Brighton & Hove City Council

NHS Brighton and Hove

Joint Commissioning Board

Title:	**Joint Commissioning Board**
Date:	**9 March 2009**
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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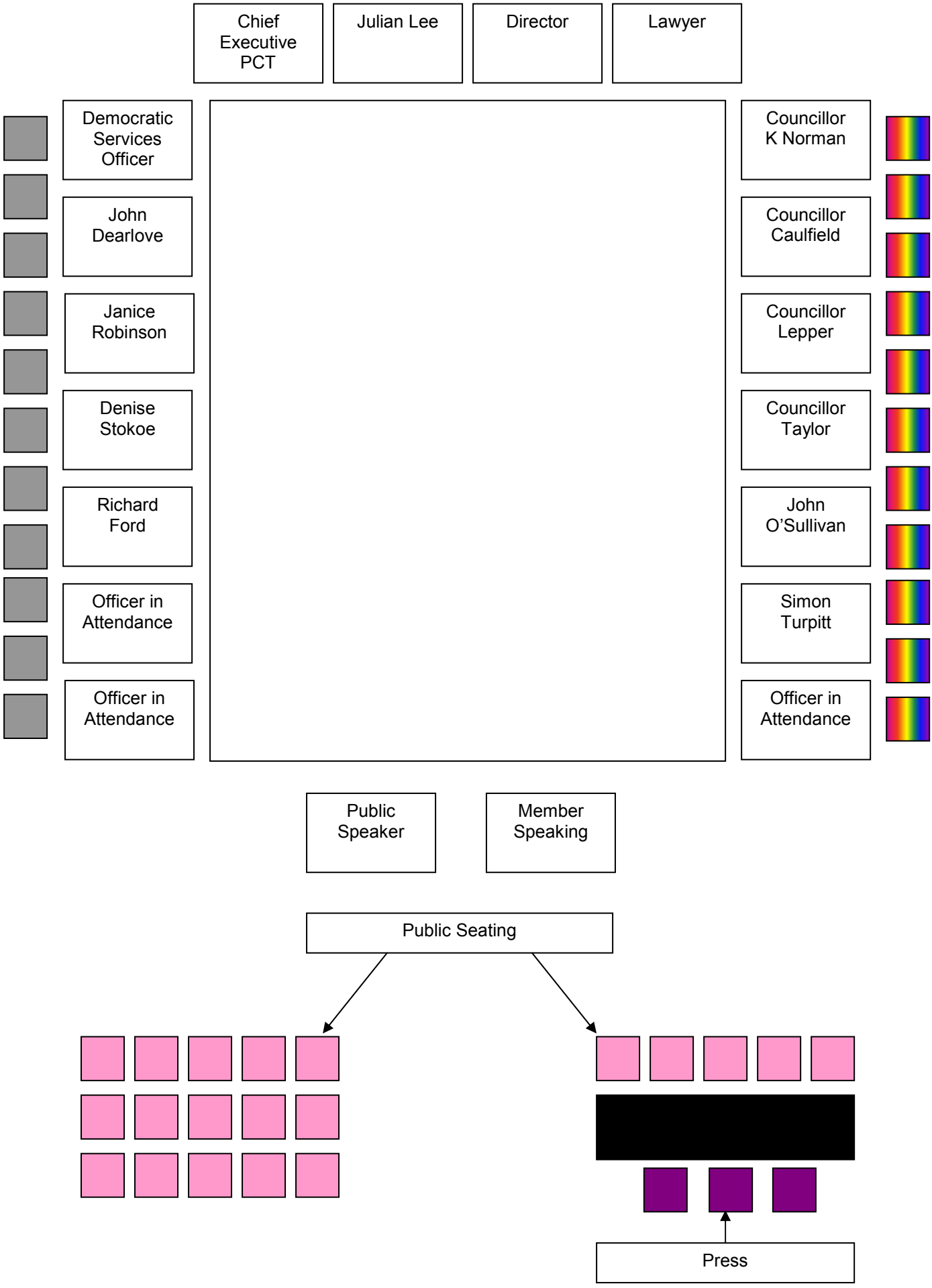

JOINT COMMISSIONING BOARD

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:
Councillor Jeane Lepper, Brighton & Hove City Council Councillor Keith Taylor, Brighton & Hove City Council Richard Ford, Sussex Partnership Trust Simon Turpitt, South Downs Health NHS Trust John O'Sullivan, South Downs Health NHS Trust

AGENDA

Part One **Page**

44. 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 either that it is confidential or 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 categories of exempt information is available for public inspection at Brighton and Hove Town Halls.

45. MINUTES OF THE PREVIOUS MEETING 1 - 6

Minutes of the meeting held on 23 February 2009 (to be circulated separately).

46. CHAIRMAN'S COMMUNICATIONS

47. PUBLIC QUESTIONS

(The closing date for receipt of public questions is 12 noon on 2 March 2009)

No public questions have been received by the date of publication.

48. FINANCIAL PERFORMANCE REPORT - MONTH 10 7 - 10

Report of the Director of Finance, NHS, Brighton and Hove (copy attached).

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

49. OLDER PEOPLE MENTAL HEALTH PLANNING FRAMEWORK 2009/10 TO 2011/12 11 - 80

Report of the Director of Strategy, Brighton and Hove City PCT (copy attached).

Contact Officer: *Kathy Caley* *Tel: 545467*
Ward Affected: *All Wards*

50. PHYSICAL DISABILITY STRATEGY - CHOICE, INDEPENDENT LIVING AND PERSONALISED CARE: A DRAFT STRATEGY FOR PHYSICAL DISABILITY SERVICES 2009-2012 **81 - 214**

Report of Director of Strategy, Primary Care Trust (copy attached).

Contact Officer: *Linda Harrington* *Tel: 01273 545439*
Ward Affected: *All Wards*

51. LEARNING DISABILITY PARTNERSHIP BOARD - ANNUAL REPORT **215 - 232**

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

Contact Officer: *Naomi Cox* *Tel: 29-5813*
Ward Affected: *All Wards*

52. DEPRIVATION OF LIBERTY SAFEGUARDS **233 - 244**

Report of Director of Adult Social Care and Housing and Head of Partnerships and Public Engagement (copy attached).

Contact Officer: *John Child* *Tel: 01273 296912*
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, 27 February 2009

JOINT COMMISSIONING BOARD	**Agenda Item 45** Brighton & Hove City NHS Teaching Primary Care Trust Brighton & Hove City Council

BRIGHTON & HOVE CITY COUNCIL

JOINT COMMISSIONING BOARD

5.00PM 23 FEBRUARY 2009

COMMITTEE ROOM 1, HOVE TOWN HALL

MINUTES

Present: Brighton & Hove City Primary Care Trust representatives:
Julian Lee (Chairman), John Dearlove, Janice Robinson and Denise Stokoe;

Council representatives:
Councillor Maria Caulfield, Cabinet Member For Housing
Councillor Ken Norman, Cabinet Member for Adult Social Care & Health;

Co-opted Members:
Richard Ford, Sussex Partnership Trust

Apologies: Councillor Jeane Lepper (Brighton & Hove City Council), Councillor Keith Taylor (Brighton & Hove City Council), Simon Turpitt (South Downs Health NHS Trust) and John O'Sullivan (South Downs Health NHS Trust) Darren Grayson, Chief Executive, Brighton & Hove City PCT and Simon Scott, Strategic Commissioner Mental Health & Substance.

PART ONE

38. PROCEDURAL BUSINESS

38 (a) Declarations of Substitutes

38.1 There were none.

38 (b) Declarations of Interests

38.2 The Director of Community Care, (Adult Social Care) declared a personal interest in Item 43 – Dementia Care at Home – Future Options Paper, as her son worked for the ICAST service.

38 (c) Exclusion of Press and Public

38.3 In accordance with section 100A of the Local Government Act 1972 ("the Act), the Board considered whether the press and public should be excluded from the meeting during an item of business on the grounds that it was likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present during that item, there would be disclosure to them of confidential information (as defined in section 100A (3) of the Act) or exempt information (as defined in section 100I(I) of the Act).

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

39. MINUTES OF THE PREVIOUS MEETING

39.1 **RESOLVED** – That the minutes of the Joint Commissioning Board Meeting held on 26 January 2009 be agreed and signed by the Chairman.

40. CHAIRMAN'S COMMUNICATIONS

40.1 There were none.

41. PUBLIC QUESTIONS

41.1 There were none.

42. SECTION 75 PARTNERSHIP BUDGET STRATEGIES 2009/10

42.1 The Board considered a report of the Director of Finance, Brighton & Hove PCT and the Director of Finance and Resources, Brighton & Hove City Council which updated members with respect to the proposed financial strategies for the health and social care elements of the S75 Partnerships in advance of the budget debate at Full Council on 26th February 2009. This included information about uplifts, identified budget pressures and efficiency savings to be met during 2009/10 (for copy see minute book).

42.2 The paper further outlined the council's Adult Social Care & Housing budget strategy and provided a more detailed break down of the budget to support the Learning Disability Commissioning Strategy previously discussed at Joint Commissioning Board. The paper also provided details of the NHS Brighton and Hove budget strategy.

42.3 Janice Robinson recognised that officers had a difficult job to do but said she would welcome more detail showing how reductions would be made. She would also like to know the impact of reductions on the service; for example, the loss of posts in the Learning Disability Service.

42.4 The Director of Adult Social Care & Health assured the Board that there was a great deal of detail in the report that had been checked by the Management Team. Posts had been deleted as a result of Value for Money surveys. Economies and efficiencies were in place where officers thought they could be made. Some efficiencies had been made because front line services were being improved and modernised. The Director

acknowledged that this process was not easy and that next year would present a greater challenge. There would be a need for closer partnership working.

42.5 Denise Stokoe expressed unease about targeting savings at self directed support and the personalisation programme. She asked if this was realistic. This could lead to cynicism in the public domain.

42.6 The Head of Supporting People & Lead Commissioner for Learning Disabilities explained that personalisation will reduce the anticipated costs for growth in services by preventing people being placed into inappropriate services when they are in crisis. In this way targeted services will provide the necessary "breathing space" while appropriate services that represent value for money are put in place. The Head of Financial Services reported that the Social Care Reform will support the personalisation programme including the administration of self directed support.

42.7 The Director of Adult Social Care & Housing stressed it would be necessary to manage the message about the whole transformation of adult social care. There would be a need to install an access point and sum up strategies. Changes would focus on prevention, value for money and customer care. Officers would bring a report to a future meeting of the Board on the government review of funding of social care.

42.8 The Director of Community Care explained that Value for Money and Personalisation would have an impact and that savings could be made.

42.9 Councillor Norman highlighted the need to inform the public about the changes in adult social care. The Chairman agreed that people became suspicious when they did not understand why change was taking place.

42.10 Janice Robinson was concerned that if the overall approach did not work it would be a risk for the PCT's finances. She asked if there was some way PCT officers could keep in touch with council officers.

42.11 The Director of Finance, PCT reported that resources would have to be pooled as times grew more challenging. The Head of Finance, Brighton & Hove City Council stressed that proposals in the report had been discussed with colleagues in the health service. The Director of Strategy PCT reported that she met with the Director of Adult Social Care & Housing on many occasions.

42.12 **RESOLVED -** (1) That the Adult Social Care & Housing directorate's budget strategy as set out in Appendix 1 be noted.

(2) That the budget strategies for the health and social care elements of the Section 75 arrangements as set out in Appendix 2, be recommended for agreement by Full Council and the NHS Brighton and Hove Board.

(3) That the detailed information provided to support the Learning Disabilities Commissioning Strategy set out in Appendix 3, be noted.

43. DEMENTIA CARE AT HOME - FUTURE OPTIONS PAPER

The Special Circumstances for non-compliance with Council Procedure Rule 23, Access to Information and Section 100B(4) of the Local Government Act as amended (items not considered unless the agenda is open to inspection at least 5 days in advance of the meeting) are that the legal implications of the report had not been finalised in time for the despatch of the agenda.

43.1 The Board considered a report of the Director of Strategy, Brighton & Hove City PCT which set out options for the future of Dementia Care at Home (DCAH) Service (for copy see minute book). The paper recommended the approval of option four – cessation of the modified DCAH service with the existing ICAST service enhanced, utilising the skills and capacity of the existing DCAH staff. Details of all the options, with benefits and risks for each, were outlined in the report.

43.2 Denise Stokoe stressed the importance of the evaluation of the enhanced ICAST service. She made the point that although there may be a successful pilot, it might not be realistic to have a full scale service.

43.3 The Lead Commissioner, Older People, PCT advised that a detailed service specification would be developed for the proposed new service and would include robust monitoring and evaluation criteria.

43.4 The Associate Director, Older Peoples Mental Health, SPT explained that evidence had shown that early intervention could extend the period a person could remain living in their own home.

43.5 Janice Robinson asked for assurance that money diverted into the service had not been lost to people who needed to go into residential care. The Director of Community Care replied that this was not the case and that there was a community care budget that funded people in long term care.

43.6 Janice Robinson stressed the importance of a very precise evaluation study. She wanted officers to ensure that the service was constructed showing who received it, who did not receive it, and the length of delay in long term care.

43.7 The Lead Commissioner, Older People explained that national and local policy developments, in particular the emerging outcomes of the National Dementia Strategy would be reviewed and inform the development of the local service. It was also hoped that this would be a two way process and that the Brighton and Hove service would also contribute to this emerging national and regional evidence.

43.8 Richard Ford welcomed the proposals and conveyed thanks to all involved in this work. He considered it important to review the proposals in six months time in light of the National Dementia Strategy. He stressed the need for early intervention for people developing dementia. This should fit into the whole service model for the city. Other services should also be reviewed.

43.9 Councillor Norman endorsed the proposals and considered that they fitted in well with other priorities and strategies such as the personalisation programme.

43.10 **RESOLVED -** (1) That option four be approved (cessation of the modified DCAH service with the existing ICAST service enhanced, utilising the skills and capacity of the existing DCAH staff). Most of the staff employed by DCAH will be transferred to the 'Enhanced ICAST' service, with only three RMNs redeployed into other services within SPFT. This will ensure that the skills of the existing workforce are retained.

(2) That it be agreed that a service specification will be drawn up for the Enhanced ICAST service to ensure that clear outcomes are specified and performance can be appropriately monitored. This will be completed in time for the start of the next financial year. Once the service has been operational for six months, a full evaluation will be carried out, and commissioners will decide whether or not to tender the service at that point. A paper will then be brought to the JCB, setting out the recommendation for the future of the service.

The meeting concluded at 5.33pm

Signed Chair

Dated this day of

JOINT COMMISSIONING BOARD	**Agenda Item 48** Brighton & Hove City NHS Teaching Primary Care Trust Brighton & Hove City Council

Subject:		**Financial Performance Report – Month 10**		
Date of Meeting:		**9th March 2009**		
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 10, and the forecast year end outturn. It highlights emerging pressures and sets out plans to address these.

2. RECOMMENDATIONS:

2.1 Board members are requested to note the financial position of the pooled budgets - forecast at breakeven – and the actions underway to manage the pressures within the system;

2.2 Board members are requested to note the conclusion of the procurement of the substance misuse and community alcohol services tender, and the award of the contract for the delivery of the service to Sussex Partnership NHS Foundation Trust.

3. RELEVANT INFORMATION:

Year End Forecast 2008/2009

3.1 The table below sets out the budget for the financial year. 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 previously, 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 during the 2009/10 financial year – and the forecasts are those of the PCT, drawing on information provided by the provider bodies, rather than those of Sussex Partnership Trust.

M10 Forecast Outturn Variance by Client Group:	SDH	SPT	PCT	BHCC	Total
PCT Pool:	**£000**	**£000**	**£000**	**£000**	**£000**
HIV/AIDS Services Client Group	(31)	-	-	-	**- 31**
Intermediate Care Services Client Group	(238)	-	-	-	**- 238**
Older People's Mental Health Services Client Group	-	(120)	-	-	**- 120**
Substance Misuse Services Client Group	-	46	-	-	**46**
Working Age Mental Health Services Client Group	-	559	-	-	**559**
Integrated Equipment Store	115	-	-	-	**115**
	(154)	**485**	**-**	**-**	**331**
Council Pool:					
Learning Disabilities Services Client Group	**-**	**-**	**-**	**64**	**64**
Total Pool Forecast	**(154)**	**485**	**-**	**64**	**395**
Application of Risk Share	**n/a**	**(300)**	**n/a**	**n/a**	**(300)**
Savings/ Recovery Plans	**154**	**(185)**	**0**	**(64)**	**(95)**
Forecast Outturn at Month 10	**-**	**-**	**-**	**-**	**-**

3.3 The position on the South Downs Health-led services remains positive and consistent with previous reports, with a forecast underspend on the intermediate care services client group offsetting a pressure on the integrated equipment store.

3.4 The position on Learning Disabilities has remained consistent with the previous forecast, with a forecast overspend of £64,000. There is an element of risk within this forecast, however, as the LD team are awaiting the resolution of a number of continuing care cases. However, the City Council remains confident of delivery of the year end position of break-even. Neither the City Council nor the PCT are anticipating the contribution of additional funds to this service.

3.5 The position on mental health and substance misuse services is complex, and has slightly improved since the last forecast. As last month, the operation of the

risk share agreement reached between Directors of Finance is shown for transparency. Following return of the commissioning underspend in 2007/2008, SPT has committed to meeting a £300,000 forecast overspend overall and to ensuring that service pressures are constrained. SPT, with the support of officers in the City Council, continues to forecasting a significant reduction in the service pressures around older people and substance misuse, although the pressures on the working age adults service remain as previously reported.

3.6 The recovery actions on older people's care group mean that a net underspend of £120,000 is forecast for the year end. For substance misuse, the forecast pressures have been reducing due to much improved care package monitoring, but a small overspend remains likely.

3.7 This does leave a residual pressure with the provider of £185,000 which must be addressed by the end of the financial year. Sussex Partnership Trust have committed to meeting this pressure and have confidence about the delivery of the remaining elements of the financial recovery plan. The two key drivers of the anticipated recovery are (a). an increase in the submitted claims for Housing Benefit for relevant clients, which is anticipated to provide backdated income towards the end of the financial year, and (b). a change in the purchasing arrangements for a number of high cost placements. The City Council and the PCT are working closely with the provider to ensure continued delivery of the financial recovery plans.

Procurement of Substance Misuse Service

3.8 The PCT has now completed the retendering for the Tier 3 Substance Misuse and Community Alcohol services, currently provided by Sussex Partnership Trust. The PCT Board has now considered the results of the procurement and approved the award of the contract to Sussex Partnership Trust. The Sussex Partnership Trust tender submission was of a high quality, and delivered value for money, and Sussex Partnership Trust has committed to a number of significant service improvements, including delivery of the new acute brief interventions project. The retendering exercise has provided valuable intelligence on the market for mental health service provision, and has delivered a strengthened contractual basis for an improved service, from a service provider rated 'excellent' by the Healthcare Commission.

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 2008/2009.

Finance Officer Consulted: Michael Schofield/ Nigel Manvell Date: 24 February 2009

5.2 Legal Implications:

The report sets out how the Council and its health partners propose to manage the pooled budgets over the forthcoming financial year. In managing any budget pressures the partners must ensure that they retain the ability to meet their statutory duties to service users. There are no other specific legal/human rights implications which arise from this report.

Lawyer Consulted: Hilary Priestley Date 24 February 2009

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.

JOINT COMMISSIONING BOARD	**Agenda Item 49** Brighton & Hove City NHS Teaching Primary Care Trust Brighton & Hove City Council

Subject:		**Older People Mental Health Planning Framework 2009/10 to 2011/12**		
Date of Meeting:		**Monday 9th March 2009**		
Report of:		**Director of Strategy, Brighton and Hove City PCT**		
Contact Officer:	Name:	Kathy Caley	**Tel:**	01273 545467
	E-mail:	Kathy.caley@bhcpct.nhs.uk		
Key Decision:	Yes	Forward Plan No. (JCB 8281)		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The existing Older People Mental Health (OPMH) commissioning strategy (2005-2008) has been refreshed in line with national and local policy developments. The OPMH Planning Framework 2009 - 2012 sets out the vision for the future development and commissioning of services to support older people with mental health needs, and their carers, in Brighton and Hove. It is a joint framework across Brighton & Hove PCT and Brighton & Hove Local Authority. The planning framework and three year action plan are attached as appendix 1. In twelve months time, when year one of the action plan has been implemented, the framework will be updated and a full commissioning strategy will be published. The framework sets out the work that will be undertaken to allow robust commissioning decisions to be made. The commissioning strategy will be a comprehensive document, incorporating all of the scoping work undertaken in the first year. This will assist in setting the priorities for future years. It is envisaged that the commissioning strategy will be a 'live' document, and will need updating annually in line with national and local policy developments.

1.2 The framework has been developed by commissioners working across Brighton and Hove PCT and Brighton and Hove Local Authority, in conjunction with service users/carers and individuals from local stakeholder communities. The key principles of the framework have been jointly developed by a local health economy stakeholder group and through a series of consultations and focus groups with service users, carers and voluntary and community sector organisations. In addition specialist clinical involvement from Sussex Partnership Trust has been provided throughout the development phase.

1.3 The OPMH Planning Framework Steering Group has overseen the development of the framework, and the OPMH Planning Framework Working Group has undertaken support work to assist the development of this document. Both groups are made up of key stakeholders across the local health economy.

1.4 An OPMH Implementation Group will be established to lead the delivery of the framework. Sub-groups will be developed to take specific areas of the action plan forward.

2. RECOMMENDATIONS:

2.1 (1) JCB approve the Brighton and Hove Older People Mental Health Planning Framework 2009–2012.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

Background

3.1 This framework sets out the vision for the future development and commissioning of services to support older people with mental health needs and their carers in Brighton and Hove, for 2009/10 to 2011/12.

3.2 The final report of the UK Inquiry into Mental Health and Well Being in Later Life[i] (2007) highlights that currently three million older people in the UK experience mental health problems, and that this number is set to increase by up to a third in the next 15 years. Nationally, this would represent a cost to the economy of approximately £250 billion, from both direct costs to public services, and indirect costs in lost contributions to the UK economy from older people who would otherwise support the economy as workers, volunteers, unpaid carers and grandparents providing childcare.

3.3 Brighton and Hove has 36000 people aged 65 or over. This equates to approximately 14% of the total population of the city. Historically, dementia and depression have been under-diagnosed, both locally and nationally. From a local perspective, action needs to be taken to address these current inequities and to ensure that all older people with mental health needs are supported to maintain independence and maximise outcomes and quality of life.

National and local drivers for change

3.4 Many relevant national policy documents have been published over the last few years. Some have a more general theme, on delivering health and social care, whilst others have focused on mental health and older people. Below is a summary of the key principles identified across the range of publications since the previous OPMH commissioning strategy was developed in 2005:

- Personalisation via use of individual budgets, direct payments and person centred planning to provide choice and control over services
- Partnership working and coordination between services to ensure joint planning and purchasing
- Services which promote reablement and maximise independence
- Reduce inequalities and develop services which promote health and wellbeing to all
- Improve quality of NHS education and training by developing an informed local workforce
- Build on service user and carer involvement and consultation to ensure inclusion in all stages of service development
- Service availability based on need and not age, and which promote dignity and respect

- High quality, value for money mental health service provision, using best practice models and specialist services where appropriate to promote good mental health, facilitate early diagnosis, and reduce stigma

3.5 Locally there are a number of policy developments which will drive changes to the provision of health and social care services for older people with mental health needs, for example, the PCT Strategic Commissioning Plan and the LA Adult Social Care Transformation Agenda. Relevant local developments have been incorporated into the planning framework.

Key objectives of framework

3.6 The objectives of the framework are to have older people mental health services which :

- are person centred and based on an individual's need
- promote choice
- support reablement
- maximise independence and quality of life
- reduce inequalities
- enable earlier diagnosis
- are of high quality
- maximise efficiency of capacity available within Brighton and Hove
- provide value for money

The commissioning recommendations set out in section four of the framework propose how these objectives will be met.

Expected Outcomes

3.7 The framework supports the development of services in line with best practice, across all mental health service provision, but particularly in the development of dementia services linked to the publication of a National Dementia Strategy. The recommendations set out in the National Dementia Consultation document have been incorporated into the framework. The final version of the strategy was published on 3rd February 2009, and the recommendations will be included in future service development.

3.8 By rolling out individual budgets and direct payments, the framework will give service users and carers choice and control over the services they use. Services will be developed to ensure they are appropriate, of high quality and personalised to meet the needs of individuals.

3.9 A key outcome of the framework is to reduce health inequalities across Brighton and Hove for older people experiencing mental health problems. Work will build on existing health promotion initiatives and support networks to ensure that there is equitable access for all within Brighton and Hove. Services to enable better recognition of mental health problems will be developed, with support once diagnosed a priority.

3.10 The framework will boost capacity and drive up the quality of long term placements for older people with mental health needs within the city. This will further develop the work which is currently underway to implement more robust contracting, the

development of a preferred provider and incentive scheme and targeted market development work.

3.11 Community and residential (both short and long term) services will be developed, to ensure they provide the most appropriate support for older people with mental health needs. Independence will be maintained and more people will be supported to remain in their own home for longer. There will be targeted interventions earlier in the care pathway and inequalities will be addressed. This should assist in reducing subsequent crisis, and the associated increased need for long term residential/nursing care.

Implementation

3.12 The three year delivery plan will be developed into an annual action plan during each year of implementation. The Older People Mental Health Implementation Group will oversee delivery against the annual action plan.

Financial expectations

3.13 The Primary Care Trust has indicated in the recent Strategic Commissioning Plan that it will be investing in both mental health and long-term conditions, for all service users, which will include older people with mental health conditions. However, both the Primary Care Trust and the City Council will, in future years, be operating with a tightened financial environment, reflecting changes in wider economic circumstances.

3.14 The broad assumption in financial modelling underpinning the framework and current commissioning plans is that future services will be delivered within the existing financial envelope. Current services will be re-designed where appropriate to optimise service user outcomes, meet policy requirements and deliver value for money. Any new resource allocation would be subject to business case development and approval.

4. CONSULTATION

4.1 The following consultation has been undertaken in the development of the draft framework:

- Briefing note on broad framework priorities sent out to all associated organisations e.g. Pensioner's Forum, Older People's Council, Health User Bank members and PCT gateway organisations.
- Input and feedback received from OPMH planning framework working group throughout development of framework
- Feedback on commissioning recommendations sought from Community Voluntary Sector Forum Mental Health Network on Thursday 13th November 2008.
- Focus group for service users, carers and representatives from associated organisations (Carers Centre, Federation for Disabled People Direct Payment mental health representative and Alzheimer's Society) held on Monday 8th December 2008 and follow up group held on Thursday 15th January 2009.
- Primary care long term conditions education session Tuesday 13th January 2009 – dementia strategy briefing and feedback session

Comments obtained during consultation have been incorporated into the draft framework.

4.2 The following consultation is planned for the future:

- Attendance at primary care locality education sessions to inform general practice of the priorities of the OPMH planning framework and emerging work streams
- Implementation/service development sub-groups to include service user, carer and associated organisation representatives

Feedback obtained from future consultation will be used to shape service developments.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The framework sets out the strategic objectives for delivering improvements in services for older people with mental health need, and their carers. The framework is expected to be delivered within health and social care budgets and assumptions within the medium term financial strategy however elements of the action plan may require further investment and will be subject to detailed business cases and a value for money approach.

Finance Officer Consulted:
Jonathan Reid, Deputy Director of Finance, NHS Brighton and Hove 02/02/09
Anne Silley, Head of Financial Services (Adult Social Care & Housing, Cultural Services, Strategy & Governance) 02/02/09

Legal Implications:

5.2 This report and in particular the three year delivery plan set out in detail the proposals for delivery of services within OPMH. That detail addresses how the proposed local framework is informed by national policy and acknowledges the need to meet the expected increasing demands on services whilst ensuring value for money; an essential element due to the duty owed to the public purse.

The proposed shift in emphasis to greater use of preventative services, promotion of healthy living and activity, proactive identification of those requiring services, early intervention and diagnosis and personalised approach to delivery of services including a greater uptake of Direct Payments and Personalised budgets promotes compliance with the Human Rights Act 1998. In particular Article 8 of the European Convention on Human Rights (ECHR), incorporated into the 1998 Act provides for the Right to Privacy and Family Life. Interference with this Right by a Public Body is only justifiable in certain circumstances; the proposals within the framework provide for less interference and recognises the need for an individualised approach. Caution must be exercised however in the promotion of the use of Direct Payments and Personalised Budgets to the extent of the impact of the level of the individual's capacity to engage, make decisions and comply with the requirements of Direct Payment Legislation. The application

of the Mental Capacity Act will assist practitioners in applying this element of the framework.

The report describes consultation undertaken to date and plans for further consultation. This is an essential element to ensure Fairness and to ensure compliance with Article 6 of the ECHR with provides for the Right to a Fair Hearing.

Focus on equalities not only complies with domestic legislation but ensures compliance with ECHR Article 14 (in conjunction with Article 8 Right to Family Life and Privacy).

The overarching elements of the proposed framework is to ensure the best delivery of services to include greater choice, inclusion and an increase in care at home. In implementing the framework practitioners and decision makers must also ensure consistent adherence to statutory requirements governing Community Care and provision of Mental Health services and treatment.

Lawyer Consulted: Sandra O'Brien 06/02/09

Equalities Implications:

5.3 An key aim of the framework is to reduce health inequalities across Brighton and Hove for older people experiencing mental health problems. Providing additional services for early diagnosis will enable improved support to be provided to service users and carers with the aim of preventing subsequent crisis. The work focused on improving the capacity and quality of long term placements within the city will result in higher quality care and fewer people needing to be placed outside the city, reducing existing inequalities in service provision.

A full Equalities Impact Assessment has been carried out as part of the development of the framework.

Sustainability Implications:

5.4 The framework aims to reduce the number of people placed in care homes outside of the city. By achieving this aim, there will be a reduction in the numbers of staff from the local authority travelling greater distances to review service users. Placing service users within the city will also mean that family and friends also have less of a distance to travel to visit individuals.

Crime & Disorder Implications:

5.5 There are no specific implications.

Risk and Opportunity Management Implications:

5.6 The final publication of the National Dementia Strategy was expected prior to the development of the OPMH planning framework. However, there was a delay in the publication, and the national strategy has only just been published (03/02/09). The National Dementia Consultation document has been used in the development of the framework. The OPMH planning framework will be reviewed in line with the National Dementia Strategy, with full implications included in the publication of the LHE OPMH Commissioning Strategy, in twelve months time.

The framework presents opportunities to meet other strategy priorities for the local health economy including reducing health inequalities and reducing delayed transfers of care

Corporate / Citywide Implications:

5.7 The aim of the framework is to ensure that all older people with mental health needs have equitable access to services, which support them to maintain their independence and quality of life.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 None considered

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The framework sets out proposals to ensure that older people mental health services in Brighton and Hove are provided in line with national and local policy direction.

SUPPORTING DOCUMENTATION

Appendices:

1. Older People Mental Health Planning Framework 2009 - 2012
2. Older People Mental Health Planning Framework Appendices

Documents In Members' Rooms

1. None

Background Documents

1. High Quality Care for All – NHS Next Stage Review Final Report (June 2008)
2. Healthier people, excellent care – A vision for the South East Coast (June 2008)
3. Putting People First – A shared vision and commitment to the transformation of Adult Social Care (2007)
4. New ambition for old age – next steps for NSF (2006)
5. Everybody's Business – Integrated mental health services for older adults (2005)
6. Age Concern – Improving services and support for older people with mental health problems (2007)
7. Transforming the quality of dementia care – consultation on a national strategy (2008)
8. Improving access to psychological therapies (2008)
9. A collective responsibility to act now on ageing and mental health (2008)
10. Age Concern – Undiagnosed, untreated, at risk – the experiences of older people with depression (2008)
11. Alzheimer's Society – Dementia – out of the shadows (2008)

[i] *Improving services and support for older people with mental health problems.* The second report from the UK Inquiry into Mental Health and Well-Being in Later Life. Age Concern (2007)

Brighton & Hove

NHS
Brighton and Hove

Brighton and Hove
Older People Mental Health Planning Framework 2009/10 - 2011/12

March 2009

Final Draft for Ratification

Contents

Executive Summary

Background

The Older People Mental Health (OPMH) Planning Framework sets out the vision for the future development and commissioning of services to support older people with mental health needs and their carers in Brighton and Hove, for 2009/10 to 2011/12. It has been developed by Brighton and Hove PCT and Local Authority in conjunction with individuals from various stakeholder groups.

Nationally, mental health in older people has been identified as a key priority area. If prevalence rates remain the same, the number of older people living with dementia and depression is expected to increase dramatically. Concurrently, actual prevalence rates for dementia and depression in older people are relatively low in comparison with expected prevalence figures. Only a third of people with dementia receive a formal diagnosis and only 15 percent of older people with clinical depression receive treatment.

In Brighton and Hove there are approximately 36000 people aged over 65, or 14 percent of the total population. Unlike the majority of the south east, and England as a whole, the percentage of Brighton and Hove residents aged over 65 is expected to decrease, with only a slight increase seen in the population aged over 85.

Purpose of Planning Framework

To identify and address the key issues for older people with mental health needs the framework:

- Identifies and reflects the key national and local policy developments since the previous strategy was drawn up
- Consults with local service users and carers to ensure they are involved in service development
- Provides an analysis of demand and capacity locally, and identifies areas where there may be gaps in service provision
- Sets the general direction of travel for OPMH services locally by proposing future commissioning recommendations which will:
    - Ensure services are person centred and needs led
    - Promote choice
    - Support reablement
    - Maximise independence and quality of life
    - Increase uptake of health promotion and prevention services
    - Enable earlier diagnosis
    - Drive up the quality of service provision
    - Maximise efficiency of capacity available within Brighton and Hove
- Takes into account other relevant local strategies being developed within Brighton and Hove
- Ensures the most effective use of resources
- Provides an action plan detailing how the recommendations will be taken forward over the next three years

In twelve months time the framework will be reviewed and updated with relevant information to allow a full commissioning strategy to be published. It is anticipated that the commissioning strategy will be a live document, subject to change linked to associated national and local developments, and will require regular updating.

Key Commissioning Recommendations

The table below summaries the key commissioning recommendations set out in the framework.

Care Pathway Area	Key Commissioning Recommendations
Overarching	- Expand use of individual budgets for OPMH services to increase choice and control - Services to promote reablement - Development work with service providers to ensure needs of individual are met regardless of age - Training programmes for all staff - Develop clear and concise referral pathways - Information and support services for service users and carers
Prevention/Health promotion	- Existing services to be advertised and promoted effectively - Services to reduce social isolation and prevent crisis - Strengthen support networks - Build on existing health promotion work - Effective links with working age mental health services on substance and alcohol misuse to prevent later mental health issues
Early Diagnosis and Support	- Services to enable accurate early diagnosis and treatment - Provide support for carers - Support and information available following diagnosis - Services to support health, independent and wellbeing - Services to prevent later crisis and avoidable admissions
Community	- Review of existing day services - Increase effective home care support - Specialist mental health support available to mainstream services to enable management of low to moderate mental health needs and to remove existing barriers to services - Short term community services to facilitate reablement
Residential/Nursing and Inpatient	- Increase capacity of high quality care homes, especially in OPMH nursing homes - Short term services to facilitate reablement, effective discharge and maximise outcomes - Remove age barriers to services, ensuring quality remains - Mental health support to mainstream acute services to better manage OPMH need - Partnership with potential new service providers - Reduce out of area placements not through choice
End of Life	- Link with local work ongoing in end of life strategy to ensure OPMH needs are adequately reflected - Older people with mental health needs given choice about where they die

Implementation of the Older People Mental Health Planning Framework

An OPMH Implementation Group will be established to oversee the implementation of the framework. Sub-groups will be developed to take specific areas of the action plan forward.

Section 1 – Introduction

This framework sets out the vision for the future development and commissioning of services to support older people with mental health needs and their carers in Brighton and Hove, for 2009/10 to 2011/12.

In twelve months time, when year one of the action plan has been implemented, the framework will be updated and a full commissioning strategy will be published. The framework sets out the work that will be undertaken to allow robust commissioning decisions to be made. The commissioning strategy will be a comprehensive document, incorporating all of the scoping work undertaken in the first year. This will assist in setting the priorities for future years. It is envisaged that the commissioning strategy will be a 'live' document, and will need updating annually in line with national and local policy developments.

1.1 Background

The final report of the UK Inquiry into Mental Health and Well Being in Later Life[i] (2007) highlights that currently three million older people in the UK experience mental health problems, and that this number is set to increase by up to a third in the next 15 years. If prevalence rates remain as they are now, the UK could have:

- Approximately 3.5 million older people with symptoms of depression severe enough to require intervention
- Approximately 1.6 million older people who meet clinical criteria for a formal diagnosis of depression
- Almost 1 million older people with dementia
- Estimated 91,000 older people with schizophrenia

Nationally, this would represent a cost to the economy of approximately £250 billion, from both direct costs to public services, and indirect costs in lost contributions to the UK economy from older people who would otherwise support the economy as workers, volunteers, unpaid carers and grandparents providing childcare.

Brighton and Hove has 36000 people aged 65 or over. This equates to approximately 14 percent of the total population of the city. Historically, dementia and depression have been under diagnosed, both locally and nationally. From a local perspective, action needs to be taken to mitigate the impact of this and to ensure that older people with mental health needs are supported to maintain independence and have a high quality of life. The previous Brighton and Hove OPMH commissioning strategy requires updating to reflect recent developments in policy, both nationally and locally.

1.2 Planning framework aims

The framework has been developed by commissioners working across Brighton and Hove PCT and Brighton and Hove City Council, in conjunction with service users/carers and individuals from local stakeholder communities.

The framework:

- Identifies and reflects the key national and local policy developments since the previous strategy was drawn up
- Consults with local service users and carers to ensure they are involved in service development

- Provides an analysis of demand and capacity locally, and identifies areas where there may be gaps in service provision
- Sets the general direction of travel for OPMH services locally by proposing future commissioning recommendations which will:
    - Ensure services are person centred and needs led
    - Promote choice
    - Support reablement
    - Maximise independence and quality of life
    - Increase uptake of health promotion and prevention services
    - Enable earlier diagnosis
    - Drive up the quality of service provision
    - Maximise efficiency of capacity available within Brighton and Hove
- Takes into account other relevant commissioning strategies being developed within Brighton and Hove
- Ensures the most effective use of resources
- Provides an action plan detailing how the recommendations will be taken forward over the next three years.

The Older People Mental Health Steering Group has overseen the development of the framework, and the Older People Mental Health Working Group has undertaken support work to assist the development of this document. See appendix 1 for Steering Group and Working Group members.

An OPMH Implementation Group will be established to oversee the implementation of the planning framework. Sub-groups will be developed to take specific areas of the action plan forward.

1.3 Scope of the framework

This framework encompasses both functional and organic areas of mental health for older people. However, with the publication of the first national dementia strategy expected in early 2009, and the local identification of dementia as an important area for attention in the PCT's Strategic Commissioning Plan, a large part of the development work for 2009/10 to 2011/12 will focus on dementia services.

Currently, the term 'older people' represents those aged over 65. People with mental health needs under the age of 65 are generally considered in 'working age' mental health policy developments. This framework is aimed at older people with mental health needs and their carers. It will also outline the need to address the interface with working age mental health services, particularly around young onset dementia.

1.4 Approach the framework will take

The framework looks at service delivery across the different aspects of the OPMH care pathway, for both functional and organic mental health needs. The points below summarise the framework priorities as agreed by the OPMH Steering Group. These priorities have been drawn up based on consultation with local stakeholders, and from national and local OPMH policy developments. The priorities are discussed in more detail in section four, where recommendations are outlined.

Overarching

- Link to ongoing work with other local strategies
- Fundamental principles of personalisation, choice and control to be reflected in all service developments
- Services to promote reablement, maximise independence and improve quality of life
- Services to be available on a needs basis rather than an age basis

- Reduce inequalities
- Training and support
- Provide clarification on roles, responsibilities and functions of all organisations
- Information and support to be easily available for service users, carers and public generally

Prevention/Health Promotion

- Prevent people from becoming susceptible to poor mental health by provision of services which promote good mental health

Early Diagnosis and Support

- Enhanced primary care support for early diagnosis of mental health problems and ongoing management

Community Services

- Community services to better support people to live independently and delay the need for more intensive, long term service provision.

Residential/Nursing and Inpatient services

- High quality capacity to be available in local care home market for those with ongoing long term care needs, reflecting the changing nature of type of care required and reducing the number of out of area placements not through choice
- The most appropriate capacity for respite care and short term/transitional services to be available

End of life care

- Support people to die in a place of choice

1.5 How the framework will be funded

The assumption is that future services will be delivered within the existing financial envelope. Current services will be re-designed where appropriate to optimise service user outcomes, meet policy requirements and deliver value for money. Any new resource allocation would be subject to business case development and approval.

