Brighton and Hove City NHS
Teaching Primary Care Trust

Joint Commissioning Board

Title:	**Joint Commissioning Board**
Date:	**15 September 2008**
Time:	**5.00pm**
Venue	**Committee Room 3, Hove Town Hall**
Contact:	**Caroline De Marco** Democratic Services Officer 01273 291063 caroline.demarco@brighton-hove.gov.uk

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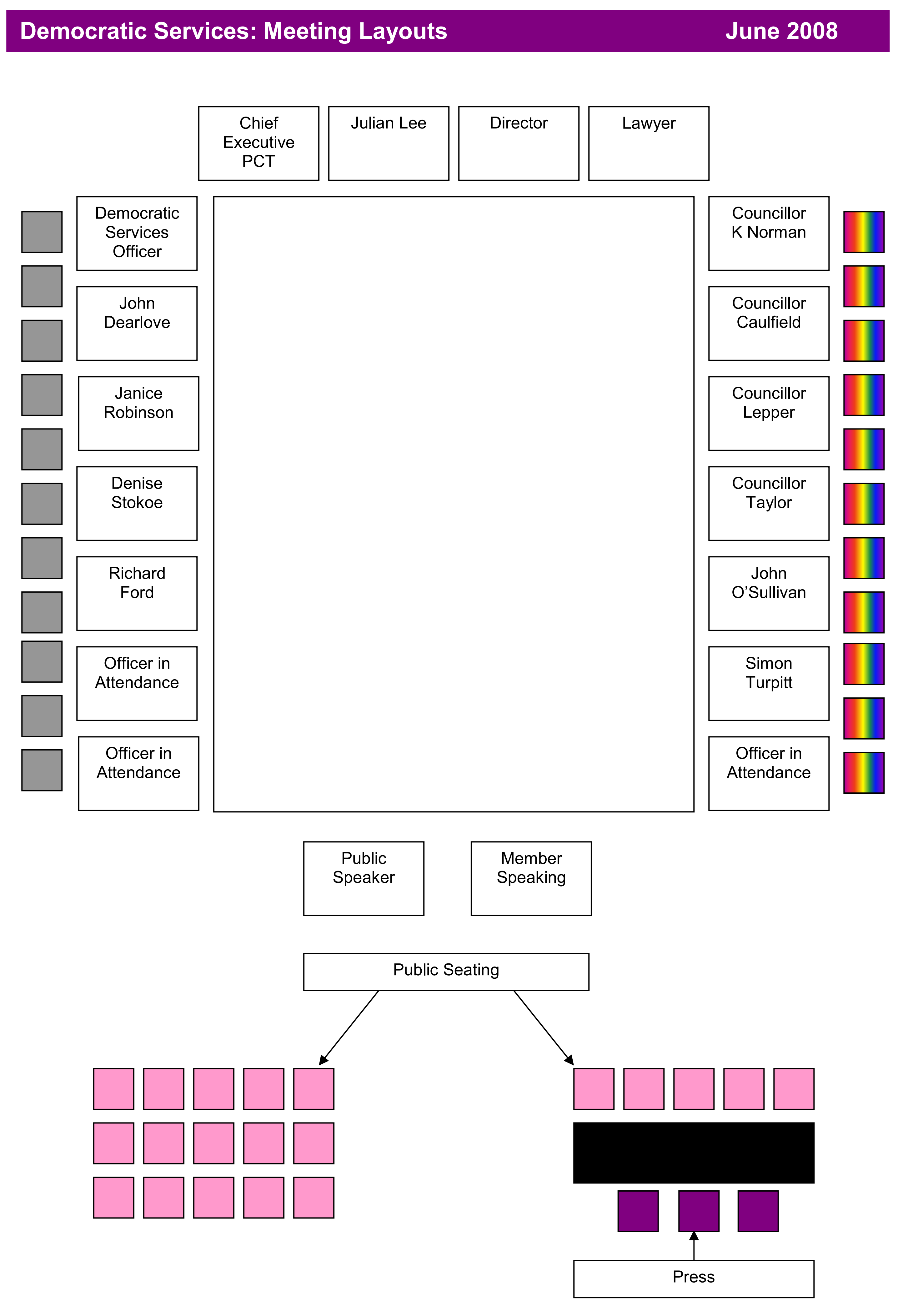
Democratic Services: Meeting Layouts
June 2008
Chief Executive PCT
Julian Lee
Director
Lawyer
Democratic Services Officer
John Dearlove
Janice Robinson
Denise Stokoe
Richard Ford
Officer in Attendance
Officer in Attendance
Councillor K Norman
Councillor Caulfield
Councillor Lepper
Councillor Taylor
John O'Sullivan
Simon Turpitt
Officer in Attendance
Public Speaker
Member Speaking
Public Seating
Press

The following are requested to attend the meeting:
Brighton & Hove City NHS Teaching Primary Care Trust Representatives:
Julian Lee (Chairman), John Dearlove, Janice Robinson and Denise Stokoe
Council Representatives:
Councillor Maria Caulfield (Cabinet Member For Housing) and Councillor Ken Norman (Cabinet Member for Adult Social Care & Health)
Co-opted Members:
Richard Ford, Sussex Partnership Trust Councillor Jeane Lepper, Brighton & Hove City Council John O'Sullivan, South Downs Health NHS Trust Councillor Keith Taylor, Brighton & Hove City Council Simon Turpitt, South Downs Health NHS Trust

AGENDA

Part One **Page**

14. PROCEDURAL BUSINESS

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

(b) Declarations of Interest by all Members present of any personal interests in matters on the agenda, the nature of any interest and whether the Members regard the interest as prejudicial under the terms of the Code of Conduct.

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

NOTE: Any item appearing in Part 2 of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.

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

15. MINUTES OF THE PREVIOUS MEETING — 1 - 4

Minutes of the meeting held on 28 July 2008 (copy attached).

16. CHAIRMAN'S COMMUNICATIONS

17. PUBLIC QUESTIONS

(The closing date for receipt of public questions is 12 noon on Monday 8 September 2008)

No public questions received by date of publication.

18. FINANCIAL PERFORMANCE REPORT - MONTH 2 — 5 - 8

Report of the Director of Finance, Brighton & Hove PCT (copy attached).

Contact Officer: Michael Schofield Tel: 01273 545312
Ward Affected: All Wards

19. LEARNING DISABILITIES FINANCIAL RECOVERY PLAN 2008/09 — 9 - 14

Report of Finance & Resources, Brighton & Hove City Council (copy attached).

Contact Officer: *Nigel Manvell* *Tel: 01273 293104*
Ward Affected: *All Wards*

20. RE-TENDERING OF VOLUNTARY SECTOR MENTAL HEALTH PROVISION **15 - 22**

Report of Director of Assurance and Development, Brighton & Hove PCT (copy attached).

Contact Officer: *Simon Scott* *Tel: 01273 545414*
Ward Affected: *All Wards*

21. RE-TENDERING AND RE-CONFIGURATION OF SUBSTANCE MISUSE SERVICES **23 - 32**

Report of Director of Assurance and Development (copy attached).

Contact Officer: *Simon Scott* *Tel: 01273 545414*
Ward Affected: *All Wards*

22. SELF DIRECTED SUPPORT STRATEGY **33 - 60**

Report of Director of Adult Social Care & Housing (copy attached).

Contact Officer: *Brigid Day* *Tel: 01273 295374*
Ward Affected: *All Wards*

23. FAIRER CONTRACTING **61 - 66**

Report of Director of Adult Social Care & Housing, Brighton & Hove City Council, and the Director of Strategy, Brighton & Hove PCT (copy attached).

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

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

Date of Publication - Friday, 5 September 2008

BRIGHTON & HOVE CITY COUNCIL/BRIGHTON & HOVE CITY NHS TEACHING PRIMARY CARE TRUST

JOINT COMMISSIONING BOARD

4.00PM, 28 JULY 2008

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Brighton & Hove City Primary Care Trust representatives:

Julian Lee (Chairman), John Dearlove and Janice Robinson.

Council representatives:

Councillor Ken Norman, Cabinet Member for Adult Social Care & Health, Councillor Maria Caulfield, Cabinet Member for Housing.

Co-opted Members:

Councillor Jeane Lepper, Brighton & Hove City Council

Richard Ford, Sussex Partnership Trust

Apologies: Darren Grayson, Chief Executive, PCT. Amanda Fadero, Director of Quality & Engagement, PCT.

PART ONE

8 PROCEDURAL BUSINESS

8a Declarations of Substitutes

8.1 There were none.

8b Declarations of Interests

8.2 There were none.

8c Exclusion of Press and Public

8.3 The Committee considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in Schedule 12A, Part 5A, Section 100A(4) or 100 1 of the Local Government Act 1972 (as amended).

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

9 MINUTES

9.1 **RESOLVED** – That the minutes of the meeting of the Joint Commissioning Board held on 16 June 2008 be approved and signed by the Chairman.

10 CHAIRMAN'S COMMUNICATIONS

10.1 There were none.

11 PUBLIC QUESTIONS

11.1 There were none

12 FINANCIAL PERFORMANCE REPORT – MONTH 2

12.1 The Board considered a report of the Director of Finance (PCT) that set out the results of the year end audit of the pooled joint commissioning budgets, and matters arising. It also provided details of the budgets for 2008/2009, and developments in respect of the financial management implications for the move to Foundation Trust Status of the Sussex Partnership Trust, expected during 2008/2009 (for copy see minute book).

12.2 Janice Robinson raised the issue of the 30% increase in continuing care payments. The Director of Finance (PCT) explained that there was an increase across the country but in Brighton & Hove the increase was about 30%. Officers were looking at trends and it was possible that this figure could be slightly reduced. The Director of Adult Social Care and Housing, Brighton & Hove City Council, stressed that it was early in the year and there were changes in trends. A number of continuing care cases had been carried forward to this year. There was also an unpredicted demand in the area of both physical and learning disabilities. There were higher costs and greater needs and the Partnership needed to gain a firm grip on these figures.

12.3 Richard Ford welcomed the risk share arrangements detailed in paragraph 3.8 of the report. In relation to the Month 2 Forecast outturn detailed in paragraph 3.10, he stressed that it was difficult to predict future figures. The budget would become clearer in the next few months.

12.4 **RESOLVED** – (1) That the conclusion of the audit of the PCT financial statements, which includes information about the section 75 agreement, be noted, and the proposal to prepare a balance sheet for 2008/2009 be approved.

(2) That it be noted that Board members have considered the 2008/2009 budgets;

noted the ongoing review work in respect of the mental health 'baseline' and considered the proposed risk share arrangements in respect of the provider pools – both of which arise from the move towards Foundation Status of Sussex Partnership Trust.

(3) That the forecast break-even outturn at Month 2, including the ongoing discussions around the application of the prior year underspend, be noted.

13 LEARNING DISABILITIES FINANCIAL RECOVERY PLAN 2008/09

13.1 The Board considered a report of the Director of Adult Social Care & Housing which provided an update on Financial Recovery Plan progress for the Learning Disability Service in 2008/09 (for copy see minute book).

13.2 The report explained that the Learning Disability Service continued to experience significant demand pressures with additional costs and budget overspends projected in the current year and in future years. The Service had responded by identifying measures in the Financial Recovery Plan likely to reduce expenditure. This process had achieved a significant improvement in the budgetary position. However, whilst the financial recovery process produced significant savings last year and work streams had been identified to close the deficit, there was a real risk that some of the savings would not be delivered this financial year. The work streams necessary to achieve such ambitious targets within short timescales could only be sustained in the short term. In the longer term the financial recovery progress would arise out of the revised Commissioning Strategy and address the underlying issues of high unit costs.

13.3 Councillor Lepper referred to paragraph 3.3 of the report and asked how many service users placed out of area had moved back into new schemes in the city. The Head of Housing Needs and Social Inclusion reported that the reference to these service users moving back to the city last year was an error in the report. The report should have referred to new schemes in the future. The intention of the Lead Commissioner was to have new schemes in the city with better accommodation than at present. Negotiations were taking place for a new scheme in the Lewes Road area with a private landlord. There were currently 120 services users placed out of area in Sussex.

13.4 Councillor Caulfield informed the Board that officers were investigating the possibility of adapting the general housing stock for service users who wanted to return to the city.

13.5 John Dearlove referred to the table in paragraph 3.5 and highlighted the need to produce a balanced budget. Councillor Caulfield stressed that there was a stringent check on the budget and there was a three year strategy which would look at the budget in the long term. Year on year savings were being achieved. The Director of Adult Social Care & Housing stressed that the council was required to make a 3% efficiency saving each year, whilst absorbing growth in demand.

13.6 John Dearlove drew attention to the high cost of care in Brighton & Hove, compared with other authorities. Councillor Caulfield replied that officers were working with East & West Sussex to try to drive unit costs down.

13.7 The Director of Finance (PCT) informed the Board that he would have expected to see details in a table of the targeted savings for different areas, compared against what was actually achieved. The Chairman concurred.

13.8 Richard Ford stressed the need to sustain the quality of care and to ensure that the needs of staff were properly considered. The Head of Housing Needs and Social Inclusion replied that savings had been achieved without affecting front line services. There had been no redundancies. The Director of Adult Social Care & Housing agreed that the quality of care was important. Meanwhile, staff would be involved with the revised Learning Disability Commissioning Strategy.

13.9 **RESOLVED** – That the progress on the Financial Recovery Plan be noted.

The meeting concluded at 5.38pm

Signed Chair

Dated this day of 2008

JOINT COMMISSIONING BOARD	**Agenda Item 18** Brighton and Hove City NHS Teaching Primary Care Trust Brighton & Hove City Council

Subject:		**Financial Performance Report – Month 2**	
Date of Meeting:		**15th September 2008**	
Report of:		**Director of Finance, Brighton and Hove PCT**	
Contact Officer:	Name:	**Michael Schofield**	**Tel: 01273-545314**
	E-mail:	Michael.Schofield@bhcpct.nhs.uk	
Wards Affected:	All		

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report sets out the financial position of the pooled budgets at the end of Month 4, and the forecast year-end outturn. It highlights emerging pressures and sets out measures to address these. The report also comments on and notes progress with medium term financial planning. The report also sets out information about progress on developing and including Key Performance Indicators for the services within the pooled budget.

