated and addressed. For parents with learning disabilities this needs to be through the tight working together of the agencies supporting children and Adults.

4.6 Essentially in every case the local authority and the Court are being asked to balance the impact of long term support of a parent to parent their child, where capacity to parent might diminish, in relation to the growing complexity of the parenting task and be subject to the vagaries of government and local authority commissioning arrangements vs the positive research provided regarding effective early permanence planning, in terms of early placement for children which is associated with better outcomes for them. In all cases carefully considered assessment based upon the individual needs and strengths of a parent and their child must form the basis for decision making.

4.7 In summary the main aim of good practice in supporting parents with learning disabilities and their families is to improve children's wellbeing, specifically to enable them to stay safe, healthy, active, achieve and to be nurtured, respected, responsible and included. Connected to this aim is to enable children to live with their parents, as long as this is consistent with their welfare, through the provision of support that they and their families require.

There is however little available research available in respect of the longer term outcomes for those children whose parents require a significant amount of support to enable them to parent in the longer term versus a significant amount of research regarding the importance of achieving early permanency for children upon future outcomes.

4.8 This table tells us about the number of children currently open to Children's Social Work Service who are subject to Child in Need Plans (CIN), Child Protection Plans (CP) who are Children in Care (LAC) in pre- court proceedings (PLO) and in Court Proceedings. It then shows us the number of children where a parent with Learning Disabilities is a factor and the percentage this is within the whole group of children.

	Count at 31-03-16	Count with a Parental Learning Disability Factor	% with a Parental Learning Disability
CIN	2056	151	7.3%
LAC	436	39	8.9%
CPP	388	53	13.7%
PLO	89	10	11.2%
Proceedings	57	9	15.8%

4.9 **Protocol:**

The multi-agency joint working protocol has been developed for any staff or volunteers working with parents where complex issues associated with their learning disability might impact on their ability to care for children and for those working with children whose parents or carers have complex problems, as a result of having a learning disability.

We have referred to the work of the Norah Fry Centre in Bristol, examples of best practice highlighted from SCIE research and other local authorities. A working group representing the Directorate of Families Children and Learning and informed by research, including the work of the Norah Fry Centre, and key stakeholders have collaborated to produce a protocol to inform the work of children's and adult's services to ensure that parents with a learning disability get better co-ordinated multi-agency support.

The aim of the protocol is to support and guide practitioners in making assessments and in offering interventions that are in the best long term interests of children.

The protocol and the practice guidance (in development), recognise that both services for Children and Adults do not work to support individuals living in the community in isolation. We stress the importance of a Whole Family Approach being adopted by all agencies, in the context of their work to improve both the identification and support for parents who have a learning disability.

4.10 **Our Offer:**

As a result of forging closer working relationships, our offer to parents who have a learning disability has developed. We offer:

- Early assessment, particularly pre-birth, involving Childrens and Adult assessments to inform joint planning and support.
- Specialist consultation for social workers to inform interventions. For example, since August 2016, a range of Learning Disability clinicians have attended the 4 weekly Drop-in Consultations to offer advice and guidance to Child Social Workers.
- Competence led specialist assessment from Parent Assessment Manual trained social workers.
- Joint work and training between Children and Learning Disability services.
- Creative collaboration and co-commissioning regarding packages of support.
- Assessment and intervention that makes for reasonable adjustments, supported by Learning Disability professionals when required.
- Assessment that is coordinated, timely and considers both children and adults needs and rights, to inform decision making and support planning.
- Bespoke interventions to enable parents to learn and adapt their parenting skills within the range of their abilities, including clinical support for parents, where appropriate, in terms of cognition and functioning.

In development:

- Shared bank of accessible resources for Children's and Adult Services to support learning.
- Training for child care professionals to support development and delivery of information in more accessible formats, including "easy read" formats for standard documents, such as reviews and reports
- Evaluation of joint working protocol via multi-agency LSCB audit (2018).
- Evaluation of practice and research with Sussex University to promote further learning and development of the joint working protocol.

4.11 **Training:**

Training for social workers is being provided via Children's Services Lead Practitioner in conjunction with a Clinical Psychologist attached to the Community Learning Disability Team. Additionally Children's Services have invested in training 26 social workers in the Parenting Assessment Manual training. The Early Parenting and Assessment Programme continue to offer a bespoke combined assessment and

intervention programme working with parents to enable them to provide for their babies both physically and emotionally.

Children's Services foster carers have received training from our Lead Practitioner on working to support parents with learning disability when they are residing in a Parent and Baby placement for the purposes of modelling, teaching and assessment.

4.12 **Evaluation:**

We will be undertaking multi-agency audit to evaluate our work as set against improving outcomes for children to further inform our practice. We will additionally be visiting other local authorities to inform our learning and working with our Young Carers Family Coach to gain a better understanding of the particular issues faced by children who reside with a parent who has a learning disability, to inform future interventions.

4.13 **Accommodation:**

In making for safe and stable arrangements it is recognised that all families are different and that there is not a one size fits all approach. Commitment is evident within Children's and Adults services to work creatively to support parents who have a learning disability maintain care of their children. An example is the use of Grace Eyre carers to offer support to parents to maintain their own independence, to enable the parents to care for their child, alongside the support of housing colleagues to locate suitable safe accommodation for families who are vulnerable.

4.14 **Further Support:**

There is clear recognition of the need for a variety of interventions to meet the needs of parents with learning disabilities. How effective these interventions are is largely determined by resources available and the extent to which the interventions meet a child's needs and how long they will be available. Decisions for children's future have to be based on realistic and sustainable packages of support. In addition to meet children's changing needs as they develop, a baby, toddler, primary, secondary aged child all require parenting that will meet their needs or parenting plus support that will meet their needs. Support can come through many different sources and combinations from wider family support or services, statutory or voluntary.

4.15 In order to identify a menu of support discussions are underway across Directorates e.g. Children's, Adults and Housing and with

Commissioners and with partner organisations, which include key advocacy services to find creative solutions to provide parents with the best opportunity to enable them to provide for their children into the longer term. Such as those provided by our Early Parenting and Assessment Programme and in conjunction with commissioned services such as Grace Eyre.

5. Important considerations and implications

Legal:

5.1 The legal context for safeguarding children is based on the paramountcy principles as laid out in the Children Act 1989 and 2004 Children's Act. This means that the child's needs override the rights of the parents. The principle are:

a. A child's welfare is paramount when making any decisions about a child's upbringing, known as the "paramountcy principle"
b. The court must ascertain the wishes and feelings of the child and shall not make an Order unless this is "better for the child than making no Order at all"
c. Every effort should be made to preserve the child's home and family links

5.2 The Care Act 2014 provides a duty to adults assessed has having care and support needs which arise from or are related to a physical or mental impairment or illness.and as a result of those needs are unable to achieve 2 or more of the specified outcomes (which includes carrying out caring responsibilities, if the person has a child) with the consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on the adult's wellbeing

5.3 Article 23 of the United Nations Convention 'Rights of Persons with Disabilities states 'Disabled people have the same right as anyone else to have a relationship and start a family.' 'Must have access to appropriate information and support, must have rights respected and upheld in practice, including any support they need as parents. No child must be separated from their parents simply on the basis of a disability on the part of the child or a parent.

5.4 The Equalities Act 2010 provides protection from discrimination of any person because they are perceived to have, or associated with

someone who has a protected characteristic and places a duty to make reasonable adjustments to processes in order to avoid discrimination.

5.5 Actions taken and decisions made by the Local Authority in relation to children and their families must take account of individuals' human rights enshrined in the Human Rights Act 1998; most notably Article 8 – Right to Privacy and Family Life.

Lawyer consulted: Sandra O'Brien Date: 29/6/2017

Finance:

5.6 There are no direct financial implications at this stage but the objectives outlined within the report will need to be delivered within the overall budget resources available.

Finance Officer consulted: Sophie Warburton Date: 15/06/2017

Equalities:

5.7 There are legal rights for both parents with learning disabilities and their children, as outlined above. This proposal has been developed specifically to enable these rights to be consistently supported and balanced, enabling the best possible outcomes. The protocol directly responds to one of the Fairness Commission recommendations and is intended to enable agencies to better meet our legal duties

Equalities Officer consulted: Sarah Tighe-Ford Date: 15/06/2017

Sustainability:

5.8 No sustainability implications are noted.

Sustainability Officer consulted: Mita Patel Date: 15/06/2017

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

5.9 Covered in the paper.

Brighton & Hove City Council

Working Together to Support Parents with a Learning Disability or Learning Difficulty.

Joint working protocol: Brighton and Hove City Council; Directorate of Families, Children and Learning and Health and Adult Social Care.

Brighton & Hove City Council

Contents:

1.0 Executive Summary:

This multi-agency joint working protocol has been written for any staff or volunteers working with people who experience challenges associated with their learning disability or learning difficulty, that might impact on their ability to care for children and for those working with children whose parents or carers have complex problems and need support, as a result of having a learning disability or difficulty.

This joint working protocol has been drafted as a response to recommendations made as part of Brighton and Hove City Council's Fairness Commission Report (2016).

A working group representing the Directorate of Families Children and Learning and key stakeholders have collaborated to produce a protocol to inform the work of children's and adult's services to ensure that parents with a learning disability and learning difficulty receive better co-ordinated multi-agency support.

Questions about childcare and parenting are clearly sensitive and can have important implications for people with challenges in relation to cognitive functioning and the stigma and difficulties associated with having with such difficulties may make parents reluctant or unable to ask for help.

Fear of a child being removed from their care has been expressed by parents as an obstacle to seeking help or fully engaging with services. Practitioners from all agencies need to be aware of this fear and should work with the parents and families openly, building on their strengths.

Families may struggle for a long time with a high level of stress, delaying seeking help until a crisis situation; thus leaving little opportunity for preventative intervention. Children in this situation may fear being removed or may themselves be requesting support. Balancing the rights and needs of both children and adults in families can pose difficult dilemmas that need to be owned, articulated and answered. It is government policy to promote the well-being of children through timely and appropriate support whilst the principle of wellbeing is also promoted in the Care Act 2014 for adults who would struggle to meet 2 or more specified outcomes (including carrying out caring responsibilities if the individual has a child)

This protocol gives information about research and guidance for good practice to assist in supporting the needs of children and their families and stress the importance of all agencies adopting a Whole Family Approach in the context of their work to support Parents who have a learning disability or learning difficulty.

2.0 Definitions:

The 'formal' definition of the commonly used expression 'learning disability' as set out by the Department of Health (2001) is:

'A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); with a reduced ability to cope independently (impaired social functioning); which started before adulthood, with a lasting effect on development'. (Department of Health, 2001, page 14)

There is also a far wider group of adults who may be described as having a learning difficulty. These adults do not have a formal diagnosis (because their impairment is milder) and may relate to difficulties in learning experienced as a result of trauma and would not generally fit the eligibility criteria for support services in their own right from Learning Disability Services, however their needs for services may still be significant and they may be eligible for support from Health and Adult Social Care services.

This protocol uses the term 'learning disabilities or difficulties' to include this far wider group of parents who often struggle with the same issues when parenting but who might not be involved with specialised services (Edgerton 2001).

Research estimates that there are 985,000 adults in England with a learning disability, equivalent to an overall prevalence rate of 2% of the adult population. Estimates of the number of adults with learning disabilities who are parents vary widely from 23,000 to 250,000. (Public Health England - Improving Health and Lives: Learning Disability Observatory).

Learning Disability or Learning Difficulty:

In general the difference between a learning disability and learning difficulty is highlighted as**:**

Difficulty = obstacle
Disability = something that incapacitates

Learning difficulty: Any learning or emotional problem that affects, or substantially affects, a person's ability to learn, get along with others and follow convention.

Learning disability: A lifelong condition that can range across a spectrum of ability and starts before adulthood affects development and leads to help being required to:

- Understand information
- Learn skills
- Cope independently

There may be other neuro-developmental conditions which can impact upon a person's functioning, such as Autism, which would not be classified as a Learning Disability. The principles upheld in this joint working protocol include the need for consultation and collaboration between Adult and Specialist Services and Children's Services applies, alongside an appreciation of the need to jettison stereotypes and to appreciate the individual circumstances of each child and their particular family circumstances.

http://www.mindroom.org/index.php/learning_difficulties/what_are_learning_difficulties/learning_difficulty_or_learning_disability/

The protocol should be read by staff and volunteers working across children's, adult services, health, family justice and criminal justice and the community and voluntary sector.

3.0 Policy Context:

The Protocol should be read in conjunction with:

- Pan Sussex Child Protection Procedures.
- Working Together to Safeguard Children 2015
- Valuing People Now: A New Three year Strategy for People with Learning Disabilities 2009 HM Government

The legal framework for the Protocol is:

- The Children Act 1989
- The Children Act 2004, sections 10, 11.
- Children and Families Act 2014.
- Care Act 2014
- The Mental Capacity Act 2005
- The Mental Health Amendment Act 2007 (Deprivation Of Liberty Safeguards)
- Human Rights Act 1998
- Disability Discrimination Act 2005
- Equalities Act 2010.

Good practice guidance is:

- Finding the Right Support? A review of issues and positive practice in supporting parents with learning difficulties and their children. Norah Fry Research Centre, University of Bristol, 2006
- Good Practice Guidance on Working with Parents with learning Disabilities (DoH 2007)
- Independence Matters (2003)
- Improving the Life Chances of Disabled People 2005
- Working Together to Safeguard Children 2015

4.0 Aims of the Protocol:

The aim of this protocol is to improve joint working to support adults with a learning disability or learning difficulty who are parents by:

- Improving interagency and departmental communication and assessment through the use of this protocol.
- Acknowledging and understanding the impact of the individual's cognitive impairment or condition on their ability to parent their children.
- Considering the needs and safety of children.
- Recognising the individual needs of the parents as defined in the Care Act 2014.
- Supporting family life and positive parenting, where considered safe to do so.
- Promoting the early identification of an early help for parents with learning needs and assessment during pregnancy
- To offer a basis to enable learning together, to further develop practice.

Brighton and Hove City Council promotes a Whole Family Approach across all services that support Families and Children. This Whole Family Approach requires adult and child services to work together towards positive outcomes for parents and their children.

People with learning disability or difficulty are amongst the most socially excluded and vulnerable groups in Brighton and Hove. Parents who have a learning disability are often subject to multiple disadvantages, experiencing very significant levels of health and social inequality as compared to other families. Nationally, research suggests parents with a learning disability are at greater risk of having their children become subject to Child Protection Plans and Care Proceedings (Emerson et al 2005, Booth &Booth, 2004).

People with learning disability or learning difficulty can parent their children well but many require support to do so. Services face challenges to understand and meet the needs of parents with learning disabilities and parents with a cognitive impairment/ condition may need support to develop their understanding, resources, skills and experience to meet the needs of their children. This requires all services to work closely together to develop an approach based around commonly understood principles of good practice.

5.0 Overarching Principles of Good practice:

- Local authorities and all other agencies working or in contact with children have a responsibility to safeguard and promote children's welfare.
- Children's needs are usually best met by supporting their parents to look after them.
- Professionals should respect and support the private and family lives of parents who have additional support needs associated with physical or sensory impairment, learning disability/ difficulty, disability, mental health problems, long-term illness or drug or alcohol problems.
- Support needs should be addressed by enabling parents to access universal and community services wherever possible and appropriate, with reasonable adjustments made to facilitate engagement with support on offer.
- Additional support needs should be met by the timely provision of specialist assessments and services.
- Agency responses should be needs-led, aim to support family and private life and prevent unnecessary problems from arising.