Section 2 – National and Local Context

2.1 National drivers for change

Many key policy documents and papers have been published over the last few years. Some have a more generic theme, on delivering general health and social care, whilst others have focused on mental health and older people. Below is a summary of the key principles identified across the range of publications since the previous OPMH commissioning strategy was developed in 2005:

- Personalisation via use of individual budgets, direct payments and person centred planning to provide choice and control over services
- Partnership working and coordination between services to ensure joint planning and purchasing
- Services which promote reablement and maximise independence
- Reduce inequalities and develop services which promote health and wellbeing to all
- Improve quality of NHS education and training by developing an informed local workforce
- Build on service user and carer involvement and consultation to ensure inclusion in all stages of service development
- Services based on need and not age, and which promote dignity and respect
- High quality, value for money mental health service provision, using best practice models and specialist services where appropriate to promote good mental health, facilitate early diagnosis, and reduce stigma

A more detailed analysis of the key publications can be found in appendix 2.

2.2. Local drivers for change

Within Brighton and Hove there are a number of policy developments which will drive changes to the provision of health and social care services for older people with mental health needs. These include:

- PCT Strategic Commissioning Plan (2008 – 2013) which outlines key PCT priorities for the next five years. Priorities include a focus on dementia, reducing delayed transfers of care and reducing inequalities
- LA Adult Social Care Transformation agenda focusing on the personalisation of services and reablement
- Overarching provision of appropriate short term services, which meet the needs of individuals to maintain independence, facilitate discharge and maximise outcomes
- Development of local independent provider market
- Up to 200 new nursing home beds expected in the city in the next two years
- Integration of inpatient functional mental health services with working age mental health services

Section 3 – Needs Analysis

3.1 Population needs – now and in the future

3.1.1 Projected population figures for Brighton and Hove

The projected population pattern for Brighton and Hove is noticeably different to the general pattern within the south east, and England as a whole.

Chart 1 – Total population projection comparison for Brighton & Hove and England as a whole

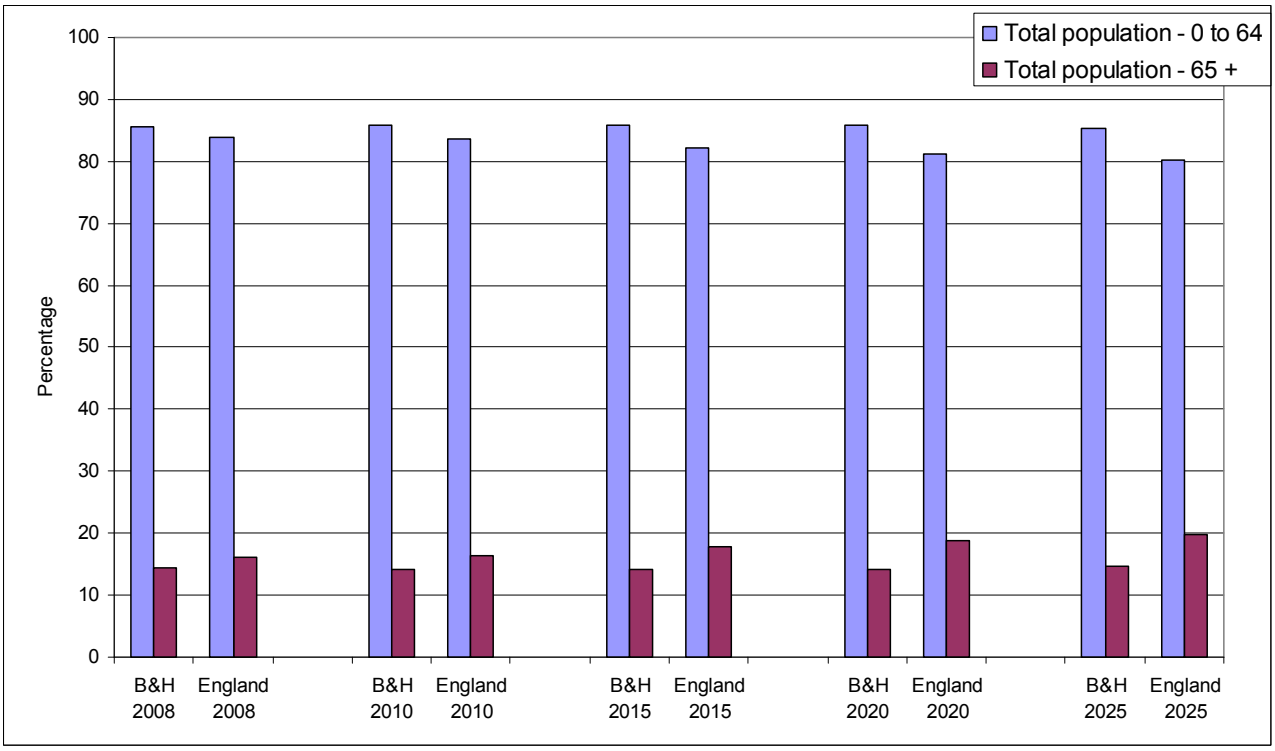
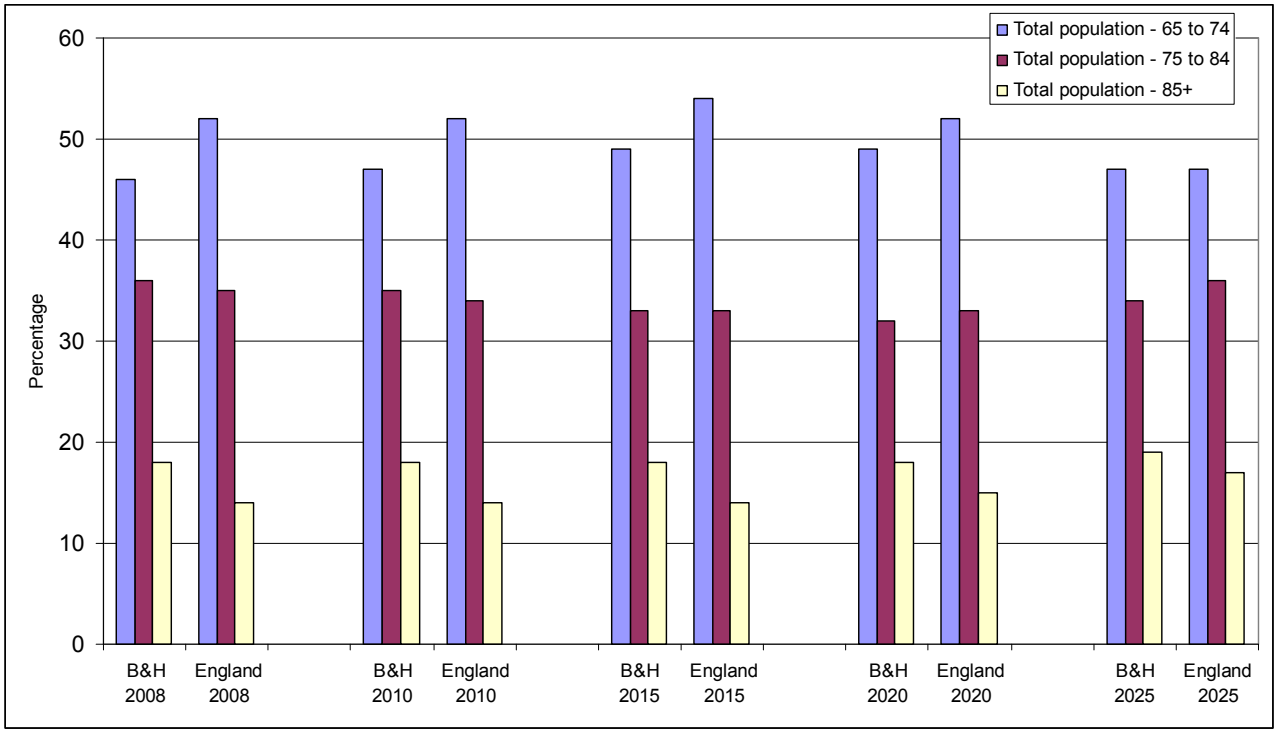


Chart 1 demonstrates that in 2008 the population breakdown in Brighton and Hove and across England is quite similar, with only a slightly higher percentage of people aged 0 to 64 in Brighton and Hove. However, the differences in the population projection by 2025 is more pronounced, with Brighton and Hove having approximately 5% more people aged 0 to 64[ii].

Chart 2 demonstrates that in 2008, Brighton and Hove has a smaller percentage of people aged between 65 and 74 compared to England as a whole, but that this is set to level out by 2025. Chart 2 also shows that in 2008 Brighton and Hove has a higher percentage of people aged over 85, and that the percentage of people aged over 85 will increase slightly by 2025, but this increase will be more noticeable across England. The differences between Brighton and Hove and England are not as pronounced for the 75 to 84 age range, but by 2025 Brighton and Hove will have a slightly smaller percentage of 65 to 74 year olds compared to across England[ii].

Chart 2 – Over 65s population projection comparison for Brighton & Hove and England



The data from charts 1 and 2 indicates that the rest of the country is expected to see considerable growth in the older population, where as Brighton and Hove will see a reduction in the percentage of the population aged over 65. However there will be a small increase in the total numbers of people aged over 65, but growth will be much greater in the working age population. See appendix 3 for full population figures.

Commissioning Implications

- The population projection for Brighton and Hove differs to other areas across England
- Locally the associated increased demand for residential/nursing homes will not be experienced in the same way as nationally. However, there are already identified capacity issues in OPMH nursing homes, and this will need to be addressed
- Whilst there will not be a vast increase in the percentage of older people in B&H, the total number of older people will increase, and this may create a greater demand for OPMH services.
- As many people within the 65 to 74 age band are often carers of partners or older relatives, having less people in these age categories could mean more of the people aged 85+ are reliant on health and social care services for support.

3.1.2 Older people housing in Brighton and Hove

The Older People's Housing Strategy is in development across Brighton and Hove. As people age health complications, financial difficulties and decreasing social networks can cause vulnerability. The housing strategy aims to increase well being and independence by improving the housing options available to older people and by tackling poor quality housing.

Evidence has indicated that living alone can have a detrimental affect on older people. The charts below indicate the percentage of those aged 65 to 74 and those over 75 living alone in Brighton and Hove[ii].

Chart 3 Percentage of 65 to 74 year living alone

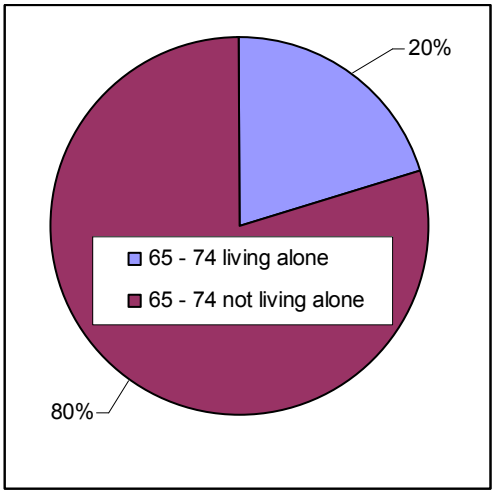
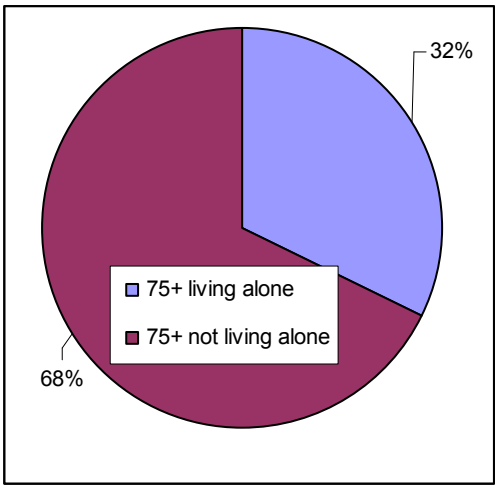


Chart 4 Percentage of 75+ living alone



N.B. POPPI website only gives information in the 65 – 74 and 75+ categories. Therefore it has not been possible to break down the information across the 75 to 84 and 85+ categories.

As displayed in the charts, a higher percentage of people aged over 75 live on their own. A report commissioned by Age Concern[iii] highlights that older people living alone:

- are more likely to report difficulties in accessing public services and amenities
- are more likely to experience loneliness
- report lower rates of satisfaction with life
- report higher rates of negative experiences of ageing (men only)

Living alone does not necessarily mean that an older person will have a poorer quality of life. If an individual is able to maintain extensive social networks, via friends and family, they are less likely to experience loneliness. However, it is possible that people living alone and encountering physical or mental ill health may have difficulties joining in with social activities. Therefore they may be less likely to have support networks and may become isolated.

The 2001 census looked at the housing tenure of older people[iv]. Table 1 displays the tenure figures for older people in Brighton and Hove.

Table 1 – Housing tenure for over 65s in Brighton and Hove

Tenure	**60 – 74 years old**	**75 – 84 years old**	**85+**	**Total**
Owner occupier	72.3%	64.8%	49.4%	67.2%
Shared ownership (part rent, part buy)	0.4%	0.4%	0.3%	0.4%
Social rented (Sheltered and general housing)	15.7%	17.9%	16.6%	16.5%
Private rented	8.3%	8.8%	9.1%	8.6%
Rent free (e.g. with friends or family)	1.9%	3.4%	3.8%	2.6%
Communal establishment (e.g. nursing or care home)	1.3%	4.6%	20.8%	4.8%

As demonstrated, the most noticeable change in housing tenure as people age is a reduction in the percentage of owner occupiers, and an increase in the percentage of people living in a communal establishment. As outlined in the draft older people housing strategy, is it thought that as people age they sell their homes, but due to a shortage of private sheltered or extra care housing schemes, the only option available to them is the move to a communal establishment. As this could result in a loss of independence, it is not considered to be the best option for many individuals.

Telecare is one form of support that can enable an individual to safely remain in their own home. CareLink Telecare is a service used in Brighton and Hove to support people in their own home. A range of devices are available including:

- alarm call pendants in case of a fall, accident or sudden illness
- bed occupancy sensors to indicate if a person does not return to their bed after getting up in the night
- temperature sensor which operates in extreme temperatures e.g. if hob has been left on
- flood detector in kitchen or bathroom which will raise an alert if something overflows
- property exit sensor which operates if a person leaves the property
- medication reminders

The Commission for Social Care Inspection (CSCI) telecare profile report for Brighton and Hove in December 2008[v] identified some barriers to people taking up the service e.g. requirement to have a telephone line and a key holder. Work is underway to resolve these issues, as well as looking at response services and alternative devices, to increase the success of the service.

Commissioning Implications

- Older people living on their own are more likely to experience isolation and loneliness, and difficulties engaging in community activities may add to this.
- The quality of a person's home is closely linked to their physical and mental health, and poor housing can result in reduced well-being, independence and quality of life.
- As individuals age, their housing requirements may change and inappropriate housing can increase depression and social isolation. A wide range of housing options will need to be available to meet the various needs, and information on the different housing options will need to be sufficiently available.
- To enable people to remain in their own homes, better support services will be required.
- Increased use of telecare may support more people to remain in their home

3.1.3. Ethnicity in Brighton and Hove

The ethnicity figures for Brighton and Hove indicate that in the population aged 65 and over, 96.25% of individuals fall into the '*White – includes British, Irish and Other White'* category. When looking at only those aged over 85 years, this increases to 99.14%[vi]. See appendix 3 for full figures. These figures would indicate that there are very small populations from ethnic groups other than 'white' in Brighton and Hove.

Nationally the figures are very similar to the local picture, as the census indicates that in the population of England, aged over 65, 97.08% fall into the 'white' group[vii]. However, it is expected that there will be a significant increase in older BME individuals in the next decade, as middle aged people reach retirement. This is likely to be replicated in Brighton and Hove.

The key challenges for older BME people include[vii]:

- having poorer health, particularly mental illness

- experiencing inequalities in income, wealth and housing conditions, which can impact on health and wellbeing
- being less likely to make use of health and social care services, and being less aware of what help is available
- cultural differences in expressing illness, which could be a particular issue for mental illness
- lack of data collection on the mental health of BME elders, which can make it difficult to plan appropriate services
- language barriers preventing an understanding of available services
- unfamiliarity with social care services, which may not exist in all cultures

Commissioning Implications

- The number of BME elders is likely to increase in the future as middle age people begin to retire. The services of Brighton and Hove will need to meet the requirements of these communities
- Existing services will have to be flexible to the specific needs of the BME community e.g. provision of leaflets in a range of languages/use of interpreters, etc
- Social marketing techniques could be used to target specific groups

3.1.4 LGBT population in Brighton and Hove

The 2001 census did not collect information on sexual identity, but anecdotal evidence indicates that as many as 40000 people identify as LGBT, or 21 percent of the total population, in Brighton and Hove[viii]. It is difficult to identify the numbers of LGBT older people living locally.

General research suggests that the health and social care needs of the older LGBT population are likely to be the same as other older people, but they may experience additional discrimination[vii]. A number of identified issues include[ix]:

- feeling highly stigmatised
- being frightened to be open about their sexuality to service providers
- service providers being embarrassed and ill informed

Commissioning Implications

- Awareness training for all staff in care homes and partnership working with relevant professional bodies could help to reduce discrimination
- A more detailed understanding of the needs of older LGBT individuals could help to identify additional service needs

3.1.5 Dementia in Brighton and Hove

The OPMH needs assessment undertaken in 2004 indicated that the most reliable source of UK prevalence data for dementia is the Medical Research Council's (MRC) Cognitive Function and Ageing study. Locally this method of assessment indicates that the expected number of people aged over 65 with some form of dementia in Brighton and Hove should be approximately **3261**. See appendix 3 for a breakdown of expected population with dementia in Brighton and Hove.

However, the total number of people currently listed on local GP practice registers as having dementia is only **937**. This would imply that in Brighton and Hove there are high numbers of individuals who have dementia, but are not yet diagnosed and included on GP registers. This could indicate an extensive area of unmet need.

These findings are echoed across other PCTs within the south east coast region as work undertaken by the SHA indications[x].

Commissioning Implications

- A large proportion of people with dementia are not currently diagnosed and registered on GP lists. It is therefore possible that they, and their carers, are not receiving vital support
- Early and formal diagnosis of dementia is a key focus area for the future
- The role of Primary Care should increase to reflect the high numbers of people anticipated to have dementia and to close the gap between the expected and actual prevalence figures

3.1.6 Young onset dementia

The Brighton and Hove branch of the Alzheimer's Society produced a report which sets out that the expected number of people with young onset dementia in Brighton and Hove should be **82**[xi]. However, other work undertaken by South Downs Health NHS Trust indicates a figure nearer to **190** people. This is an area that may require greater focus in the future to clarify the levels of local need[vi].

The term 'young onset dementia' applies to anyone aged under 65 who is diagnosed with some form of dementia[xii]. Approximately 15000 people in the UK have young onset dementia, and a third of these will have Alzheimer's disease.

Korsakoff's syndrome, although not officially classified as a form of dementia, is often included in the category of young onset dementia. Korsakoff's syndrome is caused by years of excessive alcohol consumption, and generally affects men between the ages of 45 and 65. Woman with a history of excessive alcohol consumption often develop Korsakoff's syndrome at a younger age. Symptoms include short term memory loss, difficulty in acquiring new information and problems in learning new skills[xiii].

Young onset dementia is also sometimes experienced by those with conditions including Parkinson's disease, multiple sclerosis, Huntington's disease and HIV/AIDS. Those with Down's syndrome and some forms of learning disabilities could also go on to develop dementia at a younger age.

Younger people with dementia may have similar symptoms to those of older people with dementia, but it is highly likely that their needs will be different.

Commissioning Implications

- Confirmation on the expected number of people with young onset dementia is required to allow for adequate future planning
- Liaison with working age mental health strategy to establish interfaces between services and ensure seamless care.
- Consideration should be given to the different needs of younger people with dementia

3.1.7 Depression

The NSF for Older People sets out that approximately 10 – 15% of people over 65 could have depression, and 3 – 5% could be experiencing a depressive episode[xiv]. Table 2 displays the figures for Brighton and Hove[vi].

Table 2 – Expected depression figures for Brighton and Hove

	Number of people in Brighton and Hove aged over 65
With depressive symptoms	Between 3900 and 5900
Experiencing a depressive episode	Between 400 and 2000

It is often difficult to have a clear picture of the total number of older people with depression, as it often goes undiagnosed. National figures indicate that only a third of older people with depression will actually discuss the issues with their GP. Of this third, only half will be diagnosed and receive treatment. This means that only 15% of all older people with clinical depression will receive treatment. It is possible that clinicians are not diagnosing more depression in older people as symptoms are dismissed as an inevitable consequence of ageing[xv]. It is therefore clear that action should be taken locally to ensure that diagnosis of depression in older people is a priority, and that clinicians are diagnosing appropriately, managing low level needs where possible to prevent later crisis and referring on to specialist services when necessary.

Evidence also highlights that people with long term physical health conditions e.g. diabetes or coronary heart disease, often experience depression[xvi]. Treating depression at an early point in the course of a long term physical health condition could result in a reduction in the need for future health service provision, in both physical and mental health service provision.

From the figures available it is possible to conclude that greater support services may be required to meet the high levels of older people who may be experiencing depression.

Commissioning Implications

- Education and training for primary care clinicians to ensure they are able to pick up depression in older people, can manage low to moderate mental health needs and know how to refer onto specialist services
- Health promotion activities to be targeted to reduce depression
- Treatment of depression to also focus on those with physical health needs, which will link in to the roll out of Improving Access to Psychological Services (IAPT). See appendix 2 for details of IAPT services. A local project is being lead by the Strategic Commissioner for Mental Health

3.1.8 Other functional mental health disorders

Table 3 displays the predicted figures for other functional mental health disorders, in those aged 65 and over in Brighton and Hove[vi].

Table 3 – Estimated figures for over 65s for other functional mental health disorders in B&H

Disorder	Estimated numbers in those aged over 65
Generalised Anxiety Disorder	1020
Phobias	49
Panic Disorder	232
Schizophrenia	115
Mania	39

The predicted number of people with other functional mental health disorders is relatively low in comparison to dementia and depression estimates. As a result, there is a risk that service developments in these areas may be neglected. It will be important to work effectively with the specialist services to clarify the number of people in Brighton and Hove falling into these categories and to ensure they are receiving adequate support.

There are many interfaces in OPMH services with working age mental health and substance misuse services. The pathways need to be needs based and not dependent on an individual's age. When individuals do need to transfer to older people's services the transition should be seamless. This needs to be explored in greater detail and clarity obtained on where services overlap.

Commissioning Implications

- Greater clarity required on the scale of functional mental health problems in older people in Brighton and Hove, and on whether services meet service user's needs
- Interfaces with working age mental health and substance misuse services to be addressed

3.1.9 Suicide

Brighton and Hove has a significantly higher suicide rate when compared to the population as a whole[xvii]. Each year in Brighton and Hove, approximately 38 people commit suicide. Suicide rates in older people have been falling since the 1950's however, they are still relatively high in older men[xviii]. Suicide in older people is linked to depression, physical pain, long term illness and living alone. It has been found that most older people who commit suicide have no contact with psychiatry services, and tend to live in the community. Studies have indicated that less than 25 percent of older people who committed suicide were being seen by psychiatry services, and most had not seen their GP within the month prior to their death.

Commissioning Implications

- A clearer picture of the local suicide statistics is required
- Ensure that suicide prevention strategy adequately addresses the needs of older people

3.2 Summary of OPMH services currently available in Brighton and Hove

Services for older people with mental health issues are provided by a number of different organisations, across the various aspects of the care pathway. These are summarised in table 4 below.

Table 4 – Summary of OPMH services currently provided in Brighton and Hove

Name/Type of service	**Care pathway area**	**Brief summary of service provided**
Health Promotion Services	Prevention / Health promotion	Range of services available for people aged 18+, which also provide services for those aged over 65. Services include: - Women's drop in service for those experiencing mental health problems - Homeless day centre - Cruse Bereavement Care - promote wellbeing and safety of people experiencing psychological and/or physical health problems following bereavement There are a range of healthy living services targeted at the 50+ age range and these include: - active living activities e.g. ball games, dance, indoor and outdoor fitness activities, - counselling, bereavement and mental health services e.g. crisis services and depression self help group - education services e.g. local history groups, computer courses, health promotion library - healthy eating services - sexual health services - social groups and activities e.g. film/music/art clubs - ethnic minority social groups and activities The majority of these services are aimed at older people generally, with a focus on general health and wellbeing.
Primary Care	Early diagnosis and support	Care provided by individual's GP for general health issues, which include mental health. Currently GPs keep a register of their patients diagnosed with dementia and depression under the quality and outcomes framework (QOF). Community pharmacies also provide support for self care, and health promotion services.
Voluntary sector services -	Early diagnosis and support / Community	- Alzheimer's Society relief care scheme providing assessment of need and carer relief service - Alzheimer's Society carer support service providing information and support to people caring for individuals with dementia - Alzheimer's Society provide clinics at CMHTs - MIND advocacy services for older people with mental health needs
Psychological services for older people	Community	Service provided by Sussex Partnership Foundation Trust. Provides a specialist psychological service to people over 65 years, with complex mental health problems including dementia. Most referrals are accepted through the older people's community mental health teams, Aldrington Day Hospital or inpatient facilities but direct GP referrals, referrals from other hospital consultants and from the Access teams in adult services are accepted if they meet the service's eligibility criteria.
Day Centres	Community	- Wayfield Avenue day centre for older people with functional and organic mental health needs. Run by the Local Authority. Service operates seven days a week with a total of 154 places available across the week. - Ireland Lodge day centre for older people with organic mental health needs. Run by the Local Authority. Service operates seven days a

		week with a total of 154 places available across the week. - Towner Club day centre for those with dementia aged under 65 (young onset dementia). Run by Alzheimer's Society. Service operates two days a week with ten places available on each day.
Aldrington Day Hospital	Community	Provided by Sussex Partnership NHS Foundation Trust. Specialist day hospital care primarily for people with functional mental health problems. The Service offers 10 places in the morning and the afternoon for assessment, treatment and reablement. The service is an alternative to hospital admission and speeds up discharge from hospital.
Home care services	Community	Provides personal care, practical and emotional support to individuals with moderate mental health needs wishing to remain at home. Provided by Local Authority in-house team and Independent sector.
Care Home Support Team	Community	Provided by South Downs Health Trust. The service aims to: - improve the delivery of care to those in OPMH nursing care homes identified as having complex needs - has a RMN to provide mental health support - act as an expert resource to clinical staff - support reductions in unnecessary admissions to hospital - improve person's experience whilst optimising their health outcomes The service can be used by all nursing care homes (including OPMH), elderly care wards, A&E/MASU, integrated discharge team at BSUH and SDH Community beds.
Intermediate care services (ICS)	Community / Residential / Nursing and inpatient	Provided by South Downs Health Trust. The service aims to support people discharged from hospital and to prevent unnecessary admission to hospital or long stay care. It offers the opportunity for recovery and rehabilitation through a planned programme of care and treatment. The are 61 designated intermediate care beds (as at Jan 2009) as well as a community service which supports approximately 70 places at any one time. A RMN will be in post in the ICS team in early 2009, but it is unlikely that this post will provide an adequate level of MH support.
Community Mental Health Teams (CMHTs)	Community / Residential / Nursing and inpatient	The three CMHTs (one in each locality of Brighton and Hove) are provided by SPFT and provide a range of services including: - Multidisciplinary assessment of mental health and social care needs. - Multidisciplinary treatment and care plan provision to meet need in the community - Home visits and outpatient appointments. - Therapeutic groups in the community. - Assessment and review of services funded by the Community Care Budget under Fair Access to Services Criteria - Mental Health Act Assessments. - Transfer of care to and from acute inpatient MH in patient units (under MH Act and informally) - Risk assessment and contingency planning - Carers assessment and support - Diagnostic and prognosis decision making and counselling - Medication prescription and review - Safeguarding Investigations and Protection - Gate keep and sign post for other services, statuary and non statutory
Integrated Community Advice and Support Team (ICAST)	Community / Residential / Nursing and inpatient	Integrated Health and Social Care Mental Health Service for individuals over 65 years, provided by SPFT. Providing assessment, advice and support to individuals across the city up to a period of 6/8 weeks, at their place of residence (both home and in care homes)
Older Peoples Mental Health Services	Community /	Service provided by SPFT to review all services funded by the Community Care Budget under Fair Access to Services Criteria including:

Reviewing Team	Residential / Nursing and inpatient	- Review and assessment of care needs - Put services in place to meet needs - Involvement in Safeguarding issues and monitoring standard of care provide
Transitional Care Team	Residential / Nursing and inpatient	Provided by LA/PCT. Ten to twelve short term residential beds provided at Ireland Lodge, with an aim of helping older people with functional mental health needs regain independence (often following a stay in hospital) with the goal of returning as many people as possible home. Length of stay is between 4 and 12 weeks. A pilot scheme begins in January 2009 with two transitional beds at Wayfield Avenue, for older people with functional mental health needs.
Residential Care Homes	Residential / Nursing and inpatient	- Independent sector residential care homes – there are nine OPMH residential care homes commissioned to provided OPMH residential placements in Brighton and Hove. In total they provide 151 single rooms and 32 double rooms. - Ireland Lodge Resource Centre – Service is run by BHCC and provides residential care for older people with organic mental health needs. Currently has 23 beds (6 long term, 5 respite, 2 flexible and 10 transitional). - Wayfield Avenue Resource Centre – Service run by BHCC and provides residential care for older people with functional mental health needs. Currently has 24 beds (22 long term and 2 short term) N.B. Figures as at December 2008. Using the CSCI rating system, the quality of the various residential care homes varies. Of the eight independent residential care homes, seven are classified as 'good' and one as 'excellent'. Of the two council run residential care homes, one is classified as 'good' and one as 'adequate'.
Nursing Care Homes	Residential / Nursing and inpatient	There are three independent sector OPMH nursing care homes in Brighton and Hove commissioned to provide placements. They provide 87 single rooms and 26 double rooms. N.B. Figures as at December 2008. Using the CSCI rating system, one home is rated as 'good', one as 'adequate' and one is not yet rated.
Liaison Mental health services	Residential / Nursing and inpatient	Provided by SPT. Mental Health assessment, advice, interventions to individuals at the Royal Sussex County Hospital, placed in non OPMH residential and nursing homes (including BHCC establishments), placed at Wayfield Avenue and Ireland lodge establishments. Aim is to ensure smooth transition of care between services.
Specialist inpatient services	Residential / Nursing and inpatient	SPT provide specialist inpatient services from Nevill Hospital - Brunswick Ward provides 24 hour acute inpatient care for older people with organic mental health needs. There are currently 15 beds. - Churchill Ward provides 24 hour acute inpatient care for older people with functional mental health needs. There are currently 20 beds.
Dementia care at home team	Residential / Nursing and inpatient	Home Provision as an alternative to OPMH nursing for individuals with Dementia. Focus of service is currently under review and subject to change.
Palliative Care Services	End of Life	Gold Standard Framework for palliative care is used across Brighton and Hove.

3.3 Identified issues and gaps in current service provision

Below is a summary of the key issues and gaps in current service provision as identified in a gap analysis undertaken in consultation with service users/carers and other key stakeholder organisations. The list also includes issues and gaps identified when undertaking the OPMH services needs assessment and when reviewing national and local policy developments.

3.3.1 Overarching

- Age categorisation – This can cause complications e.g. whilst 'older people' is taken to mean those aged over 65, people aged between 65 and 75 (or above) often do not feel 'old', and may have a different set of needs and requirements which need to be met in an appropriate fashion requiring changes in service provision.
- Personalisation of services - Many service users are not aware of direct payments, or they may not be eligible for receiving them. Communication about direct payments in needed. Self funders will need to be equally informed of the alternative service options open to them, to ensure equity and choice. There may also be a lack of suitable alternative providers to purchase services from.
- Reablement – OPMH services need to be included in reablement agenda roll out to ensure that these services are modernised in line with national and local policy. If this does not happen, older people will not have equitable access to opportunities which maximise their independence and quality of life.
- Transport – This is an issue for many, and a lack of appropriate transportation could add to social isolation. Often transportation is not available, and when it is, pick up times can be allocated across a two hour timeframe. This is not helpful for service users attending day services or for carers in planning the day. The length of time (potentially up to three hours) spent on buses as other service users are picked up and dropped off puts some older people off from attending services.
- Mental health support into mainstream services - Specialist mental health needs are often difficult to meet in mainstream services without additional mental health input. A RMN will shortly be in post to support ICS, but additional support may still be required to meet needs. Levels of need within Wayfield Avenue fluctuate greatly due to the mental health illnesses of service users. Current night staff and RMN hours may not be sufficient to support service users with enduring and complex mental health needs.
- Service developments - Service integration of OPMH with WAMH services, within SPFT could impact on service provision for older people e.g. reduction in the level of staff with specialist OPMH skills.
- NHS Continuing care –To ensure that NHS Continuing Care is available to all those eligible, awareness of the assessment process and eligibility criteria should be increased in those involved in an individual's care.

3.3.2 Prevention/Health Promotion

- Appropriate activities - It is important to recognise that to help people to remain in their own homes for longer, reduce social isolation and reduce the need for long term residential/nursing placements, it will be even more important to provide activities which enable people to leave their homes during the day time.
- Alternative and different service options - A greater focus is needed on prevention of ill health and general health promotion services for older people with mental health needs. New services could be developed, specialising in the needs of the older population in Brighton and Hove, specifically linked to maintaining good mental health. Examples include alternative therapies, therapeutic horticulture and gardening projects, 'singing for the brain' groups and reminiscence work.
- Barriers to services - There are a range of existing services available to older people, but barriers to accessing these exist e.g. affordability, transportation problems, lack of available places. This can create inequitable access across Brighton and Hove, and greater inequalities may result.

- Flexible service delivery - Current services predominately focus on weekday activities, but social isolation is heightened at the weekend. Increased flexibility of services could help to avert crises.
- Communication methods - Online directories do not work for those without access to computers or the skills required. Innovative communication methods are required to ensure that services reach all. Social marketing skills must be developed to reach these individuals.

3.3.3 Early diagnosis and support

- Formal diagnosis of dementia - It is estimated that there are high numbers of people with dementia who have not been diagnosed.
- Appropriate support - Additional resources may be required in psychological services for older people to treat common mental health problems or to provide input into primary care services. This should help to prevent later, more harmful costly crises. E.g. specific mental health support telephone line are no longer available after working hours.
- Inadequate identification of depression/anxiety - Evidence available indicates that many older people with depression or anxiety are not picked up by their GP and/or not referred, thereby leading to potential further crisis.
- Carer assessments – All carers are entitled to an assessment, but due to lack of resources, these assessments sometimes do not occur.

3.3.4 Community

- Clarity of role of CMHTs -The role of the CMHTs are wide and they have many responsibilities. This is positive for service users as it provides a 'one stop', multidisciplinary, integrated team. However, team time is taken up with responding to crisis, safeguarding issues, MH Act issues, etc. Hospital discharges become prioritised over the quality of going support, treatment in the community and partnership/support to primary care and other services. In addition, teams are small in numbers so staff sickness and absence has a big impact on performance and ability to develop services.
- Appropriate day time activities - There are waiting lists for day services, and a lack of awareness of appropriate alternatives. Existing day services could be made more effective, creative and stimulating. Links between OPMH, WAMH and mainstream day services need to be improved.
- Community Services -. There are limited community services for people with complex needs, but providing services for this client group could help in delaying the need for long term care.
- Home care services – Services are not always person centred e.g. allocation of very short timeframes for carers to visit service users, which results in limited time to undertake tasks in preferred manner. Inconsistency in carers is also an issue for service users.
- Reablement focus narrow - There is currently a limited focus on reablement services in OPMH.

3.3.5 Residential/Nursing and Inpatient

- Quality - is a continuing issue in both nursing homes and residential care homes. This is compounded by the lack of provision which may lead to difficult choices for the service user and their carers.
- Capacity - Current capacity is about sufficient in OPMH residential homes but there is a lack of capacity in OPMH nursing homes.
- Out of area placements - Where there is no alternative, out of area nursing placements are necessary. This is often against the wishes of the service user and their family. Out of area placements can be expensive and need to be reduced.
- Delayed transfers of care - are an issue for the whole of the local health economy. Appropriate OPMH services would support the delivery of the local health economy DTOC plan.

- Inappropriate admissions and discharges - Key information and support should be available on admission and discharge, but this does not always happen.
- Individuals with physical health needs – Difficulties can be encountered when people are admitted to Nevill hospital but have physical health needs, as the nurses employed there are not general nurses. Community nurses are often called in to manage patient need, but this is not always appropriate.
- Understanding the needs of individuals - A&E management of older people with mental health needs is sometimes problematic, with service user requirements often not taken into account, and a lack of respect for carer's knowledge of service user.
- Communication - Closer working relationships are required between SPFT and Local Authority run resource centres.
- Independent providers - Better support to independent OPMH residential and nursing homes could help to improve the quality of care provided as well as avert crises. Existing forums mainly focus on non-mental health service provision, as most attendees to the forums represent non-OPMH care homes. This could be to the detriment of care homes providing OPMH services. Feedback from providers has stated that often OPMH teams are very busy and unable to attend the care home as quickly as is requested, causing delays in the treatment of an individual. Due to the nature of the buildings used as care homes, there are often individual 'quirks' to a building e.g. a number of exits to a building meaning it is unsuitable for a person who wanders. A better understanding of these would assist in the more appropriate placement for service users.

3.3.6 End of life care

- Specific to OPMH – Strategic Commissioning Plan sets out that all Brighton and Hove residents will have equal access to high quality palliative and end of life care in a variety of settings, regardless of their diagnosis or the point at which they enter the healthcare system in line with the local end of life strategy. To ensure the needs of OPMH service users and carers are met, better links to ongoing end of life work will be required. This will help to remove the barriers and enable people to die at home should they wish.

Section 4 A – Summary of commissioning recommendations

Principles of national and local policies

- Personalisation
- High quality service provision, based on need and not age
- Reablement
- Early diagnosis and treatment for all
- Partnership working
- Reduce inequalities
- Build on best practice and evidence base available
- Improved education and training programmes for all staff
- Service user and involvement and consultation
- Remove discrimination
- Reduce stigma
- Respect dignity and diversity
- Support carers
- Value for money services
- Reliable information to be accessible to all in appropriate format

Care Pathway

Overview of commissioning recommendations

Overarching	Prevention / Health Promotion	Early Diagnosis and support	Community	Residential/ Nursing and inpatient	End of Life
- Expand use of individual budgets for OPMH services to increase choice and control - Services to promote reablement - Development work with service providers to ensure needs of individual are met regardless of age - Training programmes for all staff - Develop clear and concise referral pathways - Information and support services for service users and carers	- Existing services to be advertised / promoted effectively - Services to reduce social isolation and prevent crisis - Strengthen support networks - Build on existing health promotion work - Effective links with WAMH services on substance misuse/alcohol to prevent later MH issues	- Services to enable accurate, early diagnosis and treatment - Prompt access to psychological support services upon diagnosis - Provide support for carers - Support and information available following diagnosis - Services to support health, independent and wellbeing and prevent later crisis and avoidable admissions	- Review of existing day services - Increase effective home care support - Specialist MH support available to mainstream services to enable management of low to moderate MH needs and to remove existing barriers to services - Short term community services to facilitate reablement	- Increase capacity of high quality care homes, especially for OPMH nursing homes - ST services to facilitate reablement, effective discharge and maximise outcomes - Remove age barriers to services, ensuring quality remains - MH support to mainstream acute services to better manage OPMH need - Partnership with potential new service providers - Reduce OOA placements not through choice	- Link with local work ongoing in end of life strategy to ensure OPMH needs are adequately reflected - Older people with mental health needs given choice about where they die

Section 4 B – Detailed commissioning recommendations

The diagram in section 4 A summaries the underlying national and local principles for OPMH, which apply to the different parts of the care pathway. It then gives an overview of the commissioning recommendations for each stage, which stem from the national and local principles.

In this section each of the framework priorities across the care pathway are discussed in more detail and comprehensive commissioning recommendations are set out. The recommendations apply to both functional and organic mental health service provision, unless otherwise specified. Each of these recommendations have been factored into a three year work plan and will eventually be prioritised into annual action plans, developed by the local health economy, led by the OPMH Implementation group. For each of the recommendations, detailed project plans and business cases, with lead officers identified, will be developed to take the work forward.

4.1 CARE PATHWAY - OVERARCHING

Overarching

4.1.1 Link to ongoing work with other local strategies

There are a number of other strategies which have been developed recently, or are in the process of being developed, within the PCT and the Local Authority. A number of these will have a direct link to OPMH, and so robust links are needed to ensure the interfaces are addressed.

Commissioning Recommendations
1.1.1 Review of strategies recently agreed, and in development, to ensure interfaces and overlaps are identified, to maximise effectiveness and reduce duplication. Areas of joint working to be established. Strategies include: • Carers Strategy (in development) • Self directed support strategy (in development) • Older People Commissioning Strategy 2007 – 2010 • Urgent Care Strategy 2005 – 2008 (to be refreshed) • Community Strategy 2005 – 2008 (to be refreshed) • Older People Housing Strategy 2008 - 2013

4.1.2 Fundamental principles of personalisation, choice and control to be reflected in all service developments

As a key national and local principle, the personalisation agenda is being developed across Brighton and Hove. This will eventually need to be reflected in all aspects of OPMH service delivery.