2. RECOMMENDATIONS:

2.1 (1) Board members are requested to note the financial position of the pooled budgets as at month 4, which indicates a breakeven forecast, and the actions underway to manage the pressures within the system;

2.2 (2) Board members are requested to note the ongoing work to develop medium-term financial plans for the pool.

3. RELEVANT INFORMATION:

Year-end Forecast 2008/2009

3.1 The table below sets out the budget for the financial year, as reported at the last meeting of the JCB. As a reminder, the report now shows the 'lead commissioning' arrangements, with two 'pooled funds' held within the overall pool. This reporting format is intended to highlight lead responsibilities and to support the production of the interim and year-end financial statements including balance sheets.

Pool Contributions by Client Group:	SDH	SPT	PCT	BHCC*	Total
PCT Pool:	**£000**	**£000**	**£000**	**£000**	**£000**
HIV/AIDS Services Client Group	720	300	-	-	1,020
Intermediate Care Services Client Group	3,452	-	323	-	3,775
Older People's Mental Health Services Client Group	-	13,140	-	-	13,140
Substance Misuse Services Client Group	-	2,683	-	-	2,683
Working Age Mental Health Services Client Group	-	27,874	-	-	27,874
Integrated Equipment Store	1,322	-	-	-	1,322
	5,494	**43,998**	**323**	**-**	**49,815**
Council Pool:					
Learning Disabilities Services Client Group	**6,396**	**-**	**927**	**21,707**	**29,030**
Total Contributions to the Pooled Budgets	**11,890**	**43,998**	**1,250**	**21,707**	**78,845**
*£83,000 investment by BHCC still to be allocated.					

3.2 The table below sets out the forecast outturn for each of service areas within the pool. As noted at the last meeting, the forecasts around the Mental Health service lines need to be interpreted with caution, given the ongoing work around the 'baseline contract' – expected to be completed in September 2008 – and the forecasts are those of the PCT, drawing on information provided by the provider bodies, rather than those of Sussex Partnership Trust.

Month 4 Forecast Outturn Variance by Client Group:	SDH	SPT	PCT	BHCC	Total
PCT Pool:	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
HIV/AIDS Services Client Group	20	-	-	-	20
Intermediate Care Services Client Group	(75)	-	-	-	(75)
Older People Mental Health Services Client Group	-	(472)	-	-	(472)
Substance Misuse Services Client Group	-	143	-	-	143
Working Age Mental Health Services Client Group	-	487	-	-	487
Integrated Equipment Store	180	-	-	-	180
	125	**158**	-	-	**283**
Council Pool:					
Learning Disability Services	**-**	**-**	**-**	**163**	**163**
Total Pool Forecast	**125**	**158**	**-**	**163**	**446**
Savings/Recovery Plans	**(125)**	**(158)**	**-**	**(163)**	**(446)**
Forecast Outturn at Month 4	**-**	**-**	**-**	**-**	**-**

The forecast outturn includes the allocation of the balance of the 07/08 underspend to the Older Peoples Mental Health services client group.

PCT Pool

3.3 South Downs Health is forecasting pressures in HIV services, which relate to the provision of contraception and is in discussions with the PCT about the funding arrangements across primary care. The intermediate care budget is forecasting an underspend at this point in the year, but the Integrated Equipment Store is showing a significant cost pressure, reflecting increased demands for the service. This is being discussed by the Trust and the PCT through the Commissioning and Contracting Board, but the PCT is conscious of the significant additional recurrent investment already put into this service as part of the budget-setting process.

3.4 On mental health services, the pressures are to some degree mitigated both by the carry forward of the underspend from the prior year and the new risk share arrangements (although these will have to be formalised within new contract arrangements). Working age (adult) mental health services does have a financial recovery plan in place, but delivery has been impeded as clients have not been moved out of the Asher site to more appropriate services in the timescale envisaged. BHCC and PCT staff will be reviewing progress against this recovery plan, and it may be appropriate to bring details to a future JCB meeting. Older peoples mental health services are performing to budget to date, but there are some underlying issues to be resolved around the recurrent budget funding for the Dementia Care at Home service.

3.5 For both the South Downs Health and Sussex Partnership Trust services, the current forecast at year-end, taking into account plans for financial recovery, is for break-even. There are currently no service implications anticipated within recovery plans as these are expected to be made up of efficiency savings. At this time, there are therefore no consequent effects on other locally provided services and no commissioning decisions for the JCB to consider and approve.

BHCC Pool

3.6 The pooled budget for learning disabilities, pressures of £163,000 are identified, although the year end forecast is for break-even as the service has identified corrective measures for the remainder of the year. Delivery of the forecast outturn is also contingent on the delivery of the remaining £704,000 of the financial recovery plan, and further details of the savings for both this year and last year are contained in a separate paper on the agenda.

Medium-Term Financial Planning

3.7 The City Council has recently published its revised medium-term financial strategy, after consultation with key stakeholders including the PCT. The PCT Director of Finance has recently convened a Brighton and Hove Local Health Economy Medium Term Financial Planning group, aimed at developing a joint MTFP for all partners in Brighton, which includes the Directors of Finance from all the relevant commissioners and providers. The group has now met twice and a draft MTFP is expected shortly after 9th September, when NHS bodies have to submit their outline financial plans for the next 5 years to the SEC Strategic Health Authority and the Department of Health. The MTFP sets the context for the development of the PCT Strategic Commissioning Plan, and the Business Plans for the partner bodies, and provides a useful framework to support Joint Strategic Needs Assessment and the development of costed financial plans across the service areas. Regular updates will be provided to the JCB as the plan develops.

4. CONSULTATION

4.1 In determining levels of planned expenditure across the client group areas, both the PCT and the City Council have completed extensive consultation exercises.

The PCT has prepared an Annual Operating Plan, which highlights the processes for prioritising investment across the range of healthcare, and sets out how new monies will be spent. The City Council engages in an extensive public consultation process in the run up to the budget-setting process.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The financial implications of the report are found in the text, highlighting the performance against the pooled budgets for 2008/09.

Finance Officer Consulted: Michael Schofield/ Nigel Manvell Date: 02/09/08

5.2 Legal Implications:

There are no specific legal implications which arise out of this report as it is in the main for noting purposes only. Any management of the pooled budget however will of course need to ensure that the statutory duties of service users continue to be met.

Lawyer Consulted: Hilary Priestley Date: 28/08/08

Equalities Implications:

5.3 There are no direct equalities implications arising from this report.

Sustainability Implications:

5.4 There are no direct sustainability implications arising from this report.

Crime & Disorder Implications:

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

Risk and Opportunity Management Implications:

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

Corporate / Citywide Implications:

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

<table>
<tr><td><h1>JOINT COMMISSIONING BOARD</h1></td><td>Agenda Item 19
Brighton and Hove City NHS Teaching Primary Care Trust
Brighton & Hove City Council</td></tr>
</table>

Subject:		**Learning Disabilities Financial Recovery Plan 2008/09**	
Date of Meeting:		**15 September 2008**	
Report of:		**Director of Finance & Resources**	
Contact Officer:	Name:	**Nigel Manvell**	**Tel: 293104**
	E-mail:	nigel.manvell@brighton-hove.gov.uk	
Key Decision:	No		
Wards Affected:	All		

1. SUMMARY AND POLICY CONTEXT

1.1 The purpose of this report is to provide an update on Financial Recovery Plan progress for the Learning Disability Service 2008/09.

This report is a follow-up to the report of 28 July 2008 submitted to this Board.

2. RECOMMENDATION

2.1 The Board is asked to note progress on the Financial Recovery Plan.

3. BACKGROUND

3.1 Board members will be aware that the Learning Disability Service of Brighton & Hove City Council has experienced significant demand pressures over the last several years. The service continues to experience such pressures with additional costs and budget overspends projected for the current year and in future years. The Service has responded by identifying measures in the Financial Recovery Plan (FRP) likely to reduce expenditure and determine appropriate sources of funding for care packages. This process has achieved a significant improvement in the budgetary position.

3.2 Last year (2007/08) the service was required to achieve a substantial Financial Recovery Plan (FRP) target of £2.2 million involving considerable management, efficiency and other savings alongside reviews of placements to ensure appropriate funding of care packages. Overall, £1.35 million of the FRP was achieved including efficiency and other savings of £0.66 million, while continuing care investment of £0.69 million was also provided. A summary of the outturn 2007/08 FRP is shown at Appendix 1. The full year effect of these actions is £1.7 million.

3.3 The PCT also used financial flexibility in 2007/08 to provide additional non-recurrent funding of £0.734 million recognising the level of challenge in the Financial Recovery Plan and the longer lead-in time to achieve service remodelling, reprovision and modernisation for this client group.

4 FINANCIAL RECOVERY PLAN 2008/09

4.1 The council, as Lead Commissioner for Learning Disabilities, has a pooled budget with Brighton & Hove City Primary Care Trust. The total gross funding available for 2008/09 is £29.0 million and the pooled budget is the responsibility of the council.

4.2 The current Financial Recovery Plan target of £1.36 million for 2008/09 represents a very challenging goal for the service alongside managing continued growth demands, pressures on in-house services and the underlying issue of high unit costs. The Learning Disability budget is to an extent dependant on expenditure decisions made in the past and, as mentioned earlier, it is acknowledged that making significant change can require a long lead-in time.

4.3 The broad range of activities identified for 2008/09 will continue to yield savings in the current year and identify appropriate funding sources. The service will also benefit from the full year effect of savings from last year's activities (£1.7 million), as shown in Appendix 1, which have helped to reduce the level of investment required in 2008/09. In addition, a greater emphasis has been placed this year on achieving efficiencies by way of service re-modelling and restructuring. Re-commissioning of some services will also yield savings and begin to address longer-term issues.

4.4 Tight control and monitoring of the approval of care packages by senior managers remains in place to contain in-year pressures as far as practicable. Income maximisation measures taken in the previous financial year may also deliver further savings with respect to benefit payments. Activity for 2008/09 will therefore include:

- Income maximisation activity
- Efficiency savings
- Re-commissioning of services
- Review of care packages (including health needs)
- Service improvement, modernisation and redesign
- Management of growth to minimise referrals and/or costs as far as practicable

As at month 4 the projected outturn overspend for the Learning Disability service for 2008/09 stands at £0.163 million, with £0.704 million FRP savings still to be achieved.

4.5 As previously reported, the Financial Recovery Plan for Learning Disabilities is subject to certain risks. The plan is dependant in part on changes to individual high cost care packages. These changes necessitate detailed consultation and preparatory work and the agreement of third parties. Similarly, proposals to cut expenditure by service redesign and re-commissioning in various areas will need determined management action in order to ensure implementation. Service management has recognised these risks and is making substantial efforts to implement necessary measures. Robust and continuing scrutiny will ensure that any emerging risks are anticipated and adequately managed. Contingency proposals are similarly subject to constant review and appraisal.

4.6 The Financial Recovery Plan 2008/09 is the first step in a three-step strategy, aiming to achieve service stabilisation; put in place tight financial control systems and review high cost services. Years two and three will tackle infrastructure and costs – ensuring that the Commissioning Strategy is focused on efficiency savings and *Value for Money*. Cultural changes will also be introduced shifting emphasis to Individualised Budgets and to people doing more to help themselves rather than being dependant on the services provided. These changes will ensure that the service as a whole operates in a more cost-conscious way in the future.

5. CONSULTATION

5.1 Relevant Finance officers have been consulted in the preparation of this report.

6 FINANCIAL & OTHER IMPLICATIONS

6.1 Financial Implications:

Learning Disability Services are managed by the council within a Section 75 Partnership Agreement with the PCT. The agreement contains a financial risk sharing provision in the event of overspending. Should there be a shortfall against the 2008/09 financial recovery plan due to underachievement of savings and/or higher than anticipated service pressures, the commissioning partners (i.e. Council and the PCT) will need to agree how to manage the overspend. In the absence of any agreement, overspends are shared in proportion to partners' contributions to the pool budget.

Finance Officer consulted: Nigel Manvell Date: 2 September 2008

6.2 Legal Implications:

The continued implementation of the Financial Recovery Plan by the Council and its Partners aims to ensure both value for money and sustainability making best

use of the financial resources in order to continue to meet our statutory obligations for the foreseeable future in the face of significant and increasing demand pressures. There must always be due regard to the provision of appropriate services to meet the proper assessed needs of individual service users. There are no other legal or human rights implications which arise from this report which is for noting only.

Solicitor: Liz Culbert *Date: 3 September 2008*

6.3 Equalities Implications:

The Financial Recovery process will ensure that vulnerable adults with a learning disability continue to receive support and that this group of service users will gain access to appropriate services that can best meet their physical and social needs into the future.

6.4 Sustainability Implications:

There are no sustainability implications

6.5 Crime & Disorder Implications:

There are no implications for Crime and disorder

6.6 Risk and Opportunity Management Implications:

Risks and opportunities have been identified in the main body of the report.

6.7 Corporate / Citywide Implications:

This report is consistent with the Learning Disability Commissioning Strategy and meets the Council priority in terms of developing a healthy city that cares for vulnerable people and tackles deprivation and injustice.

7 EVALUATION OF ANY ALTERNATIVE OPTION(S):

7.1 None considered.

8 REASONS FOR REPORT RECOMMENDATIONS:

8.1 Update report requested by JCB.

SUPPORTING DOCUMENTATION

Appendices:

(1) Financial Recovery Plan 2007/08 Outturn
(2) Financial Recovery Plan 2008/09 as at Month 4

Documents in Members' Rooms
None

Background Documents
No background documents are referred to in this report.