- Agency responses should address the needs of parents and children in the context of the whole family and not as individuals in isolation from one another.
- Inappropriate tasks and responsibilities undertaken by a child or young person which adversely affect their emotional, physical, educational or social development should be prevented by providing adequate and appropriate support to the parent(s) and their family.
- The wellbeing principle needs to be at the core of Care Act assessments for parents who are eligible for support.
- Diversity should be valued and fully considered in agency responses.

6.0 Eligibility for Assessment and Access to services: preventative approaches.

Some parents with a learning disability or learning difficulty will become eligible for support through consideration of their family circumstances.

In determining eligibility for services the protocol recognises the importance of the parenting role and acknowledges the need to provide additional support to families who may not have met the threshold for certain adult focussed services.

This protocol acknowledges that parents should be assessed not only in their own right as adults but also as potentially requiring of support in order to maintain family life, as set out in the Care Act (2014). The protocol aims to enable services to work jointly to offer help and support at an early stage in order to prevent crisis and prevent children from reaching the threshold for child protection intervention.

Where a child is at risk of significant harm and in need of protection, the parenting capacity and the risks to the child must be assessed. This is best achieved through a planned joint assessment by all agencies involved in supporting both the child and the parent.

7.0 Key Recommendations:

Provision of services and support from all agencies to parents with a learning disability or learning difficulty must include:

- Information that is accessible and communication that is clear.
- Eligibility criteria and assessment pathways and processes that are coordinated and clear.
- Supports designed to meet the needs of parents and children that are based on assessment of needs and strengths.
- Long term support where necessary.
- Access to independent advocacy.
- Early help and intervention.
- Support provided for parents who are unable to care for their child.

- Parental engagement in learning and education and planning for a family.
- Flexible funding and coordinated packages of support.
- Children's welfare and safety as paramount. All professionals involved have a responsibility for the safety and wellbeing of children.
- Multi-agency training opportunities.

8.0 Whole Family Approach:

The child's needs must always be paramount and it needs to be understood that support for the adult as parent or carer will in turn support the child. Taking a whole family approach enables universal services and adult and children's services to work together to offer co-ordinated support to help families overcome challenges and to work towards positive outcomes for all concerned. It is of equal importance to listen to the views of children who live with adults with a learning disability or learning difficulty. Any assessment needs to consider how the cognitive impairment/ condition of the parent or carer impacts on the lives of the children in the household and the experience and welfare of the children must be considered when offering support and interventions to parents and carers.

Services and professionals need to think about how we can work together to remove organisational barriers in order to see the family as a whole and think about how capacity to parent can be supported by effective multi-agency working and support to prevent crisis.

Supporting families where a parent has additional needs often requires the support of many and often begins prior to babies being born

Social inclusion is a significant factor in promoting the strength and resilience of families where there are additional support needs. A degree of support and facilitated referral may be required to navigate introduction to community support to enable engagement and participation regardless of circumstance or ability.

Any assessment at **Level 2/3/4** **(B&HCC Threshold of Need)** must consider the needs of children who have caring responsibilities for a parent, carer or sibling. Research tells us that children who have parents with a learning disability or difficulty do not always feel that their views are considered by services. The assessment of Young Carers is addressed later in this protocol.

9.0 Sharing Information:

"Whilst the law rightly seeks to preserve individuals' privacy and confidentiality, it should not be used (and was never intended) as a barrier to appropriate information sharing between professionals. The safety and welfare of children is of paramount importance, and agencies may lawfully share confidential information about the child or the parent, without consent, if doing so is in the public interest. A public interest can arise in a wide range of circumstances, including the protection of a child from harm, and the promotion of child welfare. Even where the sharing of confidential medical information is considered inappropriate, it may be proportionate for a clinician to share the fact that they have concerns about a child." The Protection of Children in England: a Progress Report The Lord Laming 2009.

http://www.education.gov.uk/publications//eOrderingDownload/HC-330.pdf

Practitioners working with adults should identify and record at an early stage:

- The adult's relationship with any children
- Parenting responsibilities
- Which other agencies they need to work with if they have concerns about unborn babies, children or young people.
- Practitioners should discuss concerns with the family and seek their agreement to making referrals to services for children and families unless this places a child at increased risk of significant harm. The child's interest must be the overriding concern in such decisions.
- Young carers need to be identified, as this can have detrimental effects on children and young people's education, health and emotional well-being.

Data protection law should not be used as a barrier to appropriate information sharing between professionals to protect children or adults from harm. Sharing information in a way that is sensitive, respectful and appropriate to the level of understanding, of the parents and child, can be crucial to ensuring the delivery of timely support.

Consent or the refusal to give consent to information sharing about children should always be recorded. For further information see Information Sharing: Guidance for practitioners and managers, HM Government, 2006, the aim of which is to support good practice in information sharing by offering clarity on when and how information can be shared legally and professionally, in order to achieve improved outcomes.

http://www.governornet.co.uk/linkAttachments/Information%20sharing%20guidance%20for%20practitioners%20and%20managers.pdf

Parents with a learning disability or learning difficulty often need 'reasonable adjustments' in order to help them to understand and act on information communicated to them. Reasonable adjustments need to be based on an individual assessment and may need to include more time and consider providing concrete examples to help support learning, which may require repetition over a longer time period. Clear and concise language is important and consideration needs to be given to using visual cues and reminders, if appropriate to aid understanding.

The involvement of a range of professionals and agencies can feel overwhelming and confusing to most parents. This can be further compounded with a parent who has a cognitive impairment/ condition and can contribute to a decline in their functional abilities. Professionals must work together to facilitate a cohesive and coordinated service offer and communication strategy, which is supportive to both parents and professionals alike and where possible reduces the number of professionals who are directly involved with the family.

Where there are worries about a parent's capacity to manage the care of their child safely, information should be shared with the Front Door for Families (01273 290400/ www.brighton-hove.gov.uk/frontdoorforfamilies). Where a child is felt to be in immediate danger or in an

emergency 999 call should be made to the Police, for example, when a young child is left unsupervised.

The Front Door for Families can offer advice in the event that a professional is uncertain as to whether a referral should be made or not.

Please see Appendix 1 for referral and joint assessment flow chart.

10.0 Equal Opportunities:

The assessments of Parents with a learning disability or difficulty are sometimes influenced by stereotypes about the capacity of people with cognitive impairment/ condition, to parent.

When making any assessment it is important to be reminded that:

'People with learning disabilities have the same rights and are entitled to the same expectations and choices as everyone else, regardless of the extent or of the nature of their disability, their gender and ethnicity' (DOH 2000) 'Parents with learning disability can in many cases be supported by family and supportive networks and professionals, enabling them to respond effectively to the needs of their children (DOH, 2000) It is the minority of children whose parents have a learning disability who experience serious developmental problems, the type of problems which can be found among this minority are not unique to children whose parents have a learning disability.

When assessing parents with a learning disability or difficulty we need to undertake the following checks and balances:

- Do we have a clear idea of the **Reasonable Adjustments** and kinds of help needed by each parent to support them to understand and respond to what is being asked of them?
- Is the support on offer **Needs Led?** The family's views about their own support needs and the way in which they want services to be provided to them is as important as collating professionals views about the family and their needs.
- Does the support on offer require **A Specialised Response?** Parents with a learning disability or complex autism require professionals who can provide specialised knowledge and response.
- Are we **Intervening Early enough?** Parents are more likely to be receptive to support during pregnancy and early infancy than at a later date, once difficulties have become more entrenched. Early identification and support is more effective in offering proactive services to avert crisis and future harm.
- Are we offering a **Competence Led** model of assessment? Attention needs to be paid to competence and strength, with interventions provided to reduce deficits.
- Are we allowing enough **Time?** Parents with a learning disability/difficulty or autism often need longer to assimilate knowledge and understanding of concepts. Are we providing in our interventions a range of teaching and support techniques over a period of time to enable competence to develop?

Are we considering **the perspective of the child?** We need to consider each child individually and look at the interplay of factors in the child's particular and unique circumstances, which may differ between siblings.

11. 0 Commitment from Children's Services:

- Children's Services will receive and record contacts expressing concerns about risks to children. They will be clear with other agencies about their threshold for involvement and give feedback on what will happen as a result of a contact. They will be open to having discussions with other services regarding their concerns.

- All contacts about concerns will be recorded, whether they trigger an assessment or not, and in the event of subsequent referrals being received, will contribute to building a picture of issues and concerns which may trigger further action, which will be fed back to referring agencies.

Children's Services will, throughout their involvement with children and their families:

- Employ a policy of openness with families where information from other agencies impacts on planning for the child.

- seek consent from family members to share information with other agencies in the best interests of the child (but bear in mind this should only be done if the discussion and agreement-seeking will not place a child at increased risk of significant harm).

- be clear whether an assessment using the Strengthening Family Assessment has been undertaken or needs to be undertaken and, if so, its outcomes.

- assess the child's needs and identify desired outcomes for the child.

- provide a child-focused service to families with whom they are involved

- ensure that the wishes and feelings of child/ren are ascertained

- ensure the child is given the opportunity to be seen/heard on their own, but be aware that the child's view of 'normality' and what is acceptable may be influenced by the parenting and care they have received thus far.

- Make sure that the assessment includes both partners, not just the mother and will give consideration to what support is available in the wider family network.

- consult with primary and secondary mental health services, learning disability and adult services teams for information to support assessment of parenting capacity, and for realistic assessment of any risk, undertaking joint assessment where possible

- invite representatives from adult services, mental health and learning disability to attend Child Protection Conferences, Core Groups and Child In Need Network Meetings where they are involved with the family.

- together with relevant agencies, identify roles and responsibilities for any ongoing work with the family: a meeting is preferable where decisions need to be made and owned.

12. 0 Commitment from Adult Services/ Learning Disability Services:

- identify at an early stage any children within families and specifically those with a caring responsibility, and share this information with Children's Services.
- ensure, when assessing adults' needs as defined under the Care Act 2014, that any support to help their caring responsibilities as a parent is taken into account.
- retain a Whole Family Approach, ensuring that they are not focusing solely on the adult, making the children 'invisible'
- understand that although a parents functional abilities may impact on their abilities as a result of their learning disability or difficulty which may pose a risk that children may be harmed, it is not a predictor alone of harm or neglect. Consideration needs to be given to other risk or ameliorating factors such as social networks, mental health/ emotional wellbeing.
- invite representatives from Children's Services or other services to multi-professional care planning meetings where they are involved with the family, with the agreement of the service user
- provide a representative to attend Child Protection Conferences where at all possible or at the very least, provide a report on the support being provided to the parent(s).ensure they are kept informed about plans for any children and incorporate these into future care planning in respect of the adult family members they are supporting.
- Consider parents' caring responsibilities when caring planning for adults with a learning disability/difficulty or autism so support packages do not disrupt the parent/child relationship
- Timely consultation and assessment to identify whether reasonable adjustments are likely to be needed and the nature of these.
- Any assessment or potential interventions need to be shared with the network around the parent / carer, so that recommendations can be utilised in all settings.
- CLDT will be providing training to child care professionals to support development and delivery of information in more accessible formats, including "easy read" formats for standard documents, such as reviews and reports.

13.0 Together:

- CLDT and Child Lead Practitioners will provide a library of resources and tools.
- Common shared approach to early joint child and adult assessment with shared plans and timescales for completion.
- Direct Consultation and facilitation with Parents and Professionals involved in Statutory Child Care processes.

14.0 Mental Capacity:

A parent's learning difficulty or disability may impact on their capacity to make decisions. The mental capacity of all adults and young people between the ages of 16-18 years must be considered in the context of an assessment of need.

- Every adult must be presumed to have capacity unless it is established that they lack capacity through an assessment.
- All practicable steps must be taken to assist a person lacking capacity to make a decision.
- An unwise decision does not mean that a person lacks capacity.
- Any decision or action taken on behalf of a person lacking capacity should aim to be the less restrictive option available in terms of their rights and freedom of action.

In the context of the Mental Capacity Act (2005) the decision maker is the person who wants to take the action. They are responsible for the assessment of capacity. The capacity of the individual to make a decision is determined by using a two stage test:

1. Does the person have an impairment of, or disturbance in the functioning of their mind or brain?

If yes, and you consider that the person is unable to make the decision then the 4 stage test of capacity *must* be carried out.

2. Four stage capacity test. On the balance of probabilities does the person:

- Understand the information relevant to the decision.
- Retain the information (long enough to make the decision).
- Use or weigh up the information to make the decision
- Communicate the decision by talking, using sign language, or any other means.

If a person fails to sufficiently demonstrate one part of this test they are deemed to lack capacity in relation to that specific decision.

If the person lacks mental capacity to make the decision in question the identified decision maker should make the decision in their best interests. They may also need to consider whether to engage an Independent Mental Capacity Advocate. The decision maker should always make reference to the Mental Capacity Act (2005), Code of Practice (3).

.. There may be a number of decisions that need to be assessed by a Social Worker in Adult Social Care (Learning difficulties) or the Community Learning Disability Team (Learning Disability and/ or complex presentation requiring specialist clinical intervention) to obtain an overall understanding of the adults ability to assess risk and carry out functional tasks that would help to inform the children's social workers assessment of the adults ability to be an effective parent/ caregiver. Any assessments of an individuals ability mental capacity to meet their own needs or understand the risk of not doing so for themselves or their child would need to be influenced by consideration of appropriate clinical supports such as the use of Speech and Language Therapy to develop communication guidelines.

Children's Services must remain mindful of the need to exercise influence with due regard to the issue of a person's capacity, particularly in relation to agreements entered into voluntarily

(s.20 CA 1989). When there are doubts regarding a parent/carers mental capacity, joint work between Adult Services and Children's Services is crucial and the need for a Mental Capacity Assessment, completed by either Children's services (with appropriate support and guidance) or Adult Services must be considered to inform planning.

15.0 Screening and Assessment Considerations:

Professionals intervening where parents have a learning disability or learning difficulty need to consider their communication as part of the assessment process. A parent's intellectual functioning (cognitive ability) may be impacted and as a consequence this may have an effect on the child's daily lived experience and their development. Parents with a learning disability or learning difficulty may take longer to understand and learn how to respond to their children's changing needs.

The timescale of any assessment will be an important consideration and this needs to be agreed in respect of any joint assessment process between Children and Adult Services, at the outset of the assessment.

It is acknowledged that some parents may not have the cognitive abilities to parent their child safely through to adulthood. In these circumstances Children's Services will work with parents, as much as possible, to achieve permanence for children with alternative carers.

There are some instances where a parent with a learning disability or difficulty may be unable to live with or care for their child. Where such issues arise with parents with such disabilities/ conditions deliberate harm is rarely identified against their children, with harm most commonly arising out of an act of omission. (McConnell and Llewellyn, 2002; Tymchuk, 1992).

Being separated or unable to care for their children can cause parents significant distress and sometimes mental health issues. Sensitive and compassionate support from both children's and adult services is required. In these circumstances please consider referral to the Looking Forward team based at City View Children's Centre at Brighton General. This team will work with children and adult services partners to support parents with their loss and work to address issues relating to capacity to parent.