Commissioning Recommendations
1.2.1 Incremental move of existing OPMH services to fully meet personalisation agenda
1.2.2 All new services to be developed in line with personalisation principles
1.2.3 Roll out direct payments and individual budgets across OPMH services in line with LA targets to provide increased choice, improve outcomes and to maximise value for money

4.1.3 Services to promote reablement, independence and improved quality of life

This is a key national policy development, and locally pilots are beginning, based on the experiences of other areas.

Commissioning Recommendations
1.3.1 Incremental move of OPMH services to support reablement in line with the LA transformation agenda. Use evaluation of in-house homecare reablement pilot to aid this.
1.3.2 Links to be made with Older People Housing Strategy to ensure that housing options available to older people appropriately meet their needs.

4.1.4 Services to be available on a needs basis rather than an age basis

Where relevant, services should be available on the basis of individual need, and not based on the individual's age.

Commissioning Recommendations
1.4.1 Ensure current developments from the publication of the Equalities Bill are incorporated in service development. Wherever appropriate, services to be open to all, regardless of age to ensure that older people will not be disadvantaged.
1.4.2 Redesign of SPFT services to be based on individuals' needs and not age e.g. removal of age barriers for functional mental health
1.4.3 Ensure all professionals and carers are aware of process for requesting assessment against the NHS continuing care criteria, to ensure approach is uniform across Brighton and Hove

4.1.5 Reduce inequalities

All older people should have equal opportunity to access services, regardless of their situation.

Commissioning Recommendations
1.5.1 Services to be equally accessible to individuals across Brighton and Hove. Where appropriate, a range of social marketing/promotion strategies to be developed to ensure that all are aware of services available to them. This will allow vulnerable communities to be targeted more effectively to improve access to timely and appropriate information and services.
1.5.2 Services provided to meet the varying needs of the communities in Brighton and Hove to ensure inequalities are addressed and reduced.

4.1.6 Training and support

To ensure that all staff involved in the care of older people with mental health needs are adequately skilled, it will be essential to provide appropriate training and support. National and local feedback has indicated that many health professionals feel they do not have adequate knowledge of mental health issues for older people, which could result in reduced recognition of symptoms. Training should also focus on reducing stigma.

Commissioning Recommendations
1.6.1 Professionals working in all aspects of service delivery to be appropriately trained in mental health awareness and management.

4.1.7 Provide clarification on roles, responsibilities and functions on all organisations

Between organisations, there is often confusion as to who is responsible for certain aspects of an individuals' care. Clarification on referral and care pathways is required.

Commissioning Recommendations
1.7.1 New and existing services to have clear pathways to ensure swift referrals to appropriate teams. Links to be made with Map of Medicine, STAN, Access Point, etc.

4.1.8 Information and support to be easily available for service users, carers and public generally

Information and support should be available to service users and carers as and when required. Public misconceptions about mental health in older people and 'normal' ageing could result in less recognition of mental health problems and fewer people coming forward to their GP when needing help.

Commissioning Recommendations
1.8.1 Ensure appropriate and informative information is provided to communities in targeted and suitable ways.

Prevention/Health Promotion

4.2 CARE PATHWAY – PREVENTION/HEALTH PROMOTION

4.2.1 Prevent people from becoming susceptible to poor mental health by provision of services which promote good mental health

To maintain good mental health, evidence indicates that people need to be kept active and involved in the life of their community. Developing services to promote and encourage this could help to reduce the number of older people who are socially isolated and so at greater risk of developing poor mental health in the future. Links also need to be made with working age mental health services, particularly around substance misuse, to help prevent crises later in a persons' life.

Commissioning Recommendations
2.1.1 Review the existing prevention/health promotion services to ensure that current services are advertised sufficiently and accessed appropriately
2.1.2 Link with ongoing work in relation to providing services and activities for people with diagnosed low mental health needs, to reduce isolation and loneliness
2.1.3 Remove age barriers in existing HP services which may attract 'younger' older people, to ensure they make the best use of available services

Early Diagnosis and support

4.3 CARE PATHWAY – EARLY DIAGNOSIS AND SUPPORT

4.3.1 Enhanced support for early diagnosis of mental health problems and ongoing management

To ensure that mental health issues are recognised as early as possible, sufficient support provided to carers, greater primary care awareness and support is required. There are examples of best practice in other areas where these areas have been addressed with great success.

Commissioning Recommendations
3.1.1 Identify areas of best practice from around the country
3.1.2 Improved early diagnosis for older people with mental health needs
3.1.3 Improved information and support to be available for older people with mental health needs and their carers
3.1.4 Ensure carers assessments are available to all

Community

4.4 CARE PATHWAY – COMMUNITY SERVICES

4.4.1 Community services to better support people to live independently and delay the need for more intensive, long term, service provision.

Community services are provided in a number of ways. Home care services provide personal care to individuals, assisting them to remain in their own home for as long as possible. Day centres and hospitals provide support and care to people with lower level needs, and help reduce isolation by providing interaction with others. Ensuring that community services are developed in line with national and local policy initiatives will ensure that they provide excellent quality of care, and meet the complex needs of the individuals.

Commissioning Recommendations
4.1.1 Link in to the implementation of the recommendations within the day services value for money review, to ensure sufficient and high quality OPMH services are available, which reduce social isolation and maximise quality of life. Day services to be used as ‘step down’ facility or support facility for people living in the community.
4.1.2 Recommendations set out in day services review to be built into future plans for Local Authority run resource centres to ensure most effective use of resources.
4.1.3 Plans for SPFT community services to be reviewed to ensure they provide the most appropriate service provision
4.1.4 Home care service provision to be flexibly meet the needs of OPMH service users and carers

Residential/Nursing and Inpatient

4.5 CARE PATHWAY – RESIDENTIAL/NURSING AND INPATIENT SERVICES

4.5.1 High quality capacity to be available in local care home market for those with ongoing long term care needs, reflecting the changing nature of type of care required and reducing the number of out of area placements not through choice

There are a number of independent providers of long term care across Brighton and Hove. Work is ongoing locally to drive up the quality in these services, and to increase the capacity available.

Commissioning Recommendations
5.1.1 Implement Fairer Contracting, Preferred Provider and incentive schemes to incrementally improve the quality of OPMH care homes
5.1.2 Undertake market development work to increase the capacity available in OPMH nursing homes, and incrementally reduce the number of out of area placements not through choice
5.1.3 Continuation and possible development of clinical support provided to care homes to drive up the quality of clinical care provided
5.1.4 Development of more robust contract monitoring frameworks, and identified relevant targets, to support the improved quality provision.

4.5.2 The most appropriate capacity for respite care and short term/transitional services to be available

A review of the short term services currently available across Brighton and Hove is underway. This will identify the areas of need and recommend options for future service delivery. The aim is to have a range of appropriate services, which flexibly meet the requirements and will reduce the reliance on more costly long term care, and to maximise independence and quality of life.

Commissioning Recommendations
5.2.1 The short term services review commissioning plan to include recommendations encompassing OPMH services, with the aim of maximising independence and reducing the need for long term placements

End of Life

4.6 CARE PATHWAY AREA – END OF LIFE CARE

4.6.1 Support people to die in a place of choice

The End of Life strategy is in development. Links will be made to this strategy to reflect the requirements of older people with mental health needs. The Strategic Commissioning Plan identified a number of service developments to improve end of life care. These include:

- Use of best practice tools e.g. Liverpool Care Pathway, Gold Standard Framework
- Possible central co-ordination point for all people near the end of life
- Additional capacity development to support more people to die in their home
- Particular focus on improving end of life care for disadvantaged groups such as those with dementia

Commissioning Recommendations
6.1.1 Ensure OPMH needs are appropriately considered in End of Life strategy to ensure that barriers are removed and people are able to die at home should they choose to
6.1.2 Ensure support is provided for carers when a person dies
6.1.3 Ensure Strategic Commissioning Plan aim of 25% of people dying at home by 2010 is achieved for older people with mental health needs. Measures outlined above to used where appropriate.

Section 5 – Finance

5.1 Current service provision spend on OPMH across Brighton and Hove

It is difficult to obtain an accurate picture of the total amount spent on OPMH services on an annual basis, as many aspects of care are still classified and coded under 'older people' rather than 'older people mental health'. This is slowly beginning to change with the introduction of programme budgeting, which refers to the use of specific categories of coding to ensure all spend in one area is captured. Therefore, a clearer picture should be available in the future as total spend figures for OPMH will be grouped together. These figures will be included in the full commissioning strategy when published.

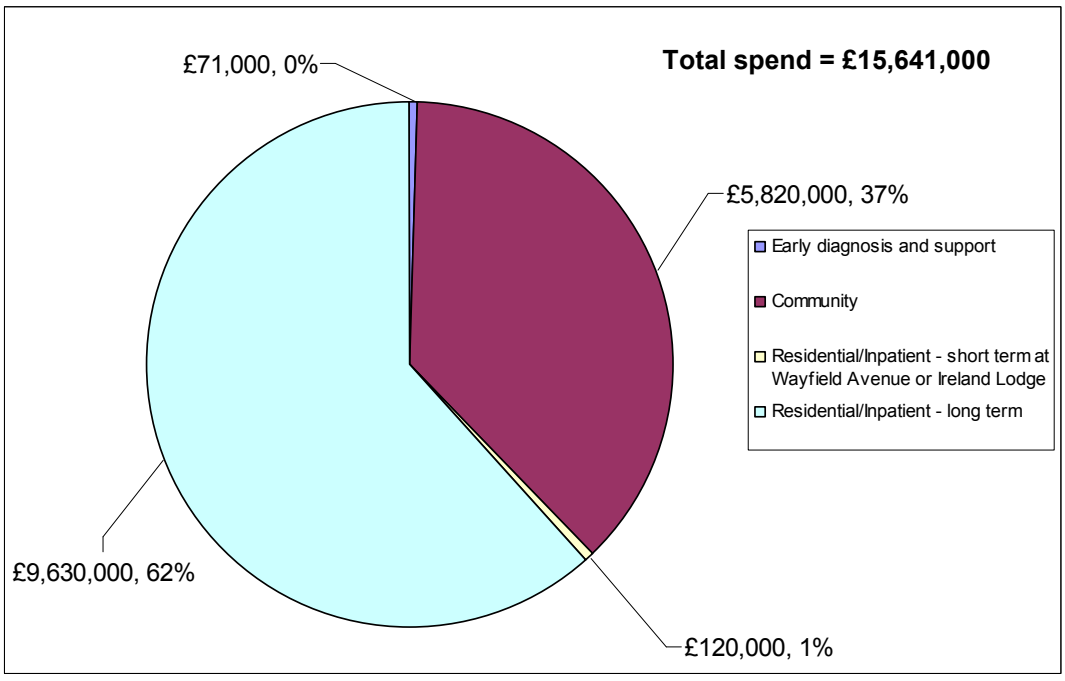
For the purpose of this planning framework, the information available has been used to estimate the total annual spend on OPMH services. Spend on OPMH services falls into three main categories:

- section 75 pooled budget - health spend
- section 75 pooled budget - social care spend
- 'other' spend including general health promotion/prevention services, support provided by general practitioners, integrated community equipment services (ICES), short term services (Intermediate Care, Transitional Care and Newhaven Rehabilitation Centre) and voluntary sector support.

Where available, the figures have been broken down into the care pathway categories used throughout this document. Chart 5 displays the breakdown for the information currently available, by total amount for category and as a percentage of overall spend. See appendix 4 for the full financial breakdown.

N.B. it is important to note that these figures are estimates, based on the finance information currently available. It has not currently been possible to breakdown most of the spend on OPMH services in the 'other' category for the purpose of this planning framework. With the exception of the Alzheimer's Society contract, no breakdown of 'other' spend is available. End of life care provision is also not included here.

Chart 5 – Percentage breakdown of overall OPMH spend by care pathway



As shown in chart 5, the most significant spend in OPMH services is on long term residential/nursing and inpatient services, with 62% of the overall budget being spent on these services. The next highest spend is on community services, with 37% of the overall budget. Short term residential/inpatient services have a very low percentage spend, with just 1% displayed. More is spent on short term services, but as this is not specifically broken down into OPMH service figures, it has not been possible include the figures here. The early diagnosis and support category has a negligible spend, which does not equate to a full percent of the over all spend.

Accurate financial information is vital to support the complex commissioning decisions that will have to be made in the future to ensure appropriate services are provided.

5.2 Projected future service provision spend on OPMH across Brighton and Hove

In line with national and local policy developments, and with the commissioning recommendations detailed in section 4, it is anticipated that there will be a gradual shift in how the OPMH budget is spent. To reflect the requirements of national and local policy, it is clear that an increased proportion of the total budget will need to be spent on improved prevention, early diagnosis and support services in the future. There will be an associated decrease in the amount spent on long term residential/nursing placements and inpatient services, as people are supported to remain independent for longer and to remain in their own homes.

Section 6 – Commissioning and Contracting

There are a number of developments within the commissioning and contracting of services that are of relevance to OPMH services.

6.1 World Class Commissioning and Strategic Commissioning Plan

A national programme is underway to deliver a health and care system which is fair, personalised, effective and safe. Commissioners will be required to be 'world class' to achieve this vision. The key objective for the future will be to commission for 'outcomes' rather than 'outputs'. This will be accomplished by developing closer links to local communities and planning and developing services to meet long term priorities. The outcome will be a shift from diagnosis and treatment to prevention and wellbeing. Commissioners will shape local services to deliver a broader choice of services, which will be personalised and of the highest quality[xix]. Input from service users and clinicians will be vital in shaping service delivery and in improving quality. Full details of the World Class Commissioning programme can be found at http://www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm

The Strategic Commissioning Plan (2008 – 2013) sets out a number of local objectives to improve the health of the city. The key focus areas identified are:

- Health inequalities
- Life expectancy
- Under 18's conception rate
- Hypertension
- Breast screening
- Delayed transfers of care
- MRSA
- Hospital admissions through alcohol misuse
- Deaths occurring at home
- Childhood obesity

Delivering on a number of these will have a direct impact on those using OPMH services in Brighton and Hove.

6.2 Fairer Contracting and Preferred Provider Scheme

To encourage care home providers to improve the quality of care provided, the Fairer Contracting scheme is being introduced in 2009/2010. The joint PCT and LA Fairer Contracting initiative will lead to the creation of a Preferred Provider scheme. Care homes eligible for the scheme will receive various benefits including higher fees and possible participation in an incentive scheme to reward homes for engaging with specific initiatives. It is anticipated that the schemes in development will help to drive up the quality and flexibility of service provision.

6.3 New providers entering the care home market

There are a number of potential new independent care home providers entering the market in 2009, though the impact of the current economic situation may slow progress on these developments. Links with the new providers will need to be forged to ensure they are fully aware of the local issues in Brighton and Hove, and develop services which respond to local need. It is possible that new care home providers will be marketing their services at individuals outside of

Brighton and Hove and self funders, who are willing and able to pay a much higher price for the placements.

6.4 Target development

To monitor the delivery of this framework and to improve the quality of care provided for OPMH services, targets and outcome measures will be established. As and when required, targets will be drawn up to reflect the key performance areas. To ensure performance monitoring against the targets is possible, comprehensive data recording will be necessary. Data collection and analysis will enable the local health economy to identify which areas need greater support to achieve the improvements in quality. This work will be taken forward in the action plan.

6.5 Contract monitoring and performance management

As services are redesigned and developed, appropriate performance monitoring mechanisms will be put in place and robustly monitored.

Section 7 – Consultation

A full equalities impact assessment has been carried out and can be found in appendix 5. Below is a summary of the consultation that has taken place to date and that which will take place as the framework is implemented.

7.1 Consultation undertaken to date

- Consultation undertaken for the Older People planning framework reviewed as the overarching principles are relevant.
- Briefing note on broad framework priorities sent out to all associated organisations e.g. Pensioner's Forum, Older People's Council, Health User Bank members and PCT gateway organisations. See appendix 6 for details of each organisation.
- Input and feedback received from OPMH planning framework working group throughout development of framework
- Initial focus group for service users, carers and representatives from associated organisations (Carers Centre, Federation for Disabled People Direct Payment mental health representative and Alzheimer's Society) held on Monday 8th December 2008. Follow up focus group held on Thursday 15th January 2009. See appendix 7 for focus group feedback.
- Feedback on commissioning recommendation sought from Community Voluntary Sector Forum Mental Health Network held on 13th November 2008. See appendix 8 for feedback.
- Primary care long term conditions education session Tuesday 13th January 2009 – dementia strategy briefing and feedback session

7.2 Consultation to take place as framework is implemented

- Attendance at primary care locality education session to inform general practice on the priorities of the OPMH planning framework and work streams emerging
- Implementation sub-groups to include service user, carer and associated organisation representatives

Section 8 – Three Year Action Plan for delivery (2009/10 to 2011/12)

COMMISSIONING RECOMMENDATION	PROJECT	TIMESCALE	AGENCIES/ORGANISATIONS INVOLVED	LEAD RESPONSIBILITY	OUTCOME
1. OVERARCHING					
1.1.1 Review of strategies recently agreed, and in development, to ensure interfaces and overlaps are identified, to maximise effectiveness and reduce duplication. Areas of joint working to be established.	Identify links with other strategies in development or previously agreed to identify overlaps and areas for joint working	2009/10 – 2011/12	LHE	PCT	• Seamless services delivering value for money for commissioners • Avoiding duplication and potential for waste • Services which meet the needs of the service user
1.2.1 Incremental move of existing OPMH services to fully meet personalisation agenda	Develop plan for roll out of personalisation agenda across existing OPMH services, learning from pilots within the LA	2009/10 – 2011/12	LHE	LA	• Services person-centred and meet the needs of the individuals • Increased choice and control for service users and carers
1.2.2 All new services to be developed in line with personalisation principles	Specify core elements of personalisation that must be included in specifications for all new services	2009/10 – 2011/12	LHE	LA	• Services to be personalised to meet the needs of the individuals • Increased choice and control for service users and carers
1.2.3 Roll out direct payments and individual budgets across OPMH services in line with LA	• Link with LA to identify services which are priorities for direct	2009/10 – 2011/12	LHE	LA	• Increased usage and uptake of direct payments for OPMH service users • Greater choice and control for

COMMISSIONING RECOMMENDATION	PROJECT	TIMESCALE	AGENCIES/ORGANISATIONS INVOLVED	LEAD RESPONSIBILITY	OUTCOME
targets to provide increased choice, improved outcomes and value for money.	payments/individual budget roll out • Seek opportunities for promoting uptake amongst OPMH service users • Evaluation of outcomes for OPMH service users using direct payments				service users • Greater diversity and responsiveness developed within provider market
1.3.1 Incremental move of OPMH services to support reablement in line with the LA transformation agenda. Use evaluation of in-house homecare reablement pilot to aid this.	Identify priority services for eventual roll out of reablement. Develop action plan for incremental roll out across existing services	2009/10 – 2011/12	LHE	LA	• More service users with increased/retained independence • Reduction in the need for long term care • Value for money for commissioners
1.3.2 Links to be made with Older People Housing Strategy to ensure that housing options available to older people appropriately meet their needs.	• Link with Older People's Housing Strategy development group • Explore opportunities offered by telecare in enabling people to remain in their own home	2009/10 – 2011/12	LHA	LA	• More service users with increased/retained independence • Reduction in the need for long term care
1.4.1 Ensure current developments from the publication of the Equalities Bill are incorporated in service development.	Ensure services are based on need and not age, where appropriate	2009/10 – 2011/12	LHE	PCT/LA	• Equitable access for all individuals inline with legislation and best practice • Increased choice and control for service user

COMMISSIONING RECOMMENDATION	PROJECT	TIMESCALE	AGENCIES/ORGANISATIONS INVOLVED	LEAD RESPONSIBILITY	OUTCOME
Wherever appropriate, services to be open to all, regardless of age. Consideration to be given to ensuring older people will not be disadvantaged.					
1.4.2 Redesign of SPFT services to be based on individuals' needs and not age e.g. removal of age barriers for functional mental health where appropriate	Redesign services based on need and not age, to remove artificial barriers to services where appropriate.	2009/10 – 2011/12	LHE	SPFT/PCT/LA	• Equitable access to services for all • Appropriate services provided in best setting • Services provided on a needs basis
1.4.3 Ensure all professionals and carers are aware of process for requesting assessment against the NHS continuing care criteria, to ensure approach is uniform across Brighton and Hove	Link to training programme being developed by Continuing Health Care team to ensure OPMH services are included	2009/10 – 2011/12	LHE	PCT	• Equitable assessment process
1.5.1 Services to be equally accessible to individuals across Brighton and Hove. Where appropriate, a range of social marketing/promotion strategies to be developed to ensure that all are aware of services available to them. This will allow vulnerable communities to be targeted more effectively to improve	Identify services to include in social marketing initiatives to target vulnerable communities.	2009/10 – 2011/12	LHE	PCT/LA	• Increased knowledge in communities regarding services available to them • Increased uptake of services from vulnerable communities

COMMISSIONING RECOMMENDATION	PROJECT	TIMESCALE	AGENCIES/ORGANISATIONS INVOLVED	LEAD RESPONSIBILITY	OUTCOME
access to timely and appropriate information and services.					
1.5.2 Services provided to meet the varying needs of the communities in Brighton and Hove to ensure inequalities are addressed and reduced.	With relevant expert help, identify key areas of inequalities across OPMH services and draw up a prioritised list to address.	2009/10 – 2011/12	LHE	PCT/LA	• Equality of access to services for all
1.6.1 Professionals working in all aspects of service delivery to be appropriately trained in mental health awareness and management.	• Generic training to be available for staff working in mental health • Specialist training to be available for staff working with individuals with dementia	2009/10 – 2011/12	LHE	PCT/LA	• Appropriately trained workforce to meet needs and requirements of service user/carers • Mainstream services trained to confidently meet the needs of individuals with low to moderate MH needs • Reduction in stigma experienced
1.7.1 New and existing service to have clear pathways to ensure swift referrals to appropriate teams. Links to be made with Map of Medicine, STAN, Access Point, etc.	• Communication networks clearly established between all relevant organisations • Clarity of referral pathways for existing services and streamlining where necessary	2009/10 – 2011/12	LHE	PCT/LA	• Teams have a better understanding of referral pathways and use them appropriately • Efficiency and value for money for commissioners • Service users receive prompt and appropriate services without delays

COMMISSIONING RECOMMENDATION	PROJECT	TIMESCALE	AGENCIES/ORGANISATIONS INVOLVED	LEAD RESPONSIBILITY	OUTCOME
1.8.1 Ensure appropriate and informative information is provided to communities and health/social care professionals in targeted and appropriate ways	Review existing information services available to identify information points and gaps, streamlining where appropriate.	2009/10 – 2011/12	LHE	PCT/LA	• Service users and carers better informed of how to access appropriate information • Information provided via most suitable methods to meet needs of service users and carers
2. PREVENTION/HEALTH PROMOTION					
2.1.1 Review the existing prevention/health promotion services to ensure that current services are advertised sufficiently and accessed appropriately	• Review existing services to obtain a clear picture on what prevention/ health promotion services are currently available and how people are informed of them • Identify gaps in prevention services and address	2009/10 – 2011/12	LHE	PCT/LA	• More people accessing existing services as a result of appropriate and alternative advertising methods • Range and capacity of prevention services available to allow maintenance of independence and avoid later crisis
2.1.2 Link with ongoing work in relation to providing services and activities for people with diagnosed low mental health needs, to reduce isolation and loneliness	Identify additional areas for service development to ensure services meet the needs of service users	2009/10 – 2011/12	LHE	PCT/LA	• Greater numbers of service users accessing services • Improved quality of life, health and well being for service users and carers, with independence maintained

COMMISSIONING RECOMMENDATION	PROJECT	TIMESCALE	AGENCIES/ORGANISATIONS INVOLVED	LEAD RESPONSIBILITY	OUTCOME
2.1.3 Remove age barriers in existing HP services which may attract 'younger' older people, to ensure they make the best use of available services	Review current eligibility criteria and service models, to ensure individuals can participate in appropriate services, which meet their needs.	2009/10 – 2011/12	LHE	PCT/LA	• Improved choice in prevention/health promotion services available to individuals • Reduced inequalities
3. EARLY DIAGNOSIS AND SUPPORT					
3.1.1 Identify areas of best practice from around the country	Link with SHA and DH to identify areas of local and national best practice. Apply knowledge and experience to local service development	2009/10 – 2011/12	LHE	PCT/LA	• Services based on best available evidence • Services meet needs of individuals and be cost effective
3.1.2 Improved early diagnosis for older people with mental health needs	• Reduce gap in predicted and actual prevalence figures • Ensure services available to allow for prompt diagnosis of mental health needs	2009/10 – 2011/12	LHE	PCT/LA	• Improved early diagnosis services • Services available to those diagnosed with mental health needs to meet the requirements of the service users and carers

COMMISSIONING RECOMMENDATION	PROJECT	TIMESCALE	AGENCIES/ORGANISATIONS INVOLVED	LEAD RESPONSIBILITY	OUTCOME
3.1.3 Improved information and support to be available for older people with mental health needs and their carers	• Ensure onward referral routes for support/signposting after formal diagnosis are clear and appropriate services are in place • Relevant training and support provided to primary care and other relevant agencies	2009/10 – 2011/12	LHE	PCT/LA	• Improved support for service users and carers • Increased knowledge and confidence within primary care to support older people with mental health needs
3.1.4 Ensure carers assessments are available to all	Increase number of carers offered assessments	2009/10 – 2011/12	LHE	LA/PCT	• Needs of carers documented and addressed • Service users are better supported by carers • Carers are able to balance caring with other aspects of life to improve the overall quality of life

COMMISSIONING RECOMMENDATION	PROJECT	TIMESCALE	AGENCIES/ORGANISATIONS INVOLVED	LEAD RESPONSIBILITY	OUTCOME
4. COMMUNITY					
4.1.1 Link in to the implementation of the recommendations within the day services value for money review, to ensure sufficient and high quality OPMH services are available. Day services to be used as 'step down' facility or support facility for people living in the community.	• Modernise traditional OPMH day services to ensure they support reablement and are outcome focused • Signpost to alternative day activity options in the community	2009/10 – 2011/12	LHE	LA	• OPMH day services to better meet the needs of service users • Services to be cost effective
4.1.2 Recommendations set out in day services review to be built into future plans for LA run resource centres to ensure most effective use of resources.	Modernisation of services currently available at Ireland Lodge and Wayfield Avenue	2009/10 – 2011/12	LHE	LA	• Resource centres to meet the identified needs of the service users • Services to provide value for money
4.1.3 Plans for SPFT community services to be reviewed to ensure they provide the most appropriate service provision	Modernisation of community services inline with the general move to outcome focused service provision	2009/10 – 2011/12	LHE	SPFT/PCT/LA	• Services to be used appropriately to meet the needs of the service users

COMMISSIONING RECOMMENDATION	PROJECT	TIMESCALE	AGENCIES/ORGANISATIONS INVOLVED	LEAD RESPONSIBILITY	OUTCOME
4.1.4 Home care service provision to expand to meet the needs of service users and carers	Ensure home care service provision is suitable to meet the needs of older people with mental health needs	2009/10 – 2011/12	LHE	LA	• Increased number of people accessing home care services • Greater number of people supported to remain at home for longer • Reduction in the need for long term care placements
5. RESIDENTIAL/NURSING AND INPATIENT					
5.1.1 Implement Fairer Contracting and Preferred Provider work to incrementally improve the quality of OPMH care homes	• Fairer Contracting programme to be rolled out across OPMH care homes • Website development to provide information to service users and potential service users	2009/10 – 2011/12	LHE	LA	• Increased quality and flexibility in care homes • Service users more informed regarding services available to them
5.1.2 Undertake market development work to increase the capacity available in OPMH nursing homes, and incrementally reduce the number of out of area placements not through	Work with potential new providers to increase the quality of care home placements available	2009/10 – 2011/12	LHE	LA	• More appropriate care home placements available with Brighton and Hove, increasing choice for service users • Reduction in the number of out of area placements

COMMISSIONING RECOMMENDATION	PROJECT	TIMESCALE	AGENCIES/ORGANISATIONS INVOLVED	LEAD RESPONSIBILITY	OUTCOME
choice					
5.1.3 Continuation and possible development of clinical support provided to care homes to drive up the quality of care provided	Review support required in OPMH care homes to improve the quality and monitoring of clinical care provided in OPMH nursing homes.	2009/10 – 2011/12	LHE	LA/PCT	• Increased clinical quality of care • Better service user outcomes
5.1.4 Development of more robust contract monitoring frameworks, and identified relevant targets, to support the improved quality provision.	Implement: • Preferred provider scheme • Clinical assessments to inform preferred provider scheme • Incentive payments for increase quality and flexibility	2009/10 – 2011/12	LHE	LA/PCT	• Increased numbers of quality care homes • Increased flexibility and responsiveness of provider market to commissioning requirements
5.2.1 The short term services review commissioning plan to include recommendations encompassing OPMH services, with the aim of maximising independence and reducing the need for long term residential placements.	Implement the commissioning recommendations for OPMH within the short term services commissioning plan (publication expected April 2009)	2009/10 – 2011/12	LHE	LA/PCT	• Increased independence for service users • Reduced and delayed need for long term placements • Prompt discharge for OPMH to appropriate range of short term services to maximise independence

COMMISSIONING RECOMMENDATION	PROJECT	TIMESCALE	AGENCIES/ORGANISATIONS INVOLVED	LEAD RESPONSIBILITY	OUTCOME
6. END OF LIFE					
6.1.1 Ensure OPMH needs are appropriately considered in the End of Life strategy ensure that barriers are removed and people are able to die at home should they choose to.	Link in with end of life strategy development work	2009/10 – 2011/12	LHE	PCT/LA	• Older people with mental health needs given more choice over place of death
6.1.2 Ensure support is provided for carers when a person dies	Link with ongoing work on Carer's Strategy to ensure end of life support is provided	2009/10 – 2011/12	LHE	LA/PCT	• Carer's receive necessary support
6.1.3 Ensure Strategic Commissioning Plan aim of 25% of people dying at home by 2010 is achieved for older people with mental health needs.	• Roll out of Liverpool Care Pathway • Development work to create central co-ordination point for people near the end of their life and additional capacity to support disadvantaged groups such as those with dementia.	2009/10 – 2011/12	LHE	PCT/LA	• Strategic Commissioning plan target of 25% to equally apply to OPMH

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[xix] *World Class Commissioning Vision Summary.* Department of Health (December 2007)

Appendices

Appendix 1 – Steering Group and Working Group Membership

Steering Group Membership

Kathy Caley	OPMH Commissioner/Chair (PCT)
Joanne Matthews	Strategic Commissioner for Adults and Older People (PCT)
Charlotte Marples	Lead Commissioner for Older People (Joint PCT/LA)
Kate Hurley	Strategic Commissioner for Assessment Services (PCT)
Denise d'Souza	Director of Community Care (LA)
Sharon Lyons	(LA)
Abbe Boeg	(LA)
Colin Lindridge	Associate Director of OPMH (Sussex Partnership Foundation Trust)
Birgitte Knudsen	Independent Provider Forum Representative
Alan Wright	Voluntary Sector Representative – Alzheimer's Society
Shirley Gray	Voluntary Sector Representative - MIND

Working Group Membership

Kathy Caley	OPMH Commissioner/Chair (PCT)
Charlotte Marples	Lead Commissioner for Older People (Joint PCT/LA)
Anne Silley	Head of Financial Services (LA)
Jonathan Reid	Deputy Director of Finance(PCT)
Jane MacDonald	Service Improvement Manager – Commissioning (Joint PCT/LA)
Kathy Sage	Data (PCT)
David Brindley	Health Promotion (PCT)
Sunanda Ray	Public Health (PCT)
Dee Suter	Intermediate Care Services (South Downs Health Trust)
Bryan Lynch	Transitional Care (LA)
Carey Wright	Integrated Team Manager (Sussex Partnership Foundation Trust)
Anne Hagan	General Manager, Provider Services, Older People (LA)

Appendix 2 – Key National Policy Documents

1. High Quality Care for All – NHS Next Stage Review Final Report (June 2008)
This publication highlights that there have been improvements in the NHS generally and actions for the future will be around continuing this, whilst moving away from focusing on increasing quantity of care to improving the quality of care. The NHS Stage review Final report's vision of the NHS of the future is one that:

- Give patients and the public more information and choice
- Works in partnership with other relevant organizations
- Has quality of care at its heart with services that are clinically effective, personal and safe

The key themes of the final report are:

- Personalising services, giving people choice and allowing them to influence service developments
- Helping people stay healthy and preventing illness
- Piloting personal health budgets
- Treating patients with compassion, dignity and respect
- Improving the quality of NHS education and training for staff providing services

The vision and themes outlined here can be applied to older people's mental health.

2. Healthier people, excellent care – A vision for the South East Coast (June 2008)
This paper sets out the South East Coast response to the NHS next stage review final report. It highlights the need for:

- Safer, better quality care
- Acknowledgement of the inequalities across the south east and the need to address these
- An equal chance for everyone to stay well and get better, especially vulnerable people or those with the greatest need
- Services which are available at convenient times and locations
- Specialist care available from experts
- Tax money to be spent wisely

Specifically relating to mental health, the paper sets out the need for:

- Reduction of inequalities and removal social isolation
- Effective support provided at home
- Early recognition and treatment
- Prompt access to psychological therapies

Once the consultation for this document is complete, it will begin to be rolled out across the south east.

3. Putting People First – A shared vision and commitment to the transformation of Adult Social Care (2007)
People are beginning to live longer, but with more complex conditions. Putting People First highlights the changing family structure and the challenges this may bring to social care provision in the future. There is the need to explore options for long term funding of care and support to ensure it is fair, sustainable and clearly sets out the responsibilities of the state, families and individuals. The key points highlighted are:

- Access to high quality support should be universal and available in every community
- Individuals should be at the heart a reformed system
- Best practice should be built on, with a move to prevention, early intervention, enablement and a high quality, personally tailored service
- Maximum choice, control and power should be available to all, with the use of personal budgets, person centred planning and self directed support
- Partnership working will be required to deliver high quality services
- Local workforce development strategies will be required

4. New ambition for old age – next steps for NSF (April 2006)
This document gives an update on the Older People NSF, which was published in 2001, and reviewed in *Better Health in Old Age* in 2004. It highlights that progress has been made but there is still more to be achieved.
The ambitions set out in the paper include:

- Treating older people with dignity and having respect for their human rights
- Improving outcomes for older people's health, independence and wellbeing, which will save money in the long term by reducing the overall demand for expensive hospital and long term care services
- Extending life expectancy and providing the opportunity to enjoy old age

The paper sets out aims for national and local organisations around three keys themes - dignity in care, joined up care and healthy ageing.

5. Everybody's Business – Integrated Mental health Services for Older Adults (November 2005)
Everybody's Business is a guide setting out the key components of a modern older people's mental health service, with dignity and respect as the underlying philosophy. It outlines that to be fit for purpose an OPMH service should:

- Recognise dignity of individual service users and respect diversity
- Respect the role of supporters and carers
- Provide practical advice and information as well as developing consistently high quality comprehensive packages of care and support, minimising bureaucracy
- Have the best and most effective treatments widely and consistently available
- Be open to all and respond on the basis of need and not age
- Protect vulnerable people
- Be provided by properly trained and committed staff, who have appropriate training to deliver age inclusive, holistic services

6. Age Concern – Improving services and support for older people with mental health problems (2007)
This report highlights five areas for action and sets out associated steps:

- Ending discrimination
    - Removing age barriers to accessing services
    - Ensure specialist services for older people are properly resourced
    - Tackle stigma attached to mental health
    - Give more attention to 'invisible' groups

- Prioritising prevention
    - Challenge the view that mental health problems are an inevitable part of the ageing process and that nothing can be done

    - Reduce isolation and strengthen social support
    - Focus on preventing depression and delirium

- Enabling older people
    - Emphasis on community development initiatives
    - Promote peer support
    - Provide support for unpaid carers

- Improving current services
    - Develop interventions at an individual and systemic level
    - Develop collaborative working
    - Pay more attention to the role of housing support

- Facilitating change
    - Improve education, training and support to those working with older people
    - Increase investment
    - Strengthen leadership

7. Transforming the Quality of Dementia Care – Consultation on a National Dementia Strategy (June 2008)
This document is currently at consultation stage, and the final version is expected to be published in November 2008. The aim of the document is to ensure significant improvements across three key areas in relation to dementia:

- Improved awareness by
    - Increasing public and professional awareness
    - Having an informed and effective workforce

- Early diagnosis and intervention with
    - Good quality early diagnosis and intervention for all
    - Good quality information
    - Continuity of support and advice

- Higher quality of care in
    - General hospitals
    - Home care services
    - Short breaks
    - Intermediate care
    - Care homes

The final strategy will provide a framework for local service delivery, with advice and guidance on planning, development and monitoring. A guide will be developed to support high quality health and social care provision.

8. Improving Access to Psychological Therapies (February 2008)
There has been ongoing work around access to psychological services, which reports transformation to the lives of thousands of people with depression and anxiety disorder. The report sets out how this should be continued.

The pathfinder sites addressed health inequalities by focusing effort on the specific needs of a range of vulnerable groups and developed pathways to meet the needs of the whole population. There has been substantial investment nationally in this programme, and it should now be rolled out locally.

9. A collective responsibility to act now on ageing and mental health (September 2008)
This paper acknowledges the need for the dementia strategy, but reinforces the need to commit to addressing the full range of mental health problems in later life. Dementia cannot be seen in isolation as depression affects up to three times as many older people, and urgent action should be taken to address this.

The paper discusses that the NSFs for older people and for mental health do not provide a big enough focus on OPMH services, and the lack of targets and performance indicators in Everybody's Business mean that important actions may not be taken.

It goes on to discuss the need to ensure that removing age barriers to services, in an attempt to avoid age discrimination, does not go on to have a detrimental effect on service delivery, as staff with generic skills, rather than enhanced OPMH skills, treat individuals.

The paper finally suggests setting higher standards of care, addressing current low levels of investment and planning for the future by workforce

10. Age Concern – Undiagnosed, untreated, at risk – the experiences of older people with depressions (August 2008)
Age discrimination has been identified as a significant obstacle to older people receiving treatment for depression. It is the view of Age Concern that the planned Equality Bill, which was released by the Government in June 2008, is a major step forward in removing this discrimination. The Bill will outlaw age discrimination in health and social care services, and introduce a duty on the public sector to promote age equality. Based on the experiences of older people, Age Concern state that the bill alone will not end the discrimination faced by older people with depression. They set out a three point plan to improve the lives of these individuals:

- Encourage older people with depression to seek help
    - Aim education programmes at older people and their families to assist in recognising symptoms, and where to seek help
    - Involve older people in campaigns that challenge negative attitudes
    - Ensure support is offered at times of increased risk e.g. bereavement

- Ensure older people with depression are correctly diagnosed
    - Work with GPs to remove ageist views that prevent people from getting the help they need
    - Improve the training and development of GPs to help them to recognise and treat depression in later life
    - Develop GP contract to incentivise diagnosis and treatment of depression in all patients

- Ensure older people with depression get the treatment they need
    - Use evidence on prevalence of depression in older people locally and effective interventions to plan and commission services
    - Ensure access to treatments for depression give fair access to older people
    - Remove age related barriers to access for effective treatments

11. Alzheimer's Society report – Dementia – Out of the shadows
This report looks at the experiences of those living with dementia, and their carers. The key themes to have emerged from the research project are:

- Early diagnosis is very important, as is enabling those diagnosed and their carers to understand and adjust. There is cause for concern as there are large variations in individual's experiences of diagnosis, with lots of negative feedback reported. This could be

a good indication of why so many cases of dementia go undiagnosed, and is an area for development and recognition.
- Key features of good diagnosis process have been identified and could be used to reinforce and improve clinical practice.
- Different practical and psychological coping strategies have emerged, which are dependant on the individual. These could be used by professionals and carers as a range of tools to support people diagnosed with dementia in the future.
- Stigma is a major issue, and media portrayal of dementia does not help this. Many negative responses were noted from those close to the people diagnosed with dementia, and also from professionals.