Appendix 1

LD Financial Recovery Plan Outturn for 2007/08

Description	Action	Savings Target	Achieved	Savings Shortfall (+)/ Over-achieved (-)	Full Year Effect Saving 2008/09
Independent Living Fund	Applications for ILF (Maximisation of Income)	65,000	35,367	29,633	93,007
Accommodaton Services - Housing Benefit	Maximise HB and Supporting People funding on 4 homes	155,000	155,000	0	207,367
Adult Placements - Housing Benefit	Applications for HB on Adult Placements	83,500	134,068	-50,568	134,484
Accommodation Services - Efficiency Savings	Cash limited budgets	126,000	126,000	0	126,000
Day Services - Efficiency Savings	Cash limited budgets	81,000	81,000	0	81,000
Communicty LD Team - Efficiency Savings	Cash limited budgets	23,000	23,000	0	23,000
CMG Contract	Reduction in unit costs through retendering	104,000	35,772	68,228	70,619
In-House reprovision	Reprovision of services in the independent sector	80,000	0	80,000	0
Review of Care Packages	Assess type and level of care, including health needs, and consider appropriate funding applications	1,390,000	690,797	699,203	899,482
Block Contracts - Efficiency Savings	2% efficiency savings target on contracts	75,000	71,165	3,835	72,120
Accommodation Services - Transport Costs	Review of vehicle usage to reduce costs	17,500	0	17,500	0
	TOTAL FRP	**2,200,000**	**1,352,169**	**847,831**	**1,707,079**

FRP Shortfall met by Transitional Measures as follows:

			Funding		
PCT non-recurrent funding	Transitional investment from PCT for Learning Disabilities for 2007-08 only		434,000	-434,000	
SHA funding for S75 support	Additional contribution to LD Financial Recovery Plan shortfall		300,000	-300,000	
Other	Management of in-year demand, etc		85,000	-85,000	
City Council non-recurrent funding	Additional contribution to LD Financial Recovery Plan shortfall		28,831	-28,831	
	TOTAL TRANSITIONAL FUNDING	**0**	**847,831**	**-847,831**	

2007/08 LEARNING DISABILITIES FORECAST OUTTURN	**0**

Appendix 2

Learning Disabilities Financial Recovery Plan 2008/09 (Month 4)

Description	Action	Target £'000	Achieved as at Month 4 £'000	Variance as at Month 4 £'000	Forecast Outturn Variance 2008/09 £'000
Review of care packages	Assess type and level of care, including health needs, and consider appropriate funding applications	700	305	395	-7
Restructure of Service	Staffing efficiencies	191	0	191	-18
Independent Living Fund (ILF) Applications		92	92	-0	0
Accommodation Services - Efficiency Saving	Efficieincy saving - cash limit target	86	-4	90	90
Management of Growth	Measures to reduce referrals and/or cost of new placements	150	200	-50	-50
Recommissioning Out-Of-Area Placements	Review placements to utilise services within the area at lower unit costs	87	44	43	0
Day Centres - Transport Review	Continued implementation of day centre review	35	0	35	0
Restructure In-House Services	Staffing efficiencies	0	0	0	0
Care Crew Restructure		0	0	0	-15
Community Learning Disabilities Team Admin	Efficieincy saving - cash limit target	20	20	0	0
		1,361	**657**	**704**	**0**

THE JOINT COMMISSIONING BOARD	Agenda Item 20 Brighton & Hove City Council

Subject:		**Re-tendering of Voluntary Sector Mental Health Provision**		
Date of Meeting:		**Monday 15th September 2008**		
Report of:		**Terry Baker**		
Contact Officer:	Name:	**Simon Scott**	**Tel:**	**545414**
	E-mail:	simon.scott@bhcpct.nhs.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The Board is asked to consider options for managing the voluntary sector market for mental health services.

1.2 This report addresses three aspects: the conclusions of the day services review, from Board recommendations of March 2006 routine market testing services to ensure best value and the impact of Self Directed support on these contracts.

1.3 This report addresses thirteen small mental health contracts many of which will not have been market tested for 5 years by March 2009.

1.4 The Third Sector Strategy for Communities and Local Government recommends that third sector organisations be of sufficient scale and capability to develop and deliver objectives and that funders and purchasers should endeavour to join-up or standardise parts of the funding or procurement chain to minimise burdens on organisations and ensure a focus on delivery.

1.5 Local Authorities are required to extend Self Directed Support (SDS) and to implement the personalisation agenda for all care groups, and is described in the Self Directed Support Strategy later on this agenda. This is a priority LAA target and a development strongly supported by working age mental health services users in their ‘Pacing the Cage’ report to commissioners about the future of day services.

1.6 The requirement for statutory bodies to make efficiency savings in line with Gershon recommendations means that current commissioning capacity to service many small contracts is limited. Current contractors regularly express the view they would like more commissioning engagement in relation to relative small sums of money, detail of relatively minor operational issues, and advice on Organisational Development direction.

1.7 In parallel to the to the SDS agenda, consolidated third sector contracts potentially provide greater opportunities for mental health provider sustainability, improved clinical and corporate governance assurance frameworks, more efficient engagement with the statutory sector, a stronger foundation for the development of direct payments and individualised budgets, a stronger potential competitor to current providers, and more energy being spent on direct service delivery, rather than fundraising and attending meetings.

1.8 The process of consolidating third sector contracts may also result in high levels of expressed anxiety during the transition period, a short term loss of inward investment

from charitable funding, and a perception that fewer separate organisations represents less choice and less competition on price and quality.

1.9 The process of rolling out Self Directed Support may require a different configuration from the consolidated contracts, and may effect sustainability of services, depending on service user choice. Current and future providers will need to consider how they operate within this environment.

1.10 The Mental Health Act 2007 requires that advocacy is available to all those detained under the Act. Financial provision has been made to commission an advocacy service to meet anticipated statutory obligations that could potentially be included in this tender. However at the time of writing, there is insufficient clarity from guidance as to what is required in this area.

1.11 Within this framework for tendering and contract configuration, the long standing and outstanding issues in relation to Day Services need to be resolved. Commissioning proposals have been formally consulted on, and the JCB has previously requested that service users develop proposals for day services, and that the Local Implementation Team (LIT) take a decision on future configuration. 'Pacing the Cage' was produced by service users facilitated by Consumer Consultancy and MIND, and accepted as the direction of travel for day services by the LIT. The key conclusions are that the Allen Centre (local Authority building) is included in the tendering above as a 'user led' service; that Aldington House is decommissioned as a block contract and the resources freed up used to contribute to a facilitate choice through individualised budgets; and that Preston Park Day service should remain in its current configuration. Although accepted by the LIT, these recommendations have not received universal service users support. Officer opinion is that it is not possible to achieve universal service user consensus on the direction of travel.

1.12 In summary, the JCB are requested to consider the following options:

1.12.1 Extending current contracts in the current configuration;

1.12.2 Tendering current contracts in the current configuration;

1.12.3 Tendering current contracts in a consolidated configuration;

1.12.4 Hold tendering and re specification of current contracts pending a review of the impact of Self Directed Support.

Option:	Strengths	Weakness
1. Extend Current contracts in the current configuration.	Preferred option of some existing providers.	Some contracts have not been market tested for 5 years; Not compatible with national Third Sector Strategy. Less efficient use of commissioner and provider management and 'back room' time. Outstanding issues regarding 'best value'.
2. Tendering current contracts in the current configuration;	Preferred option of some existing providers.	Not compatible with national Third Sector Strategy. Less efficient use of commissioner and provider

		management and 'back room' time. Outstanding issues regarding 'best value'.
3. Tendering current contracts in a consolidated configuration.	Result in larger, stronger, more stable voluntary sector contracts . Services aligned more explicitly to the Stepped Model of Care; More efficient use of provider management and commissioning time; 'Best value' established.	Some local organisations may not be sustainable; Unclear impact on other care groups; Premature in the context of Self Directed Support.
4. Hold tendering and re specification of current contracts pending a review of the impact of Self Directed Support.	Resources from these contracts may be required for self directed support; Implications for care planning to be established; Market management options for the transitional period to be established;	A further year of uncertainty for some voluntary sector organisations; Potential concern of service users regarding the speed of implementing day services changes set out in 'Pacing the Cage'.

2. RECOMMENDATIONS:

2.1 It is recommended that the Board approve holding the tendering of the services described in appendix one, pending a review of Self Directed support described in agenda item 21.

The will require the Directors of the Local Authority and PCT to approve the continuation of existing contracts for a further 12 months from the 1st April 2009. It is recommended that commissioning intentions for these WAMHS contracts be developed in line with the principles established for other care groups for Adult Social Care, and that the review work is undertaken by Adult Social Care staff, liaising as appropriate with PCT WAMHS Commissioners.

2.2 It is recommended that the Board approve Sussex Partnership Trust (SPT) working with service users to develop a User Lead Wellness Centre at the Allen Centre.

This service may be subject to the Self Directed Support agenda over time.

2.3 It is recommended that the Board Support the process of SPT reproviding Aldrington House Day Centre at the Allen Centre.

SPT have already provided assurance to the Board that individual support will be provided to each service user affected.

2.4 It is recommended that Buckingham Road Day Centre continues as it currently is provided.

This service may be subject to the Self Directed Support agenda.

2.5 It is recommended that the Preston Park Day Centre continues to be provided by the Current Provider.

This service may be subject to the Self Directed Support agenda.

2.6 It is recommended that the Board approve that the remodelling of accommodation services for adults with mental health problems be deferred, pending the wider accommodation services review due for report in January 2009.

Brighton and Hove housing department, in collaboration with Sussex Partnership NHS Trust are progressing a comprehensive review of accommodation and Adult Social Care provision for those with mental health problems. It is recommended therefore that the following contracts are extended until March 2010 and the recommendations from this review are considered at a later date.

- Brighton Housing Trust First Base Day Centre
- Brighton Housing Trust Route 1 Project
- Care Co-ops Floating Support
- Brighton Housing Trust Sackville Gardens registered care home
- Brighton Housing Trust Portland Road registered care home
- Brighton Housing Trust Westbourne Gardens supported accommodation

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The Joint Commissioning Board requested, at its meeting of 5th March 2006, that the Day Services Steering Group, develop proposals for consideration by the LIT.
3.2 Following broad consultation, the LIT agreed to implement recommendations of a user led review of day services (“Pacing the Cage”), which proposed the closure of the Aldrington House Day Service and the development of a user led day service.
3.3 February 2007: Strategic Commissioner engagement with Community and Voluntary Sector Forum in relation to the contents of this Board report.
3.4 December 2007: Publication of the city’s mental health needs assessment
3.5 January to March 2008: Rollout of stepped model care pathway by SPT
3.6 April 2008: Consultation with provider stakeholders concerning which existing contracts should form part of proposed tender
3.7 May 2008: Development of service specification
3.8 July 2008: Consultation on draft tender evaluation criteria

4. CONSULTATION

4.1 Engagement with the Community and Voluntary Sector (CVS) Forum started in February 2007, with the Strategic Commissioner explaining the tendering process requirements of the local authority in relation to existing contracts, the impact of Gershon efficiencies, and the whole system stepped model care pathway redesign. The CVS were informed at this stage to provide as early an indication as possible to the sector of the upcoming agenda. A number of meetings were held throughout the year to explore the key general issues and challenges further. Of particular concern to some third sector organisations is the impact of the re-configuration of the contracts and whether this would lead to fewer suppliers and different services. An option put to the CVS by the Strategic Commissioner was for the development of consortium arrangements by local contractors, or indeed local contractors with other suppliers. It was explained that a key feature of future suppliers would be their ability to provide strong corporate and clinical governance arrangements and to be a strong player in a potentially more competitive mental health market place. Some local organisations expressed concern about their readiness for a competitive environment while others were confident in their long track record of successful competitive tendering. The PCT's patient and public engagement team have supported some voluntary organisations in their organisational development, in response to requests from the CVS forum.

4.2 Once the SPT capacity plan and care pathway had been agreed and Practice Based Commissioning intentions finalised, the commissioning focus moved to request from the CVS and SPT which of the current services should be excluded from the tendering process and where areas of overlap in existing services provided opportunities for efficiencies through a tendering process.

4.3 From April to July 2008, voluntary and statutory sector providers met on seven occasions with commissioners to develop draft service specifications for two sets of services: engagement and advocacy, and community services. This group also agreed the tender evaluation criteria for the proposed tendering of these services. This group comprised representatives from thirteen mental health provider organisations.

4.4 Some voluntary sector providers welcome the opportunity for competitive tendering and the opportunities this may bring for service improvement, and others have expressed concern for the future sustainability of their organisations.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 Financial Implications:

The recommendations are all within existing budgets. However, the cost of services to be reprovided at the Allen Centre will need to be kept under review to ensure the new service can be provided within the existing financial envelope for the Aldrington House Day Centre.

Finance Officer consulted: Nigel Manvell

5.2 Legal Implications:

The contracts referred to in this report are 'Part B' services for the purpose of EU procurement law and UK procurement Regulations, and therefore not subject to the full application of either. The Council is nevertheless required to comply with EU Treaty objectives of non-discrimination and openness in procurement, as well as comply with its obligation to seek Value for Money when letting new contracts. Where existing contracts are being terminated or extended this must be done in accordance with the relevant contract terms and legal advice.

The Council must take the Human Rights Act into account in respect of its actions but it is not considered that any individual's Human Rights Act rights would be adversely affected by the recommendations in this report.

Lawyer Consulted: Sonia Likhari, Contracts Lawyer

5.3 Equalities Implications:

Service user equalities are addressed through deployment of resources in line with Practice Based Commissioning locality allocations, which take account of levels of need across each of the PBC localities. The findings of "Count Me In Too" will inform the LGBT equalities requirements. The BME mini needs assessment will inform this aspect of service design. Equalities issues in relation to gender will be addressed through the tender evaluation process.