All services need to offer support to help parents in this situation make sense of the decision making/process that has/is taking place. Some parents may not want to receive support from children's services in these circumstances and a referral should be made to the appropriate adult services for support.

It is important for all services to remember that some parents may respond to the loss of their child with anger and disengagement from services, this is an understandable emotional response to a significant trauma and loss and services should endeavour to remain in contact to revisit the offer of support at a later date.

16.0 Screening and Assessing Possible Indicators of Learning Disability:

- Consider parents educational background – did they attend special school? Did they have extra help in mainstream school?

- Did they sit any exams at school, and if so, what grades did they achieve?
- Health Background GP records.
- Employment/Unemployment, what did they do after leaving school? Have they acquired any qualifications, did they attend a day centre? Are they in receipt of any benefits e.g. PIP?
- Are they responsive, do they seem to understand written communication or requests and comments made and do they follow through on matters agreed? Are they aware of the areas with which they need help? Do they find complex questions frustrating and overwhelming?
- Do they see themselves as having a learning disability?
- Are they/have they ever been known to social care services?
- Do we need to consider further assessment to assist in our understanding of likely impact upon the child for e.g. cognitive, OT etc?

17.0 Accessible Information and Communication.

Parents with a learning disability have the same rights as all parents to be consulted regarding all assessments concerning their child and to be kept informed about any services or interventions that are being planned. Any potential difficulty in understanding is not a reason to override these rights.

All professionals working to support families have a responsibility to promote good communication and to check that they have been fully and properly understood. The Good Practice Guidance of Working with Parents with a Learning Disability (2007) and updated by the University of Bristol provides further information and advice.

All services should ensure that documentation and reports are written in a way that is accessible to parents to ensure that they can understand the decision making process and take measures to ensure that their views and rights are represented. Independent advocacy support is particularly important for parents who are separated from their children or involved in care proceedings.

Children's Services have a responsibility to continue to ensure that communication with parents around issues relating to contact continues to be presented in a format which is accessible and understood by the parent.

Parents and carers with a learning disability often need more time and concrete examples to help understand communications. Communication with multiple different professionals needs to be kept to a minimum and pathways developed to facilitate two-way communication?

18.0 Pre-birth assessment and Early Help Services.

All services should take steps to ensure that adults with a learning difficulty or disability who become a parent or wish to become a parent knows about the support available as well as their responsibilities as parents.

GP's, Midwifery and other health providers often come into contact with expectant parents with a learning disability either prior to or during early pregnancy. These health providers

have an important role in ensuring appropriate support is in place for parents to access and understand their ante-natal care and make choices regarding their health care and the need for onward referrals.

It is particularly important that parents with a learning difficulty, disability and /or autism are offered early support to learn the skills necessary to care for their baby. New parents, where a learning disability is identified should be provided with information and support tailored to their specific learning needs.

Children's centres also play an important role in the identification and support of parents with learning disabilities. Parents with a learning disability should have equal access to all services within Children's Centre's, Community Nursing, via the Teenage and Vulnerable Parents Team and to those supports provided by early help services.

Assessment must concentrate on the harm that has occurred or is likely to occur and the impact upon the child of maltreatment, in order to inform planning and service provision.

'*Ultimately whether a parent has a learning disability or not, it is the quality of care experienced by the child which determines whether a parenting capacity can be regarded as sufficient or not'* (Cotson, et al 2000)

All services should:

- Provide enough time to make plans for the baby's protection.
- Provide enough time to make a full and informed assessment of parenting capacity.
- Where possible avoid approaching parents for an assessment in the last stages of their pregnancy.
- Involve wider family support networks when making assessments and planning support needs.
- Avoid making premature assessments of parenting capacity before opportunities for developing skills to meet the needs of their child have been formulated.
- Enable parents to contribute their own ideas and solutions to increase the likelihood of positive outcomes.
- Offer or signpost packages of support and care that will enable parents to meet their child's needs in the future.

19.0 Parental Assessment/ Risk Considerations:

"Risk management cannot eradicate risk; it can only try to reduce the probability of harm".

(The Munro Review of Child Protection Part One: A Systems Analysis, Professor Eileen Munro, Department for Education 2010)

Most children and young people who are seriously harmed or killed are not involved with specialist mental health or probation services and subject to their risk assessments. They are much more likely to be receiving help and support through universal services such as those offered through the GPs, health visitors, walk-in centres, schools, voluntary sector or local council services such as housing.

The circumstances of people's lives and health can change frequently, meaning that the stresses and risks both for individuals and the family also change and need frequent holistic re-assessment.

It is unclear whether the frequency of neglect is any greater when a parent has a learning difficulty or disability, than that seen amongst other disadvantaged families. It is however understood that where a parent has an IQ of 55 to 60 or below the severity of their cognitive impairment, will impact upon their parenting capacity (McGaw et al, 1999), but understanding of an IQ alone is not sufficient to be able to predict neglect. The best overall predictor (Booth and Booth, 1993) is the absence of suitable societal or familial supports, which can actively prevent neglectful conditions from arising (Tymchuck,1992) Therefore active consideration needs to be given by all agencies to identifying key family and community based supports that are available to the family at an early stage.

The most significant risk identified in respect of a parent with a learning disability or difficulty and is with regard to the understanding of the need for health care and a safe, emergency response when illness or other emergencies arise (Cleaver et al 2011). These circumstances often require good identification and understanding of the significance of symptoms and often require a complex response (e.g. responding to a child choking, avoiding hazards in the home), knowing when medical care is required. Practitioners need to work to assess, teach, rehearse and model if necessary appropriate responses in the event of an emergency.

The needs of a parent or carer with a learning disability or difficulty can be wide and varied and we should not make assumptions that a parent having a learning disability or learning difficulty will lead to harm.

20.0 Funding for Support and Care:

Where additional financial assistance is required as a result of a parent's learning disability or difficulty, a whole family approach from services is required. Consideration needs to be given to funding being allocated from Children and Adult Services and consideration should be given to the consequence of not providing the service. Needs of parents and children should be clearly identified in any planning/discharge meetings so that the cost of appropriate packages of support can be agreed, if appropriate.

In some circumstances responsibility may fall to one or other service or there may be agreement to apportion costs as appropriate. Any decision to split costs needs to be brought to the Children's Care Planning Forum, with representation being made by both adults and children's services with the relevant directorates financial decision makers present.

All adults with eligible needs under the Care Act have the option to have a personal budget in relation to purchasing support to meet assessed need.

21.0 Young Carers.

*"A young carer becomes **vulnerable** when the level of care-giving and responsibility to the person in need of care becomes **excessive or inappropriate for that child**, risking impact*

on his or her emotional or physical well being or educational achievement and life chances." (ADASS/ADCS MOU 2009)

https://www.adass.org.uk/adass-and-adcs-draft-template-for-mou/

Carers (Recognition and Services) Act 1995 – young carers are entitled to an assessment of their needs separate from the needs of the person for whom they are caring.

http://www.legislation.gov.uk/ukpga/1995/12/contents

Carers (Equal Opportunities) Act 2004 – identification of young carers can be problematic. Many children live with family members with stigmatised conditions such as mental illness or learning disability/difficulty. As stated in many cases, families fear where professional intervention may lead, if they are identified. Some families may also have concerns about stigmatisation of being assessed under children's legislation.

http://www.legislation.gov.uk/ukpga/2004/15/contents

A whole family approach should be adopted when working with Young Carers. This means that children's and adult services must have arrangements in place to ensure that no young person's life is unnecessarily restricted, because they are providing significant care to an adult with an identifiable community care need.

For services to provide effective support for young carers and their families, it is vital that all members of staff working with them begin with an inclusive, wide-ranging and holistic approach that considers the needs of:

- the adult or child in need of care
- the child who may be caring and
- the family

Many Young Carers have stated that often services focus on the adult in front of them without thinking through the implications of the disability on the children in the family, which can lead to children taking on a caring role which proves harmful to them in the longer term.

22.0 Children with additional needs:

Children with disabilities have exactly the same rights to be safe from abuse and neglect as non-disabled children. Having a disability must not mask or deter appropriate enquiry and response where concerns are identified.

Over identification with parents/carers, i.e. accepting neglectful situations, which would not be accepted for other children, due to sympathy felt as result of a parent having a learning disability or as a result of a child having a disability need to be guarded against.

23.0 Purpose of the Protocol and Future Developments:

This protocol aims to form the basis for establishing that where parents are given support tailored to their particular learning styles and their family's needs, they are enabled to parent effectively, despite potential negative expectations and the very real difficulties they face. It is proposed that through joint work between services, the aims and provisions of the Children

Act 1989 and Care Act 2014 alongside broader legislative frameworks can be put into practice for the benefit of parents and children alike. The protocol acknowledged that positive outcomes for children and their families can be achieved in a range of different ways.

We plan to continue to develop our offer and propose this protocol to be a starting point for further developments in our practice and support for parents with a learning disability. To this end the protocol will be subject to an annual review by the Directorate of Families, Children and Learning.

24.0 References:

Booth & Booth (1993) Parenting with Learning Disability – Lessons for Practitioners. Br. J. Social Work (1993) 23, 459 - 480

Booth, P (2000) Parents with learning difficulties, child protection and the courts. Representing children 13 (3), 175-188.

Booth, T and Booth, W (2004) Parents with learning difficulties, child protection and the courts: A report to the Nuffield Foundation on Grant no CPF/00151/G

British Psychological Society Division of Clinical Psychology (2015) Guidance on the Assessment and Diagnosis of Intellectual Disabilities in Adulthood.

Brophy, J (2006) Research Review: Child care proceedings under the Children Act 1989.

Cleaver, H and Nicholson, D (2005) Children living with learning disabled parents'. Report for the Department for Education and Skills.

Cleaver, H et al (2011) Children's Needs - Parenting Capacity: Child Abuse, Parental mental illness, learning disability, substance misuse and domestic violence.

Cotson, D, et al (2000) 'Implementing Framework for the Assessment of Children in Need and their Families when a Parent has a Learning Disability.' In DoH, HO, DfEE. Reader – Framework for the Assessment of Children in Need and their Families: London: Stationary.

Cotson, et al (2001) cited in Emerson, E Malam et al (2005) Adults with Learning Difficulties in England 2003/4 www.ic.nhs.uk/pubs/learndiff2004

Department of Health (2001) *Valuing People: A new strategy for learning disability for the 21st Century*. London: The Stationery Office.

DH Good Practice Guidance on working with a parent with learning disability, 2007.

DOH Chapter 18 Reader - Framework for the Assessment of Children in Need and their Families. London: Stationary Office.

DOH (2000) Framework for the Assessment of Children in Need and their Families Good Practice Guidance.

Edgerton, R. B. (2001) The Hidden majority of individuals with mental retardation and developmental disabilities. In *The Forgotten Generation: The Status and Challenges of Adults with Mild Cognitive Limitations* (eds A. J. Tymchuck, C. K. Lakin and R Luckasson), p 3- 19/ Paul H Brookes, Baltimore

Emerson, et al (2005) Adults with Learning Difficulties in England 2003/4. Leeds health and Social Care Information Centre.

Fairness Commission: Brighton and Hove (2016) https://www.brighton-hove.gov.uk/content/council-and-democracy/fairness-commission

McConnell, D. & Llewellyn, G. (2000) Disability and discrimination in statutory child protection proceedings, *Disability and Society*, 15 (6) 883-895.

McGaw, S et al. (1999). Parenting Assessment Manual. Trecare NHS Trust.

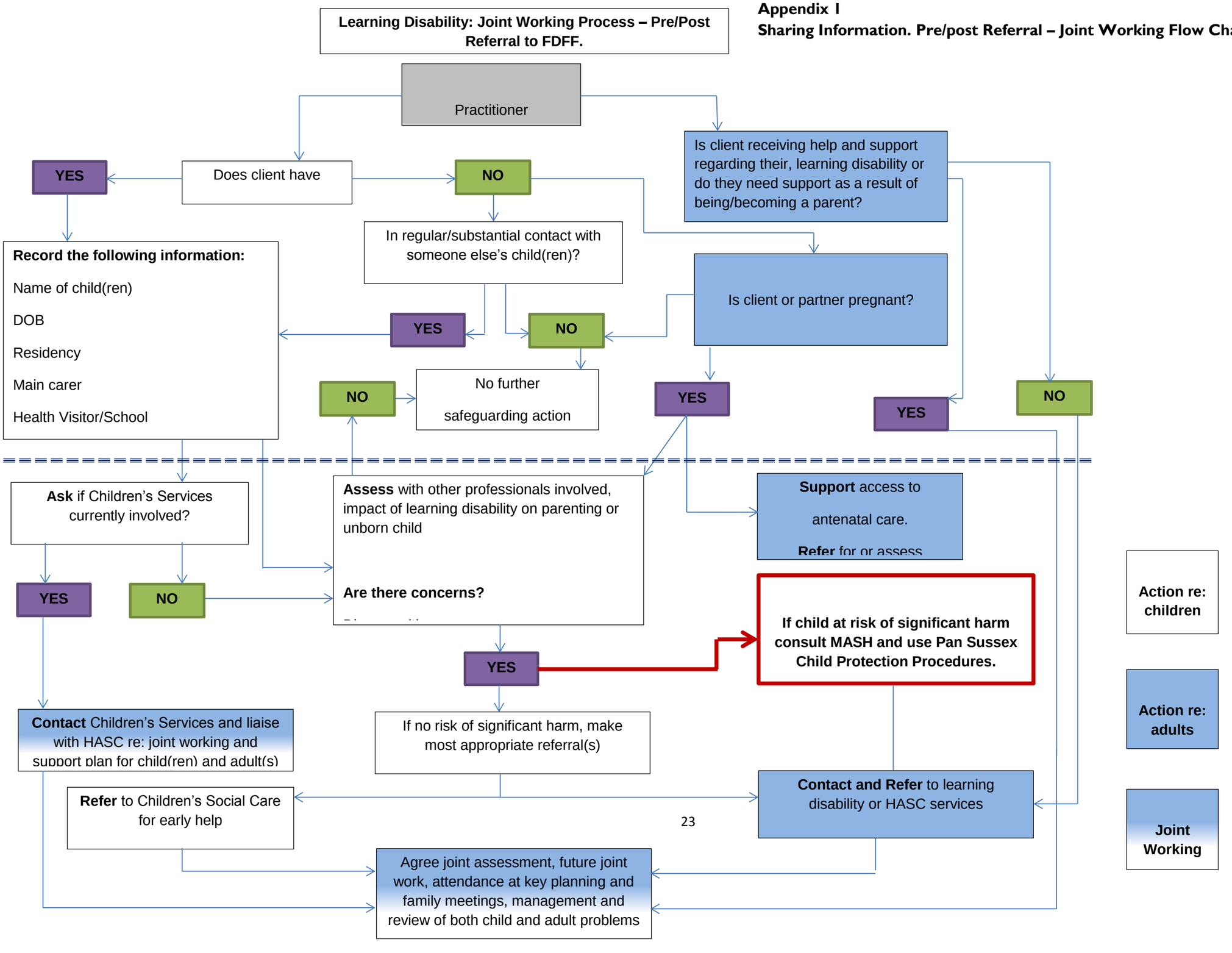
Public Health England - Improving Health and Lives: Learning Disability Observatory

SCIE – 2005 Helping parents with learning disabilities in their role as parents, www.scie.org.uk

SCLD: Supported Parenting: Refreshed Scottish Good Practice Guidelines for Supporting Parents with a Learning Disability. (2015)

Tymchuk, A (1992) Predicting adequacy of parenting by people with mental retardation'. Child Abuse and Neglect. 16. P. 165-178.