Five recommendations stem from this research:
1. Improve public understanding of dementia
2. Improve GPs understanding of dementia
3. Develop better specialist diagnosis service for dementia
4. Provide information which is timely and accessible
5. Develop strong peer support and networks to help people cope

Appendix 3 – Needs Assessment Data

Projected Population Figures for Brighton and Hove

Table 1 – Projected population figures used for charts 1 and 2 in Needs Analysis

	2008	%	2010	%	2015	%	2020	%	2025	%
Total pop - all ages	253000		255800		261800		268300		275300	
Total population - 65 to 74	17000	6.72	17000	6.65	18300	6.99	18800	7.01	18900	6.87
Total population - 75 to 84	13100	5.18	12700	4.96	12300	4.70	12300	4.58	13700	4.98
Total population - 85+	6500	2.57	6500	2.54	6600	2.52	7000	2.61	7800	2.83
Total population - 65+	36600	14.47	36200	14.15	37200	14.21	38100	14.20	40400	14.67

Ethnicity in Brighton and Hove

Table 2 – Ethnicity figures for Brighton and Hove

Ethnicity group	Aged 55 - 64	Aged 65 - 74	Aged 75 - 84	Aged 85+
White (includes British, Irish and Other White	96.25%	96.82%	98.54%	99.14%
Mixed ethnicity (includes White and Black Caribbean; White and Black African; White and Asian; and Other Mixed	0.69%	0.67%	0.35%	0.16%
Asian or Asian British (includes Indian; Pakistani; Bangladeshi; and Other Asian or Asian British	1.54%	1.37%	0.65%	0.44%
Black or Black British (includes Black Caribbean; Black African; and Other Black or Black British)	0.58%	0.48%	0.24%	0.11%
Chinese or Other Ethnic Group	0.95%	0.66%	0.22%	0.15%

Dementia in Brighton and Hove

Table 3 Indicative dementia prevalence figures for Brighton and Hove

Age group (years)	Men (%)	Men (Numbers)	Women (%)	Women (Numbers)	Total
65 – 69	1.4	65	1.5	74	139
70 – 74	3.1	120	2.2	110	230
75 – 79	5.6	182	7.1	335	517
80 – 84	10.2	250	14.1	594	844
85+	19.6	331	27.5	1200	1531
All over 65 years		**948 (29%)**		**2313 (71%)**	**3261 (100%)**

Appendix 4 – Finance data

Total approximate spend on OPMH (using 2008/09 figures)

Section 75 pooled budget - health spend

Service	Category	Net Figure
CMHT (including psych and outreach)	Community	£2,700,000
Inpatient - organic wards	Residential/Inpatient - long term	£1,800,000
inpatient - functional	Residential/Inpatient - long term	£2,000,000
day hospitals/services	Community	£540,000
Total		**£7,040,000**

Section 75 pooled budget - social care spend

Service	Category	Net Figure
Home Care	Community	£1,400,000
Long term nursing	Residential/Inpatient - long term	£1,830,000
Long term residential	Residential/Inpatient - long term	£3,000,000
Short term	Residential/Inpatient - short term	£120,000
Dementia Care at Home	Community	£870,000
Wayfield Avenue and Ireland Lodge residential (76% of £1.323m)	Residential/Inpatient - long term	£1,000,000
Wayfield Avenue and Ireland Lodge day service (24% of £1.323m)	Community	£310,000
Total		**£8,530,000**

Other

Service	Category	Net Figure
Alzheimer's Society Contract	Early diagnosis and support	£71,000
Short term Services (Transitional Care and Intermediate Care)	Residential/Inpatient - short term	Break down not available by OPMH
Integrated Community Equipment Service (OPMH)	Community	Break down not available by OPMH
GP/Primary care support	Early diagnosis and support	Break down not available by OPMH
Prevention services	Prevention/Health promotion	Break down not available by OPMH
Palliative care services	End of life	Break down not available by OPMH
Total		**£71,000**

TOTAL SPEND FOR OPMH		**£15,641,000**

Appendix 5 – Equalities Impact Assessment

	Brighton and Hove City PCT Policy Equality Impact Assessment Sheet		
	Name of Policy:	Older People Mental Health Commissioning Strategy 2009 - 20012	
	Author of Policy:	Kathy Caley, Older People Mental Health Commissioner	
	Policy assessed by:	Extensive consultation undertaken throughout strategy development. See full strategy, including consultation details, at following link: **ATTACH ONCE RATIFIED AND ON WEBSITE**	
	Date of Impact Assessment:	January 2009 – Prior to ratification of final strategy	
	Date for review:	End of strategy period – 2011/2012	
	What is the purpose of this policy?	This strategy sets out the vision for the future development and commissioning of services to support older people with mental health needs and their carers in Brighton and Hove, for 2009/10 to 2011/12. The strategy has been developed by commissioners working across Brighton and Hove PCT and Brighton and Hove City Council, in conjunction with service users/carers and individuals from local stakeholder communities.	
	Who is the policy aimed at?	Older People Mental Health services across the local health economy	
	Impact of this policy	**Positive Impact (yes/no/don't know)**	**Negative impact (yes/no/don't know)**
1.	**Is the policy/guidance likely to have an impact on one of the following groups:**		
	• Black and Minority Ethnic (including gypsies and travellers)	Yes	
	• Gender (including Trans)	Yes	
	• Religion or belief	Yes	
	• Sexual orientation (including	Yes	

	lesbian, gay, bisexual and heterosexual)		
	• Age (younger or older people)	Yes	
	• Disability (including learning difficulties, physical disability, chronic illness, sensory impairment, developmental difficulties and mental health problems)	Yes	
		Positive Impact (yes/no/don't know)	**Negative impact (yes/no/don't know)**
2.	**Will the policy have any potential impact on** **i) promoting equality** **ii) eliminating discrimination**	Yes	
	Human Rights		
3.	**Does the policy show any potential impact in relation to the Human Rights Act 1998**	Yes	
4.	**Please describe the evidence and information that has been used to inform this policy, including any consultations with stakeholders.**		

The strategy and the commissioning recommendations set out in it have been drawn up based on national and local policy developments, and consultation with a range of stakeholders across the local health economy.

Below is a summary of the key principles identified as relevant to older people's mental health in national publications:

- Personalisation via use of individual budgets, direct payments and person centred planning to provide choice and control over services
- Partnership working and coordination between services to ensure joint planning and purchasing
- Services which promote reablement and maximise independence
- Reduce inequalities and develop services which promote health and wellbeing to all
- Improve quality of NHS education and training by developing an informed local workforce
- Build on service user and carer involvement and consultation to ensure inclusion in all stages of service development
- Service availability based on need and not age, and which promote dignity and respect
- High quality, value for money mental health service provision, using best practice models and specialist services where appropriate to promote good mental health, facilitate early diagnosis, and reduce stigma

More detail on each of the policies considered can been seen in appendix 2 of the strategy document. These policies have been drawn up following national consultations and set out the views of the public regarding future service development, particularly in older people mental health services. The information in these policies has directly informed the development of the OPMH commissioning strategy.

Locally there have been a number of policy developments which will drive changes to the provision of health and social care services for older people with mental health needs. These have also been incorporated into the strategy and include:

- PCT Strategic Commissioning Plan (2008 – 2013) which outlines key PCT priorities for the next five years. Priorities include a focus on dementia, reducing delayed transfers of care and reducing inequalities
- LA Adult Social Care Transformation agenda focusing on the personalisation of services and reablement
- Overarching provision of appropriate short term services, which meet the needs of individuals to maintain independence, facilitate discharge and maximise outcomes
- Development of local independent provider market
- Up to 200 new nursing home beds expected in the city in the next two years
- Integration of inpatient functional mental health services with working age mental health services

There have been various forms of consultation undertaken across the local health economy in the development of this strategy. These are outlined below:

- Briefing note on broad strategy priorities sent out to all associated organisations e.g. Pensioner's Forum, Older People's Council, Health User Bank members and PCT gateway organisations. See appendix 6 of the strategy for details of each organisation.
- Input and feedback received from OPMH commissioning strategy working group throughout development of strategy
- Initial focus group for service users, carers and representatives from associated organisations (Carers Centre, Federation for Disabled People Direct Payment mental health representative and Alzheimer's Society) held on Monday 8th December 2008. Follow up focus group held on Thursday 15th January 2009. See appendix 7 of strategy for focus group feedback.
- Feedback on commissioning recommendation sought from Community Voluntary Sector Forum Mental Health Network held on 13th November 2008. See appendix 8 of strategy for feedback.
- Primary care long term conditions education session Tuesday 13th January 2009 – dementia strategy briefing and feedback session

5.	**Please describe the likely positive or negative impact indicated in sections 1, 2 and 3**

Implementation of the older people mental health strategy will have a number of positive impacts:

- To ensure that all vulnerable groups are aware of services, social marketing techniques will be undertaken, to increase the knowledge of these communities. This will tackle inequalities experienced across the city. Barriers to services will also be investigated, with a view to addressing the problems some service users and carers may encounter.
- As the Equalities Bill is incorporated into service delivery, service availability will become more equable as services will be based on need and not age
- Mental health awareness training will be provided to staff to reduce stigma and discrimination felt by those with mental health needs
- Information availability will be assessed to ensure that the most appropriate methods are used to communicate with communities so they are adequately informed
- Service redesign will ensure that the most appropriate services are available to as many people as possible

- Increasing mental health support and training for mainstream services will allow more service users to cared for in mainstream services, rather than specialist mental health services
- Eventual development of improved diagnostic services will address the gap in the expected and the actual numbers of people diagnosed with depression and dementia. Once properly diagnosed, better support and services can be provided.
- Personalisation agenda will be rolled out across OPMH services ensuring that services are person-centred and meet the needs of the individual.
- Direct payments and individual budgets will be incrementally rolled out across OPMH services giving improved choice and control for the service user.
- Roll out of reablement philosophy will promote independence for older people, and will result in a reduction in the need for long term care
- Development of more robust contract monitoring framework and associated targets will drive up the available capacity and quality of residential and nursing care home services

6.	**If you have answered 'Don't know' to any point in sections 1, 2 and 3 – what additional information is required to make an assessment**		
n/a			
7.	**If you have identified negative impact, can amendments be made to this policy to avoid this impact**	**Yes** (give details and go to Q 10)	**No** (give details and go to Q 8)
8.	**If 'No' to Q7 – can the policy be delayed to allow a more detailed assessment to be undertaken**	**Yes (contact Equality and Diversity Manager)**	**No (give details and go to Q 9)**
9.	**If 'No' to Q8 – what rationale is there for proceeding with this policy in its current form? Include this information in any report to the Board, PEC, IGC as appropriate.**		
n/a			
10.	**Please describe arrangements for monitoring the actual impact of this policy, including contact details of responsible member of staff**		
There will be ongoing monitoring via the Older People Mental Health Implementation Group, lead by the OPMH Commissioner.			
11.	**Conclusion**		

As a result of this process the policy will be:

a) submitted without amendment

Signed: Kathy Caley

Position: Older People Mental Health Commissioner

Date: 5th January 2009

Completed forms should be attached to policies for approval to the relevant Board / Committee and

copied to the Equality and Diversity Manager.

Once policies have been approved, the Equality Impact Assessment sheet should be published on the PCT website.

If a more detailed Equality Impact Assessment is required, or additional information is needed is to complete this sheet, please contact the Equality and Diversity Manager.

Appendix 6 – Briefing note on broad strategy priorities

Briefing note sent to:

- Health User Bank (HUB) members
- Carer's Centre
- Brighton and Hove Local Involvement Network (LiNK)
- Older People's Council
- Pensioner's Forum
- Black and Minority Ethnic Community Partnership
- Federation of Disabled People
- Alzheimer's Society
- Mind in Brighton and Hove
- Spectrum – Lesbian, Gay, Bisexual and Transgender Community Forum

Appendix 7 – Feedback from Focus Groups

Below is a summary of the key points covered in the focus group held on the 8th December 2008.

Overarching/General

Age Limits

- Should not just be over 65's- a wider age range is needed. Especially relevant for early onset dementia

Individual Budgets

- Councils need to examine eligibility criteria for individual budgets- need to be lowered threshold so more can use them.
- Need to include those who are self funding.
- A lot of information and support is needed.
- Concern about those "employed" through Direct Payments e.g. no consistent training and checks

Information

- Should not be reliant on using IT/web based information – many older people do not have IT access or skills.
- An up to date directory of care provision and wider services and facilities for older people would be very useful. Suggested that it is delivered to all homes. Not funded by the taxpayer, but by advertisers instead.
- Information could be available via churches, community centres. GP's, pharmacies, buses, Post Office, supermarkets etc
- Need to build on what's out there already e.g. the Carers' centre have an A-Z of where to get help
- Information could be given by health and social care professionals- needs to be a consistency of person, and for them to think holistically (? Link to information prescriptions)
- After diagnosis person and carer may be in shock. Need info to take away with them and a number to ring or place to go to access more info if needed.

Training for staff

- Social workers need a toolkit, and training so they understand needs, especially of dementia.
- Positive risk training – i.e. giving the power to the "customer" (e.g. through Direct Payments) – this is a new way of looking at things, not "doing to" people but allowing then to be empowered.

- Staff need support. Suggested that meditation training available for staff. The MBCT course is now approved by the National Institute of Clinical Excellence and therefore could be used for staff and service users/carers.

Memory Screening service

- There used to be one in Brighton & hove but this stopped due to lack of funding. There is one in West Sussex – why can't Brighton residents use it? Why can't we reinstate one in B & H?

Prevention

Reducing social isolation

- Keeping people at home involves taking them out of their homes for social activity.
- Transport is a big issue; council only provide transport to Churchill Square. There is a need for transport to other places, e.g. the Holmbush Centre in Shoreham, and also day trips. The monthly outings provided through the Alzheimer's society are always very popular. Need to be at reasonable cost.
- Weekends are the hardest, older people can get very lonely - need to provide activities and trips at weekends too.
- Neighbourhood projects could be helpful e.g. neighbourhood care or providing a buddy type service.

Health promotion

- Alternative and complementary services may be useful. E.g. meditation.
- Carers centre have therapists providing a range of treatments – helps physical and mental wellbeing. Also offering Mindfulness (Buddhist).
- Could include Pilates, Tai Chi, Yoga.
- Alzheimer's Society want to train relief carers/ workers in Therapeutic Horticulture – will assist people unable to leave their homes.
- Carers centre have a Gardening project – it was agreed that gardening could prove a good source of social interaction and also activity.
- Singing classes/Music therapy- suggested by Alzheimer's society based on "Singing for the Brain" classes run elsewhere.
- Reminiscence work
- Swimming (supported?). Need for a hydrotherapy pool in Brighton and Hove.
- Art therapy/classes
- Volunteering - full training would need to be provided and ongoing support. Older people could prove a big resource.
- Wii use (as per Age Concern!)
- Older peoples "playgrounds" (speak to Angela Flood)
- Activities need to be local (though equitable across the city), in the daytime, accessible and affordable. Many activities also provide a break for carers.
- Use of Health Trainers to provide one to one motivational support on a short term basis

Early diagnosis and support

Phoneline

- Support specifically for older people. Information on local services, available evenings and weekends, as well as daytime.

A & E

- There have been problems with older people with mental health issues in A&E e.g. lack of understanding, lack of respect for carers, with mental health problems not perceived and taken into account.

Community

Hospital discharge

- Does not always work well. Hospital admission and discharge are key points for provision of information and support.

Social care (home care)

- Is not person centred e.g. allocation of about 15 minutes to dress and breakfast etc. Need for more time allocated.

Consistency

- Consistency of care for the housebound needed, with the same person at the same time

Day services

- Could be made more effective, creative, stimulating. Need to include appropriate physical exercise such as slow walking, music, Wii etc.
- "Extenge" - exercise programme for those with limited mobility

Transport

- Mentioned in many contexts: accessing day centres, need for improved transport re day trips, accessibility, etc. Some disagreement re effectiveness of ramps for wheelchair users
- Transport to Day Centres is problematic- service users could be picked up any time between 9 and 11, spending up to 3 hours on the bus. Many service users won't go to Day Centres for this reason.
-

Question: should we be integrating people into the "mainstream" to help reduce stigma and prejudice? But this could mean that Carers don't get the respite.

Comment: Reablement may prove a burden on unpaid carers

Appendix 8 – Feedback from Community Voluntary Sector Forum Mental Health Network

The following points were collated after an overview of the draft OPMH Commissioning Strategy was presented to the CVSF mental health network:

- Age Concern has a strategy around depression and social isolation, which includes promoting use of a Wii! The OPMH Strategy should be aware of this work and link in where appropriate.
- What are the financial allocations and how do services interface older/younger people MH services?
- Floating support needs to be considered
- No increase in resources is not helpful
- Counselling: not at acute end and inter-generational
- Availability of information, but how recorded / accessible
- Commissioning process: reward collaboration

Joint Commissioning Board	**Agenda Item 50** NHS Brighton & Hove Brighton & Hove City Council

Subject:		**Choice, Independent Living and Personalised Care: A Strategy for Physical Disability Services 2009-2012**
Date of Meeting:		**9th March 2009**
Report of:		**Director of Strategy Primary Care Trust**
Contact Officer:	Name:	**Linda Harrington** **Tel: 545 439**
	E-mail:	Linda.harrington@bhcpct.nhs.uk
Key Decision:	Yes	Forward Plan No: JCB 5524
Wards Affected:	All	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT

1.1 This is the first Physical disability Commissioning Strategy for the City. It is a joint strategy across Brighton & Hove PCT and Brighton & Hove City Council and outlines the development of services for adults with physical disability over the next three years 2009-2012

2. RECOMMENDATIONS:

2.1 That the Joint Commissioning Board note and endorse the attached strategy.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The PCT, as lead commissioner for services in the City for adults with physical disabilities, has been working with the local authority, and a wider representative stakeholder group, to develop this strategy. The strategy which identifies demand and need for services and provides the opportunity to develop better commissioning and improved management of limited resources across the health and social care sector.

The strategy identifies the local and national drivers for change and provides an assessment of need based on demographic information, local activity and trends. It then maps out the future direction including:

- Involvement and engagement
- Person centred care and self directed support
- Promotion of independence and extended living opportunities
- Improved support to those with complex and higher dependency care needs through the commissioning of alternatives to high cost residential, nursing home care
- Increased opportunities for local; citizenship and community participation

3.2 In order to implement the strategy, an action plan has been developed which will be taken forward by a new Physical Disability Strategy Steering Group. This group will have representation from across the statutory and voluntary sector and will report progress for all key projects to the relevant boards including the Brighton & Hove PCT Board and Adult Social Care Cabinet Meetings. This implementation action plan is attached at appendix 3.

3.3 The Strategy has been informed by the Joint Strategic Needs assessment 2009 which has been developed for Adults aged 18 to 64 with physical disability to support budget and service planning. The JSNA is attached at appendix 2.

4. CONSULTATION

4.1 The strategy has been developed by a steering group with representation from the statutory and voluntary sectors. A period of engagement and consultation was led by the PCT and took place from October until end of January 2009 with key stakeholders including voluntary sector and communities of interest, Disability Equality Scheme steering group and service users groups, relevant clinical groups and networks. Further consultation has been carried out since December in the development of an Equalities Impact Assessment.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The strategy is expected to be delivered within health and social care budgets however elements of the action plan may require further investment and will be subject to detailed business cases and a value for money approach. The strategy sets out objectives and where a changed approach is proposed. The expectation is that through service modernisation efficiency savings will be generated which will fund the new approaches

The PCT currently spends £435m in providing health care across Brighton and Hove. A significant proportion of this health care is provided to the working age population with physical disabilities. A key part of the Physical Disability Action Plan will be to establish baseline funding streams for physical disabilities and to ensure that these can be clearly linked with appropriate healthcare outcomes.

Expenditure across social care on physical disabilities (adults under 65) is approximately £9m. A proportion of the City Council's capital budgets on adaptations and Disabled Facilities Grants is applied to physical disabilities.
Finance Officer Consulted: Anne SilleyJonathan Reid Date: 25/11/08

Legal Implications:

5.2 The Physical Disability Strategy has been developed in accordance with national and local policy and follows a comprehensive analysis of assessed need within Brighton and Hove, taking into account the outcome of consultation with relevant stakeholders.

The Strategy should therefore ensure that the Council continues to be able to meet its statutory duties to service users, in accordance with individual need, and in compliance with the Human Rights Act.

Lawyer Consulted: Hilary Priestly *Date: 11/11/08*

Equalities Implications:

5.3 An Equalities Impact Assessment has been completed on the strategy and will be supported by an EIA on the associated action plan. The full Equality Impact Assessment panel was scheduled for 16th Feb however due to the inability of stakeholders to meet on the 16th the panel will now meet on the 23rd February to complete the full EIA. It is important that the strategy is considered by Cabinet and JCB in March, as recommended by members in December 08, so that this area of work can be included within the CSCI review also scheduled in March. Therefore it is recommended that a verbal update on the outcome of the assessment panel will be given at the Adult Social Care Cabinet meeting on the 6th March and the Joint Commissioning Board on the 9th March.

Sustainability Implications:

5.4 The strategy aims to improve access to and quality of services for disabled people without additional impact upon the environment.

Crime & Disorder Implications:

5.5 A higher proportion of disabled people are subject to abuse and hate crime than for the City population as a whole and this strategy aims to support disabled people to access support, advice and services that will address this inequality.

Risk and Opportunity Management Implications:

5.6 Demand for, expenditure on and unit costs of services for adults with physical disabilities has been increasing year on year and future growth is a financial risk. This strategy provides an opportunity to work across health and social care to strengthen commissioning and deliver improved value for money and reduce the financial risk and to meet the council priority of better use of public money.

Corporate / Citywide Implications:

5.7 This strategy meets the council corporate priority of reducing inequality by increasing opportunity. It is relevant to disabled people who live, work and use services from across the council and this strategy will apply equally to disabled people from across the City.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 The strategy has been developed to address the financial risk and to develop improved demand planning, the alternative would be no strategy which would present a financial risk.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The strategy, JSNA, and three year implementation Action Plan have been developed by the Primary Care Trust in partnership with the local authority. The Joint Commissioning Board is now asked to agree the strategy on behalf of the local authority, and Primary Care Trust.

SUPPORTING DOCUMENTATION

Appendices:

1. Choice, Independent Living and Personalised Care: A Strategy for Physical Disability Services 2009-2012
2. Appendix A: Relevant Policy Strategy and Legislation
3. Appendix B: Joint Strategic Needs Assessment: Adults Aged 18 to 64 years with Physical Disabilities
4. Appendix C: Three year Action Plan for Physical Disability Services 2009-2012
5. Appendix D: Glossary
6. Appendix E: Summary report of consultation and engagement activity

Documents In Members' Rooms

1. Physical Disability Strategy

Background Documents

1. None

Brighton & Hove

NHS
Brighton and Hove

Choice, Independent Living and Personalised Care

A Strategy for

Physical Disability Services

2009-2012

Table of Contents

1 Acknowledgements

This strategy has been developed with contributions from:

- Service user and carers
- Representative of organisations of disabled people
- Members of a Strategy Steering Group
- Disability Equality Scheme steering group and service users group
- Integrated Service Improvement Programme (ISIP) workshop members
- Care Services Improvement Partnership (CSIP)

2 Executive Summary

The joint Physical Disability Commissioning Strategy sets out the future direction of physical disability services in Brighton and Hove from 2009 - 2012.

The purpose of this strategy is to extend choice, strengthen independent living, deliver personalised care and create greater citizenship opportunities for people with a physical disability.

The strategy supports a social model of disability which shifts the focus from impairment (the medical model) to the recognition of the impact of social and environmental barriers for people and how these can restrict and exclude people with a disability from mainstream society[1].

Relevant to a range of disabilities (cognitive, mobility, sensory, and communication) and health conditions a broad scope is required and responsiveness to a range of individual needs. The strategy whilst relevant to all age groups and people with other disabilities addresses focuses on the needs of adults (18-65yrs) with a physical disability and the associated care services. It is therefore important to cross-reference this strategy with other key areas of work[2] to ensure a comprehensive approach to the development of services, efficiency and best use of resources.

The development of the strategy has been informed by: national and local policy and guidance, a Joint Strategic Needs Assessment for Adults with Physical Disabilities, and listening to the views of disabled people and their carers.

Disabled people have told us that services must be planned and commissioned based upon a social model of disability. The social model recognises the need to address the environmental and attitudinal barriers which exist and prevent full equality for disabled people. Disabled people and their carers want more involvement and meaningful engagement in the process of planning for service improvement. Service users and carers have identified areas for improved access and support including: information services, during hospital admission and at point of hospital discharge, to support independent living and to access mainstream community activities.

As a result of the above the strategy has five overall strategic objectives outlined below:

[1] Social model of disability: Disability within the social model is defined as "the loss or limitation of opportunities to take part in society on an equal level with others due to social and environmental barriers".

[2] Key areas of work are included at Appendix A

Five strategic objectives:

- To actively involve and engage physically disabled people and their carers in the future planning and development of services.
- To develop personalised and self directed care
- To promote independence and extend opportunities for independent living
- To improve support to those with complex and higher dependency care needs
- To increase opportunities for local citizenship and participation in communities

For each of the five objectives above the strategy identifies: relevant local priorities the key actions for delivery and the desired outcomes. The key actions of this strategy include:

To strengthen service user and carer engagement and involvement the key actions are:

- To ensure service user and carer involvement in the planning, development, monitoring and reviewing of future services through the development of inclusive engagement structures.

- To develop a service user led centre for independent living to provide a focal point for community information, independent living support and further opportunities for service users and carers.

To further develop personalised and self-directed care the key actions are:

- To ensure information services are highly visible and integrated thereby strengthening the one-stop shop approach to information, advice and advocacy services.

- To strengthen health promotion and well being initiatives through the introduction of designated health trainers and Expert Patient Programmes.

- To develop self care and management by increasing take up of self directed care including Direct Payments and individual budgets.

- To ensure care delivered is timely, responsive, accessible and person centred

To increase support to individuals and their families to maintain independence and independent living the key actions are:

- To strengthen the focus of services on reablement and rehabilitation to support independence and independent living.

- To improve management of disability during hospital stay and in discharge planning to facilitate a return to independent living

- To improve access to accessible and adapted housing

- To deliver primary and community services which support independence, are delivered as close to home as possible, with appropriate access and re-access to support as needs change

To improve support to those with complex and higher dependency care needs and their carers the key actions are:

- To develop a commissioning framework to broaden support options available locally this will include:

- Development of Extra Care Housing for adults aged 18-65 years

- Improving access to short term, transitional services for those in transition (e.g. those leaving hospital or specialist rehabilitation services or children's care services),

- Improving longer term support for those who wish to return to the city from out of area placements and those wishing to remain living independently within their own homes

- Exploring further integrated working for those with complex health and care needs to ensure appropriate and greater co-ordination of care

- Strengthening current procurement initiatives to ensure high quality and value for money care is purchased for the city's population

To increase opportunities for local citizenship and partnership the key actions are :

- To increase opportunities for employment, and training to include support for finding and retaining employment, accessing training and retraining opportunities.

- To ensure that people with a disability are able to access the city's wide range of mainstream community activities.

- To develop a centre for independent living model which will develop strong links with the wider community and develop further opportunities for community participation.

Delivering the Strategy

To successfully deliver this strategy a whole systems approach is required. A cross-representational Physical Disability Commissioning Strategy Steering Group will be established to steer and monitor implementation of the strategic action plan. Due to the wide-ranging scope of the strategy a project management approach will be taken to implement the key actions of the strategy.

3 Setting the scene

3.1 Introduction

Brighton and Hove City Primary Care Trust (B&H PCT) has, together with Brighton and Hove City Council, jointly developed a three-year strategy (2009 to 2012) to improve opportunities and support services to people with a physical disability.

The strategy encompasses the whole health and social economy of Brighton and Hove, and must be read in conjunction with local disability schemes[3], which provide the local plans for ensuring equality of opportunity for disabled people.

National and local policy sets out the direction for the delivery of health and social care and this strategy outlines how local services will develop to meet national policy whilst ensuring the most effective use of resources.

3.2 Scope

This strategy is based on the social model definition of disability, which shifts the focus from impairment (the medical model) to the recognition of the impact of social and environmental barriers for people and how these can restrict and exclude people with a disability from mainstream society[4].

The strategy's remit is broad, relevant to a range of disabilities (cognitive, mobility, sensory and communication) health and long term conditions. Specific focus is given to the needs of younger adults (18-65yrs) with a physical disability, and the related adult support services to ensure that work, family, social and personal life considerations for working age adults are addressed.

However whilst the principles and aims of the strategy will be relevant to all it is necessary to refer to the relevant individual plans for information on other detailed work programmes. To assist this other relevant strategies and areas of work are listed in Appendix A.

3.3 Key Strategic Objectives

The Government's vision for disabled people is set out in Improving The Life Chances of Disabled People[5] It states:

> "By 2025, disabled people in Britain should have full opportunities and choices to improve their quality of life and will be respected and included as equal members of society"

[3] http://www.brightonhovecitypct.nhs.uk/pct/howwework/equalities/documents/DisabilityEqualitySchemeDraft17.pdf

[4] Social model of disability: Disability within the social model is defined as "the loss or limitation of opportunities to take part in society on an equal level with others due to social and environmental barriers".

[5] Improving the Life Chances of Disabled People, Prime Minister's Strategy Unit 2005

To improve the life chances of people locally the following key objectives have been identified:

- To actively involve and engage physically disabled people and their carers in the future planning and development of services
- To develop personalised and self directed care[6]
- To promote independence and extend opportunities for independent living[7]
- To Improve support to those with complex and higher dependency care needs
- To increase opportunities for local citizenship and participation in communities by improving access to the city's services and facilities e.g. education, employment, leisure and other activities

*Throughout the strategy recognition and consideration of the support needs of carers: both carers of disabled people and disabled people as carers themselves will be evaluated.

3.4 Key Principles

This strategy is underpinned by the following key principles:

- Services should be designed and developed in partnership with users and carers.
- The strategy must ensure that the needs of those more traditionally excluded[8] are fully considered.
- Services commissioned must provide high quality, evidence based care and represent value for money.
- The commissioning plan will seek to sustain a balanced financial position across the local health and social care economy.

3.5 Key Challenges

Key challenges for the strategy are:

- Ensuring that the plan is responsive and flexible in order to address a wide range of disabilities and individual needs.

[6] Personalised care: This is where the individual is central to the decision making and planning of care and has choice as to how their needs are met

[7] Increasing disabled people's opportunities to live independent lives at home, at work and in the community

[8] Including disabled people from black and minority ethnic communities, and disabled people who are lesbian gay, bisexual or transgender

- Achieving the necessary coordination and integration of commissioning plans and support systems to ensure a shared approach.

- Delivery of the plan and significant service improvements within a financially challenged local health economy.

3.6 Risks

3.6.1 Securing ongoing service user engagement and involvement

3.6.2 Stronger local service user engagement and involvement is required to ensure that services are responsive and flexible to meet local need. A robust and inclusive model is required to secure wider representation locally.

3.6.3 Financial Plan

Across the local care economy key services for physical disability experience a consistently high level of demand. As treatment and technology advances and more people with complex needs are supported to live at home the demand on services and existing budgets has increased. This has led to significant pressures within both health, housing and social care budgets.

In addition, the economic environment is more challenging than in previous years – health, housing and social care services will face increasing and competing demands for prioritisation within a tightening financial envelope. The key risk here is that, as identified in both this strategy and the Joint Strategic Needs Assessment, the funding streams for physical disability services are often less directly 'visible' and receive less direct focus than others as they are often located within other service pressures. This is because services for adults aged 18-65 years with a physical disability are often associated with other conditions (particularly within a healthcare context).

3.6.3 Management information

This strategy's assessment of need is largely based on national data applied to the local population. This has enabled an estimate of local incidence, and prevalence rates and expected type and level of disability locally. Improved record keeping across the local health economy is required to facilitate a more robust analysis of future needs.

3.7 Mitigating Factors

Development of a robust model for ongoing service user engagement and involvement is a key priority of the three year action plan (included at Appendix D) and will be taken forward in year one.

The Joint Strategic Needs Assessment (JSNA) and action plan highlights the key budget lines for physical disability services. To mitigate the recognised financial risks above, work will continue to further assess need and identify spend against physical disability. A Physical Disability Steering Group will be established to monitor implementation and financial impact of the proposed initiatives and to secure closer alignment of performance and financial reporting, budget planning and

commissioning. This group will help ensure that the profile of the needs of service users with a physical disability will be maintained within the prioritisation processes within health, housing and social care.

4 Drivers for Change

4.1 National context

This strategy is developed in the context of national legislation, policy and initiatives aimed at achieving full equality for disabled people by 2025[9] and a government drive to give a right to independent living.

It is also developed at a time of major reform within health and social care that will shape the way services are delivered in the future, giving renewed priority to:

- Good prevention services and early-targeted intervention;
- Supporting those with more long term needs;
- Equality of citizenship and reducing health, social and community inequalities;
- Improving access to community services, integrated and personalised care
- Greater integration and joined up working between health and social care services.

The main guiding legislation and national policy for the Physical Disability strategy include:

- The Disability Discrimination Act (1995)
- The Disability Equality Duty (2005)
- World Class Commissioning and the Darzi Review “Our NHS, Our Future” (2007)
- Our health, our care, our say: a new direction for community services' (DOH (2006)
- Putting People First: A shared vision and commitment to the transformation of Adult Social Care
- Improving the Life Chances of Disabled People, Prime Ministers Strategy Unit, 2005

It is also informed by clinical and best practice guidelines such as:

- Long-term conditions National Service Framework (DOH 2005)
- National Stroke Strategy (2007

[9] Equality 2025 - the UK Advisory Network on Disability Equality is a network of disabled people, who will act as a reference group for the government to ensure input from disabled people at the start of policy development. The intention is that policy changes across all government departments will be referenced by the network and therefore validated by disabled people.

- Standards for Services for people who are deafblind or have a dual sensory impairment in partnership with the Department of Health
- Stepping Away for the Edge, Improving Services for Deaf and Hard of hearing
- Transforming Community Equipment Services Project, (DOH 2006)

4.2 Local context

In addition to key national policy the strategy is developed in line with the city's overall strategic plan for local health and social care services. Several key documents set out the future direction for services across the city.

Brighton & Hove City Council Corporate and Directorate Priorities set the framework for this strategy and are to:

Corporate Priorities	Directorate Priorities
• Protect the environment while growing the economy • Better use of public money • Reduced inequality by increasing opportunity • Fair enforcement of the law • Open and effective city leadership	• Providing homes to meet the needs of the city • Improve housing quality in the City to ensure all have access to decent homes • Deliver Value for money services • Work in partnership to improve the commissioning and provision of services • Reduce inequality • Deliver excellent customer services

Brighton & Hove City Council (Adult Social Care) is taking forward an ambitious Personalisation Programme with the vision of creating an integrated range of effective services and opportunities and delivering timely and appropriate responses to individuals' needs and aspirations and which support people to lead fulfilled and healthy lives.

The city is committed to empowering people to make informed choices about the sort of support that suits them and to achieve the outcomes they want to maximise their independence and quality of life. This includes safeguarding those people whose independence and well being are at risk of abuse and neglect.

To deliver this vision, services are being re-designed to offer:

- clear advice and information through multi skilled contact points
- self assessment, easy access to simple services (e.g. equipment, community services, telecare)
- identification of and signposting to partnership solutions to improved quality of life
- self directed support options at all stages for all social care users
- an integrated approach to reablement for the majority of social care users
- a robust care management service for those who need it
- a professional and effective process to safeguard vulnerable adults

The new service will work to a set of key principles, including:

- a service that enables people to make decisions and choices wherever possible
- a service that facilitates independence whereby people can access the appropriate resource at the right time and move on
- a service that is flexible and designed to meets changing needs
- a service that listens to people's views and is open to change
- a fair service for all parts of the community that does not discriminate on the basis of income or background
- a service that represents good value for money for the community and the person using the service

The Primary Care Trust (PCT) has developed its Strategic Commissioning Plan for 2008-2013 – this is the overall commissioning plan for the city's health care services. It sets out the plans for improving health care services to ensure "High Quality Care for All" in line with World Class Commissioning and the Darzi Review and the three key principles of: better health and well being, better care and better value for all, underpinned by the organizational competencies to deliver them. The PCT has identified six key overall commissioning goals for the next five years. The goals are for:

i) Average life expectancy to increase above expected trends with biggest gain in the most deprived areas

ii) Children grow to adulthood with maximum life chances and best possible health

iii) Improve quality and response for mental health, sexual health, alcohol and drugs services

iv) Improve quality and response in primary care services

v) Improve quality of life for people living with long term conditions

vi) To have a range of services nationally recognized as best practice

Healthier people excellent care for NHS South East Coast (2008) – sets out a shared vision and recommendations for health services in the South East Coast region over the next 10 years. The PCT has agreed and signed upto a number of pledges for the improvement of health services. Relevant to this strategy are pledges for staying healthy, acute and planned care and long term conditions. Key pledges for Long Term conditions are set out below:

No	Long Term Conditions - Pledge
1	By 2010 health and social care to be jointly planned and purchased for long term conditions where appropriate, so that people will receive co-ordinated and personalised care that is tailored to their needs.
2	By 2011 90% of patients with long-term conditions will have personal care plans
3	By 2012 all patients will receive ongoing support , education and training to help them better manage their own condition
4	Networks of clinicians will be developed to improve the quality of care for people with long-term conditions
5	We will work with the NHS and employers to rehabilitate people so that they return to work at the earliest opportunity

Other key local strategies with which the physical disability strategy is cross-referenced are summarised in Appendix A and include:

- Older Peoples Commissioning Strategy (2007-2010)
- Strategy for Self Care
- Housing Strategy
- Strategy for Self Directed Support
- Carers Strategy
- Extra care housing strategy

5 Local assessment of need

This strategy is informed by the city's Joint Strategic Needs Assessment for Adults (aged 18-64 years) with physical disabilities 2009 (included at Appendix B)

The JSNA provides an assessment of local need based on local demographic and activity information and national studies applied to the local data. The report does however recognise the challenge this presents due to a number of factors including:

- much of the available data relates to impairment rather than disability and therefore reflects the medical model of disability, which is less useful than the social model in guiding the planning of services to respond to users needs.
- local activity is often not broken down by age range, or level of individual need
- uncertainty over future trends, and the use of measures which give only a partial indication of levels of disability and dependency.

Due to these difficulties most forecasting models of future health and care are based on current levels of need[10].

Overview of Joint Strategic Needs Assessment:

- The social model of disability highlights that disabled people face social, environmental and attitudinal barriers which can restrict their activity and participation in society. Policies that increase independence and enablement are important in supporting good outcomes for people with physical disabilities.
- Evidence highlights that people with physical disabilities experience disadvantage in many aspects of daily life. They are more likely to live in poverty as well as experience problems with hate crime and harassment, housing and transport.
- The specific needs of people with physical disabilities who are members of groups that potentially experience additional barriers to participation, such as Lesbian, Gay, Bisexual and Transgender (LGBT) people, people from Black and Ethnic Minority (BME) groups, and Gypsies and Travellers, should be taken into account in service planning and delivery.
- It is estimated that approximately 14,000 Brighton and Hove residents aged 18 to 64 have a moderate physical disability, and 3,400 have a severe physical disability.
- In the 2001 census, a higher proportion of Brighton and Hove residents aged less than 65 reported having a limiting long term illness compared with the

[10] The Parliamentary Office of Science and Technology[10] acknowledges the difficulty in forecasting future demand;

England average, and a higher than average proportion of residents aged 16 to 74 reported that they were permanently unable to work.

- Approximately 6,700 local residents aged 18 to 64 are expected to have a moderate personal care disability, and 1,293 are expected to have a severe personal care disability.

- The number of people with a physical disability living in Brighton and Hove is expected to increase by between 3.5% to 5.0% between 2008 and 2015.

- Brighton and Hove has a young age distribution and a reduction in the number of older people living locally is projected. Therefore the proportion of all people with physical disabilities who are aged less than 64 years is likely to increase. The young age distribution of the local population means that for health conditions which are typically young onset, such as multiple sclerosis, there are likely to be a higher than average number of new diagnoses in the local population each year compared with other authorities with a similar sized population.

- One in twenty adults aged 18-64 in Brighton and Hove receive Disability Living Allowance, (DLA) however the rate varies by geographical area and in the electoral wards of East Brighton and Queens Park one in twelve receive DLA.

- Residents with a physical disability were more likely to live in a home in disrepair and more likely to be fuel poor.

- Households with a disabled member are more than twice as likely to rent from a local authority or social landlord (37 per cent of all households with a disabled member live in social housing, compared with 15 per cent of all households living in social housing across the City). The City has a large privately rented sector, and there may be barriers to fitting adaptations for people with physical disabilities in these properties.

- Historically Brighton and Hove has had a relatively high number of people living in long stay residential and nursing care. Since 2003 the number has fallen considerably. However the unit cost of this care is rapidly increasing and is high compared to other local authorities.

- During the same period the number of people with physical disabilities helped to live at home by Brighton and Hove City Council has increased considerably, and local performance is higher than the England average.

- In 2006/07 the rate of Brighton and Hove residents with physical disabilities aged 18 to 64 receiving direct payments was low compared to the national average, however since this data was published the actual number receiving payments locally has increased from 39 in 2006/07 to 65 in 2008/09

- The proportion of homelessness acceptances with physical disability as the priority need in Brighton & Hove is consistently two to three times higher than the England average, indicating a high level of need locally.

- More than 200 applicants on the housing register require a property that is partially or fully adapted for wheelchair use. Of the 88 requiring a fully adapted property, 76% are aged less than 60 years.

In summary the JSNA makes the following recommendations:

- Ensure that service planning takes into account the projected increase in the size of the population aged under 65 with physical disabilities
- Ensure local people with physical disabilities are involved in planning and development of services
- Ensure that services provide high quality information at the initial point of access to promote independence and enablement
- Ensure those involved in service planning and delivery consider and respond to the needs of specific groups including as BME groups, LGBT people and gypsies and travellers,
- Improve access to accessible and adapted housing
- Ensure the needs of carers of people with physical disabilities are considered in service planning and delivery
- Increase the number of local people in receipt of self directed care
- Consider how knowledge of the needs of local people with physical disabilities can be improved, including improved data collection, and include this information in the revised version of this Joint Strategic Needs Assessment.