5.4 Sustainability Implications:

Implications will be established through the development of the Self Directed Support Strategy.

5.5 Crime & Disorder Implications:

None. Current service levels for mentally disordered offenders will be maintained.

5.6 Risk and Opportunity Management Implications:

The recommendations contain risks within the development of the Self Directed Support Strategy.

5.7 Corporate / Citywide Implications:

There are none.

SUPPORTING DOCUMENTATION

Appendices:

1. Summary of existing voluntary sector contracts

Scope of the contracts to be incorporated:

Tender one **Average Contract Value = £26,780.2**					
Contract	**Description**	**Finance PCT (£)**	**Finance LA (£)**	**Total Spend (£)**	**% Total of contract value**
Mind	Advocacy Provision	48,105	26,253	74,358	55.5
Insight Projects	A user involvement service managed by service users, providing a range of services including support and signposting to users	39,763	11,183	50,946	38
Mind Activities Fund	Small miscellaneous budget for MIND team to dispense to MH users	1,190		1,190	0.9
Rethink - Advocacy	Advocacy Provision, promotion and advice and guidance	6,326		6,326	4.7
Rethink- Voices	To assist service users in contribution and participation in user led forums		1,081	1081	0.8
Totals		**95,384**	**38,517**	**133,901**	**100**
	% Funding Split between PCT and LA:	**71%**	**29%**		

Tender two **Average Contract Value = £70,109.2**					
Contract	**Description**	**Finance PCT (£)**	**Finance LA (£)**	**Total Spend (£)**	**% Total of contract value**
Mind - Community Projects	Resource room, welfare benefits advisor, promotion, advice and information and user engagement	34,887	95,581	130,468	27
Rethink - SOS	Support for survivors of suicide	14,158	29,612	43,770	9
Rethink - Mendos	Support for people coming out of the criminal justice system	21,156	11,893	33,049	7

Impact	Young People's Counselling Services	4,559		4,559	1
Threshold	Women's Mental Health Services	38,525	16,181	54,706	19
Care- Co-ops	Women's Drop -in	1,353	12,525	13,878	3
Preston Park Resource Centre	Day centre provision		171,429	171429	35
Totals		**114,638**	**337,221**	**451,859**	**100**
	% Funding Split between PCT and LA:	**25%**	**75%**		

Documents In Members' Rooms

None

Background Documents

None

THE JOINT COMMISSIONING BOARD	Agenda Item 21 Brighton & Hove City Council

Subject:		**Re-tendering and Reconfiguration of Substance Misuse Services**		
Date of Meeting:		**Monday 15th September 2008**		
Report of:		**Terry Baker**		
Contact Officer:	Name:	**Simon Scott**	**Tel:**	**545414**
	E-mail:	simon.scott@bhcpct.nhs.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The Board is asked to note that Sussex Partnership NHS Trust were served notice in March 2008 for the provision of community substance misuse services following the Drug and Alcohol Action Team (DAAT) Joint Commissioning Group decision to market test this service.

1.2 The National Treatment Agency for Substance Misuse produced updated guidance for substance misuse treatment systems in 2006 (Models of Care Update 2006), placing greater emphasis upon securing effective treatment journeys for substance misusers which include all aspects of treatment available through a single process, rather than treatment systems which require service users to attend different services for each aspect of drug treatment. This service framework requires the roles of care co-ordinator and keyworker to be merged and resourced sufficiently to allow for the effective development and delivery of all aspects of an individual’s care plan.

1.3 The National Institute for Health and Clinical Excellence (NICE) produced guidance for prescribing and psychosocial treatment for drug misusers in July 2007, based upon a robust analysis of the evidence base for the effectiveness of a range of treatment options. The following interventions are supported:

- Substitute prescribing of methadone or buprenorphine for maintenance or abstinence based forms of treatment for opiate dependent people.
- Individualised care through an effective Keyworker system.
- The introduction of contingency management. This involves rewarding the service user for providing illicit drug free tests, or to complete healthcare objectives (e.g. Hepatitis B vaccination course).
- Cognitive Behavioural Therapy to treat anxiety or depression, but not to treat substance misuse problems specifically.
- The introduction of Behavioural Couples Therapy, where the partner of the substance misuser does not use substances problematically.
- Referral to self-help groups to support and sustain treatment gains.

- Support for families and carers of drug misusers, through brief interventions or up to five sessions of more intensive family support.

1.4 The Board is asked to note and approve recommendations for the re-configuration of drug treatment provision.

2. RECOMMENDATIONS:

The majority of investment in drug treatment services is derived from the Drug and Alcohol Action Team (DAAT) pooled treatment budget. The Board is asked to note that these recommendations are subject to DAAT joint commissioning group approval.

2.1 It is recommended that the Board approve the tendering of clinical aspects of drug treatment in line with NICE guidance.

2.2 It is recommended the Board approve that the City Council work with the new provider and the Primary Care Trust post tender award to agree the best model of working, for those activities currently delivered by staff seconded from the local authority to Sussex Partnership NHS Trust.

2.3 It is recommended that the Board approve the introduction of contingency management schemes within drug treatment to promote abstinence from illicit drugs and improve outcomes for health based interventions. It is recommended that the DAAT JCG, DAAT Chair and the JCB approve the precise detail of any voucher or other individual incentive scheme before it is introduced, after the contract has been awarded.

2.4 It is recommended that the Board approve the re-profiling of community based voluntary structured day care provision from voluntary sector providers, with the exception of Drug Rehabilitation Requirement programmes and the programme for substance misusing parents of children at risk. Providers delivering other group based interventions will ensure that existing care planned commitments are fulfilled, before re-profiling is completed. Commissioners will support the development of self help groups, should current levels of provision prove inadequate.

2.5 It is recommended that the Board approve the re-profiling of existing voluntary sector provision (CRI and Brighton Oasis Project) from structured day care and counselling to increased Keywork capacity (5.3 whole time equivalent staff providing100 places), family support (one whole time equivalent), and cognitive behavioural interventions to treat depression and anxiety (30 places). Services delivered by voluntary sector providers were tendered in 2005 and new contracts established in April 2006. Further market testing of these services is not therefore required at this stage.

2.6 It is recommended that the Board approve sustaining group based approaches within residential drug treatment services.

2.7 It is recommended that an analysis of need and potential uptake of Behavioural Couples Therapy is undertaken from April 2009, with a view to introducing this component subsequently, as this is yet to be introduced to the UK.

2.8 It is recommended that the Board approve, in line with NICE guidance, cessation of group based psycho-educational approaches to harm reduction, such as the group based hepatitis training provided by MIND. Individualised approaches should be developed within services, in particular homelessness services, pharmacies and drug treatment services to replace these.

2.9 It is recommended that the Board approve that the contract for substance misuse treatment be let with treatment for alcohol dependency as a component part. Existing alcohol treatment provision carried into this contract alongside additional PCT investment, but that a separate contract is let for a new alcohol brief interventions service.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 July 2006: The National Treatment Agency publishes “Models of Care Update 2006”, which emphasises the role of the Keyworker in guiding service users through a treatment journey, which includes engagement, delivery and community reintegration phases.

3.2 July 2007: The National Institute for Health and Clinical Excellence publish guidance for treatment of drug misuse.

3.3 September 2007: The Department of Health publish updated clinical guidelines for the treatment of substance misuse, incorporating the recommendations from Models of Care and NICE guidance.

3.4 December 2008: The Commissioning Manager for Substance Misuse briefs Drug and Alcohol Action Team partners on the implications of NICE guidance.

3.5 February 2008 to June 2008: The Commissioning Manager leads a stakeholder consultation group to draft a revised care pathway for drug treatment, describing greater efficiency through the use of a single keyworker approach.

3.6 March 2008: The DAAT Joint Commissioning Group agree that clinical community based drug treatment services should be market tested.

3.7 March 2008: The DAAT JCG agrees that day programmes delivered as part of Drug Rehabilitation Requirements should be maintained in line with existing legislation.

3.8 April 2008: The PCT commission MIND to produce user led recommendations for drug treatment and comment upon the implementation of national guidance.

3.9 June 2008: Substance misuse and Children and Young People’s Trust stakeholders confirm that day care elements of the successful programme for substance misusing parents of children at risk should be retained.

3.10 July to August 2008: The Commissioning Manager develops the service specification for drug misuse in line with care pathway re-design.

3.11 July 2008: CRI and Brighton Oasis Project submit proposals for re-profiling of day care staff and volunteers to deliver aspects of Keywork, family support and cognitive behavioural therapies to treat depression and anxiety for those with drug dependency.

4. CONSULTATION

4.1 Consultation with DAAT partners

Issue:	Concern that the introduction of contingency management would create adverse publicity.
Response:	Recommendations to use voucher based rather than cash based incentives. Communications leads and Chief Officers should be briefed in advance of the introduction of contingency management. This initiative should be appraised of the outcome of the current NTA pilot.

4.2 Consultation with Criminal Justice Partners

Issue:	Concern that all day programmes would be decommissioned, leaving Drug Rehabilitation Requirements (DRR) undeliverable.
Response:	Day programmes which form part of DRR should be retained until such time as NICE and Home Office guidance is harmonised.

4.3 Consultation with CYPT

Issue:	Concern that day programmes for parents who are substance misusers would be decommissioned.
Response:	POCAR day programmes should be sustained in the medium term, while greater evidence of effectiveness is established.

4.4 Consultation with service users

Issue:	Support for contingency management and single Keyworker but concern about withdrawal of group based programmes and restriction in choice.
Response:	Maintain group based programmes in DRR, POCAR and Residential options. Re-assurance that stepped model of care does not restrict choice.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 Financial Implications:

The existing PCT and Council investments in community substance misuse services, currently delivered by Sussex Partnership NHS Trust, will be made available from April 2009 for the appointed provider. The financial envelope for these services will be subject to normal budget setting protocols and will be expected to be contained within relevant inflationary and other uplifts.

Finance officer consulted: Nigel Manvell

5.2 Legal Implications:

The contracts referred to in this report are 'Part B' services for the purpose of EU procurement law and UK procurement Regulations, and therefore not subject to the full application of either. The Council is nevertheless required to comply with EU Treaty objectives of non-discrimination and openness in procurement, as well as comply with its obligation to seek Value for Money. The Council must take the Human Rights Act into account in respect of its actions but it is not considered that any individual's Human Rights Act rights would be adversely affected by the recommendations in this report.

Lawyer Consulted. Sonia Likhari, Contracts Lawyer

5.3 Equalities Implications:

Service specifications and tender evaluation criteria have been developed to ensure equalities requirements will be met. Improving access for women, LGBT and BME

groups are currently being developed through system-wide actions plans and will be included within the specification, where appropriate.

5.4 Sustainability Implications:

None. Tender evaluation will test sustainability.

5.5 Crime & Disorder Implications:

None. Criminal justice programmes will be maintained. Vouchers offered as part of contingency management will be of low individual value, so are unlikely to be misused.

5.6 Risk and Opportunity Management Implications:

Should the partnership fail to run the tendering process in time, or is unable to appoint a provider, the PCT will negotiate a contract extension with Sussex Partnership NHS Trust.

5.7 Corporate / Citywide Implications:

Aligning drug treatment to evidence based practice should promote the effectiveness of drug treatment in the city. Competitive tendering will enable the best value solution to drug treatment to be implemented.

SUPPORTING DOCUMENTATION

Appendices:

1. Summary of National Treatment Agency “Models of Care” and NICE drug misuse psychosocial interventions guidance

Documents In Members’ Rooms: None

Background Documents: None

Appendix 1

1. Summary of National Treatment Agency "Models of Care 2006"

Models of Care: Update 2006 calls for a greater focus on service users' journeys and "flow" through drug treatment systems, and improvement in delivery of effective pathways of care. This will require improved strategic partnerships between health and criminal justice, as well as improved partnerships with those responsible for housing, education and employment services. Access to such mainstream provision is vital for drug misusers in treatment, to maximise treatment gains and prevent relapse into illegal drug misuse.

Drug treatment is not an event, but a process usually involving engagement with different drug treatment services, perhaps over many years. Each client's drug treatment journey is different and depends on a range of factors including health status, relationships, nature of the drug problem and the quality of the drug treatment they receive. However, drug treatment use is often episodic, with service users dipping in and out of treatment over time. Evidence from the US suggests that an average time in treatment for someone with a heroin or crack dependence problem is five to seven years, with some heroin users requiring indefinite maintenance on substitute opioids. Evidence also tells us that service users gain cumulative benefit from a series of treatment episodes. However, the biggest improvements in client outcomes are likely to be made in the first six years of treatment.

The treatment journey is conceptualised into four overlapping components, each with key objectives. These components comprise:

- Treatment engagement
- Treatment delivery (including maintenance)
- Community integration (which underpins both delivery and treatment maintenance or completion)
- Treatment completion (for all those who chose to be drug-free and who can benefit).

Although it will be useful to see these phases of the treatment journey as conceptually separate, there is room for considerable overlap. It is important to note that the phases do not mean that treatment is a linear journey, with service users progressing through the three main phases of engagement, delivery and completion. Instead, these are the main elements of a treatment journey which may occur in a variety of combinations during a client's time in treatment. Considering these phases can be particularly helpful in informing the focus of care plans at different stages and in maintaining a focus on the treatment journey.