Appendix 1
Sharing Information. Pre/post Referral – Joint Working Flow Chart



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.

Subject:		**Food Poverty Action Plan Progress Update: Extract from the proceedings of the Neighbourhoods, Communities & Equalities Committee Meeting held on the 13 March 2017**
Date of Meeting:		**13 June 2017**
Report of:		**Executive Lead for Strategy, Governance & Law**
Contact Officer:	Name:	**Mark Wall** **Tel: 01273 291006**
	E-mail:	mark.wall@brighton-hove.gov.uk
Wards Affected:	All	

FOR GENERAL RELEASE

Action Required of the Health & Wellbeing Board
To receive the item referred from the Neighbourhoods, Communities & Equalities Committee for consideration.

Recommendation:

(1) That in regard to the Action Plan, the ASC & CCG actions in Aim 2C around building nutrition and hydration into care assessments, creating innovative ways to allow people to eat together by combining Adult Social Care (ASC) care packages, ensuring that food issues are considered in Home Care Commissioning Process, developing a trigger mechanism when a meal service for vulnerable people is under threat; and how social enterprise model Community Meals/ Meals on Wheels delivery could be stimulated be referred to the Health & Wellbeing Board for consideration.

BRIGHTON & HOVE CITY COUNCIL

NEIGHBOURHOODS, COMMUNITIES & EQUALITIES COMMITTEES

4.00PM 13 MARCH 2017

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillors Daniel (Chair); Moonan (Deputy Chair), Simson (Opposition Spokesperson), Littman (Group Spokesperson), Bell, Gibson, Hill, Lewry, K. Norman and Penn.

Invitees: Joanna Martindale (Hangleton & Knoll Project); Anusree Biswas Sasidharan (BME Brighton & Hove Police Engagement Group), Jane Lodge (CCG) and Jane Ross (Community Works).

PART ONE

60 FOOD POVERTY ACTION PLAN PROGRESS UPDATE

60.1 The Chair welcomed Becky Woodiwiss and Emily O'Brien to the meeting and invited them to introduce the report.

60.2 Becky Woodiwiss stated that a report had been brought to the committee in November and this was an update on the progress made to implement the citywide Food Poverty Action Plan.

60.3 Emily O'Brien stated that a great deal of good work in developing and implementing the Food Action Plan, which had been recognised at a national level and she had been invited to speak to the Welsh Assembly on setting up Food Action Plans. She then outlined various aspects of the Plan and not that there were still significant challenges to be addressed including 1 in 5 people in the city were struggling to meet household costs, 1 in 5 council tenants regularly reduced meal sizes or skipped a meal and 2 in 5 felt that they ate less healthily than they could. There was a higher level of food poverty amongst young people and a third of people in the City Tracker survey indicated that disabled people felt insecure about food poverty. She also noted that there was a fear of food prices increasing as a result of Brexit.

60.4 Emily O'Brien stated that the council was involved in over half of the actions that had been identified in the Plan and its partnership was welcomed as it meant that there was a collective approach to the problem. She noted that the Partnership was working with schools to support children and maintain the success of CHOMP.

60.5 The Chair thanked both Becky and Emily for attending and providing the update on the action plan.

60.6 Members of the Committee welcomed the report and queried whether there were any areas where more support or action was required and whether the local discretionary fund was fully utilised. The need for sign-posting to advice and support for people with mental health was also raised as well as the role of home care and support workers in regard to providing information about nutrition.

60.7 Emily O'Brien stated that there was a need to look at hospital discharges and whether people were eating properly and had access to healthy food. It may be that the situation had been recognised but it would help to have stronger links with Adult Social Care so that information could be shared and updated. In regard to the local discretionary fund she was unsure if it was fully used. She stated that the Action Plan was only half way through and more could be done if resources were available e.g. she wanted to develop a food tip sheet for specific groups of people and noted that home visits were not really long enough to enable people to provide information and help in terms of eating healthily. Perhaps it would be possible to combine care packages so that people leaving hospital could be seen together thereby having a 45mins tine period, in which they could be seen and eat together.

60.8 The Executive Director for Neighbourhoods, Communities & Housing stated that she would ensure an update on the local discretionary fund was sent to all Members of the Committee.

60.9 Councillor Littman stated that it was an important report and proposed that the recommendations be amended to include that proposals for next steps are included in the next report to committee.

60.10 The Chair welcomed the amendment and formally seconded it. She also suggested that the matter of adult care should be referred to the Health & Wellbeing Board for further consideration.

60.11 Councillor K. Norman welcomed the proposal to refer the issue to the Health & Wellbeing Board and formally seconded the Chair's amendment.

60.12 The Chair noted that the recommendations had been amended and put them to the vote which was carried.

60.13 **RESOLVED:**

(1) That the report be welcomed and the progress made by all partners in delivering the Food Poverty Action Plan be noted;

(2) That officers be instructed to bring back a report at the end of action plan period highlighting successes, learning and proposals for next steps; and

(3) That in regard to the Action Plan, the ASC & CCG actions in Aim 2C around building nutrition and hydration into care assessments, creating innovative ways to allow people to eat together by combining Adult Social Care (ASC) care packages,

ensuring that food issues are considered in Home Care Commissioning Process, developing a trigger mechanism when a meal service for vulnerable people is under threat; and how social enterprise model Community Meals/ Meals on Wheels delivery could be stimulated be referred to the Health & Wellbeing Board for consideration.

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 Adults as well as Healthwatch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Joint Strategic Needs Assessment review

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 11th July 2017.

1.3 Author of the Paper and contact details

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

2. Summary

2.1 Since April 2013, local authorities and CCGs have had equal and explicit obligations to prepare a Joint Strategic Needs Assessment (JSNA) which provides a comprehensive analysis of current and future needs of local people, and is used to inform commissioning of services that will improve outcomes and reduce inequalities.

2.2 This duty is discharged by the Health & Wellbeing Board and overseen by the City Needs Assessment Steering Group.

2.3 Each year the programme for in-depth needs assessments is proposed, by the City Needs Assessment Steering Group, to the Health and Wellbeing Board. This paper sets out the proposed programme.

2.4 As agreed at the November 2016 Health and Wellbeing Board, a review of the JSNA has been undertaken. This paper summarises the

findings from the review and sets out the programme for development of the JSNA over the next three years.

2.5 As an appendix to this paper, the JSNA overarching summary for 2017 is provided for approval by the Board.

3. Decisions, recommendations and any options

3.1 That the Board approve the 2017 JSNA summary for publication, as set out in section 4.3 and provided in Appendix 1.

3.2 That the Board approve the priorities for in-depth needs assessments in 2017/18 as set out in section 4.4.1.

3.3 That the Board approve the development programme for the JSNA over the next three years, building on the feedback from the consultation, as set out in section 4.5.7.

3.4 That the Board request that officers continue to develop the JSNA to support the overall approach and whole system development of health and care services, including informing policy and resource allocation.

4. Relevant information

4.1 Background information

4.1.1 Needs assessments provide a comprehensive analysis of current and future needs of local people to inform commissioners and providers how they can improve outcomes and reduce inequalities. They also ensure relevant strategies including the Joint Health & Wellbeing Strategy are based on high quality evidence, and have been used as a valuable resource for community and voluntary sector organisations (for example in making external funding bids).

4.1.2 Evidence within needs assessments usually includes local demographic and service data; evidence from the public, patients, service users and professionals; and national research and best practice. These elements are brought together to identify unmet needs, inequalities and overprovision of services. They also inform commissioners and providers how they can improve outcomes for local people.

4.2 Our local approach to JSNA

4.2.1 The JSNA is delivered using a city wide partnership approach. The programme is overseen by the City Needs Assessment Steering

Group, which includes representatives from the council's Public Health, Adult Social Care, Children's Services, Housing, Policy and Communities Equality & Third Sector teams; the CCG; HealthWatch; Community Works; Sussex Police and the two universities.

4.2.2 The programme has three elements:

- Overarching resources: Including the JSNA summaries (~80 sections, each updated at least every three years), data snapshots, survey briefings and Annual Reports of the Director of Public Health
- Rolling programme of in-depth needs assessments on a specific theme or population group
- Community Insight, an online resource providing a wide range of data mapped at small area level across the city as well as up to date reports for these areas.

4.2.3 All resources described above are accessible via the Local Intelligence website (http://www.bhconnected.org.uk/content/local-intelligence) the Strategic Partnership data and information resource for those living and working in Brighton & Hove.

4.2.4 Online usage statistics show that the JSNA is accessed:

- Community Insight: 640 times per month average
- Needs assessment resources: 150 times
- Surveys: 65 times
- Other reports:170 times

4.2.5 The LGA Equality Peer Challenge conducted in 2016 highlighted the JSNA and Community Insight website as notable practice and commented "the JSNA was well understood and well used by all partners".

4.3 JSNA summary 2017

4.3.1 An overarching short summary of the Brighton & Hove population and its needs is provided in Appendix 1 and presented for approval by the Board.

4.3.2 This has been approved by the City Needs Assessment Steering Group and the Health and Adult Social Care Directorate Management Team.

4.4 In-depth needs assessments programme 2017/18

4.4.1 The in-depth needs assessment annual programme has been updated by the City Needs Assessment Steering Group and is presented for approval by the Board:

- **Advocacy services** (reporting July 2017)
- **International migrants** (approved by Health and Wellbeing Board in 2016; reporting by October 2017)
- **Pharmaceutical needs assessment** (Health and Wellbeing Boards are required to develop and update pharmaceutical needs assessments from 1st April 2015, and then at least every three years thereafter. The last assessment was published in March 2015 and therefore the next assessment needs to be published by March 2018.)
- **Self-harm** (to report by March 2018): proposed by Children's, Families and Learning, BHCC with broad partnership support from the City Needs Assessment Steering Group, in particular from HealthWatch, Sussex Police and both universities.

4.5 JSNA Review 2017

4.5.1 The Brighton & Hove JSNA has been running in its current form since 2012 and was established following wide engagement and consultation.

4.5.2 The Health and Wellbeing Board agreed at its November 2016 meeting that it was timely to undertake a review of the JSNA to ensure the processes and outputs continue to meet users' and stakeholders' needs in a way that remains sustainable.

4.5.3 The aims of the review were to:

- Inform future development of the JSNA to ensure it meets future demands of statutory and other partners
- maximise the influence of the JSNA to inform commissioning
- raise awareness of the JSNA

4.5.4 The review was composed of the following elements:

4.5.5 **An online stakeholder survey (February - March 2017):** There were 85 respondents across the City Council, CCG, other statutory partners and the voluntary and community sector.

4.5.5.1 The key themes for improvement identified from the survey were made into questions used for the table discussions at the workshop. These were:

- What do partners across the city need from the JSNA?
- How can the JSNA inform commissioning and effective integration across the city?
- How can the JSNA help us to understand communities and neighbourhoods across Brighton & Hove?

- What should the JSNA look like (products and supporting resources)?

4.5.6 **The partnership workshop was held in March 2017**. Cllr Daniel Yates (Chair of Health and Wellbeing Board) opened the event and key speakers included Rob Persey (HASC), John Child (CCG), Kaye Duerdoth, (Community Works) and Jess Sumner (Age UK). The session was attended by 47 participants from across statutory and voluntary and community organisations in the city.

4.5.7 Key themes from the review

4.5.7.1 The key themes from the survey and the workshop are:

Strategic

- Ensure a close link between JSNA and changing needs of decision makers regarding informing strategic priorities and to inform commissioners.
- Increase ownership of JSNA across organisations – more partners contributing intelligence and championing the JSNA.

Content

- Develop future models of service need by making more use of risk stratification, predictive analytics and aggregated service user data sources
- Strengthen focus on place and neighbourhoods.
- Increase focus on “assets” as well as “needs” and ensure inclusion of the voice of local people where it is not present.
- Review the number and the format of JSNA summaries produced (e.g. consider one section on long term conditions rather than sections on individual conditions) and explore whether the use of interactive profiles with links to live data.
- Publish updates as part of an ongoing process rather than just once a year (but we would need to consider how to involve the voluntary and community sector).

Promotion

- Better promotion of the JSNA across the city to users and potential users.
- The title “Joint Strategic Needs Assessment” could be reconsidered so that it better reflects the assets approach and communicates that the resources are valuable for partners in addition to health and social care.

4.5.8 Areas for focus in Years 1, 2 and 3

4.5.9 The City Needs Assessment Steering Group has agreed a proposed development programme for 2017/18 to 2019/20.

4.5.10 Year 1 2017/18

Strategic

- Review how the JSNA is embedded in the new Brighton & Hove Caring Together programme governance structures
- Explore how links with the Universities can be strengthened, through Leading Places, in particular around models of care and projections for future need.

Content

- Publish revised population, needs and assets profiles, including future projections, for commissioning geographies (e.g. GP clusters/ Adult Social Care districts. Explore links to the larger Sustainability and Transformation Partnership areas).
- Start to build in data from the Clinical Commissioning Group risk stratification tool.
- Pilot a small number of key JSNA summaries, for example Our population and Long-term conditions, as interactive profiles.
- Continue with the format and methods of in-depth needs assessments, ensuring that all they have a short community summary published alongside the main report.

Promotion

- Review branding of the JSNA
- Establish a rolling communications programme with regular briefings and more widely disseminate offer of demonstrations and training for Community Insight.
- Engage more widely with partners and consider identifying named leads who could add more local intelligence to Community Insight.
- Support partners to promote the JSNA in their teams; and identify how these can be used in neighbourhoods to inform community conversations, support ongoing work and receive feedback.

4.5.11 Proposed areas for focus in Years 2 and 3 (2018/19 and 2019/20)

Strategic

- Continue to drive developments in the integration of health and social care and use this new knowledge to model future needs across the city, providing robust projections which support the integration of health and social care

Content and promotion

- Consolidate the number of JSNA summaries and roll out in the more interactive format of profiles, moving from an annual cycle to a rolling programme of profiles updated at different points throughout the year and communicated widely.
- Review inclusion of assets and voice evidence and the communication of the JSNA as an assessment of both assets and needs

5. Important considerations and implications

Legal:

5.1 The Health and Social Care Act 2012 (s196) requires the function of preparing a JSNA to be discharged by the Health and Wellbeing Board. Specifically, from April 2013, local authorities and Clinical Commissioning Groups have equal and explicit obligations to prepare a Joint Strategic Needs Assessment (JSNA) which provides a comprehensive analysis of current and future needs of local people to inform commissioning of services that will improve outcomes and reduce inequalities.

5.2 S218A of the NHS Act 2006 (as amended) and the NHS Pharmaceutical Services and Local Services Regulations 2013 require Health and Wellbeing Boards to develop and update pharmaceutical needs assessments from 1st April 2015, and then at least every three years, thereafter. The last assessment was published in March 2015 and therefore the next assessment needs to be published by March 2018.