6 Overview of Performance and finance

Performance: Services are measured against a number of national and local standards. Overall the city has a varied picture of performance with some services performing highly and showing real strength and others requiring further improvement.

The Health Care Commission assesses the overall health performance of the city. Health targets include condition specific and cross cutting performance targets. The most relevant performance measures for physical disability are a combination of performance targets and quality standards. The new Care Quality Commission will continue to monitor performance across specified targets and quality standards, and will reflect the significant shift in emphasis across all health services towards commissioning for quality. Funding for service providers is increasingly dependent on meeting specified, and challenging, quality targets.

The position in Adult Social Care is currently under review. The Commission for Social Care Inspection (CSCI) is leading a national consultation to inform the future performance management of Adult Social Care. Early indications are that there will be a strengthened focus on evidence of local delivery of the White paper "Our Health, Our Care, Our Say" national outcomes. A National Indicator Set (NIS) will apply within which the thirty-five Local Area Agreement targets will be critical. In addition Councils will continue to collect the Performance Assessment Framework indicators during 08/09 until the consultation is concluded .

The NHS Operating Framework (2008) outlines the key priorities and "vital signs" on which local health and social care services will be monitored. Relevant targets include:

- Percentage of patients seen within 18 weeks for admitted and non-admitted pathways
- Patient experience of access to primary care
- Adults helped to live at home.
- Proportion of people with long term conditions supported to be independent and in control of their condition (NIS 124)
- Timeliness of social care assessment (NIS 132)
- Timeliness of social care packages (NIS 133)
- Adults and older people receiving direct payment and/or individual budgets per 100,000 population (aged 18 and over) NIS 130 and a LAA target

- Proportion of carers receiving a carers break or a specific carers service as a percentage of clients receiving community based services (NIS 135 and a LAA target)

- VSA14: Quality stroke care (outcome: Reduction in stroke related mortality and disability) Patients who spend at least 90% of their time on a stroke unit and higher risk TIA cases who are treated within 24 hrs

- Also in 2009 two additional service user experience indicators are planned: NIS 127 regarding satisfaction and NIS 128 regarding dignity and respect

The Primary Care Trust measures performance against all of these key targets on a monthly basis, and works across key partnership agreements to ensure that these targets are met.

6.1 Local Authority - Key performance indicators

The city performs well in terms of those helped to live at home; with over 90% helped to live at home. Table 1 shows a steady increase in the number of people helped to live at home and Table 2: shows a steady fall in the number of people supported in residential and nursing home care since 2003.

Table1: People with a Physical Disability helped to live at home (Rates per 10,000 population aged 18 to 64 years)

	2003/04	2004/05	2005/06	2006/07	2007/08
Brighton and Hove	4.2	3.9	6.1	6.7	7.6
England	4.2	4.2	4.5	4.5	4.7
SE England	3.9	3.7	4.3	4.6	5.0

Source: CSCI Performance Assessment Framework

Table 2: Long stay supported residents receiving residential and nursing home care (Rates per 10,000 population aged 18 to 64 years)

	2001	2002	2003	2004	2005	06	07	08
Brighton and Hove	3.5	3.7	4.5	3.8	3.6	3.0	2.5	2.4
IPF Comparator group	3.6	3.3	4.3	3.8	3.5			
England	2.9	2.9	3.4	3.2	3.0			

Source: Key Indicators Graphical System

However the city performs relatively less well with regard to unit cost. For both residential and nursing home care unit costs are shown to be above the unitary average and close to the outer London boroughs' average.

Table 3: Unit costs per week residential and nursing home care for Brighton and Hove 2004/05 to 2007/08

2004/05	2005/06	2006/07	2007/08
£734	£804	£893	£993 (provisional)

Improving local performance for self directed care is a key priority for the city; the number of people accessing direct payments in the city is improving with an increasing number of people receiving care via direct payment 36 (2006) 54 (2007) and 65 March (2008)

6.2 Health Performance

There are no specific physical disability performance indicators within health; indicators are condition specific or cross cutting targets. The PCT Strategic Commissioning Plan outlines local health priorities and associated targets. Targets of relevance to this strategy include:

- Vital Sign 14: Quality stroke care (outcome: Reduction in stroke related mortality and disability) Patients who spend at least 90% of their time on a stroke unit and higher risk TIA cases who are treated within 24 hrs. The reporting method for this indicator is currently under revision by the DoH and therefore performance against target will not be confirmed until later in 2009.

- Proportion of people with long term conditions supported to be independent and in control of their condition (NIS 124) and

- Healthier People, excellent care pledges one to five for Long term conditions

In addition to the above targets individual services are monitored against agreed outcome measures and include targets to support: better health outcomes improved functional independence and individual patients' experience of care, a reduction in wait times and delayed transfers of care and prevention of admissions.

The Physical Disability commissioning strategy must maintain performance where services are performing highly and support the delivery of new targets across the local health and social care economy. A further comprehensive needs analysis will inform work streams and monitoring of the associated action plan will ensure alignment of performance and financial reporting, budget planning and commissioning.

6.2.1 Financial context

Primary Care Trusts and Local Authorities receive budget allocations based on a weighted capitation formula, which includes population need, size and age structure and variation in the cost of providing care.

For both health and local authorities, the financial environment is impacting on the funds available for investment. This is driving an increased focus on efficiency and value for money, and means a renewed emphasis on prioritisation for new investment. As an example, the underlying funding formula for the NHS has now changed, and places a greater weighting on funding areas with an older population and a greater degree of rurality than was previously the case. The PCT has now moved from being broadly 'on target' in terms of funding, to being 7% 'above target.' While the allocations for the next two years are broadly secured, this will inevitably have implications for 2011/12 and future years.

However, both health and social services have invested significantly across the range of services for adults with physical disabilities in recent years, as can be seen below. More investment will be required in the future, but as outlined in more detail in the costed activity plan, much of this investment will be funded through improvements in productivity and efficiency. Some upstream new investment will be required – for example, in delivering the personalisation agenda – but this is anticipated, in due course, to deliver efficiencies which will be reinvested to focus on

targeted areas for improvements. Both health and adult social care have seen a renewed focus on commissioning for quality, with a strong emphasis on using system reform tools, such as better contracting, strengthened market management and procurement, and CQUIN (Commissioning for Quality Indicators, which incentivises improvements in targeted service areas) to deliver better outcomes within a narrowing financial envelope.

6.2.2 Expenditure on Health Services for adults with physical disabilities

The PCT currently spends £435m in providing health care across Brighton and Hove. A significant proportion of this health care is provided to the 18-65 yrs age group with physical disabilities. However capturing the relevant health expenditure is challenging because of the broad range of health specialities, care groups and diseases covered. As an example, primary care practitioners provide extensive support to service users as part of their broad package of care.

However, some areas of key health expenditure can be identified and utilised as drivers for change. This includes acute hospital services, specialist and general rehabilitation services, health continuing care spend, and specific primary and community services. As an example, combined expenditure on neurorehabilitation services is around £5m per annum, with around 33% of activity attributable to adults aged 18-65. The PCT has been working closely with both local health providers and the local authority to ensure that these services are fit for purpose and to establish the nature of investment required in future years. Further details on these areas of expenditure can be found in the Joint Strategic Needs Assessment which accompanies this strategy.

For each of the next two years, the PCT has identified that it will be funding additional growth (varying from 3.25% to nil, dependent on the specific service area) and tariff uplifts of between 1 and 2.2% across local health services.

Looking to targeted investment to align with this strategy, a key priority of the PCT Strategic Commissioning Plan is to improve health outcomes and to reduce health inequalities. Financial investment has been allocated to ensure that the quality of service is improved across the board, and issues of access are addressed for all key service user groups – including those with physical disabilities and their carers. The PCT is also funding additional capacity to support carers, and to improve the quality and responsiveness of primary care. These broader programmes of investment will impact on adults with physical disabilities, and one of the objectives of the Strategy, and the supporting working groups, is that it enables a clearer focus on the specific investment needs in this area.

A key part of the Physical Disability three year Action Plan will be to continue work to identify and establish baseline funding streams for physical disabilities and to ensure that these can be clearly linked with appropriate healthcare outcomes. This is part of a wider increased emphasis within healthcare on the link between investment and outcomes.

6.2.3 Expenditure on Social Care Services for adults with physical disabilities

Expenditure across social care on physical disabilities (adults under 65) is approximately £9m. A proportion of the City Council's capital budgets on adaptations and Disabled Facilities Grants is also applied to physical disabilities

The local authority community care budget currently supports 800 people with substantial and critical care needs with their care and accommodation needs. This budget has been under continuing year on year pressure as people with higher dependency care needs remain living in their own homes.

6.2.4 Joint Commissioning and Other Services

The PCT and the local authority have a number of key partnership arrangements, including formal joint commissioning agreements.

Two services relevant to this strategy are the integrated community equipment service and the intermediate care service, with a combined total investment across the two organisations of £4.7m. These services have seen considerable additional investment in recent years, reflected in improved service outcomes.

The PCT and the Local Authority also have a number of contracts with the third sector and independent providers and routinely work together to secure strengthened value for money.

The Joint Strategic Needs Assessment (Appendix B) captures the key budget lines for physical disability services.

7 Service profile and future priorities

This section profiles current service delivery and highlights the future direction for service development, identifying local priorities for service improvement, key actions for delivery and desired outcomes.

A three-year action plan (included at Appendix B) will steer implementation and monitor progress against the key actions. Each work programme of the action plan will incorporate an Equalities Impact Assessment (EIA).

Five overall strategic objectives:

- Strengthened involvement and engagement of disabled people and their carers in future service planning and development
- Strengthened personalised care and increased self directed support
- Promotion of independence and extended independent living opportunities
- Improving support to those with complex and higher dependency care needs
- Increased opportunities for local citizenship and participation in local communities

7.1 Objective 1: Strengthened Involvement and engagement of disabled people and their carers in future service planning and development

Future direction:

World Class Commissioning places service user engagement and involvement at the centre of commissioning plans. The involvement of people with a physical disability and their representatives is key to ensuring the delivery of appropriate and responsive services. It is important to provide opportunities for people to voice their views on the services they have received and to influence the way services are planned for and provided in the future.

Local Position:

Locally work is underway to strengthen the involvement and engagement of service users and carers through the development of Local Involvement Networks (LINks[11]), and partnership working with the voluntary sector to widen service user engagement and representation.

[11] LINkS Local Involvement Networks

Local priorities:

- To develop effective and inclusive structures to enable people with a disability, their carers and representatives to be fully involved in the planning and development of services, ensuring that those traditionally excluded are included and supported to fully participate

- To ensure user feedback is a central part of our planning and monitoring of services

- To secure appropriate user representation on key programmes of work

Key Actions:

- We will agree with service users and carers a model for future engagement to ensure full involvement in the implementation and monitoring of the physical disability strategy

- We will work in partnership with people with disability and carers regarding the future model for a service user led independent and healthy living centre

Desired Outcomes:

- Increased number of people engaged in the planning and development of services with representation and involvement from those traditionally excluded

- High quality, responsive services which reflect and meet individual need

- A reduction in health and care inequalities

7.2 Objective 2: Person centred care and self directed support

Future direction:

National policy[12] has been driving a reform of the way care is delivered with a strong emphasis on choice and personalised care, earlier intervention and prevention, streamlined assessment and the development of empowerment models of care and initiatives for consumer-directed care or self-directed support.

Local position:

Care navigation, coordination and management

To support this reform of care access to high quality information, care navigation and support services is required. Disabled people and their carers have told us that they were at times unaware of existing support and were unclear where to go for advice and help. Service users and their carers have asked for clear and easily accessible information[13] and for easier and faster access and re-access to services.

Locally a number of initiatives to improve signposting, care navigation and management have been introduced. The city has developed a number of models of care management including community matrons, a case management team and a number of specialist nurse posts. Integrated Care Pathways[14] (ICPs) have been developed across services to improve patient experience and ensure smooth transition between services and delivery of care[15]. Local protocols are in place for transitional care planning to ensure coordinated planning of care between children's and adult's services from the age of 14 years.

Self care and self directed support

The local authority social care transformation programme will transform the way care is delivered in the city, facilitating clearer and faster access to support and developing a stronger focus at assessment and review on reablement.

Currently personal care is purchased either through Direct Payments or the care management service. Uptake of Direct Payments in the past has been slow, but is now increasing. A detailed review of current systems was completed and nine recommendations are being followed to increase the local take up of Direct

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[12] The NSF for LT conditions, Our health our care our say, Putting People First

[13] PCT DES , MS Stakeholder event

[14] A care pathway is the journey that individuals may expect to access the assessment and care interventions from the statutory and non-statutory agencies. The Chronic Disease Management strategy defines an ICP as a "multidisciplinary outline of anticipated care placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience"

[15] Care pathways hare been developed for the following health conditions: stroke, chronic Obstructive Pulmonary Disease, Cellulitis, intravenous antibiotics, Management of infections, Heart failure, Falls, Urinary problems/catheters

Payments. This includes building further flexibility into the scheme and further investment in the Direct Payment support service.

The target for 07/08 was for 70 services users with physical disability to be in receipt of a direct payment and for 08/09 the target was increased to 140. Progress against targets is overseen and driven by a cross agency Direct Payment Implementation Group.

The current national piloting of Individual Budgets[16] extends individual choice and control further. Users of social care services will receive a single assessment the purpose of which is to assist people to identify their need for support, how they wish these to be met and to determine the resource allocation. People will be able to choose from a range of services such as equipment, home care, housing adaptations and low level preventative services. Currently a pilot for individual budgets is underway within Adult Learning Disability services.

A Self Directed Support strategy will be completed during 09/10, which will outline the city's plan for the future extension, and development of self directed support options.

Local priorities:

- To develop clearly visible and integrated information services, which are responsive and accessible to the needs of people with a physical disability and their carers.

- To strengthen focus on earlier interventions and prevention services and initiatives.

- To increase the use of self directed support options, with more people purchasing care through Direct Payments and the introduction of individual budgets for people with a physical disability with support, advice information and training for service users and carers.

- To deliver faster and more responsive assessment and review services with a strengthened focus on the promotion of independence and reablement.

Key Actions:

- We will develop a one-stop shop approach to information services through the centre for independent living. This will provide a focal point for support and advice to the wider community.

- We will review current delivery of advice and advocacy services to ensure that they are relevant and fully accessible to disabled people, and are supporting

[16] Our health, Our Care, Our Say

people to manage self-directed care and increase opportunities for independent living.

- We will introduce Expert Patient Programmes which are accessible and relevant to people with disability and/or long-term conditions and ensure that the wider expert patient programme is accessible, relevant and appropriate to people with a disability and peoples' cultural needs.[17]

- We will develop a self-care strategy to achieve optimum quality of life and health outcomes.

- We will recruit designated health trainers focused specifically on the health needs of those with disability and/or long term conditions to help people maintain health and remain living independently in their own homes.

- We will work with people to develop personalised care plans.

Desired Outcomes:

- Reduction and minimalisation of disability
- Increased number of people empowered to manage their health and care needs
- More streamlined interventions and improved co-ordination between services
- Improved access and reaccess to support
- Reduced number of unplanned hospital attendances and admissions and reliance on higher dependency care

7.3 Objective 3: Promotion of Independence and extended independent living opportunities

The Putting People First[18] vision and framework for a personalised adult care system supports independent living for all adults. To effectively promote independence and extend opportunities for independent living a whole systems approach to health and care is required with integrated care pathways and coordination of resources. A number of local services are key to the promotion of independence and independent living. These include specialist and general rehabilitation services, housing and primary and community services.

Rehabilitation

[17] Ensure balanced programme in terms of age, gender

[18] Putting People First a shared vision and commitment to the transformation of adult social care (2007)

Rehabilitation following injury or severe illness can help to prevent or reduce long term disability, increase personal independence and bring quality of life benefits.

Rehabilitation is a complex process involving a range of approaches: clinical, social, vocational and educational. Therefore care must be well coordinated with clear referral processes, strong partnership working and good communication and team working across care pathway.

Specialist neurorehabilitation[19] services

The National Service Framework (NSF) for Long Term Conditions provides clinical evidence of the effectiveness of rehabilitation and emphasises the importance of flexible and responsive services which allow re-access to care as needs change[20].

A Sussex wide review of specialist neurorehabilitation has been completed and a commissioning framework agreed to secure access to a comprehensive and integrated range of services for the adult population of Sussex.

Within the city of Brighton and Hove a broad range of specialist neurorehabilitation services are delivered. Services provided include a post acute inpatient service, an outpatient service and mobility service, a multi disciplinary community rehabilitation team and a vocational rehabilitation service.

In addition other specialist services are spot purchased from the independent and voluntary sector including slow stream rehabilitation and/or specialist placements and specialist community outreach and day care.

For Brighton and Hove the key priorities are to ensure early access to appropriate specialist services and timely, smooth transition between services ensuring that care is person centred and provided as close to home as possible. Key issues to be addressed within the strategic action plan will include management of transfer of care and hospital discharge, access and reaccess to specialist support, and longer-term rehabilitation.

Housing

Good housing is a key to independence for those with physical disabilities. Having independence in this context means having choice and control over the assistance and/or equipment needed to go about daily life and having equal access to housing opportunities.

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[19] The British Society of Rehabilitation Medicine (BSRM) [19] provides a conceptual and service definition of rehabilitation:

Conceptual definition: A process of active change by which a person who has become disabled acquires the knowledge and skills needed for optimal physical, psychological and social function

Service definition: The use of all means to minimise the impact of disabling conditions and to assist disabled people to achieve their desired level of autonomy and participation in society

[20] Eleven evidence-based quality requirements (QRs) are established throughout the patient care pathway. QR 4-6 are concerned with rehabiltation, adjustment and social integration

Barriers to accessible housing for people with physical disability is compounded by much of the city being hilly preventing full wheelchair accessibility. Many homes were built in the 19th century and subsequently converted into flats, often with small rooms and narrow stairways making accessibility and adaptation difficult. Key areas of housing priority for the city are access to accessible and adapted properties; including temporary accommodation to prevent homelessness, and the provision of housing with care.

Homelessness As overall homelessness in the city has been reducing in the last few years there has also been a reduction in homelessness amongst those with physical disability as the main priority need. However, at least one household every week is accepted as homeless with physical disability as the main reason for priority need. The local authority has recognised that there is a shortage of adapted temporary accommodation in the city for homeless applicants, while they are waiting for suitable permanent accommodation and as a result the City Council is funding the adaptation of six self contained flats for this client group, with more to come following feasibility studies.

New Housing Development In 2001 the city council adopted the Lifetime Homes Standard to ensure that all new housing built in Brighton & Hove is accessible and adaptable to changing household needs. The city is also ensuring that 10% of all new affordable homes are built to the authority's new wheelchair standard Accessible Housing & Lifetime Homes, adopted in March 2008 which sets standards higher than national requirements.

Extra care housing - For those with more complex needs who are unable to live at home the development of extra care housing can offer people an alternative to residential or nursing home care. Extra care housing has the potential to provide greater opportunities for independent living and increased choice and control over the care and support received through the delivery of personally tailored services.

Existing extra care housing services are primarily aimed at older people, however a successful central application in 2008 will enable the development of ten extra care flats specifically designed for adults under 65yrs with a physical disability.

Access to accessible social housing

In 2007/8 32 fully adapted wheelchair accessible properties became available for letting, the majority of these owned by housing associations (24). Currently there are 88 applicants waiting for this type of accommodation, so demand far exceeds supply of this type of property. There is an almost equal need for one and two bedroom properties and a smaller demand for larger family homes.

For those waiting for accommodation that is partially adapted for wheelchair use (e.g. the property will have internal and external level or ramped access, but some parts of the property may not be fully wheelchair accessible) the level of demand in comparison to supply is more severe with 126 households waiting but only 24 properties becoming available a year. Of this group the largest need is for one bedroom properties.

Following a service review Choice Based Lettings now incorporates a mobility rating that indicates whether an available property is suitable for a wheelchair user or someone with limited mobility. All new affordable housing that meets the wheelchair standard is advertised before it is built in order to ensure that the features installed are designed around the specific needs of the future occupants. To ensure the best use of local housing stock, an Accessible Housing Register is being developed and an Accessible Housing Officer recruited to improve the way in which Accessible and Adapted properties are advertised and let in the city.

Adaptations to homes - Each year almost £2m is spent on adaptations to improve the accessibility of people's homes across the public and private sectors, helping around 500 households. Currently there is a long waiting list of those needing adaptations. The House Condition Survey estimates that 6,950 adaptations are currently needed by households with a disability.

The Disabled Facilities Grant scheme (DFG) funds major adaptation within the private housing sector and are a mandatory requirement for local authorities to provide. Providing DFGs can be a lengthy process as they require a full tendering process for works. DFGs are subject to means testing and an assessment by an Occupational Therapist. The most needed adaptations are for the redesign of the bathroom, followed by grab/hand rails.

In 2007/08 the number of grants processed was 124 with a total expenditure of £930,000. The average payment per grant was around £8,000. The number of grants planned for 2008/09 is 159 with a planned expenditure of £1,273,000.

The Housing Adaptations Service is responsible for the completion of major and minor adaptations within public sector housing and major adaptations for the private housing sector[21]. This is an integrated case management service comprised of occupational therapists, technical and administrative staff. The integration was the result of evidence on the best way to manage an adaptations service, and recent Department of Health guidance commends this model. If adaptations are either not feasible, or not considered to be 'reasonable and practicable' then a dedicated officer from either Housing Options or the Under-Occupation Officer can work with the family to see what alternatives may be available to them.

If an adapted property is unable to be re-let to a Disabled applicant due to external steps or an other inaccessible feature, attempts will be made to recycle the adaptations with the and equipment resited to where a need has been identified.

Community equipment and assistive technology

The city's Integrated Community Equipment Store (ICES) is a jointly commissioned service within a Section 75 agreement for the provision of equipment. In recent years, both health and adult social care have invested in this service to ensure

[21] The Integrated Community Equipment Service currently provides all minor (i.e. <£1,000) adaptations in the private sector.

continued improvements in the quality of care. The Daily Living Centre (DLC) provides information and advice on equipment and is a demonstration centre for items of equipment. Telecare and assistive technology is provided as part of the Carelink service. Demand for community equipment has risen dramatically and a particular increase has been seen from the acute sector as more people are supported to live at home.

As of 2007 Telecare had received a total of 317 referrals for Telecare devices across all age ranges. The majority of requests were received directly from current CareLink users. Twenty-four installations had been completed including: smoke alarms, bed/chair occupancy sensors, property exit sensors, and temperature extremes sensors. Installs are scheduled for flood detectors, medication reminders, medication dispensers and bogus caller alerts.

Local priorities

- To improve access and reaccess to rehabilitation and reablement models of care including clinical, social, vocational and educational rehabilitation

- To ensure that care is well coordinated and delivered in the most appropriate setting, and as close to home as possible

- To implement housing initiatives to improve access to accessible and adapted accommodation, prevent homelessness and support people to remain living independently within their own homes.

Key Actions

- We will implement the agreed commissioning framework for neurorehabilitation services across Sussex incorporating acute, post acute and community services, supported by a clinical network and local commissioning plans. This will include development of the longer term plan for inpatient neurorehabilation, strengthening the earlier supported discharge model and providing more care closer to home.

- We will improve care pathways and multi agency management of hospital discharge for people under 65 years,

- We will improve access to accessible and adapted accommodation to prevent homelessness and to support independent living and develop housing with care to enable people to remain living independently within their own homes.

- We will increase use of assistive technologies telecare and telehealth to support independent living

- We will ensure carers of people with physical disability and/orlong term conditions have access to specialist carers assessment, advice information, training and support, (including care planning, flexible, planned and emergency

respite care) to support greater personalisation of care, and opportunities for independent living.

Desired Outcomes:

- Better health outcomes and improved well being
- Increased functional independence and reduced reliance on more higher dependency care models
- improved personal experience of care through greater choice and control improved wait times and more streamlined support

7.4 Objective 4 - Improved Support to those with complex and higher dependency care needs

For those with higher dependency care needs it is important to ensure that there is choice as to how needs are met, that the care received is of high quality and evidence based and that opportunities for independence and independent living are maximised.

A broad range of care options are required to meet the needs of individuals and to support independent living. Services must be person centred, responsive and flexible to changing needs.

Support to people in transition

Support maybe required to assist people when leaving hospital or specialist rehabilitation services or when moving from children's services to Adult Social Care.

Within the city two to three young people are referred from Children's services each year. Generally their needs are very complex and specialist and currently there are a limited range of options to support the needs of this age range. As a result young people may remain within the family home or often need to move to residential care outside of the city for their needs to be met.

For those leaving hospital or specialist services and returning to independent living a wider range of support options are required including short-term support services, and access to supported and adapted housing.

Care home placements

Whilst this strategy aims to reduce reliance on higher dependency care access to high quality 24 hr care within the city is required as part of a broad range of care services.

Currently care home placements are purchased by the Local Authority or Health (via continuing care) jointly or by individuals funding their own care. All placements are purchased through spot contracts and from a range of independent providers.

The number of people with a physical disability living out of the city in care home placements whilst small has remained constant for a number of years and accounts for about a quarter of the allocated funding in physical disability adult social care services.

Continuing Health Care funds an increasing number of placements for those with a physical disability. Over the past two years the costs of placement activity has increased significantly. The budget for 2008/2009 for continuing care, directly linked to physical disability, is around £950,000. The budget for neurorehabiliation support, through continuing care, is a further £500,000, but the actual expenditure is around £800,000. The PCT has recognised that the costs of continuing care (across all service areas) continues to grow and has set aside additional funding to address this challenge. At the same time, the PCT is exploring a number of options for delivering strengthened value for money, discussed in more detail below.

The framework for continuing care assessment has changed in recent years, and the PCT and the Local Authority have been explicit about their desire to work jointly in addressing the overall pattern of need, rather than simply moving costs around within the system. This approach does deliver better value for money, and an improved outcome for service users.

Intensive personal and live in care

The number of people living at home with intensive care packages is again very small but accounts for just under half of the allocated adult social care funding Personal care is provided by the independent sector and the local authority home care service. The local authority service focuses specifically on hospital discharge, complex needs, terminal care and prevention of admission.

Local Priorities:

- To develop local alternative models of care which enable people to remain or return to more independent living so reducing reliance on longer term care options and providing value for money for the city

- To ensure all providers endorse a strong ethos of independence and provide opportunities where possible for greater independence, moving on and a return to independent living

Key actions:

- We will agree a commissioning framework across social care, housing and health, which develops capacity within the city to support those with complex needs. This will include: improved access to short term services for those in transition (e.g. those leaving hospital or specialist rehabilitation services or children's care services) longer term support services for those who wish to return to the city from out of area placements and those wishing to remain living independently within their own homes

- We will explore models for further integrated working for those with complex health and care needs to ensure that people's needs are being met most appropriately and to facilitate a greater focus on independence and independent living.

- We will develop quality supported and adapted housing options as an alternative to higher dependency care options

- We will develop local slower stream rehabilitation opportunities for people leaving hospital following spinal injury, acquired brain injury and stroke to facilitate greater independence and a return to independent living.

- We will strengthen current procurement initiatives to ensure high quality and value for money care is purchased for the city's population. Both the PCT and the local authority already engage in joint procurement to achieve optimum value for money, but there are further opportunities for market development and rationalisation. The PCT is working with the NHS South East Coast Collaborative Procurement Hub to deliver strengthened value for money across both health and social care.

Desired outcomes:

- Increased individual choice through a broader range of care options
- An increased number of people with complex needs supported locally within the city
- Improved service user experience of care through smoother transition between care services
- Improved quality and value for money services within the city

7.5 Objective 5: Increased opportunities for local citizenship and participation

The Disability Discrimination Act legislates that disabled people must enjoy the same rights and opportunities as other members of the community to participate in education, training, employment and leisure. Government policy is leading a welfare reform, demanding further action to support disabled people in the labour market e.g. The Pathways to Work[22] pilots introduced by the Department of Work and Pensions to encourage and assist people on Incapacity Benefit to return to work.

Access to mainstream activities and services is key to enabling people to participate in social, family and community life. People with a physical disability may need support to maximise opportunities and our services will need to address how best to achieve this.

Employment support, vocational rehabilitation and training opportunities

A number of services are provided locally to support people whilst in work and to help people start and return to work. Coordination and promotion of services and improving access to relevant services will ensure that people are supported and have increased working opportunities.

Transport

Disabled people and carers have requested increased flexible transport options to assist them in their every day lives. They have told of the difficulties they have in attending health appointments and of a loss of independence with inflexible transport arrangements. Carers have told of difficulties coordinating transport with care arrangements and in attending health appointments with the person they care

[22] Pathways to Work Dept of Works and Pensions - Pathways to Work provides a single gateway to financial, employment and health support for people claiming incapacity benefits.

for. The PCT will be strengthening its overall support arrangements for Carers over the next two years, in line with the Carers Strategy, including arrangements for advocacy and these views will be built into the new arrangements. In addition, the contracting arrangements for patient transport are changing – PCTs will be directly commissioning these services from 2010/2011, and this will provide a good opportunity to ensure that the new contract reflects the needs of carers more fully

Day Care

The local authority and independent providers currently provide Day care. The local authority day care service is at Montague House. The service has an average total of 73 service users with most people using the centre between two and three times a week. The majority of service users are aged between 56 and 65 years. The service facilitates external training courses selected by service users and hosts the low vision clinic. Specialist day care and outreach work is commissioned through the independent voluntary sector.

Local priorities:

- To increase access to mainstream employment, training and leisure opportunities

- To support carers in their caring role so that they are able continue to manage own health, everyday lives including work

Key Actions:

- We will develop a centre for independent living to deliver a one stop shop approach to independent living, improving access to information, advice and support for the city's disabled community and their carers. This will involve a multi agency review of current services to compliment and maximise resources.

- We will coordinate and promote existing support services to maximise opportunities for greater access to employment, training, community and leisure opportunities

- We will link with the Disability Equality Scheme review to scope existing accessibility to mainstream activities and include a review of our existing transport links.

Desired Outcomes:

- Improved health and wellbeing and a reduction in health and social inequalities

- Increased number of people and their carers participating in employment, training, other meaningful daily activities

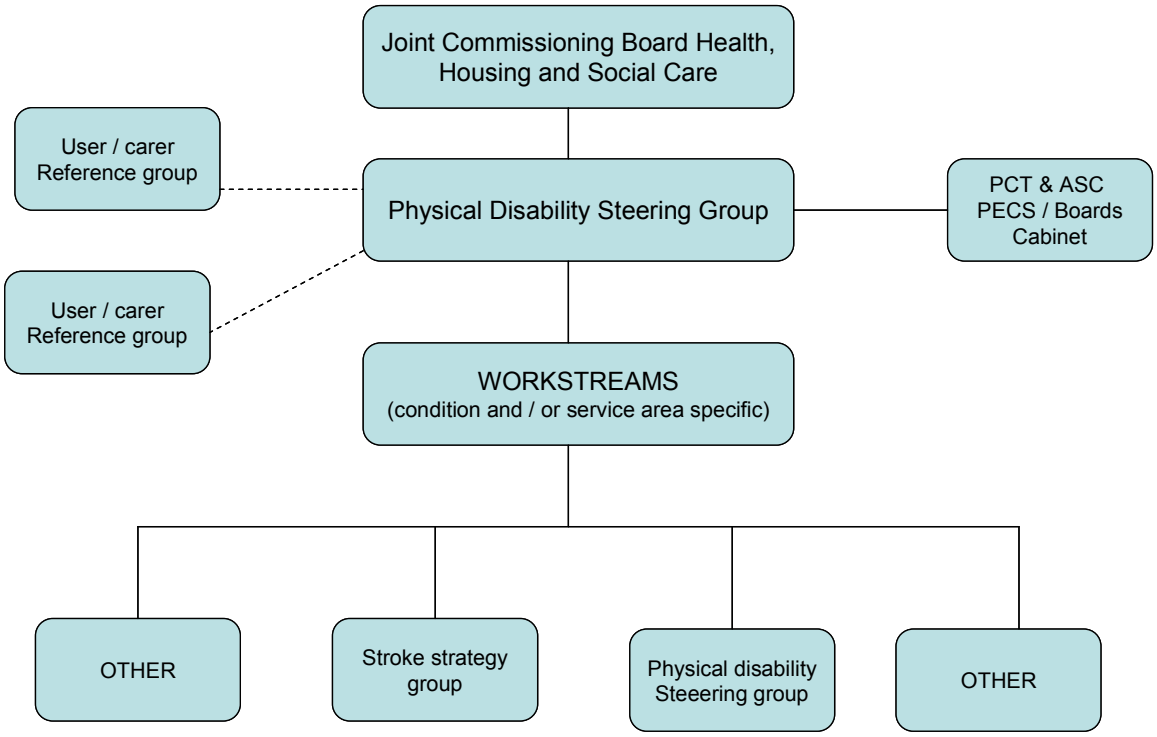
- Improved access to mainstream community resources and activities

8 Next Steps

Implementation and monitoring of the Joint Commissioning Strategy and associated three year Strategic Action Plan will be the responsibility of the Physical Disability Commissioning Strategy Steering Group.

The steering group will be responsible for the annual work plans and the monitoring of key projects. The group will have representation from across the local health economy and will secure appropriate public and provider engagement.

The steering group will be accountable to the Joint Commissioning Board and report on progress for all key projects to the Brighton and Hove City PCT Board and the Brighton and Hove Local Authority Adult Social Care Cabinet .



9 Appendices

9.1 Appendix A: Relevant policy, strategy and legislation

9.2 Appendix B: Joint Strategic Needs Assessment; Adults aged 18 to 65 years with Physical Disabilities (2009)

9.3 Appendix C: Three Year Action Plan - Physical Disability Services 2009-2012

9.4 Appendix D: Glossary

9.5 Appendix E: Summary of consultation and engagement activity

Appendix A - Relevant Policy, strategy and legislation

1. National Guidance -The main guiding legislation and national policy for the Physical Disability strategy are as follows:

The Disability Discrimination Act (DDA) 1995 and The Disability Equality Duty (05)
Since Dec 96 it has been unlawful to treat disabled people less favourably than other people for a reason related to their disability. Reasonable adjustments must be made to ensure equity of access for disabled people this is to include adjustments to the physical environment to overcome physical barriers, and adjustments to the way services, and goods are provided. Since December 06 public bodies have had a duty to promote disability equality

World Class Commissioning and the Darzi eview "our NHS, Our Future" (07) Provides the vision for future excellence in NHS commissioning with the overall objective of adding life to years and years to life. The three key principles outlined are: better health and well being , better care and better value for all, underpinned by the organizational competencies required to deliver

NHS Improvement Plan; Putting People at the Heart of Public Services (05)
Introduced the next stage of the modernisation of the health service and shift to personalised care, a focus on health and well being not only illness and further devolution of decision making to local organisations.It outlined the governments commitment to improving the care and quality of the life for people with long term conditions with a health service designed around the patient.

Choosing Health – 2004 public health white paper outlines key principles for supporting the public to make healthier and more informed choice about health

The Health and Social Care Planning Framework 05-06 and 07-08 and National Standards, set the framework for the planning and commissioning of future services and introduced a standards driven system. A number of core developmental standards were set

Our health, our care, our say: a new direction for community services' (DOH 2006)
The white paper set the strategic direction for health and social care services and introduced a number of initiatives to bring about a major shift in the delivery of care.. Health and social care services are to become more person-centred, flexible and responsive to individual needs, people are to have greater choice and control over the way in which their needs are met and how services are delivered and improved.

Putting People First: **A shared vision and commitment to the transformation of Adult Social Care** Sets out the direction for adult social care over the next 10 year; the shared aims and values which will guide the transformation of adult social care. It recongises the need to work across services and agendas with users and carers in order to transform people's experience of local support and services. Emphasis is given to access to univeral services, early intervention and prevention, choice and control and social capiotal (ensuring people are able to participate in communities)

Improving the Life Chances of Disabled People, Prime Ministers Strategy Unit (05) This report outlines how improving the life chances of disabled people must consider four key areas. They are by helping disabled people to achieve independent living, by improving support for families with young disabled children, by facilitating a smooth transition into adulthood and by improving support and incentives for getting and staying in employment. Strategy for disabled people is led by the Office for Disability Issues which reports to the Minister for Disabled People.

In addition to the above a number of national quality standards and best practice guidance are relevant to the physical disability strategy such as:

National Stroke strategy Dec 2007 outlines the vision for future improvements to and development of stroke care. The strategy includes a 10 point action plan and 20 Quality Markers to drive service improvements in the delivery of stroke care

The NSF Long term Conditions 2005 introducing a ten year programme of change to be fully implemented by 2015. The aim of the NSF is to ensure that services are patient-centred. Whilst the NSF has a focus on neurological conditions, the standards and 11 quality requirements are also relevant to other long-term conditions as well

Other relevant clinical guidelines and service standards include:

- Royal College of Physicians (RCP) Guidelines for Stroke,
- National guidelines for Acquired Brain Injury
- National Institute for Clinical Excellence (NICE) (including guidelines for :Multiple Sclerosis, Epilepsy)
- Standards for services for people who are deaf/blind

2. Relevant local strategies - in response to national policy and guidance the following local documents are relevant to physical disability services:

Disability Equality Schemes - Locally disability schemes have been developed by all major trusts. Our commissioning responsibility is to ensure that contracts and service level agreements reflect and contribute to the aims of local schemes and:

- Address equality issues with clear policies for tackling discrimination experienced by disabled people
- Support disabled people to achieve their full potential

Strategic Commissioning Plan - outlines the overall commissioning plan for the city's health care services. It sets out the plans for improving health care services in line with World Class Commissioning and the Darzi Review

Older Peoples strategy (2007-2010) –provides a three year plan for the commissioning of health and social care services for older people in Brighton and Hove.

**Extra care housing strategy - the development of extra care housing is consistent with the strategic aims of *Our health, our care, our say* and *Putting People First* in ensuring that people: have a better quality of life; exercise maximum control over their lives; are enabled to live independently; and, are treated with respect and dignity. Extra care housing represents an integrated response to the accommodation and care needs of older and vulnerable people. It promotes independence and provides options for the further reduction of admissions to residential care. The Extra Care Housing Strategy 2005, sets out a framework for the long term development of extra care housing for older people in Brighton & Hove. This strategy followed a period of City wide consultation and built on the successful bid for Department of Health (DoH) capital funding in 2004 that enabled the redevelopment of New Larchwood in Coldean.

Discussion paper for proposed reablement model for Brighton and Hove Adult Social Care and Housing Service - This paper sets out a clear direction for adult social care in Brighton and Hove where people will be supported to learn or re-learn skills that enable them to accommodate their condition and hence maximise and sustain their independence. This approach will form an integral part of responding to the social care needs of people with a physical disability and will complement the rehabilitation services provided through the health service.

Self Care Strategy (05-08) - Currently being refreshed

Carers Strategy - a joint commissioning strategy for carers is being developed based on the The National Strategy for carers that says that by 2018: carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role;carers will be able to have a life of their own alongside their caring role;carers will be supported so that they are not forced into financial hardship by their caring role; carers will be supported to stay mentally and physically well and treated with dignity; children and young people will be protected from inappropriate caring and have the support they need to learn, develop and

thrive, to enjoy positive childhoods and to achieve against all the Every Child Matters outcomes.

Housing Strategy (LA) 2008-13 Healthy Homes, Healthy Lives, healthy City - an overarching documents that co-ordinates a number of action plans concerned with housing need within the city

3. Supporting legislation

- National Assistance Act 1948
- Chronically Sick & Disabled Persons Act 1970
- NHS & CCA 1990
- Community Care (Direct Payments) Act 1996
- Disability Discrimination Act 1995
- Disabled Person (Services, Consultation and Representation) Act 1986
- Human Rights Act
- Race Relations Act
- Carers Act
- Housing legislation

JOINT STRATEGIC NEEDS ASSESSMENT

ADULTS AGED 18 TO 64 YEARS WITH PHYSICAL DISABILITIES

REFRESHED VERSION FEBRUARY 2009

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Acknowledgement

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1. Executive Summary

1.1. Key Themes

- The social model of disability highlights that disabled people face social, environmental and attitudinal barriers which can restrict their activity and participation in society. Policies that increase independence and enablement are important in supporting good outcomes for people with physical disabilities.

- Evidence highlights that people with physical disabilities experience disadvantage in many aspects of daily life. They are more likely to live in poverty as well as experience problems with hate crime and harassment, housing and transport.

- The specific needs of people with physical disabilities who are members of groups that potentially experience additional barriers to participation, such as Lesbian, Gay, Bisexual and Trans (LGBT) people, people from Black and Minority Ethnic (BME) communities, and Gypsies and Travellers, should be taken into account in service planning and delivery.

- It is estimated that approximately 14,000 Brighton and Hove residents aged 18 to 64 have a moderate physical disability, and 3,400 have a severe physical disability.

- In the 2001 census, a higher proportion of Brighton and Hove residents aged less than 65 reported having a limiting long term illness compared with the England average, and a higher than average proportion of residents aged 16 to 74 reported that they were permanently unable to work.