Treatment engagement
The treatment system needs to be able to engage people rapidly and retain them once they have entered treatment. Two issues important to improving treatment engagement are timely access to treatment and a focus on supporting retention for at least three months in structured treatment for adults with dependent drug misuse. Each drug treatment system will be assessed on its ability to engage service users on these two issues, through performance management on national waiting times and retention targets by the NTA, as outlined in the Government's treatment effectiveness strategy. During the engagement phase of treatment, service users will need to be assessed to ensure treatment can be tailored to their needs and at this stage they may benefit from motivational work focused on maximising engagement. Particular consideration may need to be given to preventing disengagement of

certain drug users (e.g. those from some Black and minority ethnic groups, younger drug users and clients with mental health and substance misuse problems). The engagement of service users may be enhanced by a specific process of induction into treatment, so it is made clear and comprehensible for individuals what are the roles and responsibilities of the service provider and what are the expectations on service users themselves.
Following assessment, care plans will be agreed with the clients and structured treatment will begin. There also needs to be more explicit commissioning of interventions that engage service users and build "therapeutic alliances", which are crucial to treatment retention and positive changes in treatment. A range of interventions to support engagement could be explicitly commissioned, including brief interventions, services for the children of drug users, advocacy and support arrangements and interventions to contact, engage and follow up people (e.g. outreach for rough sleepers, motivational interventions).

Drug treatment delivery
Drug treatment providers need to deliver effective and evidence based drug treatment interventions, following completion of a care plan that has been agreed with the client. Drug treatment practitioners should work to build an effective therapeutic alliance with service users, encouraging full participation by them in delivering their own care plans. Good-quality drug treatment should be associated with improvement across a range of domains, including an individual's substance use, health, social functioning and in reduced public health and offending risks posed to others. In delivery of drug treatment, a greater emphasis is required on improving service users' physical and mental health, importantly for those with hepatitis C infection and for those misusing alcohol.
Increases in the use of cocaine and crack cocaine by service users may have a negative impact on client outcomes, unless this is addressed, particularly with injecting drug users.
The children, carers or significant others of service users should also be considered during care-planned treatment. The needs of the children of drug-misusing parents also require greater attention. During this phase, clients should begin to receive other interventions to meet their wider needs. These interventions could include improving housing status, getting other healthcare needs met by other health specialists (e.g. liver disease and dentistry), help with children and family issues, and provision of assistance to enable service user back to work or education. These nondrug treatment interventions should be set out in the client's care plan and links made with appropriate services to ensure the client receives them. This includes the initiation of elements of community integration.
To ensure that the delivery of drug treatment meets the client's needs in a timely way, local treatment systems must ensure continuity of care between the criminal justice system and drug treatment. This is particularly relevant for clients entering and leaving prison.
Clients who are on long-term maintenance (ideally in shared care) should be considered to be continuing in the delivery phase of treatment.

Improving community integration
Whether service users are in treatment (e.g. maintained on substitute opiate medication) or leaving treatment they should have access for social support (e.g. housing support, educational support, employment opportunities) to maximise positive gains they have made in treatment. Service users who are stable but who wish to be maintained on substitute opioid medication should have opportunities to receive social support, education and employment where appropriate.
For stable individuals who do not need to continue in specialised drug treatment services, there should be clear pathways into maintenance and monitoring in primary care settings with ongoing community integration interventions and support.

However, it is vital that such service users have explicit accessible pathways back into specialised structured drug treatment services if needed (e.g. in case of relapse). DAT partnerships should consider linking their drug treatment targets to wider mainstream targets, that relate to housing, education and employment for drug users.

Improving treatment completion

Few service users who enter drug treatment intend to be in specialist drug treatment indefinitely. For those who wish to be drug-free, commissioners and providers need to create better pathways and exits from specialist drug treatment. These pathways should include drug-related and non-drug related support. Drug treatment providers and commissioners are responsible for the drug-related support, and should form the necessary local strategic links to enable clients to access non drug-related support, including improved social support, housing, education and employment opportunities to maximise treatment gains.

This approach will require treatment systems to be configured both to create effective exit routes out of specialised drug treatment, including efficient access to Tier 4 provision for those who wish to be drug-free, and to be well integrated with primary care and other systems of support and care for those in maintenance treatment.

Drug-related aftercare support, such as support groups or individualised sessions or alternatively from mutual aid groups run by Narcotics Anonymous or non-12-Step equivalent groups, has been demonstrated to sustain abstinence.

Improving community integration and treatment completion may require some drug treatment system or service redesign, including:

- As well as planning for numbers in treatment and numbers of clients retained in treatment, commissioners should plan for numbers of planned client exits from treatment
- Investing in quality drug treatment delivery to maximise gains and service users' improvement in treatment (whether achieving stability on maintenance treatment or achieving effective abstinence)
- Enhancing routes to treatment completion or, for stable patients who no longer need specialist care, better routes to community maintenance in primary care settings
- Commissioning a range of aftercare provision for service users to follow structured treatment, as a development of Tier 2 interventions, and ensuring a range of other support mechanisms for ex-service users (e.g. drug-free support such as Narcotics Anonymous or equivalents)
- Investing in strategic partnerships with housing, education and employment, together with bespoke initiatives for drug misusers aimed at reintegration.

2. Summary of NICE drug misuse psychosocial interventions guidance

2.1 Person-centred care

Treatment and care should take into account service users' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow service users to reach informed decisions about their care. If the service user agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

2.2 Supporting families and carers

● Discuss with families and carers the impact of drug misuse on themselves and other family members, including children.

– Offer an assessment of their personal, social and mental health needs.
– Give advice and written information on the impact of drug misuse.

● Where the needs of families and carers have been identified:

– offer guided self-help (usually a single session with written material provided)
– inform them about support groups for example, self-help groups specifically for families and carers and facilitate contact.

● If families and carers continue to have significant problems, consider offering individual family meetings (normally at least five weekly sessions). These should:

- provide information and education about drug misuse
- help to identify sources of stress related to drug misuse
- promote effective coping behaviours.

2.3 Brief interventions and self-help

● At routine contacts and opportunistically (for example, at needle and syringe exchanges), provide information and advice to all people who misuse drugs about reducing exposure to blood-borne viruses.

– Give advice on reducing sexual and injection risk behaviours.
– Consider offering testing for blood-borne viruses.

● Do not routinely provide group-based psychoeducational interventions that give information about reducing exposure to blood-borne viruses and/or about reducing sexual and injection risk behaviours.

● If concerns about drug misuse are identified by the service user or a staff member, offer opportunistic brief interventions focused on motivation to people:

– in limited contact with drug services (for example, those attending a needle and syringe exchange or primary care settings)
– not in contact with drug services (for example, in primary or secondary care settings, occupational health or tertiary education).

These interventions should:

– normally consist of two sessions each lasting 10–45 minutes
– explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour, and provide non-judgemental feedback.

● Routinely provide information about self-help groups.
  – These groups should normally be based on 12-step principles; for example, Narcotics Anonymous and Cocaine Anonymous.
  – Consider facilitating initial contact, for example by making the appointment, arranging transport and accompanying the person to the first session.

2.4 Formal Psychosocial Interventions

2.4.1 Contingency management

Drug services should introduce contingency management programmes to reduce illicit drug use and/or promote:

● engagement with services for people receiving methadone maintenance treatment

● abstinence and/or engagement with services for people who primarily misuse stimulants.

Contingency management to improve physical healthcare

● For people at risk of physical health problems resulting from drug misuse, consider offering material incentives (for example, shopping vouchers worth up to £10) for concordance with or completion of specified harm-reduction interventions, in particular for:
  – hepatitis B/C and HIV testing
  – hepatitis B immunisation
  – tuberculosis testing.

2.4.2 Behavioural couples therapy

● Consider behavioural couples therapy for people who are in close contact with a non-drug-misusing partner and who present for treatment of stimulant or opioid misuse, including those who continue to use illicit drugs while receiving opioid maintenance treatment or after completing opioid detoxification. The intervention should:
  – focus on the service user's drug misuse
  – consist of at least 12 weekly sessions.

2.4.3 Cognitive behavioural therapy and psychodynamic therapy

● Consider evidence-based psychological treatments (in particular, cognitive behavioural therapy [CBT]) for comorbid depression and anxiety disorders in line with existing NICE guidance for people who:
  misuse cannabis or stimulants
  have achieved abstinence or are stabilised on opioid maintenance treatment.

● Do not routinely offer CBT and psychodynamic therapy focused on the treatment of drug misuse to people who misuse cannabis or stimulants or those receiving opioid maintenance treatment.

- The evidence related to intensive outpatient treatments and day treatments does not support the notion that 'more is better' when comparing more intensive treatments to standard outpatient treatment in relation to drug use outcomes.

ADULT SOCIAL CARE & HEALTH CABINET MEETING JOINT COMMISSIONING BOARD	Agenda Item 22 Brighton & Hove City Council

Subject:		**Self Directed Support Strategy**	
Date of Meeting:		**11 September 2008** **15 September 2008**	
Report of:		**Joy Hollister, Director of Adult Social Care & Health**	
Contact Officer:	Name:	**Brigid Day, Interim Head of Adult Social Care**	**Tel: 29-5031**
	E-mail:	brigid.day@brighton-hove.gov.uk	
Key Decision:	Yes	Forward Plan No. ASC 2191	
Wards Affected:	All		

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 Self Directed Support is a new way of delivering social care which forms a major part of the three year Adult Social Care personalisation programme

1.2 It is based on a new national policy initiative that is being piloted nationally and was introduced the Department of Health white paper 'Our health, Our Care, Our Say' (2006) and a subsequent concordat between local government associations, NHS, regulatory bodies , Association of Directors of Social Services, and care providers 'Putting people First' (2007)

2. RECOMMENDATIONS:

2.1 That the strategy is agreed

2.2 that work in developing an implementation plan is taken forward to deliver the strategy in stages over a three year period , with evaluation and review of each stage as it proceeds. A draft project outline is attached as an appendix

3. RELEVANT BACKGROUND INFORMATION/

3.1 Self Directed Support is a way of redesigning the social care system so that the people eligible to receive services take control over them.

The underlying principle is social care users having the same ability as other citizens to exercise choice and control over their lives and the social care they receive, enabling them to determine their own outcomes, make their own decisions and manage their own risks. Self Directed Support

puts the ‘customer’ at the centre of assessing their needs, deciding how those needs might be best met and tailoring their care accordingly. Its aim is that people are clear about their entitlements to social care and other public funding and be appropriately supported to take as much control of their lives and services as possible

3.2 A substantial body of research shows that people identified as needing social care would prefer to have access to the funding for that care and contribute to how it is used rather than letting staff decide for them. They also wish to remain in their own homes for as long as possible.

3.3 Direct Payments are a key vehicle for making self directed support a reality. Brighton and Hove City Council already operates a Direct Payments service for social care users. If someone is assessed as eligible for adult social care and decides that they want to receive that in the form of a Direct Payment they are supported to do so by social care staff and via a support contract with the Federation of Disabled people. There is a clear audit trail and review within social care systems and they are also required to open a separate bank account. The Council achieved a challenging CSCI performance improvement target of 200+ users 2007/8. Targets are in place to further increase the number of Direct Payments in 2008-9 through systems change, staff training and performance management.

3.4 Self Directed Support builds on this existing system and takes it further through a personal budget with the purchasing power to enable recipients of services to become more active consumers. It widens the budgets available for use to include Supporting People, disabled facilities grants and benefits such as independent Living fund and Access to Work

3.5 People are told the level of their entitlement (i.e. budget) then plan how they will use their budget to get the support that best suits them. Robust new systems are required to ensure that the personal budget sum is fair and transparent, is enough to cover the support needed and is sustainable within the available budget. The national proposed model is a ‘Resource Allocation System’ (RAS) which ascribes monetary value to specific types of need and support and then consolidated into one overall budget figure. The RAS needs to be developed and tested locally to align with local costs and budgets. There is no national template for this, but the council is commissioning a prototype with a number of other authorities to test out locally on a ‘dry run’ early next year

3.6 The local authority ensures that the person has the necessary assistance to create their support plan and can take a direct role in providing this either directly or through advocates or ‘brokers’. The local authority also ensures that the risks and responsibilities are understood and the person or their carer/ family are able to manage.

- The person is accountable to the local authority for how they spend the money, and the local authority has a duty to check that the support plan is meeting the needs and outcomes agreed and that the plan operates within the allocated budget.

- People control their budgets to the extent they want – there will be a range of control options/levels – from direct payment to having services commissioned by the local authority

- People can use their money flexibly to achieve the outcomes identified and agreed as most important to them. They can use statutory services and other forms of support in the independent and private sectors. If they change their minds, they can re-direct their budget to alternative support

- The aim is for people to use their money to achieve the outcomes that are important to them in the context of their whole life plus their role and contribution within the wider community

3.7 The Dept of Health has just concluded a pilot of Individual (personal) Budgets in 13 local authorities, the full report of which is expected in spring 2009. Up to 50 local authorities have already started to develop this area and a national organisation 'In Control' provides models and guidance. The council is a member of this.

3.8 A current local pilot of individual budgets in the Learning Disability service is underway using the community care budget (and utilising the In Control model) . It is testing out Personal Budgets with a small group of service users. A project group oversees the development of a bespoke Resource Allocation System and to work though the issues which inevitably arise as new practice is developed in action. This important first step is already providing vital learning and experience on which the broader, corporate self directed support strategy can be built. It will be vital to bring this experience into the overall Adult Social Care programme.

3.9 Self Directed Support is a priority and high profile theme within the new Local Area Agreement for Brighton and Hove. The specific National Indicator – NI 130, is included as one of the 35 for enhanced performance and close scrutiny by central government.

3.10 The Implementation Plan will set out plans for user and carer involvement and participation in the strategic governance and scrutiny structures for the Self Directed Support programme, as well as be partners in the inter-agency work groups taking forward elements of the work. The Council should ensure that users and carers have any support they may need to be a full part of these processes.