Lawyer consulted: Natasha Watson Date: 3 July 2017

Finance:

5.3 The resources required to support this work are funded by public health grant and are reflected within the service and financial plans for public health. £22k of the Public Health grant is specifically allocated to the production of the JSNA as well as staff time both within Public Health and externally.

Finance Officer consulted: David Ellis Date: 15/06/17

Equalities:

5.4 Needs assessments consider specific needs of groups with protected characteristics. The JSNA is a key data source to inform action to improve outcomes in all groups and meet the public sector equality duty (including Equality Impact Assessments).

Sustainability:

5.5 No implications: Sustainability related issues are important determinants of health & wellbeing and these are integrated in the summary. The JSNA will support commissioners to consider sustainability issues.

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

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

Families, Children and Learning, Health and Adult Social Care and the CCG are part of the City Needs Assessment Steering Group which agreed the suggested needs assessments for 2017/18, the JSNA 2017 summary and the programme for JSNA development at its April meeting.

6. Supporting documents and information

6.1 JSNA summary 2017

Health and wellbeing in Brighton & Hove

An executive summary of the JSNA 2017 (HWB version July 2017)

The Brighton & Hove Health and Wellbeing Board is required to produce a Joint Strategic Needs Assessment (JSNA). The JSNA provides a description of the current and future health, social care and wellbeing needs of the local population, and does so by collating a variety of evidence, including information from existing in-depth needs assessments; health and social care data and local views and experiences.

The JSNA is used to identify local health and wellbeing priorities and inform the commissioning and delivery of local services, as well as local strategies including the Brighton & Hove Joint Health and Wellbeing Strategy (JHWS).

This executive summary is based on data available at March 2017.

The full set of JSNA resources can be accessed at:
http://www.bhconnected.org.uk/content/needs-assessments

Our population

Brighton & Hove is one of the most deprived areas in the South East and has a population with significant health needs and inequalities.

285,300

Estimated number of residents in 2015

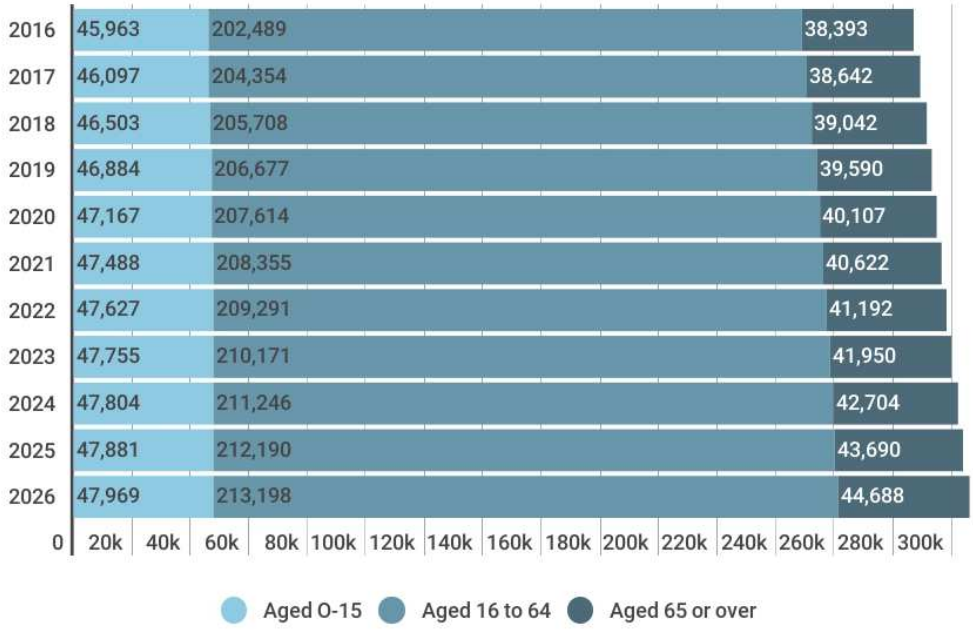
12.5% (32,500 people)

Increase since 2005

South East (9.1%) and England (8.3%)

a bigger increase than seen regionally or nationally

Our resident population is predicted to continue to grow:



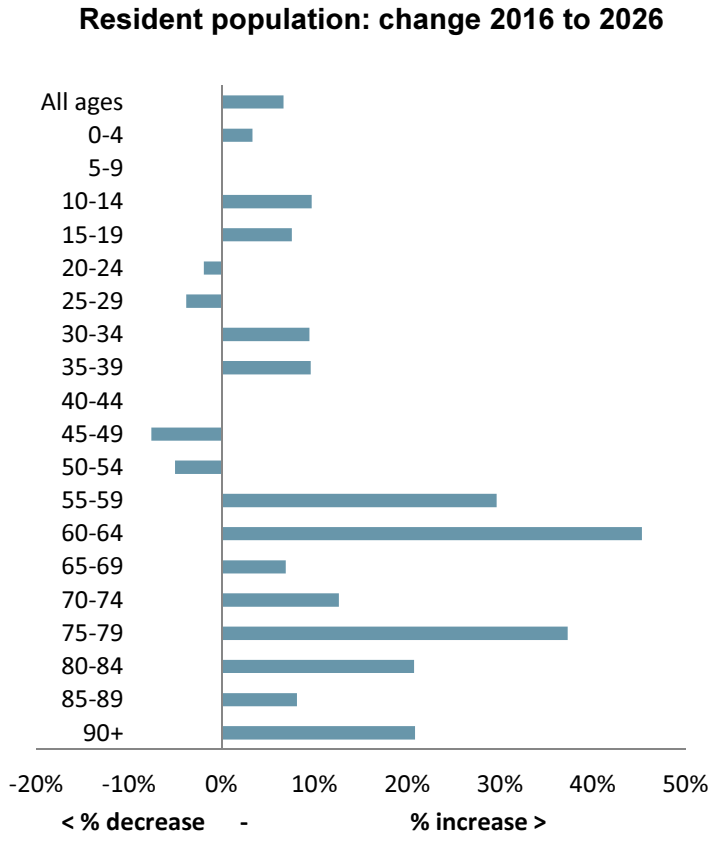
305,900

Predicted number of residents in 2026

6.6% (19,000 people)

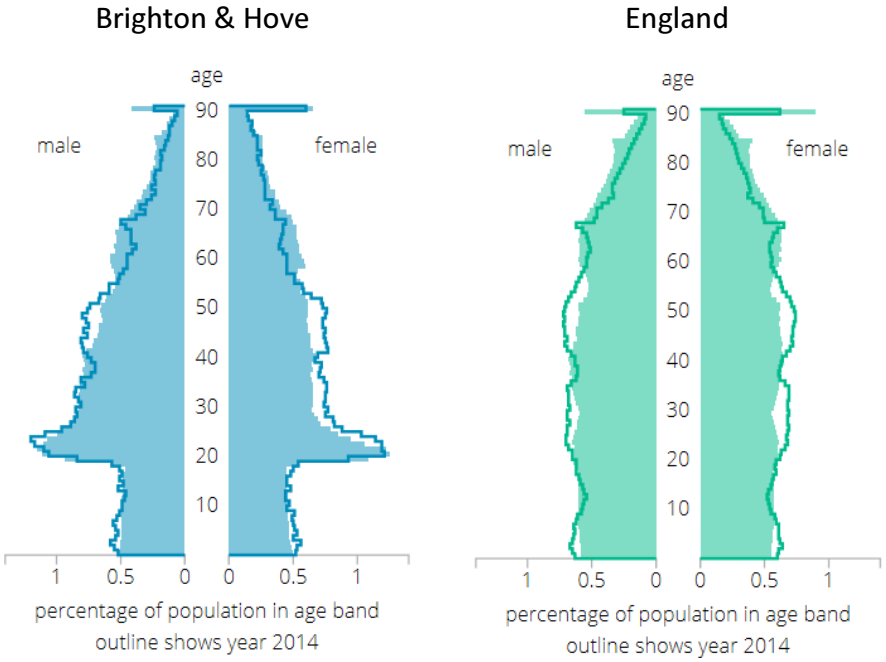
Increase compared to 2016

Our population



The city's population is predicted to get older with the greatest projected increase (37%, 9,300 extra people) in the 55-64 years age group. The population of people aged over 70 is predicted to increase by 21% (5,500 people), including those aged 90 or older (500 people, 21%). The population aged 20 to 29 is predicted to fall by 3% (1,600 people).

Our population profile is younger than England, but is ageing over time.



Key: Filled colour 2034, outline 2014

As people live longer the size of the older population will increase leading to a growing number of people living with multiple long-term conditions. Plans will need to be put in place to manage their future health and care needs set against a challenging economic background.

Our communities

Our city consists of different population groups living in a range of geographical communities. The large student and Lesbian, Gay, Bisexual and Trans (LGBT) communities are key characteristics of the city's population profile. **The most up to date data and our best estimates show:**

50% / 50%

Brighton & Hove has an even population split by gender (although there are differences by age)

2,875 adults

estimated to be trans

20% (53,351 people)

One in five residents are from a BME background

16% (44,569 people)

Have a health problem or disability that affects their day to day activities either a little or a lot

17,376

Estimated number of adults have a moderate to severe physical disability

4,746

Estimated number of residents with a learning disability

12% (27,229 people)

In 2011, full time students aged 18 or older

34,220 people

In 2014/15 full or part time students at Brighton and Sussex universities

11 - 15%

Estimated percentage of residents aged 16 or over who are lesbian, gay or bisexual

9% (23,987 people)

One in ten residents provides unpaid care for a family member, friend or neighbour

11.750

Estimated number of ex-military service personnel in the city

Our communities

41,000

Residents born outside of the UK

11,000

From Asia

18,000

From Europe

11,000

From another part of the world

16,000

From countries in the EU

13,000

Member countries before 2004

3,000

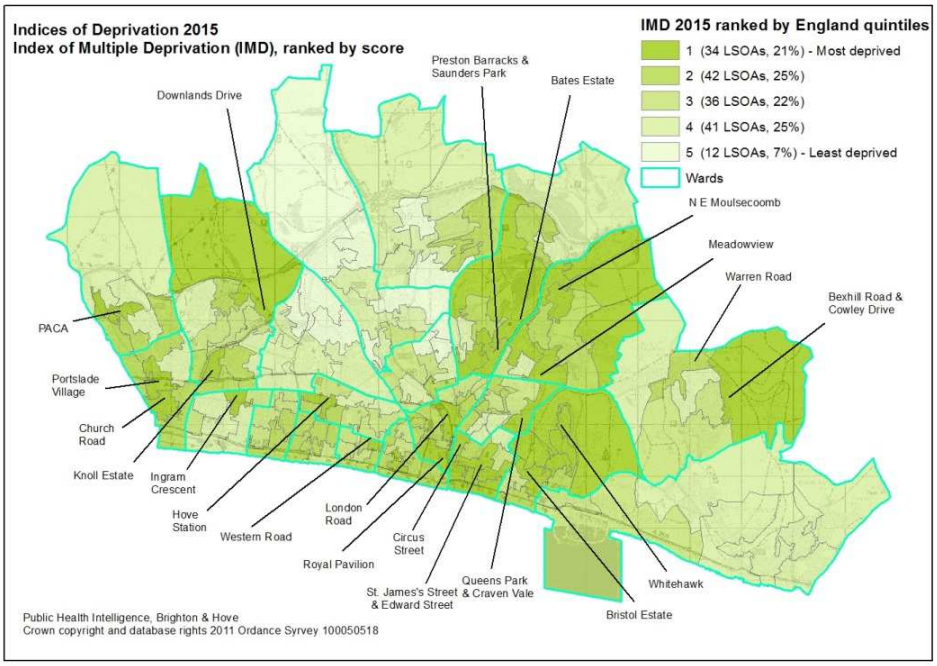
Eastern European member countries

Community assets

Brighton & Hove has a strong voluntary and community sector and many residents who volunteer and work to improve their neighborhoods and city:

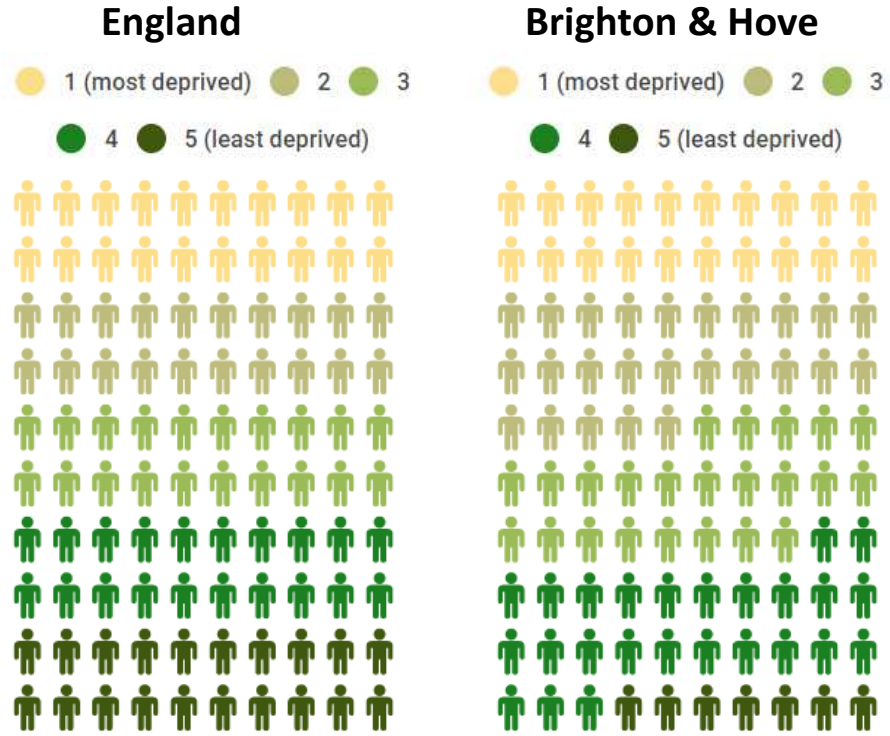
- 71% of respondents to the City Tracker Survey 2016 felt that they belong very or fairly strongly to their immediate neighbourhood, the same as the national comparator
- 70% of respondents agree that people pull together to improve their neighbourhood compared with 68% nationally
- 44% of residents indicated that they volunteer and give their time on an unpaid basis to a local group, club or organisation which is an important means of connecting with the community, compared to 41% nationally
- 89% of people agreed that people from different backgrounds get on well together in the local area, the same as the national figure.

Our city



Indices of deprivation highlight that some areas are more affected by deprivation than others. The highest concentration of deprivation is in the Whitehawk, Moulsecoomb, and Hollingbury areas. Along the coast, to the west of the city and in Woodingdean there are also pockets of deprivation. All these areas are in the 20% most deprived areas in England.

Percentage of the population living in each national quintile of deprivation



Our city is the 102nd most deprived local authority of the 326 in England according to the 2015 Index of Multiple Deprivation. In 2015, 45% of the population of the city lived in the 40% most deprived areas in England and only 7% in the 20% least deprived areas .

Wider determinants of health

Our health and wellbeing is influenced by a wide range of social, economic and environmental factors, as well as lifestyles and fixed personal characteristics such as age and hereditary factors.