- Approximately 6,700 local residents aged 18 to 64 are expected to have a moderate personal care disability, and 1,300 are expected to have a severe personal care disability.

- The number of people with a physical disability aged 18 to 64 living in Brighton and Hove is expected to increase by between 3.5% and 5.0% between 2008 and 2015.

- Brighton and Hove has a young age distribution and a reduction in the number of older people living locally is projected. Therefore the proportion of all people with physical disabilities who are aged less than 65 years is likely to increase. The young age distribution of the local population means that for health conditions which are typically

young onset, such as multiple sclerosis, there are likely to be a higher than average number of new diagnoses in the local population each year compared with other authorities with a similar sized population.

- One in twenty adults aged 18 to 64 in Brighton and Hove receive Disability Living Allowance (DLA), however the rate varies considerably by geographical area. In the electoral wards of East Brighton and Queens Park one in twelve receive DLA.

- Residents with a physical disability are more likely to live in a home in disrepair and are more likely to be fuel poor.

- Households with a disabled member are more than twice as likely to rent from a local authority or social landlord (37 per cent of all households with a disabled member live in social housing, compared with 15 per cent of all households living in social housing across the City). The City has a large private rented sector, and there may be barriers to fitting adaptations for people with physical disabilities living in these properties.

- Historically Brighton and Hove has had a relatively high number of people with physical disabilities living in long stay residential and nursing care. Since 2003 the number has fallen considerably. However the cost of this care has increased rapidly in recent years and is high compared with other local authorities.

- During the same period the number of people with physical disabilities helped to live at home by Brighton and Hove City Council has increased considerably, and local performance is higher than the England average.

- In 2006/07 the rate of in Brighton and Hove residents with physical disabilities aged 18 to 64 receiving direct payments was low compared to the national average, however since this data was published the actual number receiving payments locally has increased from 39 in 2006/07 to 65 in 2008/09.

- The proportion of homelessness acceptances with physical disability as their priority need in Brighton and Hove is consistently two to three times higher than the England average, indicating a high level of need locally.

- More than 200 applicants on the housing register require a property that is partially or fully adapted for wheelchair use. Of the 88 requiring a fully adapted property, 76% are aged less than 60 years.

1.2. Recommendations

- Ensure that service planning takes into account the projected increase in the size of the population aged under 65 with physical disabilities
- Ensure local people with physical disabilities are involved in planning and development of services
- Ensure that services provide high quality information at the initial point of access to promote independence and enablement
- Ensure those involved in service planning and delivery consider and respond to the needs of specific groups including as BME groups, LGBT people and gypsies and travellers,
- Improve access to accessible and adapted housing
- Ensure the needs of carers of people with physical disabilities are considered in service planning and delivery
- Increase the number of local people in receipt of direct payments
- Consider how knowledge of the needs of local people with physical disabilities can be improved, including improved data collection, and include this information in the next version of this Joint Strategic Needs Assessment.

2. Introduction

This report is one of a series using the planning principles and structure of the Joint Strategic Needs Assessment (JSNA), as set out in the Commissioning Framework for Health & Wellbeing published by the Department of Health[1].

In conjunction with the Strategy for People with Physical Disabilities, and the Sussex-wide Neuro-Rehabilitation Strategy, this report is intended to be used support budget and service planning for the year 2009/10 and 2010/11.

The process of producing this report has highlighted that much of the detail on activity, financial and service-modelling, that is required for effective commissioning, is held in separate places across the relevant agencies.

This is intended to be an interim report and it is planned that a revised JSNA will be produced by 2010/11.

3. Defining physical disability

Physical disability affects a wide range of people in a wide range of ways; it can arise as a result of an accident, illness or congenital disorder and may be caused by a range of health conditions such as neurological, circulatory, respiratory and musculo-skeletal disorders.

The Disability Discrimination Act (DDA) has a broad definition of disability, describing it as:

> *a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities*[2]*.*

The Equality and Human Rights Commission defined a physical impairment as

> *a condition affecting the body, perhaps through sight or hearing loss, a mobility difficulty or a health condition*[3]*.*

The World Health Organisation (WHO) began the process of defining disability with the International Classification of Impairments, Disabilities and Handicaps (ICIDH)[4]. This framework described four terms: pathology, impairment, disability and handicap (see Table 1).

Table 1: Framework of international classification of impairments, disabilities and handicaps [4]

Term	Definition
Pathology	Abnormalities or changes in the structure or function of an organ or organ system.
Impairment	Any loss or abnormality of psychological, physiological, or anatomical structure or function.
Disability:	Any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.
Handicap:	A disadvantage for a given individual, resulting from an impairment or disability that limits or prevents fulfilment of a role that is normal, depending on age, sex, social or cultural factors' (WHO, 1980).

Within this framework, which is often called the medical model of disability, a person's functional limitations (impairments) are the cause of any disadvantages experienced and these disadvantages can therefore only be rectified by treatment or cure.

The International Classification of Functioning, Disability and Health[5] has evolved from the ICIDH and allows for a dynamic rather than static or linear assessment of the interaction between functioning and disability, where functioning refers to all body functions, activities and participation, while disability refers to impairments, activity limitations and participation restrictions.

The social model of disability has been defined as:

> *"The disadvantage or restriction of activity caused by a contemporary social organisation which takes little or no account of people who have a physical impairment and thus excludes them from the mainstream of social activities"[6].*

It shifts the focus from impairment to disability, using this term to refer to disabling social, environmental and attitudinal barriers rather than a lack of ability. The social model of disability makes the distinction between 'impairment' and 'disability' (see Table 2).

Table 2: Social Model Definitions of Impairment and Disability

Term	Definition
Impairment	An injury, illness, or congenital condition that causes or is likely to cause a long term effect on physical appearance and / or limitation of function within the individual that differs from the commonplace.
Disability	The loss or limitation of opportunities to take part in society on an equal level with others due to social and environmental barriers.

The 2005 report by the Prime Minister's Strategy Unit, Improving the Life Chances of Disabled People[7], noted that the types of barriers faced by disabled people include:

- **attitudinal**, for example among disabled people themselves and among employers, health professionals and service providers;
- **policy**, resulting from policy design and delivery which do not take disabled people into account;

- **physical**, for example through the design of the built environment, transport systems, etc, and
- those linked to **empowerment**, as a result of which disabled people are not listened to, consulted or involved.

4. Limitations of locally available data describing physical disability

The available data describing the numbers of people with physical disabilities, and their needs, are subject to a number of limitations.

People with physical disabilities have highly diverse needs. This is because of a number of factors including:

- Different types of impairments, and in those with the same conditions, different severity, disease stage and the impact of other health conditions
- Socio-economic differences, meaning that some people have a higher risk of facing barriers limiting their participation
- Different social and environmental barriers faced by individuals.

Some of the data presented to estimate the numbers of people with physical disabilities in Brighton and Hove are derived from national studies and applied to the local population. Where appropriate, data has been compared across different sources ensuring that the best possible estimate is presented.

Some of the available data relates to impairment rather than disability and reflect the medical model of disability, which is less useful than the social model in guiding the planning of services to respond to users' needs.

Data relating to impairment and disability is often not available broken down by age group so presented data sometimes relate to all ages, rather than adults aged less than 65.

Within many services, client need, the severity of disability and/or the clinical diagnosis are not routinely recorded.

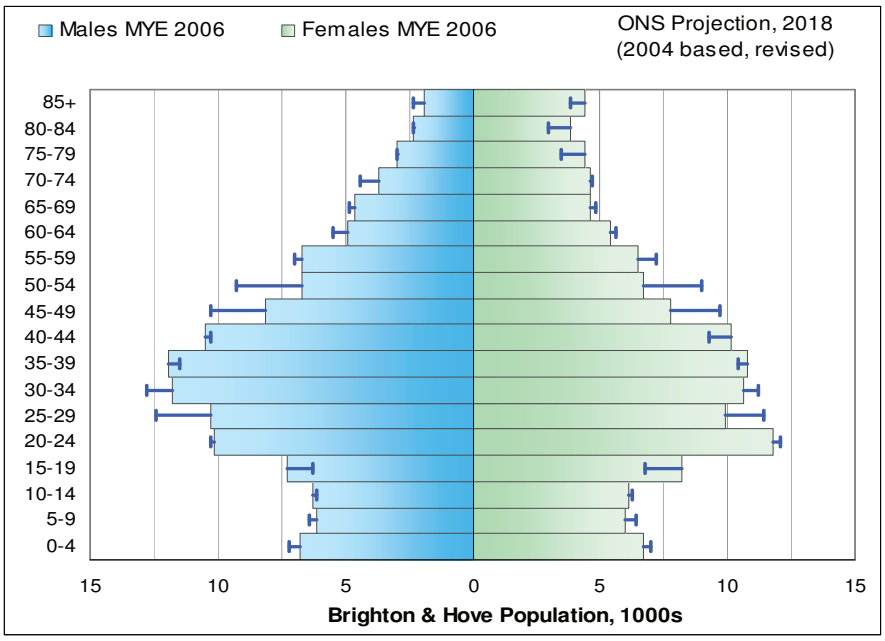
Some data is not available broken down by ethnic group, and very little data is available broken down by sexual orientation or transgender status.

5. The population of Brighton and Hove

It is estimated that 253,500 people live in Brighton and Hove of whom 172,000 are aged between 18 and 64 years[8]. A high proportion of the population are young adults, as shown in Figure 1 below.

It is predicted that the local population will increase to 257,000 by 2012 (representing an increase of 2.2% between 2007 and 2012), and to 265,000 by 2018. The expected change varies between age groups, as illustrated by the thin bars in Figure 1 below[9]. The greatest increase is expected in 45 to 54 year olds. In contrast to most other Local Authorities the number of older people is predicted to reduce by 2018.

Figure 1: Population Pyramid showing Brighton and Hove City Mid-year Estimates (MYE) for 2006 and Projections for 2018 by age and sex



It is estimated that the lesbian, gay, bisexual or transgender (LGBT) communities make up one in six of the population[10].

15% of the city's population was born outside England, a higher than average proportion that for the South East region and for England. At the same time, the Black and Minority Ethnic population, at 5.7%, is comparatively low, suggesting that those not born in England are

predominantly from white European backgrounds. In 2008 the most populous European communities were from Spain and Poland [10].

Brighton and Hove City faces substantial socio-economic issues[10]. The Index of Multiple Deprivation 2007 identifies Brighton and Hove City as the 79th most deprived authority in England (out of 354), with 9% of all Super Output Areas (SOAs) in the City falling within the 10% most deprived Super Output Areas in England and eight SOAs falling in the 5% most deprived.

Definition

The term Super Output Areas (SOAs) refers to a way of classifying geographical areas that was developed to analyse the results of the 2001 Census. SOAs were defined to include a similar population size and contain communities with similar social characteristics. The lower layer SOAs referred to in this analysis typically contain a population of around 1500 people. There are 164 SOAs in Brighton and Hove.

6. The prevalence of physical disability

6.1. Estimated prevalence of disability

The Health Survey for England 2001[11] provided information at a national level on the number of people who have disabilities. It reported both physical and sensory disability by severity and enables local level estimation of numbers of people expected to have a physical disability. The Health Survey used an adaptation of the World Health Organisation (WHO) classification system for impairments, disabilities and handicaps. It is used to estimate the proportion of the population experiencing different levels of long-term disability, with two levels of severity:

- Low (moderate)
- High (serious)

The disability questions in the HSE 2001 enquired about limitations in functional activities (seeing, hearing communication, walking and using stairs) and daily living activities (getting in and out of bed or a chair, dressing, washing, eating and toileting). These were grouped into five disability types:

- Locomotion;
- Personal care;
- Seeing;
- Hearing; and
- Communication

The survey results illustrate how the prevalence and severity of disability increases with age. Nationally, 8% of men and 9% of women aged 16 to 64 years report having a moderate disability, and 3% of men and women of the same age group report having a serious disability. Within this broad age range, the proportion with disabilities increases with age.

The survey also reports on the proportion of disability by type of disability. It shows locomotor disability accounting for the highest

proportion of disability with 38% of the total, followed by personal care disability (23%), communication (20%), hearing (12%) and sight (7%).

The Projecting Adult Needs and Service Information System (PANSI)[12] was designed to help local authority commissioners of social care to explore the impact that expected changes in the structure of the population, and in the incidence and prevalence of certain conditions, may have on the number of people with physical disabilities. The programme uses sources including national HSE data and Local Authority population estimates and projections to produce estimates for 2008, and five yearly projections from 2010 to 2025, of the numbers of people with physical disabilities at local authority level.

Definitions

Incidence: a figure describing the number of people newly diagnosed with a health condition in a defined period of time (e.g. in one year)

Prevalence: a figure describing the total number of people living with a condition at one time

The estimated number of Brighton and Hove residents with physical and personal care disabilities is shown in Table 3 below. The data show that by 2015 the numbers of people with a moderate and serious physical disability are projected to increase by 4.2% and 3.8% respectively.

Table 3: Predicted numbers of people aged 18 to 64 years with moderate and serious physical disability, and moderate and serious personal care disability, in Brighton & Hove in 2008, 2010 and 2015 (i)

	2008	2010	2015	Change 2008 to 2015
Total no of people predicted to have a physical disability				
• moderate physical disability	13,981	14,219	14,562	4.2%
• serious physical disability	3,361	3,425	3,488	3.8%
No. of people predicted to have a personal care disability				
• moderate personal care disability	7,642	7,749	7,912	3.5%
• serious personal care disability	1,293	1,321	1,357	4.9%

(i) People with a personal care disability are included in the total no of people with a physical disability. Personal care includes getting in and out of bed, getting in and out of a chair, dressing, washing, feeding, and use of the toilet. A moderate personal care disability means the task can be performed with some difficulty; a severe personal care disability means that the task requires someone else to help.

Figures 2 and 3 below present the same data by age group, and also show the projections up to the year 2025. They highlight that the prevalence of disability increases with age, and that the projected increase in the number of people with a disability will be greatest in people aged 45 and above.

Figure 2: People aged 18-24, 25-34, 35-44, 45-54 and 55-64 predicted to have a moderate or serious physical disability, Brighton and Hove, projected to 2025

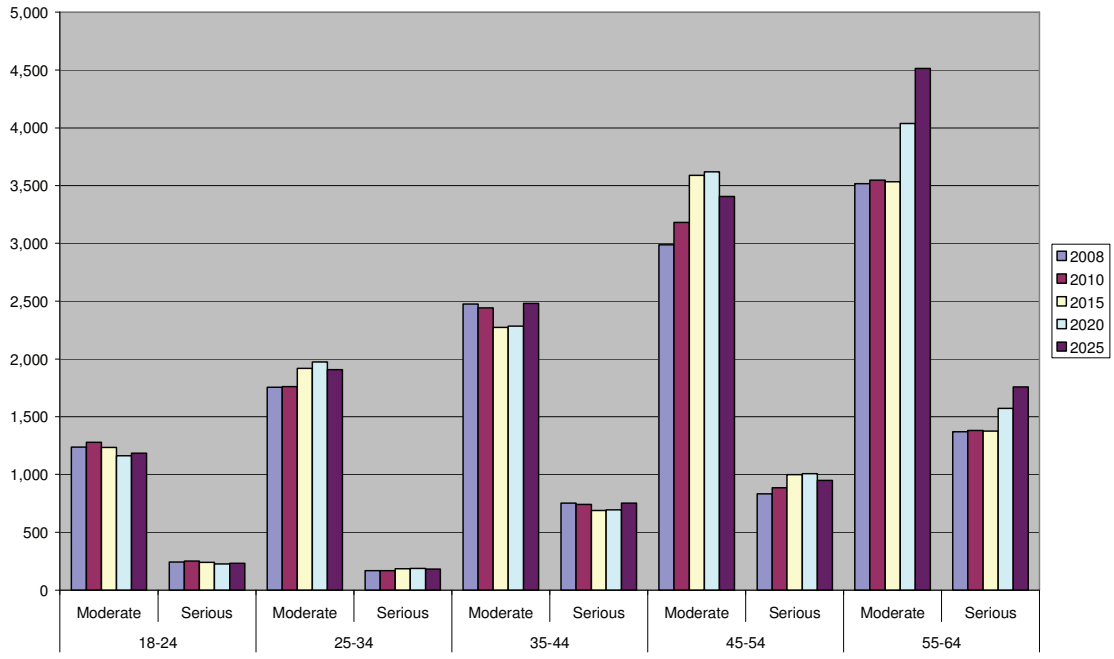
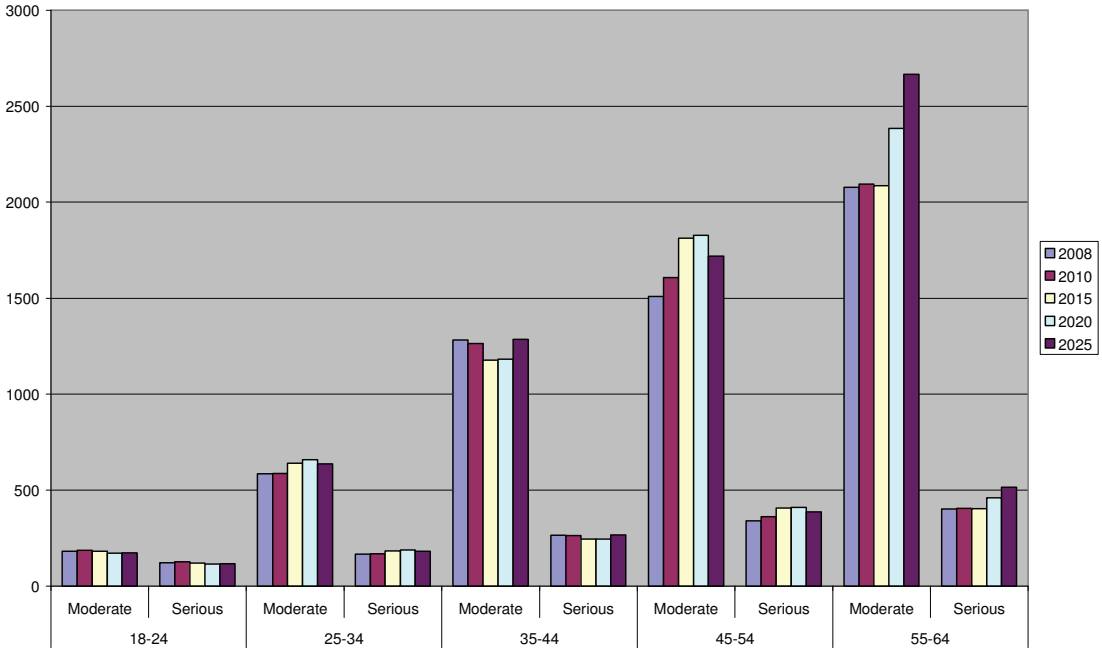


Figure 3: People aged 18-24, 25-34, 35-44, 45-54 and 55-64 predicted to have a moderate or serious personal care disability, Brighton and Hove, projected to 2025



Relatively limited information is available comparing the prevalence of physical disabilities between local authority areas. The 2001 census included a question on limiting long term illness[13]:

> *"Do you have any long-term illness, health problem or disability which limits your daily activities or the work you can do?"*

17.5% of Brighton and Hove residents defined themselves as having a limiting long term illness, which is similar to the average for England and Wales (17.6%), although higher than the average for authorities in South East England (14.8%).

Definitions

Standardised ratios are the ratio of the number of events observed in a population (e.g. Brighton and Hove) to the number that would be expected if the population had the same distribution as a standard or reference population (e.g. England and Wales).

For example, men in Brighton and Hove have a Standardised Illness Ratio of 105.7. This means that there are 5.7% more men with a limiting long term illness than would be expected if men in the Brighton and Hove population had the same rate of limiting long term illness as men in England and Wales. Therefore the local rate is higher than the England and Wales average.

Standardised illness ratios were calculated by gender and age (Table 4). The ratios for those aged less than 65 in Brighton and Hove were higher than the ratios in surrounding local authorities (except Hastings) and higher than both the England and England & Wales averages.

Analysis of the 2001 census results also provides detail on the proportion of people unable to work because of long-term sickness or disability. Respondents were classified as "permanently sick" if they ticked yes to having a limiting long term illness (see above) and the following question[14]:

> *"Last week, were you any of the following: permanently sick or disabled?"*

Standardised permanent sickness ratios were calculated by gender and age. The ratios for those aged 16 to 74 in Brighton and Hove

were higher than the ratios in surrounding local authorities (except Hastings) and higher than the England average (Table 4).

Table 4: Standardised illness ratio (aged <65) and standardised permanent sickness ratio (16-74). South East Local Authorities and National averages (Source 2001 Census)

	Standardised illness ratio (<65)		Standardised permanent sickness ratio (16-74)	
	Males	Females	Males	Females
Brighton and Hove UA	**105.7**	**101.9**	**106.0**	**99.1**
Adur CD	89.2	91.4	72.2	78.2
Arun CD	88.3	88.0	76.1	76.8
Chichester CD	73.1	68.7	51.4	48.6
Crawley CD	78.5	87.1	55.6	69.4
Eastbourne CD	102.6	100.2	90.2	91.6
Hastings CD	125.9	118.1	135.6	125.4
Horsham CD	59.5	61.9	35.7	40.8
Lewes CD	82.8	82.8	64.4	70.2
Mid Sussex CD	58.9	62.9	37.4	46.2
Rother CD	89.8	86.4	77.9	73.0
Wealden CD	69.8	70.5	50.0	54.3
Worthing CD	91.7	89.4	85.5	81.2
SOUTH EAST	**77.2**	**78.6**	**60.3**	**63.7**
ENGLAND	**98.1**	**98.2**	**96.2**	**96.2**
ENGLAND AND WALES	**100.0**	**100.0**	**100.0**	**100.0**

6.2. Physical disability and specific population groups

6.2.1. LGBT groups

The Count Me In Too Survey[15], conducted in Brighton and Hove in 2006, surveyed more than 800 people from the Lesbian, Gay, Bisexual and Transgender communities. 97.5% of respondents were aged between 16 and 65. 15% of the sample identified themselves as having a long term health impairment or physical disability. As applies to the statistics in the whole population above, respondents identifying themselves under this category cannot be disaggregated by physical, sensory or mental disabilities or long term health impairments. 4% of the sample identified themselves as deaf, hard of hearing, deafened or deaf-blind.

6.2.2. BME groups

Black and minority ethnic groups are less likely to report impairments than the White population, but they are more likely to experience poor outcomes if they are disabled[16].

In 2006/07 9.0% of physically disabled adults receiving a service were from BME groups. This is proportionate to the population aged 18 to 64 of whom 9.6% are estimated to be from BME groups [12].

6.2.3. Gypsies and travellers

A 2005 survey of the housing needs of gypsies and travellers in Brighton, Hove and Sussex[17] found that 35% (22/62) of households in permanent accommodation and 28% (n=18/64) of households on sites had a member with a disability or a long term illness.

7. Specific health conditions resulting in impairment

Table 5 presents data on the incidence and prevalence of specific conditions and diseases that can result in significant levels of physical disability.

For the purposes of this document conditions have been separated in to three distinct categories:

- neurological;
- locomotor;
- and sensory.

The national rates have been applied to the Brighton and Hove population to produce estimates of the number of people affected by these conditions in the local population.

Most condition-specific studies do not differentiate between different age groups. Where possible, incidence and prevalence rates for adults aged 18 to 64 years are highlighted in this report. However, for most conditions the rates presented refer to the whole population.

As described earlier in this report, Brighton and Hove has an unusual age distribution, with a high proportion of people aged 20 to 44 and a lower proportion of older people. This means that where a condition is more common in younger adults there is likely to be a higher number of people affected by the condition than the national data would suggest. For example, based on the application of national incidence and prevalence rates, Brighton and Hove City would be expected to have up to 17 new diagnoses per year, and up to 300 local residents living with Multiple Sclerosis. However the local Multiple Sclerosis specialist nurse reports a caseload of over 400 active cases, which may be explained by the age distribution of the local population.

Additional detail on the incidence and prevalence of specific conditions is presented in Appendix 1.

Table 5: National data on incidence and prevalence of conditions associated with impairment; and estimated number of people affected in Brighton and Hove

Condition		National data: (rate per 100 000[1] population)		Local application of national data: estimated number of people affected in Brighton and Hove	
		Incidence	Prevalence	Incidence	Prevalence
Neurological	Acquired Brain Injury including Traumatic Brain Injury[18]	175	1,200	445	3,045
	Spinal cord injury	2	50	5	125
	Young onset stroke (<65)	20		40	
	Epilepsy	24-58	430-1,000	60-150	1,090-2,535
	Motor neuron disease	2	7	5	20
	Multiple sclerosis	3-7	100-120	10-20	250-300
	Parkinson's disease	17	200	45	510
	Huntington's disease[19]		13.5		35
	Muscular dystrophy		50		125
	Cerebral palsy		186		470
	Spina Bifida		2		5
	Myalgic encephalomyelistis		300-500		760-1270
Locomotor	Rheumatoid arthritis[20]	770	1,960	1,950	4970
	Osteoarthritis	7620	12,770	19,315	32,370
	Amputation[21]	9.5		25	
Sensory	Deaf or hard of hearing aged 16 to 60[22]		4,100		6,870
	Mild to moderate deafness aged 16-60		3,900		6,535
	Severe to profound deafness aged 16-60		200		335
	Serious visual impairment [12]				110

8. Uptake of Disability Living Allowance (DLA) by electoral ward

Statistics on the uptake of DLA provide an indicator of the geographical distribution of need across the City. However caution should be used when interpreting this data because the population of disabled people in receipt of disability related benefits is smaller than the number of people with disabilities.

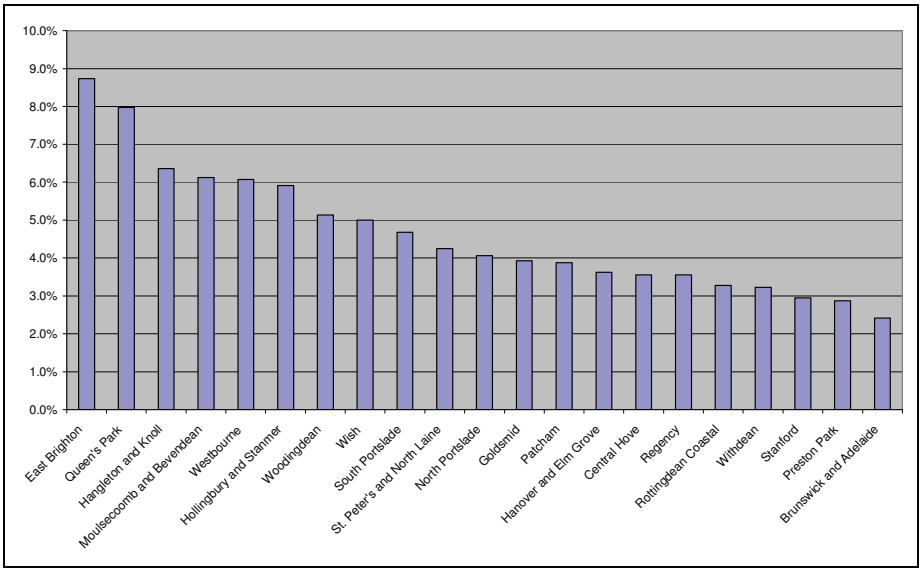
Definition:

Disability Living Allowance provides a non-contributory, non means-tested and tax-free contribution towards the disability-related extra costs of severely disabled people under the age of 65. The allowance has two components: a care component - for people who need help with personal care and are likely to go on needing that help; and a mobility component - for people who have walking difficulties and are likely to continue to have those difficulties.

In May 2008 approximately 8,500 local residents aged 18 to 64 years received payment for DLA[23], equivalent to 5% of the population in this age group.

The proportion of the population receiving the benefit varied considerably by electoral ward, from 2.4% of those aged 16 to 59 years in Brunswick and Adelaide to 8.7% in East Brighton. This variation is illustrated in Figure 4 below.

Figure 4: Uptake of Disability Living Allowance by electoral ward 16-59 year olds May 2008



(Source: DWP statistics; National Statistics ward population estimates 2006)

9. Barriers faced by people with physical disabilities

9.1. Improving the Life Chances of Disabled People

A report published by the Prime Minister's Strategy Unit in 2005, Improving the Life Chances of Disabled People[7], reviewed the evidence on the barriers and disadvantage faced by people with disabilities. It concluded that disabled people experience disadvantage in many aspects of daily life.

The report found that, compared with non-disabled people, disabled people are:

- more likely to live in poverty – the income of disabled people is, on average, less than half of that earned by non disabled people;
- less likely to have educational qualifications – disabled people are more likely to have no educational qualifications;
- more likely to be economically inactive – only one in two disabled
- people of working age are currently in employment, compared with four out of five non-disabled people;
- more likely to experience problems with hate crime or harassment – a quarter of all disabled people say that they have experienced hate crime or harassment,
- more likely to experience problems with housing
- more likely to experience problems with transport – the issue given most often by disabled people as their biggest challenge.

However, the cause of this appears to work in both directions: people are also more likely to become disabled if they have a low income, are out of work or have low educational qualifications.

A report published in 2007, Developing Appropriate Strategies for Reducing Inequality in Brighton and Hove[24], examined the barriers faced by disabled people locally and the extent to which inequality was being addressed.

Definitions

Incapacity benefit: a weekly payment for people who become incapable of work while under State Pension age. Assessment for eligibility includes a Personal Capability Assessment

Employment and Support Allowance: From 27 October 2008 this benefit replaced Incapacity Benefit and Income Support paid on incapacity grounds for new claimants. The principle of Employment and Support Allowance is that everyone should have the opportunity to work and that people with an illness or disability should get the support they need to engage in appropriate work, if they are able.

The report found that:

- Disability and Incapacity Benefit levels are high across the city. More than 50% of all working age people on benefit claim as a result of incapacity. New Incapacity Benefit claimants are 30% more likely to be aged 25 to 44 than the national average.
- There are knock on effects for carers. 22,000 people provide unpaid care across Brighton and Hove (this figure refers to carers and people cared for of all ages. 30% provide care for over 20 hours and nearly 20% for more than 50 hours per week). Around 40% providing care were economically inactive
- Disabled groups are likely to experience long term issues. People with long term limiting illnesses claiming Incapacity Benefit have been claiming for more than 5 years.
- Disabled people have a higher risk of experiencing hate crime. A survey by the Disability Rights Commission found that almost half who took part in the survey had experienced verbal abuse, intimidation or physical attacks because of their disability.

The report concluded that:

- People caring for disabled people may also be excluded from taking up employment, education or training opportunities.
- The introduction of the Employment and Support Allowance benefit is important. Tailored support is provided to help those with a health condition or disability to return to employment, while providing financial and other support where this is not possible.

- Human resources policies in local public and private sector employers are important to support disabled people.

- The policy agenda of Direct Payments is important in supporting good outcomes in people with physical disabilities.

The Brighton and Hove Private Housing Stock Condition Survey 2008[25] confirmed that there is a strong association between disability and income, as 27% of households with a disabled resident had a household income below £10,000 per annum, compared with 11% where there is no person with a disability. This represents approximately 3,700 such dwellings in Brighton and Hove. The residents of these dwellings may not only have physical difficulty dealing with repairs or adaptations to their home, but may be less likely to be able to afford alternative provision.

9.2. Housing needs of people with physical disabilities

Good housing is a key to independence for those with physical disabilities. Having independence in this context means having choice and control over the assistance and/or equipment needed to go about daily life and having equal access to housing opportunities.

Housing problems are compounded by much of the city being hilly preventing full wheelchair accessibility. Many homes were built in the 19th century and subsequently converted into flats, often with small rooms and narrow stairways making accessibility and adaptation difficult.

The 2005 Housing Needs Survey[26] found that 19.8% (22,362) of households in Brighton and Hove contain someone with a disability or long term illness.

The household composition and tenure patterns of disabled people reflect the fact that they are older, on average, than the general population. Over half of all disabled household members were over the age of 60 including 28% over the age of 75.

The largest group of people with physical difficulties were those with a walking difficulty (53.2%), a figure that the 2008 Private Sector Housing Stock Survey also confirms. 8.1% of all households reported that they contained a member who was a wheelchair user, suggesting 1,765 in the City as a whole.

Table 6: Proportion of households with a resident with a long term illness or disability

Tenure	Proportion of the population of Brighton and Hove living in this tenure (%)	Proportion of this group with a disability (%)	Estimated number of households including people with a disability
Owner occupied – with no mortgage	26%	23%	6,764 (31%)
Owner occupied with mortgage	36%	9.2%	3,654 (17%)
Privately Rented	23%	14.1%	3,544 (16%)
Housing Association (RSL)	5%	48.8%	2,521 (12%)
Local Authority	10%	44.3%	5,534 (25%)
All Tenures			22,017 (100%)

Source: Housing Needs Survey 2005

Table 6 highlights that households with a disabled member are more than twice as likely to rent from a local authority or social landlord (37 per cent of all households with a disabled member live in social housing, compared with 15 per cent of all households living in social housing across the City).

Brighton and Hove has the sixth largest private rented sector in the country (Stock Condition Survey 2008) and a relatively high proportion of disabled people live in the private rented sector (16%). This can mean that dwellings may potentially be unsuitable for adaptation and where some landlords may be reluctant to give permission for any adaptations to be undertaken.

The 2008 Stock Condition Survey found that compared to the general population, residents with a physical disability where more likely to live in a home in disrepair (12% compared to the Brighton and Hove

average of 7.7%) and more likely to be fuel poor (6.3% compared to 4.9%).

Brighton & Hove has a housing stock profile that is older than the national picture with 65.7% built before 1945, compared to 43.4% in England as a whole, many properties of which are difficult to adapt for people with mobility needs (Stock Condition Survey 2008).

9.3. Needs of specific population groups

As highlighted earlier in this report the term people with physical disabilities and sensory impairments describes a highly diverse group with a wide range of individual needs and experiences. The social model of disability, and the personalisation agenda, require that services ensure need is defined at the individual level and not prescribed by factors such as impairment type. However research highlights the need for services to take into the needs of specific groups that are potentially excluded or marginalised:

- Count Me in Too[15] identified that LGBT people with disabilities report a high level of need in relation to housing and safety. They also reported significant health issues, including mental health needs and discrimination by health services.

- Although people from BME communities are less likely to report impairments than the White population, they are more likely to experience poor outcomes if they are disabled[16].

- The 2005 Survey of Gypsies and Travellers[17] highlighted the issue of need for adaptations, including ramps outside, handrails, other alterations for access and bath / shower / toilet adaptations.

9.4. Views of service users

Consultation with, and surveys of, service users and their carers has highlighted the following needs. Users and carers want:

- A social model of disability adopted which is a broader view of disability, shifting focus from lack of ability to social and environmental barriers (Disability Equality Scheme service user group)

- Access to specialist support and clear pathways with access to support (MS Society Care Pathways review)

- Clear information and initial support – at the point of diagnosis

- Services to take into account communication needs and ensure information is provided in an appropriate understandable manner.

- People involved in service provision to understand the special needs and cultures of different vulnerable service users (not just a minimum amount).

- Services provided at home to be informed services that meet mental, physical and sensory needs.

- Choice to be given to service users.

- The discharge process from hospital to be pro-active in supporting the special needs of vulnerable people returning home or entering care.

- Access to psychological support and counselling

- One contact point for services.

- Reduced waiting times for services

- Easier access to respite care to support carers in emergencies and clear out-of-hours support

- Flexible transport options for hospital visits

The national Personal Social Services Survey of Adults Receiving Community Equipment and Minor Adaptations in England (2007-08)[27] identified that a high proportion of service users were satisfied with the local service (77%; the same value as the England average), although a higher proportion reported that the waiting time experienced had caused problems.

The Count Me in Too survey of LGBT people[15] highlighted the problems of access to services reported by deaf people.

10. Data on health, social care and housing services

10.1. Health

Limited data on health service activity related to people with physical disabilities is available.

Table 7 summarises service activity for adults (excluding older people) for the most recent three years. The data suggest a significant increase in referrals to the community rehabilitation team which reflects an expansion of this service to meet local needs.

Table 7: Service Activity 2006/07 to 2008/09; Adults aged 18-64 years; South Downs NHS Trust

		2006/07	2007/08	2008/09 *
Community Neuro-Rehabilitation Team	Referrals	71	113	139
Community Matrons	Referrals	41	48	86
District Nursing	Referrals	1,729	1,830	1,709
Intermediate Care Service	Referrals	267	358	320
Occupational Therapy	Referrals	1,570	1,737	1,967
Sussex Rehabilitation Centre (Shoreham)	Inpatient admissions	84	115	76

* Projected full year out-turn based on 10 months activity

10.2. Social Care

Social care activity information for physical disability and sensory services is presented in Tables 8 and 9.

Table 8: Social care assessment and service activity 2006/07 – 2008/09

		2006/07	2007/08	2008/09 (until Dec 2008)
Numbers of assessments undertaken 08/09	Physical disability	37	51	45
	Sensory Services	36	62	*148 (tbc)*
	Occupational Therapy	-	198	82
Number in receipt of services	Physical disability	299	285	371
	Sensory Services	50	76	*259 (tbc)*
	Occupational Therapy	781	786	-

Table 9: Other Community Care Services – adult aged under 65

Residential Home and Nursing Home placements	Transition placements	Day care activity
98 in year 2006/07; average 49 at any one time with 10 people receiving respite residential care	Approx 1 per month	Montague House: 73 service users 2006/07, mostly attending 2/3 times per week

10.2.1. Supporting people to live at home

Table 10 shows that historically Brighton and Hove has a had a relatively high number of people living in long stay residential and nursing care, however since 2003 the number has consistently fallen.

In contrast, Table 11 shows that the number of people helped to live at home has increased considerably. Brighton and Hove's performance is very high for this national performance indicator. In 2007/08 Brighton and Hove was the joint seventh highest performer out of 150 Councils.

Table 10: Long stay supported residents receiving residential and nursing home care (Rates per 10,000 population aged 18 to 64 years)

	2001	2002	2003	2004	2005	2006	2007	2008
Brighton and Hove	3.5	3.7	4.5	3.8	3.6	3.0	2.5	2.4
Institute of Public Finance comparator group of local authorities	3.6	3.3	4.3	3.8	3.5			
England	2.9	2.9	3.4	3.2	3.0			

Source: Key Indicators Graphical System

Table 11: People with a Physical Disability helped to live at home (Rates per 10,000 population aged 18 to 64 years)

	2003/04	2004/05	2005/06	2006/07	2007/08
Brighton and Hove	4.2	3.9	6.1	6.7	7.6
England	4.2	4.2	4.5	4.5	4.7
SE England	3.9	3.7	4.3	4.6	5.0

Source: CSCI Performance Assessment Framework

10.3. Housing Need in Brighton & Hove

10.3.1. Homelessness

As overall homelessness in the city has been reducing in the last few years, there has also been a reduction in homelessness amongst those with physical disability as the main priority need. However, at least one household every week is accepted as homeless with

physical disability as the main reason for priority need. Brighton and Hove City Council has recognised that there is a shortage of adapted temporary accommodation in the City for homeless applicants while they are waiting for suitable permanent accommodation and as a result the City Council is funding the adaptation of six self contained flats for this client group, with more to come following feasibility studies.

Figure 5: Homeless Households with Physical Disability as the Reason for Priority Need, Brighton and Hove: 2001/02 to 2007/08

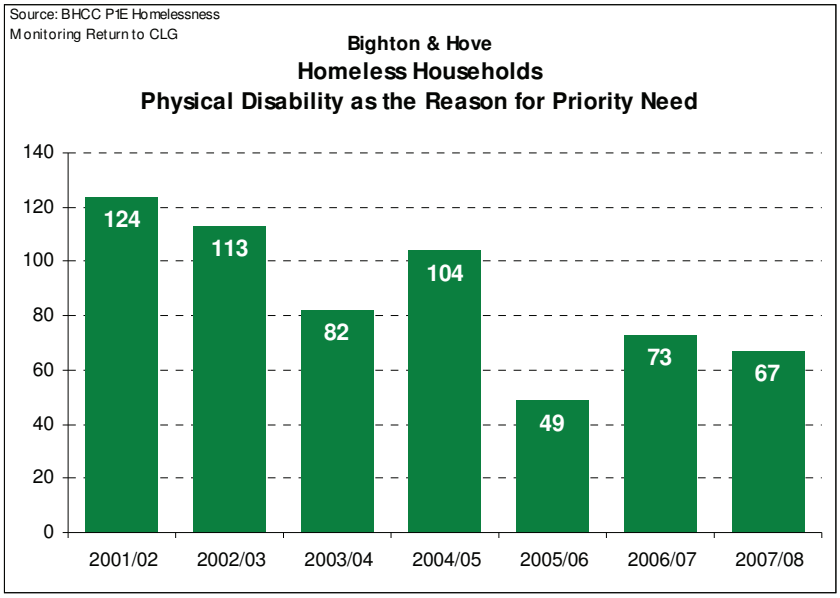


Table 12 highlights that the proportion of homelessness acceptances with physical disability as the priority need in Brighton and Hove is consistently two to three times higher than the England average.