4. CONSULTATION

4.1 The draft strategy has been launched at a stakeholder event in April attended by a wide cross section of users, carers, health and third sector organisations including voluntary sector and independent providers and opened by the cabinet member for adult social care

4.2 The strategy has been approved by TMT and directorate management groups

4.3 The implementation plan will set out a programme to consult with and involve service users and carers at all stages in the development, practical delivery and monitoring/evaluation of the Self Directed Support strategy for the city

4.4 Longer term, the Council will work with its partners to build structures and systems which maximize sustainability of user involvement in the continuing development and improvement of self directed support and which deliver user led and directed support solutions – this includes the development of an Independent Living Centre for Brighton and Hove.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications

5.1 A measured approach is needed to planning for the financial impacts of a system shift to self directed support – integrating infrastructure and development costs into the annual budget setting process and making sure financial reporting and trend analysis is able to evaluate and forward forecast actual costs and savings

5.2 Self Directed Support is an evolving concept and some of the financial impacts are as yet unclear. However by taking a measured and gradual approach to its introduction the progress can be closely monitored at each stage and highlight any unforeseen cost pressures.

Finance Officer Consulted: Mike Bentley Date: 29th August 2008

Legal Implications:

5.3 *The strategy proposed is in line with national guidance and will be implemented incrementally and reviewed at each stage in consultation with relevant stakeholders. The aim is to enable service users to have more personal choice, regarding how their services are provided, where they are able to exercise such choice. This principle is enshrined in the right to family life within the Human Rights Act.*

Lawyer Consulted: Hilary Priestley Date: 29th August 2008

Equalities Implications:

5.4 An equalities impact assessment is scheduled for the autumn

5.5 The community care budget funds care to some of the most disadvantaged groups in the city and self directed support will enable its use to be more flexible in meeting needs of hard to reach groups and different communities

Sustainability Implications:

5.6 None

Crime & Disorder Implications:

5.7 None

Risk & Opportunity Management Implications:

5.8 the strategy will necessitate a re-examination and clarify the Council's changing role in terms of commissioning and social care market place development & management – which should include appraising creative options with partners and the encouragement of new and user led services to enable self directed support

5.9 the implementation of SDS will require a robust system of risk enablement and management as an explicit process, possibly through a specific panel to sign off personal budget plans

Corporate / Citywide Implications:

5.10 This strategy will impact on all social care users and social care providers across the city

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 None

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 A draft implementation plan has not yet been formulated due to the tragic and sudden death of the strategy's author, Dave Nicholls in July. However it was felt to be important to recognise his work thus far and present this outline strategy as originally agreed with him.

SUPPORTING DOCUMENTATION

Appendices:

1. SDS Strategy
2. Proposed governance structure and workgroups

Documents in Members' Rooms

1. None

Background Documents

1. *Our Health Our Care Our Say (Dept of Health 2006)*
2. '*Putting people First' (2007)*

Self Directed Support Development Framework

Modernisation Board
Chaired by Joy Hollister

Self Directed Support Partnership
Chaired by Denise D'Souza

Agree Terms of Reference:
Vision & Strategy
Objectives
Blueprint
Targets
Implementation Plan
Strategic Leadership

Quarterly from Autumn 08

Partners/Membership

- ASC
- Scrutiny Members
- PCT
- CVS
- User Representation
- Finance

Service User Engagement Panel - reference group with a clear mandate for service user involvement throughout the development of SDS.
n.b must sort consistent language in this area –

WORKSTREAMS

SDS Systems (including RAS)

Information Advice Support Brokerage for SDS users

Future Commissioning, Contracting and Financial Planning

Performance Management

Risk Enablement

Develop **Terms of Reference** for the Partnership Board:

- Articulate and promote clear **Vision** outlined within the SDS Strategy
- Identify Board and Work Group **Objectives** to be achieved within lifetime of the Partnership Board (– clearly related to the work streams)
- Agree and oversee delivery of Effective **Blueprint and Implementation Plan to fulfil SDS Strategy**.
- Performance Management of the SDS programme and LAA/CSCI targets
- **Evaluation and Monitoring** of the SDS programme
- **Strategic Champions** for SDS across the City

Key Roles for the SDS Partnership Board:

- Adopt and monitor Blueprint – ensuring all work streams have clear objectives and timescales/milestones.
- Act as strategic Champions for SDS, and communicate the key messages for SDS to relevant networks, partnerships agencies and the wider community
- Ensure that the progress of the SDS strategy is shared and actioned across all stake holders – e.g. that actions which need to be progressed by the PCT, are taken to the appropriate forum for progression, and reported back to the SDS Partnership Board
- Ensure that the principle of Equalities are upheld within the development of SDS, including the development of an Equality Impact Assessment
- Ensure that developments are Evaluated to identify benefits and areas for improvement
- Ensure that the work of the Learning Disabilities Individual Budget pilot is integrated into the overall SDS development
- Financial Planning, identify financial implications and ensure the principles of Best Value for Money.
- Development of targets and timetable

Self Directed Support Draft Vision – for SDS Partnership Board to develop

"All eligible Adult Social Care service users will be able to access a Personal Budget to purchase a range of support for their needs, and receive the level of support they wish in order to manage their self directed support options." **By April 2011**

1st Priority - effective local systems which will enable SDS to be a reality for service users, and central to this commitment is the development of

a locally created and tested Resource Allocation System (**SDS Systems Group**)

Milestones – 2008/09:

- Establish Group + additional Sub Groups (Risk Enablement + Performance Management)
- August'08 implementation of pilot Overview Assessment to collect data for RAS programme
- Sept'08 establish SDS System Sub Group
- Oct'08 ensure that FACE have received all relevant data for RAS
- Dec'08 start testing RAS with ASC assessment teams
- March'09 receive outcome of testing RAS
- Reformation of current ASC systems to enable SDS to be embedded within ASC procedures – Financial Systems; and Assessment.
- Development of monitoring systems to ensure PI returns and evaluation of on going systems
- Establish Issues Log
- Self Assessment development

Milestones – 2009/10:

- April'09 implement new FACE Overview Assessment across all ASC assessment teams

Risk Enablement and Managing Choice Sub Group:

Development of a decision making process to work with service users to make choices in order to achieve their individual outcomes, and manage potential risks.

Milestones – 2008/09

- Establish Sub Group
- Development of a Risk and Choice Statement, which incorporates Safeguarding Adults, Child Protection, and Mental Capacity – in order to balance professional and service users responsibilities, and a consistent approaches to risk across SDS development
- Development of protocols which can be used across sectors, in order to manage potential risks
- Managing Money policy

Performance Management Sub Group:

Links with LAA + National Indicator Set performance framework; development of outcome measures regarding the service users journey within new SDS systems; and Evaluation of SDS development, including users and stakeholders perspectives

2nd Priority – Information and Support Group There will be a sufficient range of Information, Support, Advocacy, and Brokerage to enable ALL service users, and/or their carers, to take control - from assessment to managing their Personal Budgets

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Milestones – 2008/09:

- o Establish Group
- o Continue with the Direct Payments programme to further develop the support service users will receive in order to effectively access DP's, from information to managing a DP.
- o Development of a range of training programmes to ensure all relevant Council and partner agencies are fully trained/enabled to deliver choice and control to users.
- o Exploration of the range of brokerage functions which need to be accessible to service users
- o Ensure service user journey is accessible for all service users

Milestones – 2009/10:

- o Delivery of a comprehensive training programme for all relevant staff

3rd Priority –. Commissioning and Contracting Group There will be a genuine range of choices/services/opportunities available for service users to make informed decision for spending their Personal Budget

Milestones – 2008/09:

- o Establish Group
- o Continue with the development programme for Direct Payments, including increasing accessibility to employ Personal Assistants – enabling service users to choose who can support their individual needs and personal aspirations to improve their quality of life.
- o Engage with Commissioners regarding SDS principles
- o Analysis of current personal budget users spending – what are people buying who are self funded, what is in the market place already
- o Unit costs, creation of pricing mechanisms.
- o Financial planning for the shift from provided care to SDS option, with an explicit awareness of the need to recognise the costs of running dual systems while shifting to SDS.

Milestone – 2009/10:

- o SDS as a clear priority within the Community Strategy, for the LSP and PSB.
- o Consult with service users about the types of service they want to purchase
- o Work in partnership with Providers to ensure they can deliver what individual want.

Milestones – 20010/11:

- Commissioning plans and practices in place to enable individuals to purchase rather than providers to be contracted to support homogenous groups of service users.
- Provision of a "menu" or "catalogue" of services/opportunities to support service users with their purchasing power – possible Shop4Support approach.
- Development of a plan to consider the feasibility of SDS across broader public service – health; leisure; education…

All service users accessing RAS and PBs
Range of support options for service users
SDS compatible systems/procedures/policies
Fit for purpose workforce

A self sustaining stakeholder/cross sector governance structure for SDS, with a continuing investment plan for the future

Self Directed Support Strategy Brighton & Hove

1. Introduction

1.1 This paper aims to set out a radical new way forward for Adult Social Care in the city through a 'system shift' commitment to Self Directed Support that meets the strategic ambitions captured in Administration and corporate priorities as well as emerging national policy and in leading edge practice in health and social care.

1.2 Self Directed Support is central to our overarching commitment to modernise social care planning and provision for Brighton and Hove – the three year Adult Social Care Personalisation Programme. It dovetails with complementary and instrumental parts of that overall programme including: access point, re-ablement, self assessment, refocused approaches to care management and review and the promotion of health and well being for all.

1.3 The paper will describe some of the background to Self Directed Support and its rationale, discuss what the model actually involves and make initial proposals about strategic objectives and scope. It will address planning and implementation priorities and look at what the change process would need to entail for the City Council and its principal partners locally – which necessarily includes challenges to present ways of thinking and working on several fronts.

2. Background and National Strategy

2.1 There is an emerging national debate on social care delivery and it's increasingly important role in an ageing population, changing expectations and standards and increasing costs. The current national policy supports a reform and transformation of the social care system into a system of Self Directed Support – a way of redesigning the social care system so that the people eligible to receive services take control over them. The underlying principle in the current push for the strategic development of self directed support is the desire to move to a system where social care users have the same ability as other citizens to exercise choice and control over their lives and the social care they receive, enabling them to determine their own outcomes, make their own decisions and manage their own risks

– to become ‘customers rather than clients’. Self Directed Support puts the customer at the centre of assessing their needs, deciding how those needs might be best met and tailoring their care accordingly.

2.2 It’s aim is that everyone will be clear about their entitlements to social care and other public funding and will be appropriately supported to take as much control of their lives and services as they wish/is possible. Although this is being driven forward through Government policy, it has widespread support across the voluntary and independent sector.

2.3 Self Directed Support (which includes Direct Payments and Personal Budgets) is the first ‘whole system’ approach to focus on personal/individual outcomes and capacity building for social care users. Recent government policy has been consistently directed at greater personalisation and a belief that people will get better outcomes from the social care support they receive as a result. Wider public policy is encouraging organisations, including local authorities to find ways to enable users of services to direct the development of the ‘social care marketplace’ – as one way of driving up quality and value for money. This is backed up by a substantial body of research which shows that people identified as needing social care would prefer to have access to the funding for that care and contribute to how it is used rather than letting the Council decide. They also wish to remain in their own homes for as long as possible.

2.4 These themes have been developed in national publications and professional debate over the past five to ten years. The key principles and policy shifts are now embedded in legislation and best practice. Milestone documents have included:

Community Care Act (1996) – introducing Direct Payments

Improving Life Chances of Disabled People (Strategy Unit 2005) – introducing concept of Individual Budgets and the requirement for each area to have a user controlled organisation run along the principles of centres for independent living

Opportunity Age (Department of Work and Pensions 2005) – emphasising need for ‘whole system’ reform of approach to ageing

Independence, Well Being and Choice (DH 2005) – long term vision for reform of social care including strengthening user

power and control, investment in prevention, extending the use of DPs and introducing intention to test Individual Budgets

Our Health, Our Care, Our Say (Department of Health 2006) – major re-alignment of community health and social care services in terms of joint planning, localised delivery and new 'personal' outcomes. Also announced Individual Budgets.

Commissioning Framework for Health and Well Being (DH 2007) – policy framework for commissioning for personalisation and independence

Putting People First – DH et al, Dec 2007 – ministerial concordat on 'personalisation'

LAC January 2008 – setting out targets and expectations of Las in relation to mainstreaming of self directed support

2.5 Two main workstreams contributing to the evidence relating to Self Directed Support in this country. In Control (the national resource body on SDS, gathering and disseminating expertise, emerging best practice and learning) led their first pilot with six local authorities in 2003, extending this in 2005 in a second wave to over 50 local authorities. There are now over 100 local authority members of in Control. In addition, the Department of Health have just concluded a pilot of Individual Budgets in 13 local authorities, the full report of which is expected in the spring 2009. In addition to the pilot evaluation, a number of guidance documents are being written to support local authorities. The City Council has become an In Control member and is also being actively supported by CSIP (Care Services Improvement Partnership) and CSED (Care Services Efficiency Directorate) in the development of SDS in Brighton and Hove.

2.6 There are a set of values and principles underlying SDS that redefine the relationship between the citizen and the state which place social care users as citizens with the same entitlements as anyone else – especially alongside those people with social care needs who are able to fund their own support.

The In Control website sets out these principles as:

- We each should be in control of our own lives and, if we need help with decisions, those decisions are kept as close as possible to us - self-determination

- We should each have our own path and sense of purpose to help give our life meaning and significance – direction

- We should each have sufficient money that we are not unduly dependent upon others and can live an independent life – money

- We should each have a home that is our own, living with people that we really want to live with – home

- We should each get support that helps us to live our own life and which is under our control – support

- We should be able to fully participate in and contribute to family and community life - community life

- We should have our legal and civil rights respected and be able to take action is they are not- rights

2.7 Self Directed Support turns those principles into action for individuals (including some of the most vulnerable adults.) Leading edge local authorities nationally are developing a new outcome focused culture, new sets of tools and processes , different ways to support people and new professional roles and practice to enable existing resources to be allocated and services developed to achieve this end.