- A higher proportion of local pupils are achieving 5 A*- C GCSEs including English and Maths. However, only 25% of local pupil eligible for free school meals achieved 5 A*-C GCSEs, including English and Maths (lower than in England: 33%).
- The city has a similar proportion of unemployed adults to Great Britain, but a higher proportion than the South East
- There were 6,285 crimes of violence against the person recorded by the police in 2014/15. The city has a relatively high rate of violent crime per head of resident population, although this comparison does not take into account the high number of visitors to the city
- Residents are more likely than England to live in private rented housing. In 2008, up to 37,000 homes in the city were considered to be “non-decent”.
- According to 2013 estimates, 12% of households were living in fuel poverty placing children and frail older people at increased risk of ill health and death during winter months
- Similar to England, air pollution is a significant cause of ill health and mortality
- We have a higher rate of people killed or seriously injured on our roads than England.

60% of pupils

Achieved 5 A*-C GCSEs including English & Maths. Slightly higher than the England average for state funded schools (57%)

1 in 3 homes

Are damp, have poor bathrooms, kitchens, heating or insulation

More cold homes

A higher proportion of households can't afford to heat their homes and have enough left to live off, compared to England or the South East

6% unemployment

8,990 people in the city are unemployed

144 rough sleepers

Multi agency estimated number of rough sleepers (2016)

5.1%

Similar to England the percentage of adult mortality (aged 30+) attributable to long-term exposure to particulate air pollution

Life expectancy and main causes of death

79 years of life expectancy

Similar to England but worse than in the South East

84 years life expectancy

Similar to England but worse than in the South East

62 years of healthy life expectancy

Similar to England but worse than in the South East

61 years of healthy life expectancy

Worse than both England and the South East

Between 2001-03 and 2013-15 life expectancy increased from 75.1 years to 79.3 years for males and from 80.8 years to 83.5 years for females. However healthy life expectancy (based on contemporary mortality rates and prevalence of self-reported good health) has actually fallen in recent years – from 63.9 years to 62.4 years for males between 2009-11 and 2013-15 and from 64.1 years to 61.3 years for females. People are therefore living longer in ill-health and with multiple long-term conditions. This, alongside the rising retirement age, means that increasing numbers of people of working age are in ill-health.

There is a 9.6 year difference in life expectancy for males and 6.7 years for females (between the most and least deprived individuals) compared with 9.0 years and 7.0 nationally. Over the five year period 2011-2015 a total of 2,702 deaths in Brighton & Hove of people of all ages can be attributed to the impact of deprivation - equivalent to 540 deaths annually.

There is a larger difference in healthy life expectancy in the city between the most and least deprived individuals – 14.0 years for males and 12.5 years for females (although this is narrower than the gap nationally of 19.0 years for males and 20.2 years for females).

Life expectancy and main causes of death

2,130

Total deaths in 2015

583

Cancer deaths

545

Circulatory conditions

282

Respiratory conditions

172

Mental and behavioural

120

Nervous system diseases

117

External causes (includes accidents and suicides)

103

Digestive disorders

In 2015 there was a total of 2,130 deaths (all ages).

The commonest causes of death in the city are cancers, circulatory diseases, respiratory diseases and digestive diseases. The under 75 age-standardised mortality rate from cancer is higher than for England and the South East at 146.4 deaths per 100,000 people for 2013-15 compared to 138.8 and 129.4 respectively.

We also have a higher suicide rate. The rate of deaths by suicide and injury undetermined for Brighton & Hove residents for 2013-15 was 15.2 deaths per 100,000 people (age standardised), approximately 50% higher than the rate for England (10.1 deaths per 100,000).

Of all deaths in 2015, 41% occurred in hospital, whilst 23% occurred in the usual place of residence and 22% in care homes. Fewer deaths in Brighton & Hove are in hospital than across England (47% of deaths in England were in hospital).

Long-term conditions

HIV 11th highest

HIV prevalence in England & highest outside London. Higher new sexually transmitted infection rate than England.

Higher

Higher prevalence of serious mental illness, anxiety, depression and long term mental ill health than England

15.2 per 100,000

High suicide rate compared to 10.1 per100,000 people for England

4.1%

Lower recorded diabetes prevalence compared to 6.7% for England.

But recorded diabetes has increased from 3.8% in 2010/11 to 4.1% in 2014/15.

There are an estimated 16,600 people in the city with undiagnosed diabetes

69%

Breast cancer screening compared to 72% for England

1.3%

Slightly lower prevalence of Chronic Obstructive Pulmonary Disease (COPD - respiratory disease) on GP Practice Registers in 2015/16 than England (1.85%)

65%

Lower flu immunisation uptake than England for 65s and over

17,367

Estimated number of 18-64 year olds with a moderate or serious physical disability (2015)

3,508

Estimated number of 18 and overs with a moderate or serious visual impairment

22,667

Estimated number of people with a hearing impairment

Children and young people's health

26%

Overweight or obese children in Year 6 (10-11 years), lower than England (34%)

82%

Proportion of 5 year olds in the city free from dental decay. Better than seen in the South East (80%) and in England (75%)

88% breastfeeding

Within 48 hours of giving birth (74% in England)

6% of mothers smoking at delivery

The trend has been decreasing since 2008 and we are much lower than England (11%)

The city exhibits a range of positive health behaviours in relation to children and young people's health. Fewer pregnant mothers are smoking at the time of birth, more breastfeed and children aged 10 -11 years are more likely to be a healthy weight compared to England.

However, we have some of the worst rates of lifestyle behaviours at age 15 in the country, which impact upon young people's current and future health and wellbeing. We also know there is a clustering of these behaviours in young people from more deprived areas of the city.

1st

15% of 15 year olds currently smoke (2015), the highest rate in England. Average rates for the South East (9%) and England (8%)

1st

24% of 15 year olds have ever tried smoking cannabis (2015), the highest rate in England. Average rates for the South East (12%) and England (11%)

3rd

11% of 15 year olds drink alcohol at least once per week (2015), the joint third highest rate in England. Average rates for the South East (6%) and England (6%)

Children and young people's health

Challenges to children and young people's health remain:

89

The number admission episodes to hospital as a result of drinking alcohol for under 18s. The rate 58 per 100,000 people is significantly higher than found in the South East and England (both 37 per 100,000)

248

children and young people admitted to hospital for self-harm in 2015/16. 448 per 100,000 10-24 year olds compared to 431 per 100,000 for England

100

conceptions to women aged 15 to 17 in 2015. Our rate of 25 per 1,000 is higher than found in both the South East (17 per 1,000) and England (21 per 1,000)

448

high risk domestic violence cases discussed at local Multi-Agency Risk Assessment Conferences in 2015/16. 428 children were associated with these cases

19.1%

percentage of pupils with an identified need (a Statement/Education, Health & Care Plan or SEN Support). Higher than found nationally (15.4%)

3% (1,520 children)

under 18 receiving Disability Living Allowance (DLA). Similar to both the South East (3%) and England (3%)

Adults and older people's health

21%

It is estimated that one in five adult residents smoke. The proportion has fall from 25% in 2012 but is still significantly higher than for England (17%)

50%

Alcohol related attendances are 50% higher in city residents in the most deprived quintile compared to the least deprived quintile

10.4 per 1,000

Residents aged 16 to 64 use opiates/crack. Higher than the average in England (8.4 per 1,000)

There were 7.5 drug related deaths per 100,000 people in the city between 2013 and 2015. Higher than the South East (3.6 per 100,000) and England (3.9 per 100,000)

Some lifestyle behaviours can have a negative impact on our health as adults and older people. Smoking, alcohol and drug misuse in particular are significant issues in Brighton & Hove.

13%

Just over one in ten adults in the city are obese compared to more than two in ten adults in England (23%)

4.9%

Of adults cycle to work in Brighton & Hove compared to only 3% in both the South East and England

56%

Of adults achieving recommended levels of physical activity

Brighton & Hove has more residents who are physically active and has fewer obese and overweight adults compared to England.

17.3% (36,717)

Estimated number of residents aged 16 to 74 with a common mental health disorder (2014/15). Higher than the estimates for the South East (13.2%) and England (15.6%)

28.5%

Percentage of residents aged 16 or older reporting that they felt anxious yesterday (2015/16). Significantly higher than reported in the South East (19.0%) and England (19.4%)

Brighton & Hove has higher than average levels of estimated and self reported common mental health issues

Adults and older people's health

Brighton & Hove has a relatively large proportion of older people living alone and potentially isolated who are more dependent upon public services, but also more active older people than England.

Double

The proportion of independent active older people compared to the national average

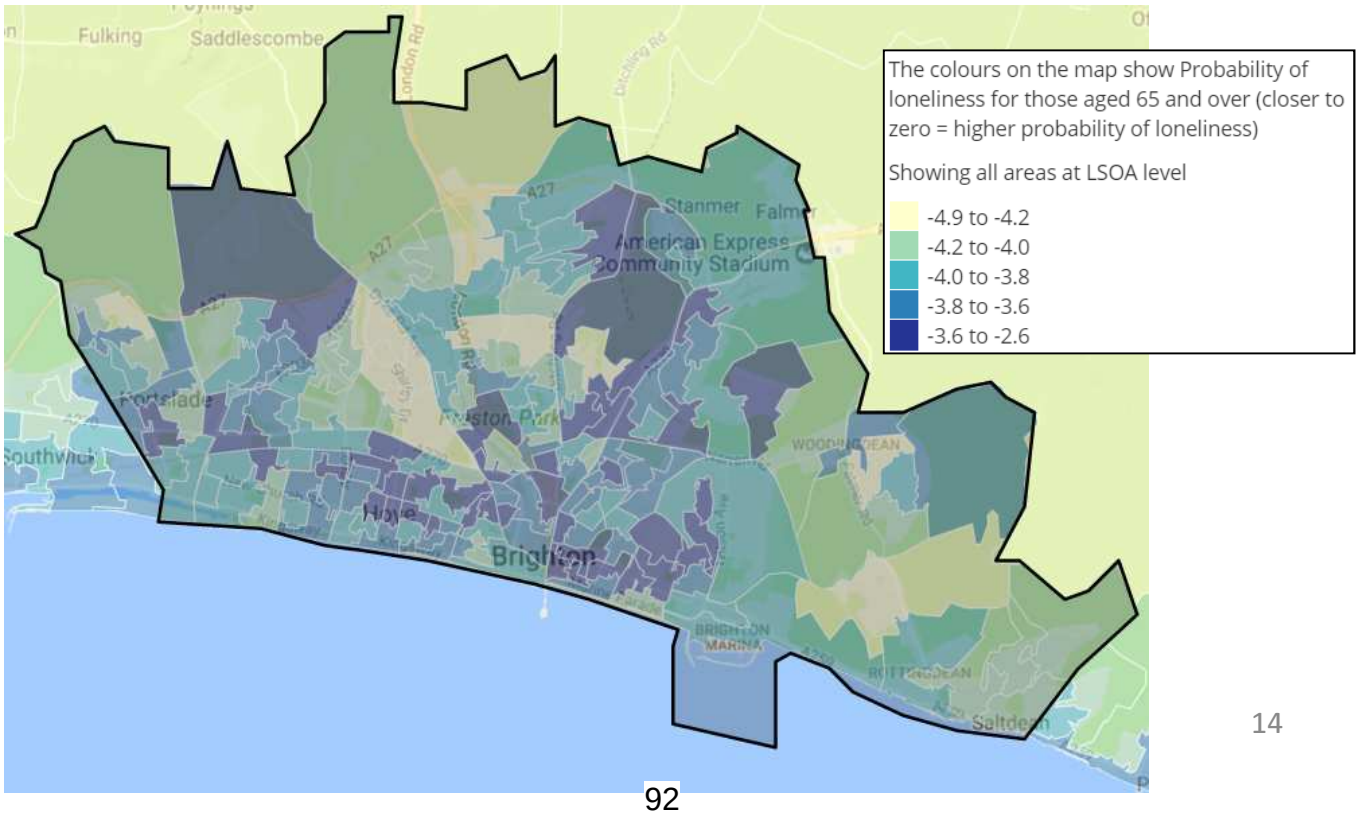
41%

More than two in five older residents live alone compared to only 31% nationally

947

There are similar rates of emergency hospital admissions due to injuries from falls in residents aged 65+ (2,220 per 100,000) compared to England (2,125 per 100,000)

Probability of loneliness for those aged 65 and over



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1. Weight management service procurement

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 11th July 2017.

1.3 Author of the Paper and contact details

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2. Summary

2.1 The aim of this paper is to set out the plans for the procurement and award of a new contract for weight management services for delivery in Brighton & Hove.

3 Decisions, recommendations and any options

That the Board grants delegated authority to the Executive Director of Health & Adult Social Care to carry out the procurement and award of a contract for Tier 2 weight management services with a term of three years.

That the Board delegates authority to the Executive Director of Health & Adult Social Care to extend the contract at the end of the three year term with the potential to extend the contract a further two years if he deems appropriate and subject to budget being available

4 Relevant information

Background information

Overweight and obesity in adults

4.1 49% of the adult population in Brighton & Hove are overweight or obese. Three per cent (n= 6,810) of adults in Brighton & Hove are estimated to be morbidly obese (BMI ≥40).

4.2 There is an association between obesity and socioeconomic status in the general population, with higher levels of obesity among more deprived groups; however the prevalence of obesity in England has increased across all groups.

Overweight and obesity in children

4.3 In 2015-16, 19.8% of 4-5 years old and 26.1% of 10-11 years old were overweight or obese in Brighton & Hove.

4.4 Children who are overweight at Reception are four times more likely than healthy weight children, to be overweight/obese at Year 6.

4.5 Children who are obese at Reception are twenty-four times more likely than healthy weight children, to be overweight/obese at Year 6.

4.6 Deprivation is highly significant in predicting obesity. Children living in the most deprived parts of Brighton are twelve times more likely to be obese at Year 6 than children living in the least deprived parts of Brighton.

4.7 Ethnicity appears to be significant in predicting obesity. Those children who are of a BME group are almost twice as likely to be obese than White British children although this is possibly influenced by deprivation.

4.8 Parents from deprived backgrounds are more likely to underestimate their child's weight, which may be contributing to the problem of social inequalities in obesity.

4.9 A child growing up in a family where one or both parents are obese have an increased risk of becoming obese themselves.

4.10 Obese children are at increased risk of becoming obese adults, making a strong case for any weight management intervention being designed with a life course approach and considering the treatment and prevention of obesity for the whole family unit.

Impact of overweight and obesity

4.11 Overweight and obesity presents a major challenge to the current and future health of the local population. Overweight and obesity are associated with an increased risk of morbidity and mortality from a range of conditions including hypertension, heart disease, stroke, type 2 diabetes and several cancers. Obesity reduces life expectancy by an average of three years and severe obesity by 8-10 years. Severely obese people are more than three times more likely to need social care than people of a healthy weight.

4.12 We spend more each year on the treatment of obesity and diabetes than we do on the police, fire service and judicial system combined. It was estimated that the NHS in England spent £5.1 billion on overweight and obesity-related ill-health in 2014/15 year and that the annual social care costs of obesity to local authorities is £352 million.

4.13 The return on investments of interventions to promote physical activity is £23 in quality of life, reduced NHS use and other gains for each £1 invested.