Table 12 Proportion of homelessness acceptances with physical disability as the priority need, Brighton and Hove and England: 2004/05 – 2007/08

2004/05		2005/06		2006/07		2007/08	
England	Brighton & Hove	England	Brighton & Hove	England	Brighton & Hove	England	Brighton & Hove
5.1%	13.6%	4.9%	9.6%	4.9%	15.2%	4.9%	15.3%

Source: DCLG Homelessness Statistical Release Table 4 & BHCC P1E Homelessness Return to ODPM

10.3.2. Access to Social Housing

A service review carried out in September 2006 on the way households accessed social housing has resulted in wheelchair accessible properties being ring fenced for those with a mobility disability and more support is given to those who are vulnerable to bid for suitable homes.

In 2007/8 32 fully adapted wheelchair accessible properties became available for letting (Table 14), of which three in four (24) were owned by housing associations. Currently there are 88 applicants waiting for this type of accommodation (Table 13), demonstrating that demand far exceeds supply of this type of property. There is an almost equal need for one and two bedroom properties and a smaller demand for larger family homes.

For those waiting for accommodation that is partially adapted for wheelchair use (e.g. the property will have internal and external level or ramped access, but some parts of the property may not be fully wheelchair accessible) the level of demand in comparison to supply is more severe with 126 households waiting (Table 13) but only 24 properties becoming available a year (Table 14). Of this group the greatest need is for one bedroom properties.

The majority of those waiting for fully wheelchair adapted accommodation are aged less than 50.

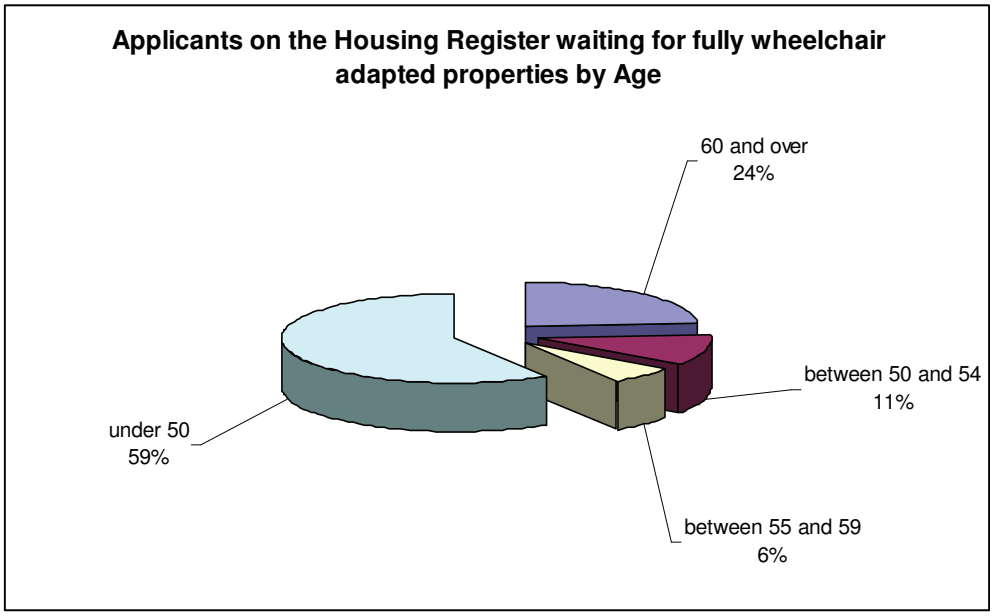
Table 13: Those on the housing register requiring disabled adapted accommodation (at 27 January 2009)

Type of property required	Number of Bedrooms Needed				
	1	2	3	4	Total
Fully adapted for wheelchair use	37	36	9	6	88
Partially adapted for wheelchair use	82	28	10	6	126
Total	120	66	22	16	

Table 14: Lettings 2007/8 to disabled adapted property

Type of property	Sheltered (older People)	Number of Bedrooms				
		1	2	3	4	Total
Fully adapted for wheelchair use	1	9	12	8	2	32
Partially adapted for wheelchair use	8	12	3	1	0	24
Total	9	22	17	12	6	

Figure 6: Applicants on the Housing Register waiting for fully wheelchair adapted properties by age; January 2009



Source: Locata

10.3.3. Adaptations to Homes

In order to address the specific housing needs of residents with a disability, Disabled Facilities Grants (DFG) are a mandatory

requirement for local authorities to provide to support people to live at home[i].

DFGs are subject to means testing and an assessment by an Occupational Therapist. The most needed adaptations are for the redesign of the bathroom, followed by grab/hand rails. Currently there is a long waiting list of those needing adaptations. The House Condition Survey estimates that 6,950 adaptations are currently needed by households with a disability.

The Housing Adaptations Service is responsible for the completion of major and minor adaptations within public sector housing and major adaptations for the private housing sector[ii]. This is an integrated case management service comprised of occupational therapists, technical and administrative staff. The integration was the result of evidence on the best way to manage an adaptations service, and recent Department of Health guidance commends this model.

During 2006/07 approximately 600 major and minor public sector adaptations were completed.

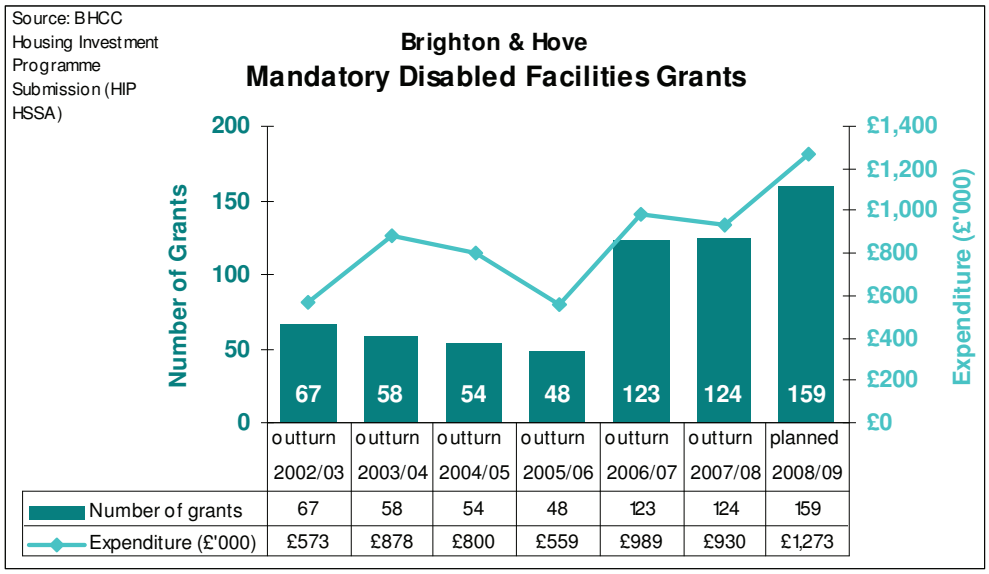
Funding for major adaptations is received through two main sources. First, the DFG funds major adaptation within the private sector and this can be a lengthy process as the DFG requires a full tendering process for works.

In 2007/08 124 grants were processed with a total expenditure of £930,000. The average payment per grant was around £8,000. The number of grants processed during 2007/08 is the same as 2006/07 and double that for the years prior to this. The number of grants planned for 2008/09 is 159 with a planned expenditure of £1,273,000.

[i] See table 10 highlighting Council performance in enabling people to live at home

[ii] The Integrated Community Equipment Service currently provides all minor (i.e. <£1,000) adaptations in the private sector.

Figure 7: Mandatory Disabled Facilities Grants, Brighton and Hove: 2002/03 to 2008/09



A recent national review of the DFG has recommended that the grant remains ring fenced and mandatory. Individual grants will be uplifted from £25,000 to £30,000 with immediate effect and a future rise to £50,000 is possible. Whilst individual budgets will not initially include the DFG, a loosening to current ring-fencing will provide greater flexibility.

The second source of funding is via the Public Sector Housing Revenue Account (HRA). The capital budget for public sector adaptations (2006/07) was £750,000, with the cost of minor adaptations approx £120,000 per year. Following the recent local decision on the Council's housing stock, the Housing Department will be reviewing the public sector HRA capital. A proactive investment approach for adaptations is planned.

10.3.4. New Housing Development

Planning policy expects all new homes in the city to meet the Lifetime Homes Standard with a further 10% of the affordable housing meeting the authority's Accessible Homes criteria (a higher specification wheelchair standard).

During 2007/08 there were 159 affordable homes completed through joint working with our partnership organisations. Of the 159 dwellings completed, 18 (11%) were fully adapted wheelchair homes.

11. Current Expenditure on Services

11.1. Expenditure on adult social care and housing

Expenditure by Brighton and Hove City Council is summarised in Table 15. In addition, between 2008 and 2011, Stroke Grant to the value of £94,000 per annum has been invested in the Community Rehabilitation Team to improve outcomes for people following stroke.

Table 15: Adult Social Care and Housing annual budget 2007/08 and 2008/09

Services	07/08 Annual budget value (net)	2008/09 annual budget (net)
Local Authority community care	£3,738,000	£4,581,000
LA mainstream e.g. Assessment, Occupational Therapy, Montague House day centre, daily living centre		£2,234,000
Housing: Housing Revenue Account (public sector housing)	£750,000	£830,000
Disabled Facilities Grant (private sector)	£972,000	£1,200,000

The unit cost of services are summarised in Table 16. The unit cost of services for people with physical disabilities per head of population is comparable to other unitary authorities with similar populations as shown in Figure 8.

Table 16: Personal Social Services Unit Costs 2007-08

Type of care	Unit	Cost
Residential and nursing care for adults with physical disabilities		
Residential and nursing care for adults with physical disabilities	Per person per week	£993
Nursing care for adults with physical disabilities	Per person per week	£791
Residential care for adults with physical disabilities	Per person per week	£1,163
Home care		
Adults with physical disabilities receiving home care	Per person per week	£174
Direct payments		
Adults with physical disabilities receiving direct payments	Per person per week	£234
Day care		
Adults with physical disabilities receiving day care	Per person per week	£201

Figure 8: Unit cost of services for people with physical disabilities per head of population 2007/08 (provisional data)

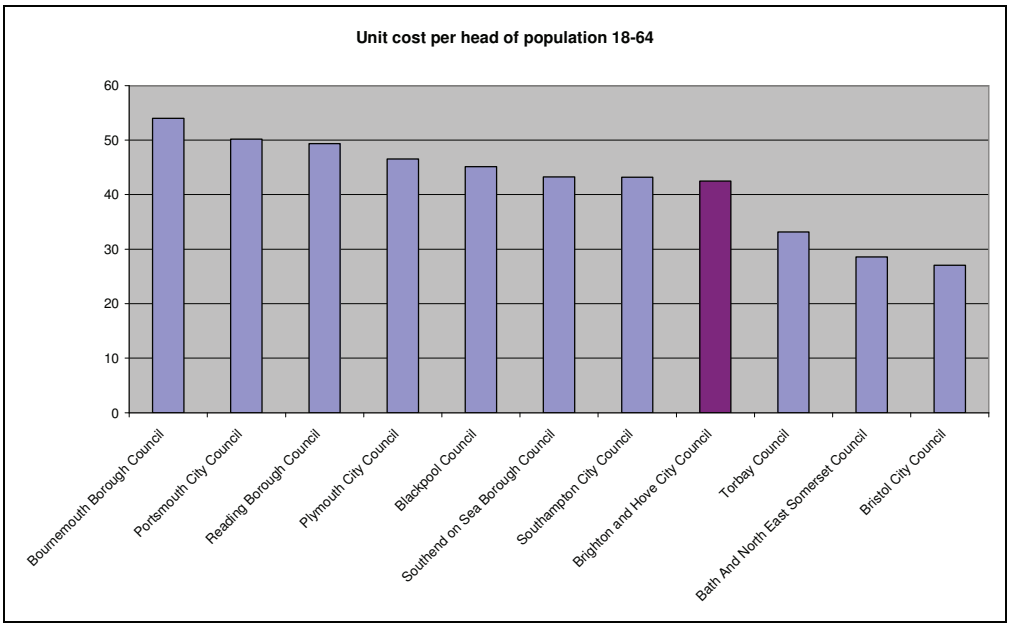


Figure 9 highlights that the unit costs for residential and nursing home care are very high compared to other authorities. These unit costs have increased rapidly in recent years, as illustrated in Table 17.

Figure 9: Unit Costs for residential and nursing home care for people with a physical disability 2007/08

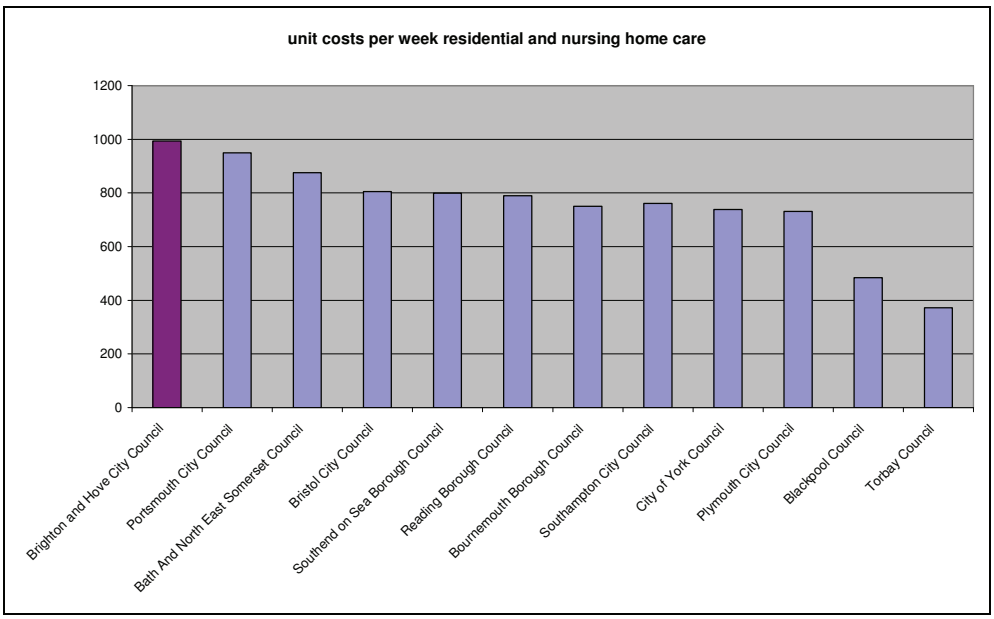


Table 17: Unit costs per week residential and nursing home care for Brighton and Hove 2004/05 to 2007/08

2004/05	2005/06	2006/07	2007/08
£734	£804	£893	£993 (provisional)

In 2006/07, the most recent year for which comparative data is available, in Brighton and Hove there was a lower than average rate of adults with physical disabilities aged 18 to 64 receiving direct payments (31 per 100,000 compared with 56 per 100,000 in England).

However, local data below shows that the number of physically disabled people receiving direct payments in Brighton and Hove has increased from 39 in 2006/07 to 65 in 2008/09 (Table 18).

Table 18: Number of Brighton and Hove residents in receipt of direct payments 2005/06 to 2008/09

2005/06	2006/07	2007/08	2008/09
36	39	54	65

11.2. Expenditure on health services

Establishing the overall level of health expenditure on adults with physical disabilities and their carers is challenging, and a key element of the costed action plan within the accompanying strategy is to continue work to establish the baseline funding for this service user group. This is vital, because much of the NHS Brighton and Hove expenditure is across wider programmes of care (e.g. primary care) or related to specific conditions (care pathways), rather than analysed by service user grouping.

In total, NHS Brighton and Hove spends over £430m per annum on commissioning healthcare, across the spectrum from primary care to palliative care, as well as support for carers and advocacy services. Within primary care, for example, NHS Brighton and Hove spends £45m – but a significant proportion of this funding is for primary care practitioners who will provide support to adults with physical disabilities.

However, some specifically identifiable areas of expenditure can be identified of particular relevance to this client grouping, and these are shown in the table below.

Table 19: Estimated Health Spending on people with physical disabilities (excludes general health services)

Service area	Total budget (£ 000)	Service activity relating to 18 to 65 year olds (%)	Estimated spend
Sussex Rehabilitation Service			
• Brighton	2,553	37%	945
• Shoreham	2,285	40%	914
Community Rehabilitation Team	732	45%	329
Integrated Community Equipment Service	1300	25%	325
Intermediate Care	1,300	17%	221
Continuing Care: Physical Disabilities	965	70%	676
Continuing Care: Neurorehabilitation	800	70%	560
Physical disability: specific PCT budgets	150	100%	150
			4,120

Of particular note is the Rehabilitation Centre, and NHS Brighton and Hove and South Downs Health are working on the Strategic Outline Case for establishing future funding requirements for this service.

12. Appendix 1: Incidence and prevalence of specific conditions

12.1. Stroke

Stroke is defined as a neurological impairment of sudden onset that is caused by a disruption of the blood supply to the brain. Numerically stroke patients make up the greatest number of people requiring neuro-rehabilitation after an acute event.

In the UK, stroke is the main cause of disability. In the Brighton and Hove City population, it is estimated that there will be 560 strokes per year. Stroke occurs more commonly in people aged over 65 and it is estimated that there will be approximately 40 strokes per year in those aged under 65. It is estimated that there are 4518 people in Brighton and Hove who have had a stroke, of whom 1450 will have a moderate or severe disability[28].

For adults aged 18-64 years it is estimated that in 2008 there are 46 male and 81 female Brighton and Hove residents who have had a stroke and require help with daily activities. These figures are expected to increase slightly to 47 males and 86 females by 2015[12].

12.2. Multiple sclerosis

Multiple Sclerosis (MS) is a chronic inflammatory demelinating disease of the central nervous system leading to progressive impairment of various systems[29]. There are three forms of the disease:

- Relapsing/Remitting MS: symptoms come and go with periods of health or remission followed by sudden symptoms or relapses (80% of patients at onset).
- Secondary progressive MS: follows on from relapsing/remitting MS. There are gradually more or worsening of symptoms with fewer remissions (approximately 50% if those with relapsing/remitting MS develop secondary progressive MS during the first 10 years of their illness).
- Primary progressive MS: from the onset of the illness symptoms gradually develop and worsen over time (10-15% of patients at onset)[30]

Patients with MS may develop a wide range of functional impairments and disabilities that will impact on their quality of life and degree of disability. It has been estimated that 15 years after onset 15% of MS patients will need walking aides and 29% will require the use of a wheelchair [29].

MS is most commonly diagnosed in adults between the ages of 20 and 40 years of age and women are almost twice as likely to be diagnosed as men[31].

Based on the application of national incidence and prevalence rates, Brighton and Hove City would be expected to have up to 17 new diagnoses per year, and up to 300 local residents living with MS. However the MS specialist nurse is reported to manage over 400 active cases. This may be explained by the age distribution of the local population, which has a higher than average proportion of young adults

12.3. Rheumatoid arthritis

Rheumatoid arthritis (RA) is a chronic inflammatory disease of the joints[32]. In time, affected joints typically become damaged. It is usually a chronic relapsing condition, but its course can vary from a mild disease to a severe destructive form in a few years[33]. Each relapse leads to damage to the joints and the amount of disability that develops usually depends on the amount of damage done over time. In a minority of cases the disease is constantly progressive and severe joint damage and disability develop rapidly.

Approximately 1% of the population have rheumatoid arthritis (RA). Women are two to three times more likely to develop RA than men with one study finding an incidence of 36 per 100 000 population for women and 14 per 100 000 for men[34]. The disease most commonly develops between the ages of 30 and 60, with approximately 80% of total cases occurring between the ages of 35 and 50[35].

Estimating disability levels in RA patients is difficult because of the remitting/relapsing nature of the disease. It has been estimated that 11-14% of patients with RA will require a joint replacement within 5 years[36]. An English study found that although 60% of RA patients were still in paid employment after 5 years, the level of work disability was 22%, and was higher in manual workers[33].The prevalence of severe disability due to RA is 130 per 100 000 population[37].

12.4. Other conditions

There are a number of conditions that can lead to physical disability some of which are outlined below:

12.4.1. Neurological conditions

12.4.1.1. Parkinson's Disease

The annual incidence of 20 per 100 000 generally occurs in older people, but covers the age range of 55 and over (Association of British Neurologists, 1992). Of the 180 per 100 000 with the disease, about 40 % have severe disability[38].

12.4.1.2. Motor Neuron Disease

An annual incidence of 2 per 100 000 and a median survival of 1.5 years leads to a prevalence of 6 per 100 000 (Motor Neuron Disease Association), with severe disability. This disease is usually progressive and rapidly fatal, but some patients experience a milder attenuated course.

12.4.1.3. Cerebral palsy, spina bifida, and other muscular dystrophies

The incidence of cerebral palsy (2 per 1000) and muscular dystrophy (1.3 – 3.3 per 10 000) have remained relatively stable, the prevalence of these conditions (200 and 90 per 100 000 population, respectively) has increased with improved survival[39],[40].

The incidence of live births with spina bifida, in contrast, is decreasing as it can now be diagnosed antenatally. The prevalence is now less than 2 per 100 000 school leavers[41].

12.4.2. Trauma

Brain injury: Traumatic brain injury (TBI), as a result of head injury, is another leading cause of neurodisability. Unlike stroke, a large number of patients with traumatic brain injuries are likely to be young with a normal, or near normal, life expectancy, but with high residual levels of disability[42]. As acute and emergency services have improved in their treatment of head injury, increasing survival rates, the need for rehabilitation services has also increased.

Head injuries requiring hospitalisation occur in the UK at the rate of about 300 per 100 000 population annually, of these approximately 250-280 will be mild, 15-20 moderate and 5-10 severe[43]. Within these numbers there are difference in the rate of head injury between urban

and rural areas, and there are peaks at 15-24 years of age and >75 years[44]. Estimating the numbers of people with residual problems from head injury is difficult[42]. However, it has been suggested that approximately 150 per 100 000 population have persistent disability resulting from head injury[45] although these are likely to be conservative estimates.

Spinal cord injury: Spinal cord injury is less common than brain injury with an annual incidence of traumatic spinal cord injury of 2 per 100,000 population.

12.4.3. Locomotor conditions

12.4.3.1. Osteoarthritis

The prevalence of severe disability due to osteoarthritis is 300 per 100 000 population[38].

12.4.3.2. Amputation

The National Amputee Statistical Database report annually on the number of patients referred to prosthetic service centres around the UK[46]. In 2005/06 there were a total of 5000 new referrals, this was a reduction on the number from the previous years and gives a rate of approximately 9.5 per 100 000 population nationally

In 2005/06 lower limb amputations accounted for 91% of all amputations with upper limb accounting for 5% and congenital amputations accounting for the remaining 4%. The most common cause for upper limb amputation was trauma; lower limb amputations were most frequently the result of conditions that cause a defective blood supply to the limb, most commonly diabetes (72% of all cases)[47]. Over half of all amputations take place in those aged over 65. The median age of men undergoing amputation is younger (66 years) than women (69 years). Those undergoing upper limb amputation have a younger age profile than those undergoing lower limb amputations, with 60% under 55 years of age. This is a reflection of the aetiology of the condition (mainly trauma).

12.5. Visual impairment

PANSI estimates that there are 111 people aged 18 to 64 years with a serious visual impairment [iii] in Brighton and Hove City in 2008, and this figure is expected to increase slightly to 115 by 2015[12].

[iii] Based on a review of the literature conducted by RNIB; this prevalence refers to estimated numbers predicted to require help with daily activities

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JOINT COMMISSIONING STRATEGY

FOR

PHYSICAL DISABILITY SERVICES 2009 - 20012

3 YEAR ACTION PLAN

Foreword:
This action plan sets out the key priory actions identified in the 3 year strategic planning framework. Of necessity, information on costing and financial impact is high level in the later years of the plan. For the most part, as discussed in the detail of the action plan, much of the action can be delivered within existing resources - it is a case of using these more effectively, and in a more directed way. Many of the actions involve scoping out future service requirements and understanding the likely cost implications of service change (typically referred to as 'business case.' There are costs involved in the preparation of these cases, but these are typically containable within existing financial envelopes. As these business cases are developed, however, the full picture of service change costs will emerge and these proposals will then go through the respective health, housing and social care prioritisation processes to secure the required investment. As the action plan is refreshed and brought to Committee, these costs will be identified and funding streams sought where appropriate.

Health, housing and social care partners are in broad agreement over the financial position moving forward. There will be significant pressures for resources in all service areas, and increased investment will need to be matched with improved efficiency. Personalised budgets (in both health and social care) are a good example. The early research evidence suggests that, the implementation of personalised budgets will have an initial cost, but this will lead to significant downstream efficiencies. The key challenge for commissioners will be to manage the initial investment within the current financial envelopes, against emerging efficiencies from earlier investments.

There are two further issues to note. First, the strategy sets out a challenging set of aspirations for commissioners. by the end of the three year period, there should be robust data and strategic plans supporting clear actions, and implementation of the high priorities (such as personalised care, and service user engagement) should be well underway. This may create a need for additional investment in system capacity - not necessarily for additional commissioner resource, but perhaps across key partnerships such as the voluntary and community sector.

Second, both the PCT and the City Council will - across the board - be implementing improvements in services and support which will directly impact on service users with physical disabilities. These may be driven by factors outside this strategy, but which will impact on the outcomes of the strategy. For example, the PCT is engaging in significant investment across the spectrum of long term conditions, including strengthening arrangements for self-managed care. This programme of change will support service users with physical disabilities.

1 ACTION PLAN FOR COMMISSIONING STRATEGY - GENERAL

► To ensure that the PCT and the local authority jointly plan for the needs of people with physical disability in the city

► Closer alignment of performance reporting, financial reporting, budget planning and commissioning

	TASK	SPECIFIC ACTIONS 09/10	10/11	11/12	AGENCIES / ORGANISATIONS LEADS	FINANCIAL IMPACT	OUTCOME MEASURE
1.1	**Undertake a comprehensive joint strategic needs assessment which will outline projections of demand for the long term needs of people with physical disability**	1.Incorporate JSNA into 3 year rolling programme of JSNAs for the city	Review JSNA and revise 2nd year action plan accordingly	Agree workplan and timescale for 12/13 JSNA	Lead: Alistair Hill (Public Health/PCT)	Existing resource	Robust board-approved JSNA, and updated action plans.
		2.Complete needs assessment for commissioning framework for complex needs support options	n/a	n/a	Lead: Alistair Hill (Public Health/PCT)	Existing resource	Completed needs assessment, highlighting clear priorities for action.
1.2	**To manage performance across key service areas**	1.Physical disability steering group to monitor KPIs for PD services covering previous PAF targets, LAA, Vital Signs and other local targets	Continue quarterly reporting	Ongoing	Lead: Carl Burns PCT head of Knowledge and Cat Harwood LA Performance team	Existing resource	Vital Signs Reporting (VS 11 Proportion of people with long term conditions supported to be independent and in control of their condition) VSA 14 quality stroke care PAF and LAA self directed support targets
		2. Ensure systematic service user feedback via SLAs and service specifications	Maintain improvements in embedding service user feedback into contracts.	Ongoing	Lead: PCT Contracts team Kate Kedge and Adult Social Care Contracts unit	Existing resource	Clear contract changes and requirements reflecting feedback.

2 ACTION PLAN FOR OBJECTIVE 1: INVOLVEMENT AND ENGAGEMENT OF PHYSICALLY DISABLED PEOPLE AND THEIR CARERS IN

- ► More effective commissioning and service development strategies which ensure equity of access
- ► High quality, responsive services which reflect and meet individual needs
- ► Reduction in health and care inequalities

	TASK	SPECIFIC ACTIONS 09/10	10/11	11/12	AGENCIES / ORGANISATIONS LEADS	FINANCIAL IMPACT	OUTCOME MEASURE
2.1	**Strengthen service user involvement and ongoing engagement**	1. Secure service user and voluntary sector representation on Physical Disability steering group and associated work streams to implement and monitor progress of the strategy	Ongoing	Ongoing	Lead: PCT Community involvement and participation manager	The PCT provides funding to support representation on relevant consultative groups including investment to federation of Disabled people	embedding of inclusive structures
		2. Consult with service users and carers on preferred model for ongoing user engagement and representation and the future model for the Centre for Independent Living	Roll out of agreed model for centre for independent living across the city ensuring that centre is 50% user led	Monitoring of service	Lead: Karin Divall /LA PCT Community involvement and participation manager	Investment in community space available from 2010/11as part of development of Vernon Gardens funded through DoH grant of £1m	50% service user led model of CIL
		3. Continue engagement with wider public and patients on disability issues - HOSC&LiNKS	Ongoing	Ongoing	Lead: PCT Commissioner Linda Harrington	Existing resource	

3 ACTION PLAN FOR OBJECTIVE 2: PERSONALISED CARE AND INCREASED SELF DIRECTED SUPPORT

- ► Information services which are responsive to need of people with disability
- ► Strengthened prevention and earlier intervention
- ► Timely, responsive, accessible and streamlined services ensuring delivery of person centred care
- ► Increased number of people purchasing self directed care

	TASK	SPECIFIC ACTIONS 09/10	10/11	11/12	AGENCIES / ORGANISATIONS LEADS	FINANCIAL IMPACT	OUTCOME MEASURE
3.1	**Ensure highly visible, integrated and effective information services**	1. Implementation of the Adult Social Care information strategy to support personalisation of service.	1. Develop information hub within centre for independent living Develop information hub at Patching lodge ASC Access Point	Review and refresh of information support to service users	Lead: LA	2009/10 Investment of £159k of DoH Social Care Reform Grant in Access Point. Community space at patching Lodge funded through DoH grant	
		2. Evaluation of information prescription pilots 08/09 and development of information directory 09 ensuring responsive to needs of disabled people	Maintenance and development of information directory	Maintenance and development of information directory	Lead: PCT Jane Bolding	Existing financial envelope	

3.1 continued	**Ensure highly visible, integrated and effective information services**	3.Review training and support needs of primary care to ensure disability aware and equipped to deliver information prescriptions, personalisation and LTC agenda (review needs across PC - GPs, pharmacy, optometrists)	Finalisation of review and implementation of outcomes, in partnership with practice-based commissioners.		Lead: PCT Linda Harrington	The review of training and support can be delivered within existing resources. However, the outcome of the review may identify a need for additional resourcing for primary care practitioners to strengthen support for service users. The initial source of funding would be through efficiencies within primary care, but a business case will be developed if additional funding is required. A key PCT commitment is to improve the quality and responsiveness of primary care.	Service user feedback
		4. Development and expansion of PALS information Hubs - ensuring appropriate access and service for people with a disability -	Ongoing	Ongoing	Lead: Jane Bolding	Within existing PCT resources	

3.1 continued	**Ensure highly visible, integrated and effective information services**	5. Explore further integration of information services with 3rd sector projects to strengthen 1 shop shop approach	Ongoing	Ongoing	Lead: Jane Bolding	In theory, this is deliverable within existing resources and reflects a rationalisation of existing services. However, a small amount of additional funding may be identified during the review.	
		6. Improve access to disability information / sign posting services during hospital inpatient stay and at point of discharge (linking with development of information hub)	Ongoing	Ongoing	Lead: PCT Linda Harrington	The funding for this improvement can be provided through the PCT additional funding (uplift) to the hospital services, via the CQUIN vehicle.	LAA - target
		7. Ensure developing information services are linked to proposed Map of Medicine, BICS, care co-ordination centre and Adult Social Care	Ongoing	Ongoing	Lead: PCT Jane Bolding	Within existing resources	co-ordinated information services

3.2	**Strengthened self care and self directed care initiatives**	1. Refresh of PCT self care strategy 09	Implementation of strategic action plan	continued implementation of action plan	Lead: PCT - Dianna Carsons	The refresh of the self-case strategy can be carried out within existing resources, but the evidence shows that the introduction of individual budgets will require an initial investment. The PCT and the BHCC are working on plans for the implementation of these services, and investment will be applied for through the prioritisation process. For both organisations, these are agreed priorities across a wide range of service users.	VSA LTC Proportion of people with LTC supported to be independent and in control of their condition; HPEC 3
		1.Increase care delivered via direct payments	Increase number of care packages delivered through direct payments	Continued trend of increase in care delivered through direct payments	Lead: Gemma Lockwood (LA)	Deliver from reprioritisation of Social Care budget supported by DoH Social Care Reform Grant. Expected efficiency savings to fund expected growth in number of direct payments in future years.	

3.2 continued	**Strengthened self care and self directed care initiatives**	3. Agree resource allocation system for social care PD budgets	n/a	n/a	Lead: Brigid Day LA	Within 2009/10 budget	
		4. Develop and introduce pilot for LA individualised budgets for younger disabled people	2. Scope and pilot model for joint health and social care budgets	Introduction of health and social care individual budgets	Lead: Karin Divall LA	Increased investment of £156k in 2009/10 and supported through Social Care Reform Grant. Reprioritisation of investment in future years	

3 ACTION PLAN FOR OBJECTIVE 2: PERSONALISED CARE AND INCREASED SELF DIRECTED SUPPORT

	TASK	SPECIFIC ACTIONS 09/10	10/11	11/12	AGENCIES / ORGANISATIONS LEADS	FINANCIAL IMPACT	OUTCOME MEASURE
3.3	**Improve and streamline access to health and social care services for disabled people**	1. Improved access points ensuring services are responsive to the needs of disabled peoplevia introduction of LA access points (08), revised care co-ordination centre (STAN) model to improve professional / community access to urgent care services		Monitor service	Lead: Brigid Day (LA) and Anna McDevittPCT	LA access points Deliver from reprioritisation of Social Care budget supported by DoH Social Care Reform Grant. The STAN model will be delivered within existing resources - the service is shortly to be competitively tendered and strengthening this service will be delivered through efficiency savings.	Reduced wait times LA 92% of people will have needs met at point of access;HPEC LTC;DTOC
		2. Review with primary care options for streamlining of health appointments to improve access for disabled people and to improve management of long term conditions	Ongoing	Ongoing	Lead: Strategic Commissioner Primary Care	The PCT funds improvements in access via a variety of means into primary care (including enhanced services schemes). It is anticipated that this streamlining can be delivered within existing resources.	Improved access and reduced wait times

	Improve and streamline access to health and social care services for disabled people	3.Audit numbers and access needs of disabled people who are housebound	Ongoing	Ongoing	Lead: strategic commissioner primary care	Within existing resources	
3.4	**Strengthen health promotion and well being initiatives**	1. Develop business case for designated disability health trainer, and review EPP to delivery responsive programme for those with long term conditions	1. Roll out of centre for independent living providing focal point for healthy / independent living information, advice and support. Delivery of individualised health trainer support and programmes of health promotion / support within disability resources	Monitoring performance of new service	Lead Head of Health Promotion PCT	This can be delivered within existing resources. The PCT is funding significant extensions to health promotion across a range of service users, and is exploring options for streamlining service delivery, which will deliver additional resource.	VSA LTC Proportion of people with LTC supported to be independent and in control of their condition
3.5	**Strengthened advice and advocacy services model which will support future self directed care model**	1. Review of existing advocacy services and develop future contract for advocacy services	1. Tender for agreed service	Monitoring performance of new service	LEAD: Linda Harrington (PCT) andGemma Lockwood (LA)	A small amount of additional funding may be required to strengthen advocacy services, but the larger gains will be through the streamlining of the existing services	VSA LTC Proportion of people with LTC supported to be independent and in control of their condition

4 ACTION PLAN FOR OBJECTIVE 3: PROMOTION OF INDEPENDENCE AND EXTENDED INDEPENDENT LIVING OPPORTUNITIES

► Improved access to a broader range of services to support independence

►Improved management of hospital stays and discharge to ensure greater independence during stay and at point of discharge

► Improved support to carers of disabled people and disabled people who are carers

	TASK	SPECIFIC ACTIONS 09/10	10/11	11/12	AGENCIES / ORGANISATIONS LEADS	FINANCIAL IMPACT	OUTCOME MEASURE
4.1	**Review of management of disability needs during hospital inpatient stay**	1. Introduction of personalised hospital care plans - to promote and maintain independence during I/P hosptial stay -include review of mobility and wheelchair access during hospital stay	Ongoing	Ongoing	Lead: Linda Harrington	The implementation of personalised care plans is already reflected in local NHS plans. The additional requirements around review of mobility can be added at minimal additional cost.	VSA LTC Proportion of people with LTC supported to be independent and in control of their condition ; HPEC3
4.2	**Improve access to accessible and adapted housing solutions**	1. All new housing proposals assessed to ensure they comply with Lifetime Homes Satandard as part of approval process	ongoing	ongoing	Brighton & Hove City Council (Planning)	Planning scrutiny within existing resources. Capital cost borne by developer and assessed as part of financial viability of individual	100% of new homes meet Lifetime homes standard. Action and 10% accessible affordable housing

4.2 continued	**Improve access to accessible and adapted housing solutions**	2. All new affordable housing proposals assessed to ensure 10% of programme complies with Accessible Homes Standard (PAN03 ie Wheelchair Standard) as part of approval process	Ongoing	Ongoing	Brighton & Hove City Council (Planning) (Housing Strategy)	Planning scrutiny within existing resources Capital cost borne by developer and assessed as part of financial viability of individual development proposals	10% of new affordable housing meets Accessible Homes Standard (Planning Advice Note 03)
		3. Provision of advice to development partners on mobility standards in new build developments	Ongoing	Ongoing	Brighton & Hove City Council (Planning) (Housing Strategy)	Integrated Adaptations Team Housing Development Team	Provision of mobility homes that meet needs of PAN03 and our client groups
		4. Improve understanding of access needs of those on the Housing Register	Ongoing	Ongoing	Brighton & Hove City Council (Housing Strategy)	Accessible Housing Officer appointed	All new applicants assessed. Backlog of applicants in Band A and Band B assessed for mobility needs
		5. Development of accessible housing register database	Ongoing	Ongoing	Brighton & Hove City Council (Housing Strategy)	Accessible Housing Officer appointed	All social housing available for letting assessed for accessibility and matched with households mobility needs

4.2 continued	**Improved access to accessible and adapted housing solutions**	6.. Implementation of choice based lettings new lets mobility rating	Ongoing	Ongoing	Brighton & Hove City Council (Housing Strategy)	Accessible Housing Officer appointed	All wheelchair suitable social housing lets ringfenced to those with mobility needs
		7. New Accessible Homes Standard social housing built with bespoke adaptations designed around the mobility needs of the prospective tenant	Ongoing	Ongoing	Brighton & Hove City Council (Housing Strategy)	Integrated Housing Adaptations Team Housing Development Team Accessible Housing Officer	New Accessible Homes Standard social housing built with bespoke adaptations designed around the mobility needs of the prospective tenant
		8. Casework support for social housing tenants in properties unsuitable for adaptation to enable moves to more appropriate adaptable homes	Ongoing	Ongoing	Brighton & Hove City Council (Housing Strategy)	Housing Strategy Caseworker Integrated Housing Adaptations Team	Improved quality of life Better use of housing resources
		9. Improve access to minor adaptations	tbc	tbc	Brighton & Hove City Council (Adult Social Care & Housing)	tbc	Ultimate target of 4 weeks

	10. Acquire temporary accommodation that can be made suitable for those with mobility needs - 6 units 09/10	Ongoing - additional units acquired	Ongoing - additional units acquired	Brighton & Hove City Council (Housing Strategy)	Empty Property Grant Disabled Facilities Grant Private Sector Renewal Grant	Increased supply of temporary accommodation suitable for those with mobility needs

	TASK	SPECIFIC ACTIONS 09/10	10/11	11/12	AGENCIES / ORGANISATIONS LEADS	FINANCIAL IMPACT	OUTCOME MEASURE
4.3	**Improved access to primary community support for independent living**	1. Develop model for local delivery of enhanced mobility services	Ongoing	Ongoing	Lead: Linda Harrington PCT	The implementation of strengthened community services is reflected in the PCT financial and service plans for the period in question. These services deliver efficiencies through reductions in acute care, which will provide a source of funding for this care pathway improvement.	
		2. Complete VFM review of telecare	Implement actions from review	Implement actions from review	Lead: Alison Sinclair (LA)	2009/10 £50k of Social Care Reform Grant. Business case to fund future actions.	
		3. Roll out of telehealth COPD pilot;	Explore telehealth options within longer term support model for stroke		Lead: Kristiina Parkinson (PCT)		

4.4	**Enable more carers (both carer who are disabled and disabled people who are carers) to receive assessments and services**	1. Development of joint commissioning strategy for carers ensuring that needs of carers of disabled and disabled people who are carers are addresed	Implement actions from strategy	Implement actions from strategy	Lead: Tamsin Peart Joint Commissioner Carers	DoH Carers grant	Increase number of carer assessments (18% 09/10);improve identification of young carers;

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5 ACTION PLAN FOR OBJECTIVE 4: IMPROVED SUPPORT TO THOSE WITH HIGHER LEVELS OF HEALTH AND CARE NEEDS

► Increased capacity and a broader range of effective support options across the city to which support independent living and provide VFM

►Improved VFM services for the city

► Improved co-ordination of care via greater integration of services

	TASK	SPECIFIC ACTIONS 09/10	10/11	11/12	AGENCIES / ORGANISATIONS LEADS	FINANCIAL IMPACT	OUTCOME MEASURE
5.1	**Development of extra care housing for younger adults Vernon Gardens (10 independent living flats)**	1. Implementation of project plan for Vernon Gdns development	Opening of Vernon Gdns - 10 extra care flats	Monitoring of service	Lead: Karin Divall LA	£1m DoH development grant: reprioritisation of social care grant	Reduction in long term placements reduction in high costs packages of care
		2. Complete comprehensive needs assessment to inform framework for higher dependency care options: including requirement for further extra care scheme/s, short term services and slow stream rehabilitation within the city	Development of business case to support commissioning intentions	Implementation of commissioning plan	Lead: Public Health Consultant and Commissioning Manger	To be determined via business case	Reduction in long term placements reduction in high costs packages of care

5.2	**Implementation of Sussex wide neuro-rehabilitation commissioning framework re-commendations**	1. Management of SRCs interim plan and move of service to PRH	Ongoing	Transition plan	Lead: Linda Harrington PCT	Existing resource - additional investment of £250K/ annum provided to support the transitional move.	Improved throughout and reduced to DTOC
		2. Development of longer term plan for SRC inpatient services in conjunction with wider strategic developments (neuro-science and BGH SOC)	Ongoing	Implementation of longer term plan for SRCs	Lead: Linda Harrington PCT	This significant change programme will form part of the wider strategic financial plans for the development of local health services. The PCT and South Downs Health are currently working on the Strategic Outline Case and will identify appropriate funding streams.	
		3. Develop business case for strengthened earlier supported discharge model - review current CNRT model and capacity	Ongoing	Ongoing	Lead: Linda Harrington PCT	The funding for this strengthened supported discharge model will be sought via the business case process, once the case has been completed and approved.	