3. What is Self Directed Support?

3.1 Self Directed Support builds on previous moves towards personalisation (e.g. direct payments, care management, person centred planning) and takes them much further. What the self directed support model adds to these techniques is the budget and the purchasing power to enable passive recipients of services to become consumers and resource managers.

It ensures that:

- Everyone is told their level of entitlement (their budget) and they decide the level of control they wish to take over it's use

- People plan how they will use their budget to get the help that's best for them and help to plan through advocates or brokers if they need them

- **The local authority ensures that the person has the necessary assistance to create their support plan and may take a direct role in providing this. The local authority also engages with the person and their supporters to ensure that risks and responsibilities are properly understood. Finally, the person is accountable to the local authority for how they spend the money, and the local authority has a duty to check at regular intervals with the person that the support plan is meeting the outcomes agreed and that the plan operates within the allocated budget.**

- **People control their budgets to the extent they want – there will be a range of control options/levels – from direct payments to having services entirely commissioned and managed by the local authority.**

- People can use their money flexibly and to achieve the outcomes identified and agreed as most important to them. They can use statutory services and other forms of support in the independent and private sectors. If they change their minds, they can quickly re-direct their budget.

- People can use their money to achieve the outcomes that are important to them in the context of their whole life and their role and contribution within the wider community.

- The local authority continues to check that people are managing can change the arrangements if people are not achieving the outcomes they want/ need to achieve and shares what has been learnt

3.2 An important innovation is that Personal Budgets combine funding streams from previously separate sources, allowing the make up of the financial package to better reflect a 'whole' picture of an individual's needs and situation. Eligible funding streams currently are:

- Council provided social care budgets

- Supporting People funds

- Independent Living Fund

- Disabled Facilities Grant

- Integrated Community Equipment Services
- Access to Work

3.3 Within the pilot authorities a number of essential steps have been identified to setting up an effective individual budget (although it is important to note that detailed solutions are still evolving across the country and will continue to do so.) Establishing the appropriate infrastructure, systems (financial, management, administration monitoring, risk management), staff competencies and commissioner/provider relationships to realise each of these steps for individual users represents a significant challenge for the Council and its commissioning and delivery partners. They will together comprise the main content of the Self Directed Support Implementation Plan which will drive delivery on this strategy.

The essential steps are:

4. Setting the Personal Budget

4.1 An initial assessment of need, using self-assessment questionnaires leads to the identification of an indicative budget sum which brings together the eligible funding streams and the provision of support to the individual to decide and manage the process.

4.2 Knowing the size of the budget is vital for the individual to be in a position to begin to design the support that suits their requirement. Robust new systems are required to ensure that the personal budget sum is fair and transparent, is enough for the person to get the support they need and is sustainable within the available budget. The model is known as a 'Resource Allocation System' (RAS) which, at its simplest, ascribes monetary value to specific types of need and support requirement, which are then consolidated into one overall budget figure. The RAS needs to be developed and tested locally in clear alignment with local costs and budgetary allocations. There is no national template for this and the specific model within different local authorities is a matter of constant adaptation and iteration. Nevertheless the RAS is the most important cornerstone to getting started on self directed support and its development is a major and priority task for the Council.

5. Planning the Support

5.1 Once aware of the level of funding, people need to work out how best to use it to meet their agreed support needs. A Support Plan is developed to set out the way forward. Support Plans will replace existing care plans and alter existing care management processes. The plan will describe what the person wants to change or maintain in their lives and how they will use their budget to do so. Good support planning will encourage people to build on the resources already in their life – such as their own interests, capabilities and gifts, what is already available in their local community and the roles family and friends may want to play – as well as what services/resources/opportunities they will need to buy in from outside these networks. Good support planning will also enable people to think creatively and flexibly about how their support needs and quality of life improvement goals can be met.

5.2 People will need differing levels and types of assistance with support planning. Some will feel confident to undertake this themselves but if people require or request help this could be available from care managers, independent support brokers, advocacy organisations, peer support arrangements or existing service providers. One of the key changes in the Council's role will be to ensure that the local environment is appropriately shaped and resourced to provide this diversity of support and an array of routes into self determination for social care users and self funders

6. Agree the Individual Support Plan

6.1 The individual's plan will need to be fully costed and demonstrate how it meets the outcomes and criteria for success established at the outset. When finally defined, the plan must also show that it can be brought in within the Personal Budget level allocated by the RAS – otherwise it can not be signed off by the Council and would need to be revised. The proposed plan would then need to be formally agreed by the Council – a process yet to be determined but probably involving a multi disciplinary panel with appropriate specialist expertise available to it - which would consider the plan, taking into account all relevant local authority responsibilities/duties including risk assessment, the protection of vulnerable adults and value for money. It would set out any specific recommendations or changes needed and then commit the Council (and other partners) to the Support Plan agreed. This is an area where the Council will need to grow it's expertise in practice – many of the

judgements to be made may be different from those staff conventionally work with.

7. Managing the Personal Budget and Organising Support

7.1 A Personal Budget can be deployed in a variety of ways, giving people real choice in the level and type of involvement they have in managing the support. For many people taking some or all of the budget as a Direct Payment will be a ready means to maximise self determination. For others it allows for someone else to manage the budget on their behalf – perhaps a family member or someone paid to undertake such a role from, say, a local voluntary sector agency. Alternatively a care manager might arrange local authority services to fulfil the plan or contract manage and individually tailored service with a single provider or several. In some authorities committing to Self Directed Support, 'Individual Service Funds' (ring fenced budgets held and operated by a service provider) and Independent Living Trust models are also being explored.

8. Review and Learn

8.1 Consistent with a sharpened focus on review systems across the Adult Social Care Personalisation Programme, an individually tailored review system will need to be developed whereby the quality of the individual's experience of their Support Plan is evaluated alongside the effectiveness of the package in delivering on individually established outcomes. This too will need to be undertaken as a partnership between the individual and the local authority and we will need to ensure that lessons learned from people's experience not only trigger improvements in the design or operation of the plan for that person but feed directly into the Council's continuing improvement of its Self Directed Support systems.

8.2 In summary a Personal Budget should:

- Give people a clear, up front idea of how much money is available to them for their support
- Make assessment simpler, more transparent and a real conversation with the individual
- Bring together support from various agencies and funding streams

- Offer people good support to plan what they want and organise it

- Let people use the money in ways that best suit their own situation and meet the outcomes they have prioritised and agreed

- Be dynamic and regularly reviewed

- Not cost the local authority any more

9. Challenges for Brighton and Hove

9.1 The kind of radical shift anticipated in this paper will require significant re-engineering of methods and tools currently in use in delivering social care and the nature of the Council's relationships with partners, suppliers as well as individual customers. It entails major changes in organisational culture in the Council and in significant partner agencies. Although it can be anticipated that these changes will be welcome to a majority of staff (returning social care to what many people perceive as its proper core values), the challenge is complex and demanding. Securing financial stability and business continuity while progressing change is critical to a smooth transition from the existing system to a new one. Although Self Directed Support should be achieved within existing resource levels, the change process will not necessarily be cost neutral in the shorter term. Part of the challenge will be to construct a strategic financial plan whereby resources are transferred in a managed and progressive way between provided care and self directed support.

9.2 In particular a series of major considerations will need to be thought through and interwoven as strands of the Implementation Plan which will follows through on this strategy's intentions and objectives. These will include:

10. Implications for Market Management and Commissioning

10.1 Commissioners in the statutory sector will need to play a leading part in making self directed support work – both in terms of the type and scope of the contracts made with providers and in ensuring that the right range of supports (information, advocacy, brokerage, care management) are in place to enable people confidently to take purchasing decisions and plan and organise their support. This will be, to some extent, about extending

customer led services that are already in place – those purchased by self-funders who bring their own resources. What people will need – and commissioners will have to facilitate, is access to good, accessible information about what they might buy and a genuine market place which offers a range services, none of which take away form the opportunity to be with friends, family and part of the community.

10.2 The Council will need to have plans for transforming the way directly provided services operate – they will need to be attractive to people to choose in a self directed support environment. Plans may need to be very careful drawn up for reducing capacity in some services where demand falls because of individual choices to purchase elsewhere. Evidence from national pilots suggests that this is most likely to be in day services and, over time, in home care, respite and care homes.

10.3 For providers too, Self Directed Support is a challenge and an opportunity. Many of them are already working towards individualising their services but for many too the shift will provoke review of objectives and culture as well as operational development questions as to how they respond to growing demand for an increased number of options available to individual budget holders. As self-funders can do now, individual budget holders will be able to 'exit' a service if they are dissatisfied. Self Directed Support will bring business opportunities for new providers and new styles of agency such as social enterprises.

11 Support Planning

11.1 The Council will need to be clear about who will be doing the support planning - options will include care managers or an independent brokerage service – consumers might want these and other options to be available. Independent services may be commissioned by the local authority but with a view to them becoming self financing as they are offering support to people who will, in effect, be funding their own care. The Council may have a role too in supporting individuals and informal networks (friends, family) to gain the skills to help someone to plan support and manage a budget.

11.2 A great deal of work is going on currently to re-specify the support service for Direct Payment users and exploring with our partners, future options for a comprehensive independent living support service/centre for the city. Functions which are

complementary: support, advocacy, brokerage must nevertheless be clear and distinct and able to operate objectively on a user's behalf. The Council and its partners will need to develop an integrated plan for how these functions are commissioned and work together to ensure best practice in maintaining choice and control for all service users – including self funders.

11.3 The Council will need to establish a robust process for statutory sign off of support plans and for agreeing risk enablement arrangements in all cases. It will also need to consider how this process links to Single Assessment Process, Carers Assessments and Supporting People Assessments.

12. Workforce and Systems Development

12.1 The Council will need to think through the changes involved for its staff and the staff of key partners in the move to Self Directed Support which will involve extensive consultation. Different roles will require new competencies - particularly for care managers. The training and development needs of staff, managers and partners will need to be identified and addressed systematically as an instrumental part of the shift in organisational culture which will be entailed putting self directed support at the centre of our work. This will be a key part in the forthcoming workforce development strategy.

12.2 It will be necessary to review current assessment and care management arrangements to ensure that they evolve to facilitate the new agenda –ensuring that self directed support mechanisms are knitted into all relevant aspects changing policy and practice which are being developed as part of the ASC Personalisation Programme.

12.3 Self directed support and the resource allocation system in particular will necessitate amendments to the financial process and systems. It will also be incorporated into the redesign of the ICT Carefirst database and recoding system.

13. Performance Management

13.1 Consideration will also need to be given to how managing the quality of services and the collection of good data are maintained when services are chosen and controlled by individuals and delivered through a far more extensive network of new and established providers, micro agencies and through individually commissioned packages than has been the case

hitherto. There will also be the challenge of reporting in against the new CLG Performance Framework for Local Authorities – the National Indicator Set – and through the LAA where Self Directed Support is one of the 35 high profile and close scrutiny targets in the newly negotiated LAA 2008 - 2010.

14. Communications

14.1 Given the scale and likely impact of the changes envisaged in this strategy a communications action plan will be developed as part of the overall implementation plan for the strategy. This will identify key audiences and messages and ensure that SDS is positioned as central to the 'new' service being developed though the Personalisation Programme. Emphasis on accessible, good quality information and support to use is critical to the success of self directed support.

15. Equalities Impact Assessment

15.1 A full EIA will be undertaken as an early priority. In addition it should be an underlying principle of the approach that ongoing EIA is in place to identify and challenge any adverse impacts on individuals or groups, ensuring consistent equality of outcomes for all service users. The communications plan for the strategy and programme should specifically address any identified minority audiences and make provision to ensure equality of information, appropriate support and access to such groups. The programme will consult with users and representative agencies to ensure that such potential differential impacts are anticipated, quickly identified in practice and effectively monitored.

15.2 We can build upon the acknowledged positive impact Direct Payments have had on the lives of individuals from minority communities. Such as the ability to employ an individual who uses the same first language as the service user. Locally, we have a growing awareness of the needs of the Lesbian, Gay, Bi-Sexual and Transsexual communities, and some of the perceived fears of accessing Adult Social Care services. The ability to purchase a personal service, has been received positively as a preferred option for individuals. The personalisation agenda is directly linked to the goal of reducing inequalities in the city.

16. Governance and Programme Management

16.1 Robust leadership and governance arrangements will need to be in place to deliver a comprehensive model of self directed

support. The broad changes identified in this strategy will need to be directed by a Partnership Board –to build on and integrate the work of the existing Direct Payments Implementation Group and chaired by the Director of Community Care. This cross sectoral Partnership Board will report to the Director of Adult Social Care and Housing to ensure the project is fully integrated into the overall Personalisation Programme and supportive of the Community Strategy and the Local Area Agreement. The Implementation Plan will detail the brief and make up of the inter-agency task groups which will undertake workstreams including: Information, Advice and Support for SDS Users, RAS and SDS systems, Workforce Development, Risk Enablement and Managing Choice, Commissioning, Contracting and Financial Planning, Performance Management Systems and Evaluation.

16.2 Neither the scale of the work involved in achieving the strategic objectives introduced in this strategy nor the complexity of some of the challenges involved to this Council, is to be under-estimated. An early task should be a review of present internal resources within the relevant officer teams across the Council which will need to work together both at strategic and operational levels to deliver the transformation to self directed support. This means looking not only at the small established Direct Payments team located in Adult Social Care, but also at staff roles and infrastructure budgets in other Divisions and Directorates – most obviously in LD services and in CYPT. The objective must be to integrate developing work on Self Directed Support across the Council and build a dedicated lead team with appropriate access to additional expertise and support to acquit the ambitious work programme involved.