4.14 Lifestyle risk factors (including poor diet and lack of physical activity) operating together explain 40% of ill health in England. That is, a 40% of the workload in the health service is potentially preventable.

4.15 Even reductions of 5% in bodyweight can have a profound impact on the health of obese people and their risk of future disease through the better control of insulin in the liver, fat and muscle tissues. Furthermore, the evidence suggests that weight loss that is maintained for a relatively short period of time has long term health benefits.

Effective weight management services

4.16 Evidence shows the most effective weight management services are multi-component, focus on diet and physical activity together, foster supportive relationships with providers or peers and encourage maintenance of healthy lifestyle. Many interventions have the potential to be delivered to families as well as to individuals.

Existing weight management services provided

4.17 To address high rates of overweight and obesity and associated conditions the Public Health Team has been commissioning weight management services across the obesity pathway in the city for several years. These services include:

- Tier 1 services (universal prevention): these are comprised of a broad spectrum of community-based interventions which are universally available to all adults living or working within the locality, for example, cook and eat sessions, walking for health, cycling infrastructure and Change4Life campaigns.

- Tier 2 (lifestyle interventions): The current contract is held by the Food Partnership as the lead provider, working in partnership with Albion in the Community; this service provides one-to-one sessions, group sessions and coaches for adults, families and children.

Weight management services to be provided under the new contract

4.18 The long term aim of the 'Healthy Weight Programme Board' is to develop a whole systems approach to healthy weight for people in Brighton & Hove. It will promote a city wide environment that should support active travel, and physical activity as part of everyday life. The 'Healthy Weight Programme Board' wants to help make a healthy choice available as an option whenever residents are eating outside the home, and to support them to shop, cook and prepare food in a way that supports a longer term healthy diet.

4.19 In addition, the new weight management services will take a life course approach; that is, intervening across the life course and at specific times where there may be specific opportunities to influence behaviour (e.g. early years, pregnancy, and menopause), times linked to spontaneous changes in behaviour (e.g. leaving home, becoming a parent), and periods of significant shifts in attitudes (e.g. peer group influences, diagnosis of ill health).

4.20 The weight management services will be provided so as to support sustainable behaviour change to improve diet and get more physically active. A 12 week programme will save costs in the longer term, but an integrated programme to support healthier lifestyles over 12 to 24 months is more likely to produce greater weight loss and sustainable lifestyle changes with associated positive health outcomes.

4.21 Weight management services should be accessible to all but particularly those at greatest risk of obesity including those living in more deprived areas, people living with disabilities and in certain BME groups. A new online platform will be required to be launched to increase accessibility to the weight management service.

4.22 The weight management service delivered under the new contract should have the capacity within the allocated budget to be scaled up and tailored to meet the needs of different population group who are at increased risk of being overweight and obese.

4.23 In order to assist and improve service delivery the monitoring and evaluation systems will be strengthened in the new contract. The contract will be managed through quarterly contract monitoring reviews and annual evaluations reports, reporting against outcomes detailed in the project monitoring and evaluation framework. Please see below and 4.26 for more details on some of the performance outcomes and objectives being reported on:-

4.24 **Relevant public health outcomes framework indicators:**

- Excess weight in children and adults
- Average number of portions of fruit and vegetables consumed daily by children and adults
- Percentage of physically active and inactive adults
- Standard evaluation framework (National Obesity Observatory)

4.25 **Objectives for the weight management service under the new contract**

<u>Key health objectives</u>

- To provide a lifestyle multi-component weight management service that:
- To support overweight and obese adults to lose weight and learn how to maintain a healthier weight and lifestyle
- To help children to achieve and maintain a healthier BMI and lifestyle

Key process objectives

- That weight management services take a life course approach
- That weight management services take whole systems approach
- That weight management services for children and young people address the family unit.
- To ensure that the weight management services are accessible to clients.
- To ensure that the weight management services are acceptable to clients and stakeholders.
- To address health inequalities by prioritising weight management services in line with Joint Strategic Needs Assessment ('JSNA') in Brighton & Hove.
- Monitor and evaluate the delivery of the service to the stated objectives

4.26 ***Performance and contract management***

The weight management service delivered under the new contract will be managed through quarterly contract monitoring reviews and through annual evaluations reports. It is expected that at least 200 people per quarter will be referred to the weight management service.

The performance of the weight management service delivered under the new contract will be assessed through a new monitoring and evaluation framework. This framework draws on NICE and the Department of Health guidance, the Standard Evaluation Framework and other sources of program guidance. This will assess how the weight management service delivered under the new contract performs against key health outcomes and health inequalities. For example:

- the percentage of adult client who should lose at least 5% of body weight,
- the percentage of adult client who should lose at least 3% of body weight,
- the percentage of adults who maintain their weight loss at 6 months and 12 month post intervention.
- the percentage of children who maintain or reduce their BMI standard deviation score at 6 and 12 months post-intervention,
- the percentage of clients who achieve NHS recommended levels on physical activity levels.
- the percentage of clients who achieve NHS recommended levels of dietary intake.
- The percentage of clients achieving positive outcomes who are from quintiles 1&2 (most deprived).
- Over the life of the contract it is expected that there will be an improvement in the trend of children identified as overweight and

obese (by NCMP data) at reception to achieve a healthy weight by the time they reach year NCMP at year 6.

In addition to these indicators, the monitoring and evaluation framework will assess how the weight management service delivered under the new contract performs against key process objectives such as ensuring the safety, accessibility and acceptability of the service and promoting a life-course, whole systems and family approach.

4.27 **Financial and other implications**

It is estimated that the value of the new contract for weight management services will be £1,200,000 over a 3 year period which represents a £300,000 saving in total compared to the existing contract worth £1,500,000.

Savings will be made by incorporating some previously provided Tier 1 (universal prevention interventions) services into the weight management services under the new contract (e.g. embedding healthy weight messages in the schools).

The provisional timetable for the procurement of the new contract is as follows:

Task	Length	Date(s)
Tender out	30-35 days +	1/9/2017
Tender back	1 day	1/10/2017
Evaluation (individual)	7-21 days	15/10/2017
Moderation and clarification	1 – 14 days	1/11/2017
Cost analysis and eval report	7-14 days	15/11/2017
Award	1 day plus 10 day standstill	1/12/17
Mobilisation	TBC	1/12/17-1/4/18
Contract Start	n/a	1/04/18

4.28 **Consultation/community engagement**

The evaluation of the weight management service provided under the existing contract collected clients' views through a survey and focus groups. The feedback on the service which is currently

provided showed high satisfaction levels and made recommendations for improvement such as improving exercises classes, ensuring privacy during weighing, and psychosocial elements of the services.

The weight management services specification for the new contract will continue to include a requirement for the provider to gather clients and stakeholders views to monitor and evaluate the services.

The CCG has also has contracts with a number of voluntary sector organisations to help obtain the views and experiences of communities we don't hear from as readily as others. The CCG has used these organisations to consult on the topic of weight management. This engagement has been undertaken with the following funded providers:-

- LGBT HIP
- FFT
- Possability People
- TDC - in partnership with HKP, SIS, BMEYPP, BMECP, Mosaic
- Downslink YMCA
- Mind
- AgeUKB&H
- Speak Out
- Carers Centre & Amaze
- Trans Alliance
- Faith in Action
- Community Works, Impetus for their Lay Assessor work) and Healthwatch.

The CCG has also facilitated a children referrals workshop to engage with all key partners working on the childhood obesity agenda.

The main aims of the workshop were to:-

- Share information between providers about current services in the city for families with children above an ideal weight and how they fit together (this is alongside briefing info sent out prior to the workshop)
- Look at the current offers and identify where there are gaps and what could fill them (note BHFP do have resources that can be used in different ways to meet needs identified)
- Consider how to increase referrals
- Consider what barriers there are both to people participating in programmes and referring to services and how to overcome them

- Develop a jointly agreed action plan

5. Important considerations and implications

Legal:

5.1 The council's contract standing orders require that authority to enter into a contract valued at £500,000 or more be obtained from the relevant committee which in this instance is Health & Wellbeing Board.

5.2 Schedule 3 of The Public Contracts Regulations 2015 will apply to the procurement of the new contract for weight management services and the contract must be awarded in accordance with Section 7 of the Regulations. The council is required to advertise the contract by way of a PIN or contract notice published in the OJEU setting out the process by which it is intended to award the contract.

5.3 The tender process conducted must be at least sufficient to ensure compliance with the principles of transparency and equal treatment of economic operators bidding for the contract.

5.4 In accordance with contract standing orders, any contract resulting from the tender process must be in a form approved by the Head of Law and executed as a deed under the common seal of the council.

Lawyer consulted: Isabella Sidoli Date: 13/06/17

Finance:

5.5 The new Weight Management contract totals £1.2m over the next 3 years which includes a saving of £0.300m, as per paragraph 4.20. This contract will be funded by the Public Health grant.

Finance Officer consulted: Sophie Warburton Date: 14/06/2017

Equalities:

5.6 Equalities implications for healthy weight and diet have been considered with age, ethnicity and disability being characteristics by which dietary habits and healthy weight outcomes particularly differ.

5.7 The weight management service specification for the new contract will require that the provider take into account health inequalities, as identified in the JSNA, in their service design and thus improve the chances of better outcomes across the whole population. Likewise, equalities implications will be a criterion to assess proposals and to award the contract.

Sustainability:

5.8 There are no significant sustainability implications. The weight management services will promote physical activity and thus the use of open spaces, active travel and reduced food consumption.

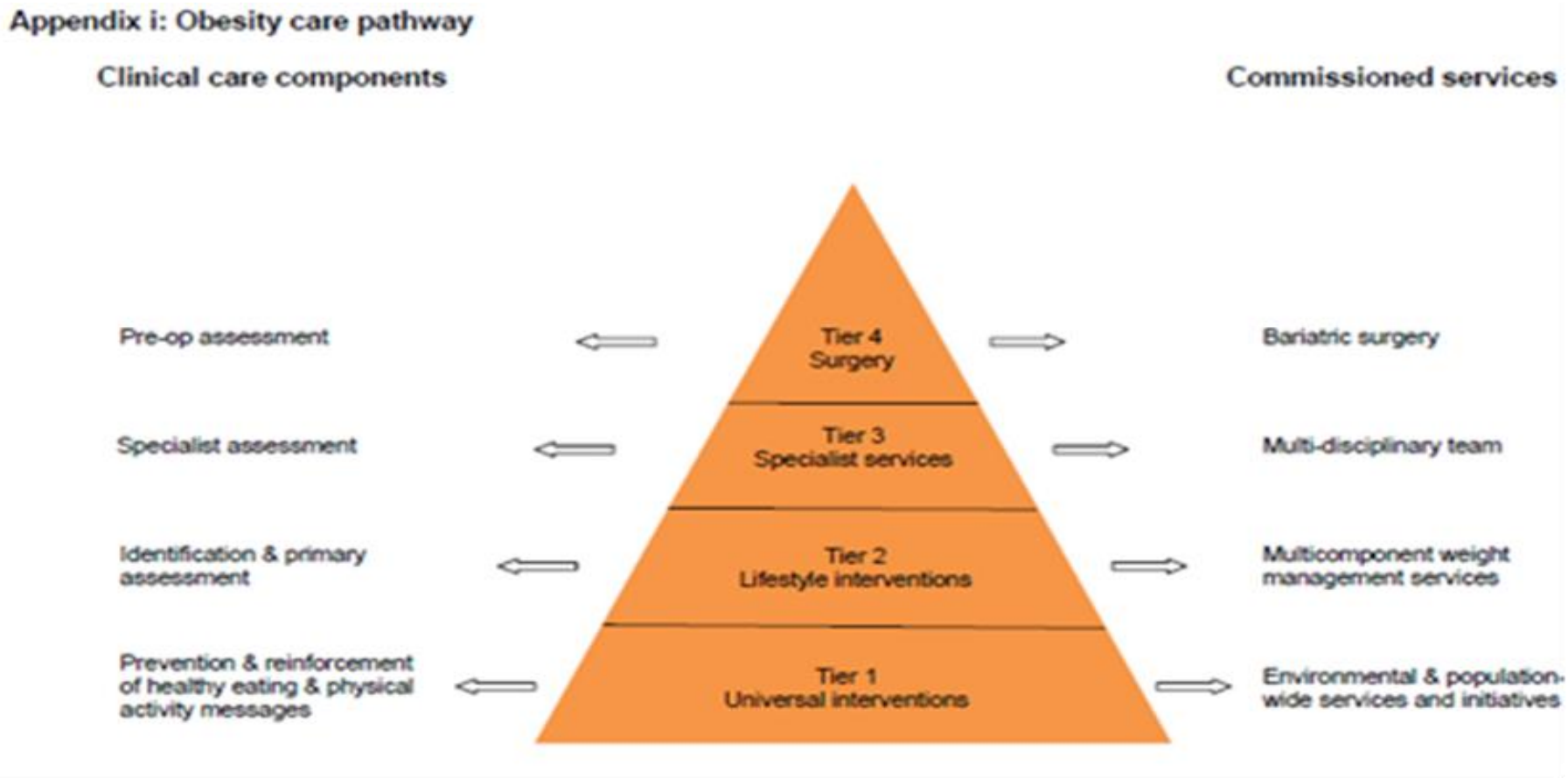
Health, social care, children's services and public health:

5.9 The implications for health, social care, children's services and public health have already been covered in this paper.

6. Supporting documents and information

Appendix i: Obesity care pathway

Appendix i: Obesity care pathway



Health & Wellbeing

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1. Annual Report of the Director of Public Health 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 11th July 2017

1.3 Author of the Paper and contact details Dr Peter Wilkinson, Acting Director of Public Health. peter.wilkinson@brighton-hove.gov.uk

2. Summary

2.1 Directors of Public Health are required to produce an annual report on the state of local public health. There are no specified requirements as to the content or format of the report.

2.2 This year's Report "Living well in a healthy city" focuses on prevention.

2.2 This report covers the period 2016/17.

2.4 The Acting Director of Public Health will make a brief presentation on the report.

3. Decisions, recommendations and any options

3.1 That the Board note the report.

4. Relevant information

4.1 This year's Report "Living Well in a Healthy City" looks at the contribution prevention can make to improving local health and

wellbeing. Prevention is one of the key priorities of Caring Together (the local place based component of the Sustainable and Transformation Partnership plans).

4.2 The Report provides background information to the significant challenges local health and social care services are facing. This includes information about how the population is changing, in terms of numbers and overall health and wellbeing.

4.3 The Report provides information on the increasing number of people living with long-term conditions and the resource use associated with these including hospital admissions and long-term adult social care support. The Report applies the evidence base to highlight how prioritising prevention will improve health and wellbeing as well as reducing the demand on health and social care services.

4.4 The role of prevention in improving health and wellbeing is considered across the life course together with examples of ongoing work and what more could be done locally.

4.5 Increased action to prevent falls and reducing social isolation are identified as key areas for improving the health and wellbeing of older people.

4.6 For all adults there are many ways to improve health and wellbeing including being more active, drinking in moderation and looking after our mental health. The mutual relationship between good physical and good mental health and wellbeing is considered in several sections of the report. Circulatory disease accounts for a quarter of all deaths in Brighton & Hove. Improving the identification and treatment of cardiovascular risk factors will provide both short and long-term benefits for patients and services.