17. Where are we now?

17.1 Brighton and Hove City Council already operates a Direct Payments service for social care users. If someone is assessed as eligible for adult social care and decides that they want to receive that in the form of a Direct Payment, they are supported to open a separate bank account and money is transferred into that account so that they can pay for the care provision of their choice. Support can be provided by a private or voluntary agency or they can recruit and employ their own carer(s). People are not able to use direct payments to pay for a Council service. The Council ensures support for people to help them take up the direct payments option through a commissioned user support service at the Federation for Disabled People.

17.2 Direct payments are proving popular nationally and proving cost effective for local authorities that are making a major commitment to their promotion and use. In Brighton and Hove progress has been slow however and we remain one of the poorer performing authorities in the country on this increasingly important and visible measure. There are currently 190 DP users in the city. However a successful improvement plan is in place.

17.3 The work to grow the scale and quality of the support service to DP users is well underway and once our strategic intentions for self directed support are clear and agreed, the scope of that development work will be extended accordingly. This will necessarily entail development consultations and discussions with a range of current and potential strategic and delivery partners, as well as the Federation.

17.4 This last year has also seen an exciting initiative on Personal Budgets within Learning Disability Services in the City Council where a pilot is underway to test out PBs with a small group of LD service users.

18. Carers

18.1 The personalisation agenda presents new challenges for carers and we will seek to ensure their needs are embedded in the practical development and implementation of this strategy. The general concerns being raised by carers groups nationally relate to the need to ensure that SDS does not increase their burden of care. It will be essential that support services are available for those who request them, and not assume that a carer will take on the responsibilities of managing PB's or DP's. The potential positive impact for carers is that their needs can also be addressed through SDS as well as those of the person they care for. Personalised care options can be used innovatively to enable carers to return to employment as well as the more traditional care relief. It is vital that we work in partnership with carers and representative organisations locally, to make sure carers' needs are addressed and their perspectives integrated into self directed support development locally.

19. Active Involvement of Service Users

19.1 It is paramount that the voice of service users is heard and listened to within the development of this strategy – and at all levels. Their experiences of current services, including Direct Payments, will enable us to develop the strategy with a service

user perspective. The challenge will be to provide a range of activities which will enable service users to influence the strategy. To more from a professional gift model to an empowerment citizenship model, without a full commitment to involving service users, would seriously undermine this strategy. We can build directly on the service user involvement facilitated for the improvement of Direct Payments locally, and grow a range of opportunities for services users and carers to be active partners. Arrangements are already being made to ensure user voices and issues are instrumental in partnership and governance structures that will drive how we set about the self directed support transformation in Brighton and Hove – to make sure that the way we deliver SDS in the city meets the distinct needs of our citizens and carries their support and ownership.

ADULT SOCIAL CARE & HEALTH CABINET MEMBER MEETING JOINT COMMISSIONING BOARD	Agenda Item 23 Brighton & Hove City Council

Subject:		Fairer Contracting		
Date of Meeting:		11 September 2008 15 September 2008		
Report of:		Joy Hollister Director of Adult Social Care and Housing Amanda Fadero Director of Quality & Engagement Brighton & Hove Primary Care Trust		
Contact Officer:	Name:	Jane MacDonald Service Improvement manager	Tel:	01273 295038
	E-mail:	jane.macdonald@brighton-hove.gov.uk		
Key Decision:	Yes	Forward Plan No. 7 Digit Ref: ASC 3345		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 In March 2008 the Adult Social Care Committee and Joint Commissioning Board approved that Brighton & Hove City Council and Brighton & Hove City Teaching Primary Care Trust (PCT) will undertake joint work to produce a further Report on Fairer Contracting with recommendations to return to members. This is in line with recommendations in the Joint Commissioning Strategy for Older People 2007-10.

2. RECOMMENDATIONS:

2.1 This Report is seeking in principle agreement of the Cabinet member for Adult Social Care and Health to the proposals listed below:

a) The new Joint Council and PCT pre placement contract for both residential care homes and care homes with nursing from 1 April 2009
b) The Preferred Provider Scheme which is included in the contract
c) Individually negotiated fees
d) The Incentive Scheme

3. RELEVANT BACKGROUND INFORMATION/ KEY INFORMATION

3.1. Background

3.2. *Quality*

Following lessons learned in local commissioning/contracting projects last year, it is clear that new processes are needed to drive up quality in care homes for older people and older people with mental health needs. Currently the Council and PCT pay those care homes that provide excellent or good care the same as those that are providing adequate or poor care. There is also a national impetus to improve users' experience in care homes. These initiatives coincide with unprecedented local activity in the care home market and it is expected that there will be improved bed capacity in the city within the next eighteen months. Monitoring of the market will continue, particularly in light of the current slowdown in the economy and impact on building projects.

3.3 *Fees report*

A Report with recommendations for Fee Rates to Care Homes will be presented later in the financial year and it is acknowledged that this will have a significant bearing on how Fairer Contracting is regarded by providers.

3.4 *National picture*

Around a quarter of local authority respondents to a recent survey (CCMN Annual survey of UK local authority baseline fee rates 2008-9) reported that they paid fees based on quality criteria. Laing and Buisson report that the actual number of local authorities with fees related to quality is likely to be closer to half and this may rise to three quarters by the beginning of the next financial year. (Laing and Buisson 2008)

3.5. Joint Council and PCT Contracts

The recommendation is for two new Council/PCT contracts, one for care homes with nursing and one for residential homes. These are based on an updated Council pre placement contract which includes details of the Preferred Provider Scheme. The updated contracts have new service specifications which are based on recommendations from the Care Service Improvement Partnership Agency.

3.6. Preferred Provider Scheme

3.7. *Overview*

The recommendation is for a Preferred Provider Scheme. This ranks care homes in the city according to quality. This quality is determined by the CSCI rating, and for nursing homes it will also include clinical standards as audited by the PCT.

Care homes on the Preferred Provider Scheme will be entitled to various benefits including preferred rates. The fees report, detailing the recommended fees to be paid to providers will be brought to Cabinet members later in the year.

A Prioritisation Protocol will be used to ensure that vacancies are filled using either the home that the service user requests or the best quality home available on the Preferred Provider Scheme. Details of the Preferred Provider Scheme will be published on the Council and PCT websites.

3.8. *Eligibility*

The Preferred Providers Scheme is open to all care homes for both older people and older people with mental health needs in the city. In order to be included on the Preferred Provider Scheme a care home must be rated **2** or **3 star** in their most

recent CSCI inspection. Additionally nursing homes must deliver clinical standards that are audited as good or excellent (**2** or **3 star**) by the PCT.

Nursing homes need to be rated **2** or **3 star** in CSCI **and** in their clinical standards to be accepted on to the Preferred Provider Scheme.

Care homes wishing to join the scheme must be able to agree the terms of the Council/PCT pre placement contract and willing to work in partnership with the Council/PCT. All care homes meeting the criteria will be accepted on to the Scheme as it becomes operational.

All care homes joining the Preferred Provider Scheme will be eligible for the Preferred rate for all **new** funded service users. Existing service users will remain at the previous rate. In April 2011 any service users at the previous rate in good or excellent homes will be transferred to the Preferred rate.

The intention is in time, to contract entirely with care homes on the Preferred Provider Scheme, unless a service user requests to be placed at a home rated as adequate. The Council and PCT will not place service users in poor homes. At present there are insufficient care homes rated 2 or 3 star to meet capacity, but this is expected to change by 2010.

Block contracts are not included in the Scheme. Currently there are three nursing homes where the Council block contracts a total of 88 beds. Two of the homes are rated good and the third is rated adequate. All care homes with block contract arrangements will be supported to improve/maintain the quality of care rating as good/excellent.

3.9. *Payments*

The same fees will be paid for both 2 and 3 star homes in order to keep the payments as straight forward as possible. This decision will be reviewed as the Scheme matures.

Preferred Provider rates will be paid for new residents from the date that a CSCI report, rating a home either good or excellent, is published. There is no differential rate between single and shared rooms on the Preferred Provider Scheme as the intention is to use single rooms whenever possible.

3.10. *Choice*

Self funders are able to choose the care home in which they are placed.

Council/PCT funded service users can elect to go to a specific care home rated with three, two or one stars. Their choice will take precedence over the Prioritisation Protocol. The Council/PCT will not make new placements at homes rated poor (with no stars). Service users will be made aware of the quality of care homes.

3.11. *Suspensions and re-admissions*

If a service provider ceases to be rated either 2 or 3 stars they will automatically drop from the Preferred Provider Scheme. This will result in placements not being prioritised and service users not placed at the Preferred Rate, although some service users may be placed at the non Preferred Provider Scheme rate.

If a care home is registered for both residential and nursing care, and there are issues with clinical standards sufficient to result in a suspension, the care home will be suspended from taking both nursing and residential placements.

If the home does not meet the requirement of the Scheme existing residents will continue to be funded at the rate at which they were placed. Similarly if a home rejoins the Scheme new placements will be made at the preferred rate with the existing residents' rates remaining at the rate at which they were placed.

If a care home does not conform to the Council/PCT's pre placement contract requirements, following all dispute resolution mechanisms, new placements will be suspended in the usual way.

3.12. Individually Negotiated Fees

Individually Negotiated Fees are agreed payments that reflect **specific** and **exceptional** care needs. There is an expectation that the majority of placements will be made at the set rate, however the care needs of an individual service user may merit an individual fee payable by either the Council (where it is a social care need) or PCT (for Continuing Healthcare).

If a home believes that they are entitled to these individually negotiated fees they must make the case to the appropriate commissioners, stating the reasons for the enhanced payment and the expected duration for it to be in place.

3.13. The Incentive Scheme

The Incentive Scheme gives Commissioners a tool to influence the market. It is based on the successful scheme operated by the Council's independent home care contracting. Homes engaging with specific initiatives such as promoting efficient hospital transfers or being part of a pilot scheme could be eligible for one off incentive payments. Homes rated as no star (poor), are not eligible for the Incentive Scheme; it is open to those rated one star and above. Incentive payments can be of varying size, and will be dependent on the specific task that is being incentivised.

4. CONSULTATION

4.1. Stakeholders

Stakeholders have been kept abreast of key developments in Fairer Contracting through regular briefing notes.

4.2. Care home providers

Throughout the Fairer Contracting process there have been regular meetings which have been attended by the Commission for Social Care Inspection, key care home providers and their representatives.

In May 2008 the Brighton & Hove Registered Care Homes Association hosted a meeting dedicated to Fairer Contracting that was attended by 34 care home owners/managers. A further meeting is planned for autumn 2008.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1. Financial Implications

Forecast expenditure in 2008/09 on nursing and residential care for older people and older people with mental health needs is £14.8 million.

The Fairer Contracting process is expected to improve quality and achieve Value for Money and is on accordance with best practice.

Fee options are being modelled to assess the likely cost pressure on the budget for 2009/10 onwards and recommendations on fee levels will be made in a separate report alongside the Adult Social Care and Housing budget strategy for 2009/10.

Anne Silley Head of Adult Social Care Finance Services 07/08/08

5.2. Legal Implications

The contracts referred to in this report are 'Part B' services for the purpose of EU procurement law and UK procurement Regulations, and therefore not subject to the full application of either. The Council is nevertheless required to comply with EU Treaty objectives of non-discrimination and openness in procurement, as well as comply with its obligation to seek Value for Money. The proposal for moving current providers over to the new Fairer Contracting method is capable of complying with this

requirement, as long as the approach to pricing is capable of withstanding Value for Money analysis. The Council must take the Human Rights Act into account in respect of its actions but it is not considered that any individual's Human Rights Act rights would be adversely affected by the recommendations in this report.

Sonia Likhari Contracts Lawyer 08/08/08

The proposals will enable the Council to ensure best value and informed choice for its service users and will therefore make the best use of its resources in order to meet its statutory duties to older people with care needs.

Hilary Priestley Senior Lawyer 11/08/08

5.3. Equalities Implications

An Equalities Impact Assessment has been carried out, and recommendations heeded.

5.4. Sustainability Implications

The new contracts have included clauses on sustainability eg use of email rather than paper based correspondence.

5.5. Crime & Disorder Implications

There are no implications for crime and disorder.

5.6. Risk and Opportunity Management Implications

A risk log has been maintained since the beginning of the project. There have been risks around identifying the Council finances for the Scheme. Currently finances are being modelled and recommendations will be made in the Fees Report.

5.7 Corporate / Citywide Implications

Fairer Contracting meets the Council's new corporate priority, 'Better Use of Public money'. It also met the previous priority of, 'prosperity' which is about developing a prosperous and sustainable economy.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Preferred Provider Schemes in use elsewhere in the country were examined. Providers' comments on alternative Schemes were considered.

6.2 There is the opportunity to do nothing. If this were the case it is unlikely that providers would have the resources or the impetus to drive up quality to the standards needed locally. The current good relationships between Commissioners and Providers would be damaged and the costs for Continuing Healthcare would remain high.

6.3 Fairer Contracting, by paying a fair rate with a fair contract is intended to secure local care home provision for local OP and OPMH. At the same time it is intended to drive up quality and make savings for the PCT. A cost pressure is likely to fall on the Council which will be assessed as part of the budget strategy for 2009/10, details will be provided in the planned Fees Report.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The recommendation is for a Joint PCT/Council contract. This will drive up quality by rewarding care homes that provide the best quality of care, and to cease placing service users in poor homes. Clinical standards, additional to CSCI standards will be used to rate nursing homes.

7.2 Stakeholders have been consulted throughout the Fairer Contracting process and are aware and largely in agreement with the recommendations.

SUPPORTING DOCUMENTATION

Appendices:

None

Background Documents

1. Fairer Contracting Report to the Adult Social Care Committee on 03 03 08

2. Fairer Contracting Report to the Joint Commissioning Board on 31 03 08

3. Laing and Buisson (July 2008) [Baseline Fees Survey 2008/09 – CCMN Special Report] Community Care Market News Vol.15 (4) pp 100-101