4.7 The chapter on children and young people includes information about the Healthy Child and Public Health Schools programmes. This chapter has information about the relatively lower local childhood immunisation coverage and the very high rates of smoking and use of alcohol and cannabis amongst local 15 year olds.

4.8 The report ends with a chapter on improving health and wellbeing through a place based or community based approach which includes sections on developing a healthy city.

4.9 There are 12 recommendations to inform work across the City aimed at improving health and wellbeing.

4.10 Although this report covers a range of action across both public health and the rest of the council, as well and NHS and CVS partners, it is not an exhaustive list of all the prevention work being done locally either within the council or across the city by both the statutory and non-statutory sectors. The report's main aim is to demonstrate some of what prevention could achieve if given the focus, resource and time to deliver.

4.11 The Board is asked to note the Report.

5. Important considerations and implications

Legal:

5.1 The NHS Act 2006 and the Health and Social Care Act 2012 requires Directors of Public Health to write an annual report on the health of their local population. The content and structure of the report can be determined locally.

Lawyer consulted: Natasha Watson Date:12 June 2017

Finance:

5.2 There are no direct financial implications from the recommendations of this report. The total Public Health budget for this financial year is £22.150m of which £20.619m comes from the ring-fenced Public health grant for 2017/18, other funding comes from agreed carry forward of grant from 2016/17 and some non-grant funding.

Finance Officer consulted: Dave Ellis Date: 13 June 2017

Equalities:

5.3 Where appropriate the report highlights local inequalities

Sustainability:

5.4 None identified

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

5.5 The Annual Report is relevant to all age groups and services.

Supporting documents and information

6.1 Annual Report of the Director of Public Health 2016/17.

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 Adults as well as Healthwatch. 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. Bon Accord Nursing Home

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 11 July 2017.

1.3 Author of the Paper and contact details
Andy Witham, Head of Adult Social Care Commissioning
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2. Summary

2.1 This paper provides on update on the position with Bon Accord Nursing following the recently published Care Quality Commission (CQC) inspection report.

3. Decisions, recommendations and any options

3.1 This report is for information only.

4. Background

4.1 Bon Accord Nursing Home (The home) is owned by Four Seasons (No9) Limited, which is part of a large, privately owned, national provider called Four Seasons.

4.2 The Home is a nursing home providing accommodation for people who are living with dementia and who require support with their nursing and

personal care needs. The home is registered to accommodate a maximum of 41 people, but several of these rooms have been converted into offices. The Current status is 36 beds.

4.3 As of the 15 June 2017 the Council are funding 15 residents, 8 are fully funded by The Council and 7 are paid the funded nursing care (FNC) only by The Council.

Quality Assurance Roles and Responsibilities

4.4 The Care Quality Commission (CQC) is the independent regulator of health and social care in England. The CQC make sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve. The CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and then publish what they find, including performance ratings to help people choose care.

4.5 The CQC make sure services meet fundamental standards, that people have a right to expect whenever they receive care. They also ensure services register care services and meet care standards, by monitoring, inspecting and regulating services and providing comprehensive reports for the public to make informed decisions about care services.

4.6 The Council and Clinical Commissioning Group (CCG), work in partnership with the CQC to gather intelligence to prioritise intervention following any significant concerns about services provided to vulnerable adults living in the City.

4.7 Significant concerns may arise from CQC inspections resulting in 'requires improvement' or 'inadequate' for the following key areas

- Are services safe
- Are Services well-led
- Are Services caring
- Are Services responsive and effective

4.8 There is a joint emphasis to support providers to improve by offering support and advice through the quality assurance role. This could include clinical advice and improvement to support Care Homes e.g. links to various services 'SALT' (speech and language team), falls prevention, end of life care, support regarding medication issues, bespoke training for autism awareness etc.

4.9 Following information gathered from a variety of sources including any safeguarding concerns, complaints, intelligence gathering from the CCG's Continuing Health Care Team (CHC) commissioning packages of care and CQC inspections outcomes etc. a joint or individual quality assurance visit would take place (The Council's or/and CCG staff).

These visits would be either planned or unplanned balancing the risks and how responsive these need to be met.

4.10 Quality assurance visits may in turn feed into the intelligence to bring forward or put back regulated inspections to be carried out by CQC, and vice a versa, CQC outcomes may bring forward more focussed visits for The Council and/or CCG to carry out.

Service Improvement Panel (SIP)

4.11 Both the Council and CCG work closely together to risk rate quality of all services. The Council uses a red, amber, green system. SIP meetings are held monthly to discuss services of high concern and may result in a professionals meeting taking place. This meeting would include various health and social care professionals, and the 'registered' provider manager and other key staff to devise supportive action plans to make improvements to services in a reasonable time frame.

4.12 Training may be a key area in supporting some areas of improvement and this would be factored into the action plans, working closely with workforce development. CCG staff are working with partner agencies on developing the Care Certificate for unregistered care staff, to enable staff to recognise when they need to refer clients and seek advice and support from more specialist community services when needed e.g. specialist respiratory nurses, wound care services etc. to enable ongoing support to individuals in a home or other community setting.

4.13 On rare occasions services may need to be suspended (during suspension services are not permitted to take any further residents, provide home care packages etc. if they are suspended) due to extremely high risks/concerns e.g. an overall 'inadequate' CQC rating or complex significant safeguarding issues resulting in staff suspensions, police investigations etc. Extra support is given to enable suspensions to be lifted as swiftly and safely as possible. Without this joined up offer of support, advice and guidance services could potentially leave the market.

Nursing Home Professional Forum

4.14 The CCG facilitates (chairs) quarterly Professionals Forum to discuss issues of concern amongst nursing homes within the City. The group is made up of professionals as follows to support nursing homes:

- Continuing Health Care
- Speech & Language Therapist
- Dementia Nurse Specialist Dementia in-reach team (CHIRT)
- End of Life care
- Clinical Specialist palliative Care
- Community Nurses and therapy support

- Tissue Viability
- The Council's Quality Monitoring representatives

Also guest representatives including Oral Health Care, Dieticians providing nutritional support etc.

Healthwatch and Impetus volunteer visits

4.15 Healthwatch Brighton & Hove CIC is a registered Community Interest Company. The role of Healthwatch CIC is a health and social care watch dog run by and for local people. It is independent of the NHS and The Council. Some volunteers work across both Healthwatch and Impetus (voluntary organisation).

4.16 Each month Impetus and Healthwatch have volunteers (lay assessors) that visit a selection of Home Care Providers and care Homes. Healthwatch undertake 'enter and view' visits to selected care Homes identified by The Council's Quality Team. The purpose of these visits is to gain a 'service user' perspective on the services provided.

4.17 Both The Council and CCG meet on a regular basis with Healthwatch to inform the programme of work 'enter and view' visits.

4.18 Impetus visit a number of 'service users' each month in receipt of Home care packages. Outcomes of these reports are shared with the relevant provider and The Council's Quality Team.

Bon Accord Nursing Timeline of Events

4.19 The CQC inspected Bon Accord on 14 & 15 April 2015 (report published 11 June 2015). Bon Accord were overall 'Good' in all 5 areas Safe, Effective, Well-led, Responsive & Caring.

4.20 The Previous manager left in Feb/March 2016. The new manager started in March 2016 (please note they were previously the deputy manager at Bon Accord).

4.21 Staff working for Sussex Partnership Foundation Trust (SPFT) started to report issues to the Service Improvement Panel (SIP) June 2016, at which point Bon Accord were included to the risk table as an Amber rating. Between the period 31 May 2016 to 6 October 2016 CCG Quality Assurance colleagues carried out three separate assurance visits to Bon Accord. The second visit was a full medication audit following a safe-guarding dated 05 July 2016; a number of recommendations were made. During these visits it became apparent that the newly appointed Clinical lead had left so Bon Accord were short on clinical staff. There was however positive feedback from the Dementia in-Reach Team CHIRT and End of Life professional on the day of visit. A further follow up visit took place on the 4 October 2016 with a further 4 actions and 20 recommendations made.

4.22 Health & Adult Social Care carried out a joint 'meet and greet' with SPFT to meet the new manager on 16 August 2016. During this initial meeting some concerns were raised re lack of supervisions and training recorded highlighted by the new manager.

4.23 A focussed quality monitoring audit also took place on the 25 November 2016 focussing on the process for renewing Deprivation of Liberty (DoLS). The outcome of this was a new electronic tracker being put into place to ensure these were carried out in a timely manner.

4.24 Due to a steady state of concerns being raised Bon Accord moved to Red on the Service Improvement Panel December 2016.

Safeguarding Concerns

4.25 There have been 15 Safeguarding issues raised since January 2017 (of these 3 are historic and 2 have happened since May 2017).

4.26 The CQC inspection took place on 6, 7 and 15 February 2017. The inspection was brought forward due to information of concern that CQC had received from relatives, the local authority and the Clinical Commissioning group (CCG) due to information of concern. The first and third days of inspection were unannounced which meant that the provider, registered manager and staff were not expecting the CQC. On the second day of inspection the registered manager resigned with immediate effect.

Multidisciplinary Team Meeting (MDT):

4.27 Due to the high levels of safeguarding's raised over a relatively short period of time (January to February 2017) and initial feedback from CQC colleagues, Sussex Partnership Foundation Trust called an urgent multidisciplinary team meeting 3 March 2017 to discuss these issues and moving forward to support the home. Representatives included the CQC inspector, Commissioners, CCG &The Council's Quality Monitoring leads and other key health Professionals. A key outcome from the MDT was to suspend Bon Accord immediately due to the high level of safeguarding issues. The suspension ensures no further placements can be made to the home until the suspension has been lifted.

4.28 A comprehensive action plan was identified which included reviews of the current Continuing Health Care and non CHC residents, informing other Local Authorities funding placements, providing medication management support, led by CCG colleagues, (meeting held 10 February 2017), Dementia in-reach support (CHIRT), and regular quality monitoring assurance visits by both CCG and The Council.

Local Authority Quality Monitoring Assurance visits:

4.29 To date a further three joint visits have been made, 29 March 2017, 13 April 2017, 18 May 2017 with a further visit arranged 20 June 2017. These visits have included an unannounced full focussed visit, a planned focus visit to check against progress, and a shorter follow-up visit. It has been recognised that Bon Accord has made some progress against actions and recommendations identified however this has been slow in places and not of a consistent level.

4.30 The CQC published their report 22 May 2017, stating Bon Accord had an overall inspection rating of 'Inadequate' in all five key areas: Safe, Effective, Well-led, Responsive & Caring. Local press interest pursued with joint press statements being released by BHHC & CCG.

4.31 Meeting with Bon Accord Senior Management: A meeting was convened on the 23rd June, led by the Head of Adult Social Care Commissioning. This meeting sought assurances from the both Bon Accord and Four seasons senior management to ensure the delivery of good quality care for the residents currently living at Bon Accord in relation to the recent inspection report and ongoing support to deliver the associated action plan. This meeting also sought assurance re the future for Bon Accord within the city. The senior management of Four Seasons confirmed that Bon Accord is not on their list of homes for intended closure and confirmed that there will be capital investment in the property. The Council is assured that Bon Accord have now put in place the necessary measures to take forward the delivery of the action plan and will continue to support as necessary.

Ongoing Support

4.32 The local authority and clinical commissioning group (CCG) quality monitoring teams are making focussed visits approximately every three weeks, these visits are to make checks against the Care Quality Commission (CQC) action plans following their original inspection back in February 2017. These visits will continue until it is deemed they are no longer required.

4.33 Sussex Partnership Foundation Trust (SPFT) dementia in-reach team (CHIRT) are visiting on a regular basis to provide specialist dementia support , along with health colleagues supporting pharmacy and medication issues with separate meetings being held. Prior to the Overall inadequate rating residents were under nine different G.P practices, this has now reduced to using four practices, this in itself should drastically reduce some of the medication issues that were happening due to the high level of practices and medication ordering for each practice.

4.34 Social workers have reviewed individuals to ensure there are no immediate safety risks, and lead enquiry officers (LEO's) have/are investigated any safeguarding issues that have been raised over the past six months.

Summary Timeline of Events

Significant Event	Date	Comments
Medication Meeting	**10 Feb 2016**	Due to medication issues Medication meeting chaired by CCG including pharmacist consultants
Follow up Medication Meeting	**25 May 2016**	Medication meeting chaired by CCG including pharmacist consultants
Sussex Partnership Foundation Trust (SPFT) started to report issues to the Service Improvement Panel (SIP)	**June 2016**	
Full Medication Audit	**05 July 2016**	CCG lead
Focussed visit Medication CCG	**13 July 2016**	(Boots unable to attend) part day
Joint 'meet & greet' visit	**16 August 2016**	Health & Adult Social Care carried out a joint 'meet and greet' with SPFT to meet the new manager. Concerns were raised re lack of supervisions and training recorded highlighted by the new manager.
Full day quality assurance visit	**06 October 2016**	CCG full day assurance visit
Focussed quality monitoring audit	**25 November 2016**	A focussed quality monitoring audit took place focussing on the process for renewing Deprivation of Liberty (DoLS). The outcome: a new electronic tracker being put into place to ensure these were carried out in a timely manner.
Moved to RED on SIP	**December 2016**	Due to a steady state of concerns being raised Bon Accord moved to Red on the Service Improvement Panel December 2017.
Safeguarding issues	**Jan 2017**	**Safeguarding issues since January 2017:** There have been 15 Safeguarding issues raised since January 2017 (of these 3 are historic and 2 have happened since May 2017).

CQC Inspection	**6,7,15 February 2017**	CQC inspection held over three days, On the second day of inspection the registered manager resigned with immediate effect.
Suspension	**03 March 2017**	BHCC suspended due to high level of safeguarding concerns
Joint Focussed visit to follow up on action plan update (CCG and BHCC)	**29 March 2017**	Joint visit by CCG and BHCC quality Monitoring leads for Nursing Homes
Joint Focussed visit to follow up on action plan update (CCG and BHCC)	**13 April 2017**	Joint visit by CCG and BHCC quality Monitoring leads for Nursing Homes
Joint Focussed visit to follow up on action plan update (CCG and BHCC)	**18 May 2017**	Joint visit by CCG and BHCC quality Monitoring leads for Nursing Homes
CQC inspection report overall Inadequate in all five domains	**22 May 2017**	CQC published their report (public domain)
CQC re-inspection	**06&07 June 2017**	CQC re-inspection over 2 days
Focussed visit to follow up on KLOE Safe – IRXs pharmacy invited	**20 June 2017**	Joint visit by CCG and BHCC quality Monitoring leads for Nursing Homes

5. Important considerations and implications

Legal:

5.1 This report is for information only so that there are no legal implications arising in respect of decision making by the Board. The Local Authority actions described in the body of this report in terms of ensuring individuals' safety and care needs are met and in working in partnership with other agencies comply with the requirements of the Care Act 2014.

Lawyer consulted: Sandra O'Brien Date: 21 June 2017

Finance:

5.2 There are no direct financial implications from the recommendations of this report. The average prices for residents at Bon Accord have been constantly higher than BHCC's set tariff for this type of care.

Finance Officer consulted: David Ellis Date: 21/6/17

6. Supporting documents and information

6.1 Not Applicable