5.3	**Improved co-ordination of care and greater integration of services with strong focus reablement and rehabilitation focus**	1. Develop 3yr stroke action plan and implement model for longer term co-ordination of stroke care introducing pilot for personalised care plans	Review model and develop plan for service at end of funding	Introduction of revised model for ongoing LT coordination of stroke care following end of 3yr DOH funding	Lead: Linda Harrington PCT	Includes £94k pa DoH grant for 3yrd 2008-2011: Additional PCT investment for stroke services allocated in the PCT Strategic Commissioning Plan, and to be delivered through the business case process	National Stroke Strategy NSF for LTC LTC HPEC1-5
		2. develop business case for additional 0.5 specialist MS nurse to increase capacity for case co-ordination / management	Ongoing	Ongoing	Lead: Linda Harrington PCT	This is likely to have an implementation cost of circa £30K, which will be funded by the business case approval process.	NSF for LTC
	Improved co-ordination of care and greater integration of services with strong focus reablement and rehabilitation focus	3. Agree model for management of long term conditions strengthening integrated working practices and streamlining access and reaccess to support	Pilot LTC model	Introduction of personalised care plans	Lead: Wendy Young PCT	The funding for the LTC model is set out in the PCT Strategic Commissioning Plan, and has been reflected in PCT financial plans for the next three years.	

	rehabilitation focus	4. Review of ABI care pathway to improve local longer term support		Ongoing	Lead: Linda Harrington PCT	Within existing resources	
5.3 continued	**Improved co-ordination of care and greater integration of services with strong focus reablement and rehabilitation focus**	5. Develop model for further integrated working to support reablement & rehabilitation service focus exploring options across care pathway from access / assessment to longer term support	Implement model	implement model	Leads: Linda harrington (PCT) and Karin Divall (LA)	2009/10 funded through existing resources Social Care Reform Grant.Reprioitisation of social care investment.	

6 ACTION PLAN FOR OBJECTIVE 5: INCREASED OPPORTUNITIES FOR LOCAL CITIZENSHIP AND PARTICIPATION

► Improve access to mainstream activities and opportunities

► Increase flexible transport options

TASK	SPECIFIC ACTIONS 09/10	10/11	11/12	AGENCIES / ORGANISATIONS LEADS	FINANCIAL IMPACT	OUTCOME MEASURE

6.1	**Increased access to employment. Training and leisure opportunities**	Review current capacity and access to return to work support services	Develop future role of day care activities & CIL to maximise opportunities for further integration into mainstream activities including employment, training		Lead: Karin Divall (LA)	Within existing day service resources.	Increased number of people and carer in employment HPEC Pledge 5;LAA target
6.2	**Review transport links to ensure greater flexibility and maximise opportunity**	Review of wheelchair accessible taxis to improve transport access to health, community & leisure activities		Develop mystery shopper programme to review accessible transport links	Lead: Karin Divall (LA)	Additional specific funding will be available to support this strategic objective.	

Appendix D GLOSSARY

Care pathway	A pre-determined plan of care for patients with a specific condition
Elective Care	A planned admission to hospital
Evidence based care	Is care that has been systematically, scientifically studied as to its effectiveness
Expert Patient Programme (EPP)	Programme designed to teach good self care and self management skills to people with long term conditions.
Extra Care Housing	Describes a type of specialised housing that provides independence and choice to adults with varying care needs and enables them to remain in their own home.
Independent Living	*'all disabled people having the same **choice, control and freedom** as **any citizen** at **home**, at **work** and as a member of the **Community**'* *Disability Rights Commission* is about securing the rights and entitlements which will ensure disabled people enjoy the same substantive freedoms everyone expects in order to lead the lives they wish to lead
Incidence	A figure describing the number of new diagnoses in a defined period
Individual budgets	A sum given to an individual, to allow them control over the way the money is spent on their care needs.
Mobility services	The services which help people with personal mobility both indoors and outdoors
Personalisation	Tthe process by which state provided services can be adapted to suit individuals. This means everyone having choice and control over the shape of their support along with a a greater emphasis on prevention and early intervention
Person-centred care planning	A process of life planning for individuals based on the principles of inclusion and the social model of disability.
Prevalence	A figure describing the number of people living with a condition or need
Rehabilitation (egs)	Describes a process whereby people are assisted to re regain or re-learn skills lost

	as a result of illness or accident or to learn new skills they have not had before. Rehabilitation is a process involving a range of approaches: clinical, social, vocational and educational.
Self directed care	A change to the way the health and care system operates to give choice, control and power over the support received
Service User	Anyone who uses, requests, applies for or benefits from health or local authority services.
Telecare/Telehealth	A combination of equipment and monitoring that helps individuals to remain independent at home

Appendix E: Summary of consultation and engagement activity with people with physical disabilities and their carers regarding physical disability services.

Introduction

This report summarises the findings from a period of engagement and consultation with service users and carers during the development of the strategy: Choice, Independent Living and Personalised care: A strategy for Physical Disability Services 2009-2012.

The strategy is a joint strategy between the Brighton and Hove City Teaching Primary Care Trust and the Brighton & Hove City Council to improve opportunities and support services to people with physical disabilities

Background

The strategy has been under development for over two years. At the start a Physical Disability Strategy Steering Group was established to help develop the strategy. This group included cross representation from statutory and 3rd sector organisations including service user representation from the Federation of Disabled People.

During the lifespan of the steering group a range of outreach work was carried out to discuss the developing strategy. This included:

- Discussions with 3rd sector organisations, service user representatives and advocacy groups on existing services and care pathways. During this time meetings were held with the Federation of Disabled People, the Multiple Sclerosis Society, Headway, the carers Centre and Sussex Acquired Brain Injury Forum (SABIF).

- Meetings with special interest groups and specialist workers were held including: the Disability Access Advisory Group and the Disability Equality Scheme Steering Group and the Disability Service users Group.

- Promotion of the developing strategy at wider events relevant to people with physical disabilities and their carers. This included: the Independent Living Day event, Carers Centre launch, Neurology network launch, and the Sussex wide steering group for neurorehabilitation

Also informative to the development of the strategy were the following workshops and events:

Integrated Service Improvement Plan process led by the Strategic Health Authority. This involved a series of workshops with representation from across the local health authority and 3rd sector to scope local priorities and assess the benefits of service priorities.

Response and recommendations:
The identified priorities have been incorporated into the strategic objectives and identified projects

PCT World Class Commissioning - consultation events
The PCT hosted 2 events in July and September which provided an opportunity for wider discussion of the priorities for the local health and social care economy.

Response and recommendations
These events have informed the PCT Strategic Commissioning Plan and annual operating plan. The Physical Disability Strategy is in line with the overall strategic direction of the PCT as outlined in the Strategic Commissioning Plan.

Report for Sussex-wide neurorehabilitation Commissioning Framework: Involving service users and carers in the development of a Sussex-wide Commissioning Framework for adult neuro-rehabilitation (June 2008)
This is a report of the findings of a series of local semi structured interviews with service users and carers with experience of stroke or acquired brain injury.

Response and recommendations:
Conclusions from the consultation have been included within the final Sussex-wide Commissioning Framework and will be taken forward through the PCT commissioning plan and monitored by both the Sussex-wide Commissioning Group and the city's Physical Disability Steering Group.

Equality Impact Assessment an initial Equality Impact Assessment screening on the strategy was undertaken and recommendations were received with regard to specific language and format of the document. A glossary was requested to support the final document and a full EIA was recommended on the action plan

Response and recommendations
A glossary to the strategy is attached at Appendix A. The draft document was reviewed and language changed as recommended. A full EIA on the strategic action plan is to be completed on the 23 rd February 2009

Formal Consultation period October 2008 - February 2009 :

From October 08 the PCT led a formal consultation period, planned in partnership with the Local Authority and The Federation of Disabled People. This included:

- A wide mail-out of the draft strategy to the 3rd sector, communities of interest, service user groups and email correspondence with individual service users (list of recipients included in Table 1)

- Inclusion of the draft document on the Local Authority and Federation of Disabled Peoples' website

- Tabled discussion at the International Day for the Disabled on 3rd December 2008;

- A service user consultancy group facilitated by the Federation of Disabled People on request of the Disability Equality Scheme service users group (1 meeting held but agreed follow up meeting postponed due to inclement weather and difficulties with travel: email responses received instead)

Outcomes from engagement and consultation - How well are service users and carers needs being met?

As a result of the above consultation period service users and their carers have identified the following concerns and priorities for further service improvement

1. The importance of a social model of disability
Service users have commented that the draft strategy needs to be more strongly rooted in the social model of disability and have felt that the draft document by its reference to specific conditions, individual services and use of terms such as severe, moderate disability and complex needs maintains a medical model of disability.

Service users have requested that reference to specific conditions, and terms as above are removed from the document to lessen the medical model of disability and to ensure that the strategy is relevant to all people with a physical disability

Response and Recommendations:
The draft document has been reviewed - the social model has been further defined, and emphasised within the strategy as the foundation for future plans Reference to specific medical conditions, services and levels of disability have been minimalised.

The title of the document has been revised to reflect principles of the strategy and direction of travel.

2. Increased involvement in decisions about services
Service users have expressed their desire to have ongoing involvement and engagement in the planning and decision making processes for service improvement.

Response and Recommendations
Strengthened involvement and engagement is included as a key objective within the strategy and specific tasks are incorporated within the strategic action plan. We will be working with service users to agree a model to ensure on going involvement and engagement. Also during 2009/10 consultation will take place to determine the future model for a service user led centre for independent living.

3. Improved access to clear and joined up information services
Service users have emphasised the need to know what services are available for information services that are responsive to the needs of vulnerable adults (e.g. people with sensory impairment) and for clear advice re: entitlements.

Response and Recommendations
Improving access and further integration of information services are incorporated within the strategic action plan. The PCT is working with the Federation of Disabled People to ensure a joined up approach to improving information services. A key action of the action plan is to improve access to advocacy services.

4. Improved access to services including primary and specialist health services, and appropriate housing - people have told us of long wait times for home adaptations and Occupational therapy assessments. The difficulties of attending health appointments and of the need for improved access to GP surgeries, dentistry and specialist health services

Response and Recommendations
A number of key actions are included within the action plan to address these issues of access. The Physical Disability steering group will be tasked with ensuring a joined up approach to these issues of access and wait times.

5. Management of disability needs during hospital stays and at discharge
Consultation has highlighted the need for improved care planning for disability needs during hospital stays and for early and improved discharge planning: including an assessment of carers needs and the needs of disabled people with caring responsibilities.

Response and Recommendations
Management of hospital stay and discharge is incorporated within the strategic action plan.

6. Improved taxi and bus transport – improved access to appropriate and affordable transport is a priority for service users

Response and Recommendations
A review of accessible transport is included as a key action within the 3 year action plan

7. Recognition and improved support to carers -
Increase recognition of carers role and importantly at transition points including hospital discharge.

Response and Recommendations
Strategy amended to ensure carers needs included within key service improvement areas and links made with the developing carers strategy.

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Joint Commissioning Board	**Agenda Item 51** NHS Brighton & Hove Brighton & Hove City Council

Subject:		**Learning Disability Partnership Board – Annual Report**
Date of Meeting:		**9th March 2009**
Report of:		**Director of Adult Social Care & Housing**
Contact Officer:	Name:	**Naomi Cox** **Tel: 29-6400**
	E-mail:	**naomi.cox@brighton-hove.gov.uk**
Key Decision:	No	
Wards Affected:	All	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The government white paper "Valuing People, a New Strategy For The 21st Century (DoH 2001)" told all local authorities to set up learning disability partnership boards. It is the Partnership Board's role to oversee and help the planning and development of services that really help local people with learning disabilities. The Partnership Board is a local "champion" for people with learning disabilities.

1.2 The Joint Commissioning Board and the Cabinet Member for Housing agreed to receive a formal report of the work of the Learning Disability Partnership Board. This is to ensure that the Partnership Board is properly accountable to governance arrangements that are embodied through the Joint Commissioning Board for the City Council and Primary Care Trust and through the cabinet system for the city council.

1.3 It was originally envisioned that the Partnership Board would submit reports twice per year. However, the Partnership Board recently decided to request an annual reporting structure, which will eventually be matched to the financial year cycle.

1.4 'Valuing People Now' (DoH 2009) requires that all Learning Disability Partnership Boards produce an Annual Report.

2. RECOMMENDATIONS:

2.1 That the Joint Commissioning Board note the report and endorse the work of the Learning Disability Partnership Board.

2.2 That the Joint Commissioning Board agree to receive annual, rather than six-monthly, reports from the Partnership Board

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The requirement to produce a report on the work of the Brighton and Hove Learning Disability Partnership Board was in part a response to the Cornwall (2006) and the Sutton & Merton (2007) Investigation Reports in to abuse of people with learning disabilities in NHS provision for people with learning disabilities in these two Trusts.

3.2 The Partnership Board receives a report every 6 months on the Safeguarding work undertaken by the Brighton & Hove Community Learning Disability Team. This report advises the Partnership Board on numbers and levels of alert and types of abuse and action taken. This gives the Partnership Board an overview of how we are keeping people with learning disabilities safe. This information is also contained within the Safeguarding Annual Report produced by Adult Social Care.

3.3 The Joint Commissioning Board received a report from the Learning Disability Partnership Board on 10th December 2007.

3.4 In 2008 the Partnership Board agreed that annual reports are a more efficient use of resources than six-monthly reports.

4. CONSULTATION

4.1 The members of the Learning Disability Partnership Board have approved the attached annual report.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 Financial Implications:

The Learning Disabilities Partnership Board determines the allocation of the Learning Disabilities Development Fund (LDDF) originally funded by the Department of Health and now part of the Area Based Grant. The Appendix describes the projects funded in 2007/08 totalling £288,320 against the LDDF allocation of £238,000 and balance brought forward from the previous year. The LDDF funding allocation is £231,000 in 2008/09, which has been allocated to specific projects, as described in the Appendix, contributing to the Valuing People Now objectives. The LDDF allocation for 2009/10 will be £232,000 subject to confirmation of the Council's budget.

Finance Officer Consulted: Anne Silley *Date: 9th February 2009*

5.2 Legal Implications:

The report sets out how the local authority is complying with the government requirement to set up a Learning Disability Partnership Board and produce an Annual Report.

The report itself demonstrates how in particular the Board will ensure that the voice of service users is heard and taken into account in planning and developing future service provision for people with learning disabilities.

Lawyer Consulted: Hilary Priestley *Date: 13/2/09*

5.3 Equalities Implications:

The work of the Partnership Board and sub groups is intended to improve opportunities and choices for people with learning disabilities in Brighton & Hove. Individual projects come under the Equalities policies of the providing organisations. All Partnership Board work follows the Valuing People principles of promoting Rights, Inclusion, choice and Independence, for people with learning disabilities.

5.4 Sustainability Implications:

Service improvements are in accordance with sustainability objectives

5.5 Crime & Disorder Implications:

The work of the Partnership Board encourages people with learning disabilities to participate as full citizens in their community. This work is also intended to influence all citizens of Brighton & Hove to improve the welcome and support for people with learning and other disabilities.

5.6 Risk and Opportunity Management Implications:

The Partnership Board aims to maximise the use of all resources and opportunities. Specific risks and opportunities are addressed within the remit of each project or piece of work.

5.7 Corporate / Citywide Implications:

The work of the Partnership Board encourages people with learning disabilities to participate as full citizens in their community.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 No suitable alternative options are available. 'Valuing People Now' (DoH 2009) requires that all Learning Disability Partnership Boards produce an Annual Report. The Joint Commissioning Board and the Cabinet Member Meeting for Housing are the most appropriate venues for the Partnership Board's Annual Report.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 To follow the recommendations of 'Valuing People Now' (DoH 2009) and ensure that the Partnership Board is properly accountable to governance arrangements that are embodied through the Joint Commissioning Board for

the City Council and Primary Care Trust and through the cabinet system for the city council.

SUPPORTING DOCUMENTATION

Appendices:

1. Annual report of the Learning Disability Partnership Board 2008
2. Easier to read version of the Annual Report

Documents In Members' Rooms

None

Background Documents

1. Valuing People White Paper 2001 & Valuing People Now 2009.
2. Joint Investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust, July 2006, Healthcare Commission and Commission for Social Care Inspection
3. Joint Investigation into the provision of services for people with learning disabilities at Sutton and Merton Primary Care Trust, January 2007, Healthcare Commission and Commission for Social Care Inspection.

Work of the Learning Disability Partnership Board since December 2007:

Partnership Board Meetings

The Partnership Board still meets on a Monday morning every second month. All presentations and reports are asked to use accessible, jargon free, language as much as possible. The meetings have in the past been held at Brighton Town hall. However, the Partnership Board decided to change venues beginning in 2009. From now on meetings will be held at the more accessible and more conveniently located Hove Town Hall.

Partnership Board meetings are arranged and administered by a Partnership Board Assistant provided by the council's Integrated Learning Disability Services. The PA to the Manager of Integrated Learning Disability Services fulfils this role.

Partnership Board Members

The Partnership Board has 27 members. This includes people with learning disabilities, family carers, council departments, and voluntary and community organisations. The full membership list is on the Partnership Board's website.

The Partnership Board has two co-chairs. Both the co-chairs are new to the Partnership Board this year. One of the co-chairs is the relevant council Cabinet Member, Cllr Maria Caulfield.

The other co-chair is elected by the Speak Out self-advocacy groups. In 2008 the Speak Out Advocacy Network had two elections for co-chair. The first election was because the previous co-chair, Ian Metherell, retired after seven years on the Partnership Board. However, the newly elected co-chair soon resigned so another election was held and Matthew Hellett was elected as co-chair.

There are two support workers to help people with learning disabilities and family carers who are members of the Partnership Board. The support workers attend the meetings and also meet with those board members before and after Partnership Board meetings to help them with their duties as Partnership Board members. The Learning Disability Development Fund pays for the support workers.

In April of 2008 the Partnership Board started using Learning Disability Development funding to pay for a development worker who helps the whole Partnership Board and the two co-chairs in particular.

Partnership Board Website

In July of 2007 the Partnership Board established a website, using Learning Disability Development Fund money. In 2008 the website name was chosen: *www.brightpart.org*.

In the summer of 2008 the maintenance of the website was given to the development worker. As a result the website has been updated this year to include a list of all the members of the partnership board, copies of all the partnership board policies, previous meeting minutes, news, and information about upcoming events. The Partnership Board development worker is now checking the website weekly and keeping all pages up to date and accurate.

Each sub group has a page on the website and those pages have also been updated. Chairs of the sub groups are now checking their pages regularly and keeping them up to date under the guidance of the development worker.

Partnership Board Achievements since December 2007

- Chose a new logo and gave the website a new name.
- Had a presentation from the Valuing People Support Team about Valuing People Now, the government's refresh of the original 2001 Valuing People paper
- Held a consultation event and fed into the consultation about Valuing People Now
- Supported the National Changing Places campaign for better public toilet facilities for disabled people
- Held two meetings to decide how to allocate the LDDF money for 2008/9
- Approved a policy to make it easier to allocate the LDDF money in the future
- Agreed a way of checking on the LDDF projects and got the first reports from the 2008/9 projects.
- Agreed how to allocate the 2009/10 LDDF money
- Received reports and information about: Family Carers Service, Training for Staff, Care Management Reviews, and 'How Person Centred Are We' in Brighton & Hove.
- Received two reports on the Safeguarding work undertaken by the Brighton & Hove Community Learning Disability Team. This report advises the Partnership Board on numbers and levels of alert and types of abuse and action taken. This gives the Partnership Board an overview of how we are keeping people with learning disabilities safe. (Safeguarding statistics are also included in the 'Annual Safeguarding Report' that is produced by Adult Social Care for the Adult Social Care Cabinet Member and for the Joint Commissioning Board).
- Created a new sub group for Work & Skills
- Found out how people with learning disabilities register with the library service so they do not have to pay for CDs and DVDs.
- Approved the new Learning Disability Commissioning Strategy
- Approved the 'New Idea' for a day options team within Integrated Learning Disability Services

Sub groups

Sub Groups do work for the Partnership Board. Each group has a web page on *www.brightpart.org* where the groups can put the details of their meetings, the work they are doing and their latest news.

Healthy Lives:

This sub group has run for many years. It works to help people with learning disabilities have better access to health care.

This sub group also oversees the Health Facilitator and Health Action Planning Project.

Person Centred Approaches:

This is another sub group that has run for many years.

In 2007-2008 this sub group managed the very successful 'How Person Centred Are We' project. This sub group also oversees the 'Self Directed Support Project' since the Self Directed Support working group merged with this group earlier in the year.

Taking Part in the City:

This sub group started in 2005 and was called the 'Better Lives Steering Group'. They have looked after lots of projects, like the Travel Buddies project and the Equal projects about volunteer work and work skills.

Before the Better Lives group there were different sub groups for day services, adult learning and employment. Now those groups work together along with people in leisure, transport, community support services, community safety and national Mencap.

In 2008 the Better Lives group decided that work & skills needed to be a separate group because there is so much work to do in that area. The remaining group changed their name to Taking Part in the City to show that they are focussing on helping people with learning disabilities experience full citizenship.

Work & Skills:

There used to be an employment sub group and then for three years the people working on employment were part of the Better Lives group. In October 2008 the Work & Skills group once again became a separate sub group because there is so much work to do in that area. This sub group has had a couple of meetings so far.

Workforce Development:

This active sub group has been going for several years. This group make sure our staff can be trained to do their jobs well. They are also looking at some ideas to help mainstream staff be more helpful for people with learning disabilities. This year the sub group launched the good practice guide, 'Choosing My Staff'.

This group manages the Developing the Wider Workforce project.

A Place to Live sub group:

This is another group that has changed over the years. Right now they are looking at plans for making sure people with learning disabilities have the same housing options as other citizens.

Since December 2007 they have completed a Best Value review of accommodation services and they are reviewing the Learning Disability Housing Strategy.

Fora (forums):

The fora are groups of people with similar interests. Fora work with the Partnership Board and are not directly accountable to the Partnership Board in the way that sub groups are.

Transitions Forum:

The main purpose of this forum is to create an interagency partnership that will promote effective transitions into adulthood, for young people with special needs and disabilities.

This forum oversees the 'Person Centred Transition Planning' project.

Learning Disability Providers' Forum:

This is a gathering for all organisations that have contracts with the council to provide services for people with learning disabilities. The Lead Commissioner is the chair of this forum.

Learning Disability Development Fund (LDDF)

This is money the government gives to local authorities to help them implement the principles of Valuing People and Valuing People Now. The Partnership Board uses that money to pay for Partnership Board expenses and for special projects. There were 16 special projects funded in 2007-2008.

LDDF projects 2007 - 2008	LDDF funding
Advocacy Groups Network • 4 speaking up groups; Big Meetings; lobbying	£38,350
Blue Camel Club • Four Blue Camel Clubs; steered by a committee of learning disabled people	£14,385
Better Work Options • Learning resource; business opportunities; art-selling group; accredited training for people with learning disabilities	£24,500
Carers Forum • Information and support sessions for carers	£5,625
Day Services Development & Equal Project • Project management; support for Better Lives Steering Group & Improving Day Services group	£31,518

Direct Payments / Individual Budgets • Undertake and increase work on Direct Payments and Individualised budgets	£12,037
Health Action Plans and Better Health • Improve health services received by people with learning disabilities	£15,300
How Person Centred Are We • Systems for measuring how we are doing on person-centred planning in the city	£10,000
LINK Project • 6 Big Meetings; 6 Partnership Board Meetings; Support to work with Sub Groups	£14,961
Older Carers • Information and planning for older people caring for someone with a learning disability	£15,564
Parents with Learning Disabilities • Group and information sessions run by parents	£5,653
Person Centred Transition Reviews • Schools implement Person Centred Transition Reviews; work with parents; link with national initiative	£15,339
Self Directed Support • Self-Directed Support for individuals; work with assessment teams; new Resource Allocation System	£15,000
Spiral Shop • Work skill training and experience; volunteering and work opportunities for 10 people.	£15,000
Travel Buddy Scheme • 20 trained travel buddies; 20 people with learning disabilities supported; future funding sought	£15,500
Voluntary work Project • 8 more people doing voluntary work; 25 people helped to continue in voluntary work; helps providers know how to support voluntary work	£6,588
Partnership Board Expenses	£15,000
Under spend that was carried over to next year's Self-Directed Support and Partnership Board Development projects	£18,000

Highlights from 2007 - 2008 projects

- The can-recycling project works with over 15 local business partners. More than 20 people with learning disabilities have been part of the collection and recycling of the cans.

- The Carers Forum held a successful housing event jointly with Brighton & Hove Council. 14 carers had individual advice sessions and those who attended benefited from a range of useful information stalls.
- The Link group made a DVD to be used as part of the Health Action Planning training for GP practices.
- The Travel Buddy Scheme was highlighted by the City Council as a "good practice" example against harassment (August '08).
- Melvin Redwood was highlighted in the local media because the Voluntary Work project helped him get his first paid job, at the age of 64.
- Artwork under the "Our Art" banner was widely sold and exhibited in the Brighton area. 10 exhibitions were held and Deirdre Waller had a solo exhibition at Hangleton library. A partnership was developed with Creative Futures to integrate "Our Art" with other disadvantaged local artists and art has been widely shown in exhibitions including the Brighton Festival.
- Service Users at Belgrave Day Service formed a Person-centred planning group and used innovative and creative ways of finding out what other service users in other services experience of person-centred planning.
- In September carers and professionals attended an information session about Health Action Planning.
- An information pack about learning disabilities and a training package were developed and delivered to GP practices.
- Accredited training in catering was developed. The council will be able to offer training for nationally recognised qualifications for adults with learning disabilities.
- 2 Travel Trainees who were supported by Travel Buddies began travelling independently.
- At Buckingham Road Day Service the staff developed catering opportunities for service users by establishing "Feast" which delivers catering events.
- 19 GP practices signed up to provide health checks and Health Action Plans between October 2007 and March 2008.
- One man realised a long-standing ambition to work at Starbucks at Gatwick Airport when the Voluntary Work Project arranged a work experience for him.
- Feedback about outcomes of person-centred plans is sent to the Person Centred Planning group and is put into a database.
- GP practices were helped to make a list of all their patients who have a learning disability.
- The Travel Buddy Scheme was part of the Car Free Day (September '08) and, together with the B&H City Council, won the Claudia Flanders Memorial Award for Accessibility in the 2008 UK Bus Awards.

LDDF Projects – 2008-2009:

There are 12 special projects in 2008-2009.

LDDF projects are now required to report back to the Partnership Board three times each year. This year the Partnership Board has approved a report form to use and the reports are put on the ‘News’ page of the website. The development worker writes a summary of all the reports and gives the summary to the Partnership Board.

So far this year the projects have sent in one report (in August). Reports are available on the Partnership Board website. The final outcomes of this year's projects will be included in the Partnership Boards' next annual report.

LDDF projects 2008 - 2009	LDDF funding
Partnership Board Expenses	£8,000
Advocacy Groups Network	£38,800
Better Work Options	£39,875
Carers Link Group	£8,543
Carers Support – Family Involvement in personalised approaches	£14,547
Developing the Wider Workforce	£5,500
Health Action Plans and Better Health	£19,000
Partnership Board Development Worker	£20,853
Person Centred Transition Reviews	£12,995
Self Directed Support	£12,753
Supported Volunteer Work Scheme	£24,823
LINK Project	£14,961
Travel Buddy Scheme	£10,350

Annual Report written by Karen Kingsland, Project and Development Officer, January 2009

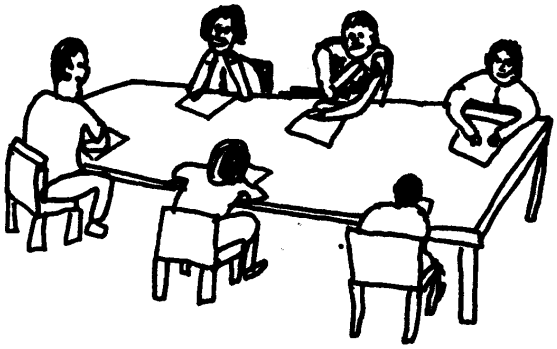
Learning Disability Partnership Board Report
December 2008

What we have done since December 2007:

Partnership Board Meetings

We meet at Hove Town Hall six times each year. Hove Town Hall is a good place to meet. It is accessible and has lots of parking and buses nearby.

Sandy Edwards takes care of our meetings for us.



Partnership Board Members

There are 27 people on the Partnership Board. Some are family carers and some have learning disabilities. Some of the people work for the council and some work for other organisations.

We have two co-chairs. One is Councillor Maria Caulfield. The Speak Out Advocacy Groups Network elects the other co-chair. They elected Matthew Hellett this year. Both of our co-chairs are new this year.

Sarah Pickard helps the people with learning disabilities and Nicola Lytle helps the family carers.

Karen Kingsland is our development worker. She helps the whole Partnership Board and the co-chairs.

Partnership Board Website

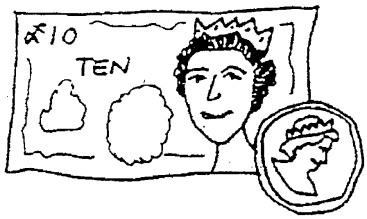
We decided to call our website www.brightpart.org. Karen looks after the website.

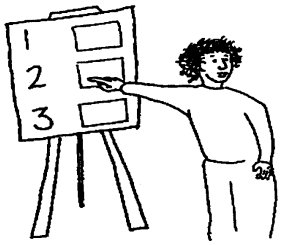
Each sub group has a page on the website. Karen helps them have good web pages.

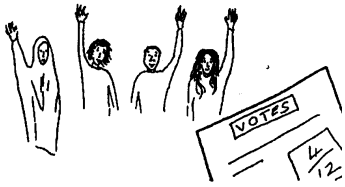
Partnership Board Achievements

- Chose a new logo and gave the website a name.
- Had a presentation from the Valuing People Support Team about Valuing People Now
- Told the government what we think about Valuing People Now
- Helped the Changing Places campaign because we want better public toilet s for disabled people
- Decided what to do with this year's LDDF money

- Chose a better way to allocate the LDDF money in the future
- Checked on our LDDF projects.
- Decided what to do with next year's LDDF money
- Learnt about:
    - Family Carers Service
    - Training for Staff
    - Care Management Reviews
    - How Person Centred We Are in Brighton & Hove.
    - How people with learning disabilities register with the library service so they do not have to pay for CDs and DVDs
- Checked on the Community Learning Disability Team's safeguarding work
- Got a new sub group for Work & Skills
- Agreed to the new Learning Disability Commissioning Strategy
- Agreed to the 'New Idea' for a day options team in the day services

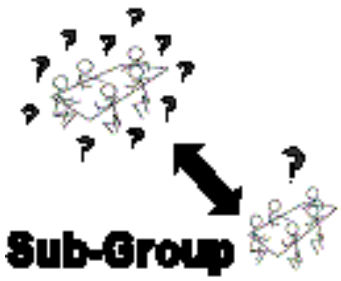






Partnership Board Sub groups

Sub Groups do work for the Partnership Board. Each group has a web page on www.brightpart.org if you want to know more about them.



Healthy Lives sub group helps people with learning disabilities have better access to health care and looks after the Health Facilitator and Health Action Planning Project.

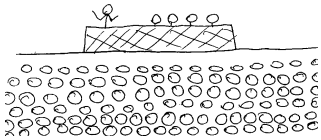
Person Centred Approaches sub group found out 'How Person Centred Are We' and looks after the 'Self Directed Support Project'

Taking Part in the City sub group used to be called 'Better Lives'. They look after day services, adult learning and employment as well as leisure, transport, community support services, and community safety.

Work & Skills sub group started in October because there is so much work to do in that area.

Workforce Development sub group make sure staff can do their jobs well. They also help mainstream staff be more helpful for people with learning disabilities. This year they made the good practice guide, 'Choosing My Staff'.

A Place to Live sub group looks at what housing there is for people with learning disabilities and makes sure there are good choices.



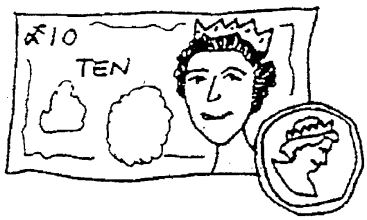
Fora (forums) that work with the Partnership Board

Transitions Forum looks at what happens when people with disabilities become adults and looks after the 'Person Centred Transition Planning' project.

Learning Disability Providers' Forum is for organisations that get money from the council to help people with learning disabilities

Learning Disability Development Fund (LDDF)

This is money the government gives us to make Valuing People happen. We use that money to pay for special projects. There were 16 special projects last year and there are 12 special projects this year.



Last Year's LDDF:

LDDF projects last year	Amount of money
Partnership Board Expenses	£15,000

Money we saved to spend on next year's Self-Directed Support and Partnership Board Development projects	£18,000
Advocacy Groups Network • Speaking up groups; Big Meetings; lobbying	£38,350
Blue Camel Club • Four Blue Camel Clubs; steering committee of learning disabled people	£14,385
Better Work Options • Learning resource; business opportunities; art-selling group; accredited training	£24,500
Carers Forum • Information and support sessions for carers	£5,625
Day Services Development & Equal Project • Project management; support for Better Lives Steering Group & Improving Day Services group	£31,518
Direct Payments / Individual Budgets • Work on Direct Payments and Individualised budgets	£12,037
Health Action Plans and Better Health • Improve health services for people with learning disabilities	£15,300
How Person Centred Are We • Measured how we are doing on person-centred planning	£10,000
LINK Project • 6 Big Meetings; 6 Partnership Board Meetings;work with Sub Groups	£14,961
Older Carers • Information and planning for older people caring for someone with a learning disability	£15,564
Parents with Learning Disabilities • Group and information sessions run by parents	£5,653
Person Centred Transition Reviews • Person Centred Transition Reviews in schools; work with parents; link with national initiative	£15,339
Self Directed Support • Self-Directed Support for individuals; work with assessment teams; new Resource Allocation System	£15,000
Spiral Shop • Work skill training and experience; volunteering and work for 10 people.	£15,000

Travel Buddy Scheme

- 20 trained travel buddies; 20 people with learning disabilities supported; future funding looked for — £15,500

Voluntary work Project

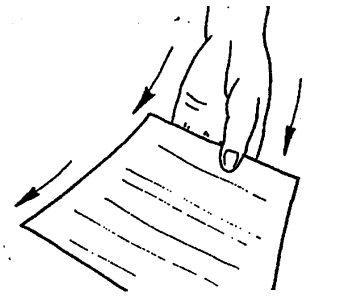
- 8 more people doing voluntary work; 25 people helped to continue their voluntary work; helping other providers know about supporting voluntary work — £6,588

Highlights from 2007 - 2008 projects

- The can-recycling project works with over 15 business and 20 people with learning disabilities.
- The Carers Forum and Brighton & Hove Council had a housing information event.
- The Link group made a DVD for training GP practices.
- The Travel Buddy Scheme got praise as a "good practice" example against harassment (August '08) and as part of the Car Free Day (September '08) and, as part of an Award for Accessibility in the 2008 UK Bus Awards.
- Melvin Redwood was in the papers and on TV because he got his first paid job, at the age of 64.
- "Our Art" sold and exhibited art at 10 exhibitions and Deirdre Waller had a solo exhibition at Hangleton library. A partnership with Creative Futures means "Our Art" gets shown with other disadvantaged local artists in exhibitions including the Brighton Festival.
- Service Users at Belgrave Day Service formed a Person-centred planning group and found out what other service users in other services think of person-centred planning.
- Carers and professionals had an information session about Health Action Planning.
- An information pack about learning disabilities and a training package were developed and delivered to GP practices.
- The council will now offer training and nationally recognised qualifications for adults with learning disabilities.
- 2 Travel Trainees who were supported by Travel Buddies began travelling independently.
- Buckingham Road Day Service established "Feast" so service users do catering.
- One man got to work at Starbucks at Gatwick Airport which he always wanted to do.
- Feedback about people’s person-centred plans goes to the Person Centred Planning group.
- GP practices were helped to make a list of all their patients who have a learning disability.

This Year's Projects

- Partnership Board Expenses £8,000
- Advocacy Groups Network £38,800
- Better Work Options £39,875
- Carers Link Group £8,543
- Carers Support – Family Involvement in personalised approaches £14,547
- Developing the Wider Workforce £5,500
- Health Action Plans and Better Health £19,000
- Partnership Board Development Worker £20,853
- Person Centred Transition Reviews £12,995
- Self Directed Support £12,753
- Supported Volunteer Work Scheme £24,823
- LINK Project £14,961
- Travel Buddy Scheme £10,350



We will tell you more about this year's projects in our next report.

(Karen Kingsland wrote this annual report)

Joint Commissioning Board	Agenda Item 52 Brighton & Hove City Council and NHS Brighton and Hove

Subject:		**Deprivation of Liberty Safeguards**		
Date of Meeting:		**9 March 2009**		
Report of:		**Director of Adult Social Care and Housing** **Head of Partnerships and Public Engagement**		
Contact Officer:	Name:	**John Child**	**Tel:**	**296112**
	E-mail:	John.child@brighton-hove.gov.uk		
Key Decision:	No			
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The Deprivation of Liberty Safeguards (DOLS) are being introduced from 1st April 2009 as an amendment to the Mental Capacity Act 2005. These safeguards will provide legal protection where deprivations of liberty or restrictions in freedoms for individuals are assessed as necessary. These arrangements will only apply to people, not otherwise provided for in terms of legal safeguards who are currently resident in hospitals or care homes registered under the Care Standards Act 2000. These safeguards apply to people in England and Wales who have a mental disorder and lack capacity to consent to the arrangements made for their care and treatment; but for whom receiving care and treatment in circumstances that amount to a deprivation of liberty may be necessary to protect them for harm and appears to be in their best interests. These safeguards only apply to people detained in a hospital setting or a care home registered under the Care Standards Act 2000.

1.2 Compliance with these safeguards is a statutory obligation. This report is seeking agreement that the DOLS service is hosted by the Access Point within Adult Social Care and run in tandem with Brighton & Hove City Primary Care Trust (PCT) now known as NHS Brighton and Hove and will be referred to as such. In addition is it seeking agreement that authorisations of deprivation of liberty can be agreed by the Director of Adult Social Care and Housing, and nominated deputies as specified in this report.

2. RECOMMENDATIONS:

2.1 That the Joint Commissioning Board support and endorse the joint approach between the Council and the Primary Care Trust in implementing the Deprivation of Liberty Safeguards.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The DOLS legislation has been introduced as an amendment to the Mental Capacity Act 2005 via the Mental Health 2007. These safeguards apply to people in England and Wales who have a mental disorder and lack capacity to consent to the arrangements made for their care and treatment; but for whom receiving care and treatment in circumstances that amount to a deprivation of liberty may be necessary to protect them for harm and appears to be in their best interests.

3.2 The Deprivation of Liberty Safeguards came into being due to the European Court of Human Rights ruling in 2004 on the Bournewood case which highlighted the need for additional safeguards for people who lack capacity and might be deprived of their liberty. The Bournewood case concerned an autistic man with severe learning disabilities who was informally admitted to Bournewood Hospital in Surrey under common law. The European Court of Human Rights found that he had been deprived of his liberty unlawfully, because of a lack of a legal procedure that offered sufficient safeguards against arbitrary detention and speedy access to a court. The Deprivation of Liberty Safeguards have closed the 'Bournewood Gap' and will ensure compliance with the European Convention on Human Rights.

3.3 The safeguards have created new roles namely 'Managing Authorities and Supervisory Bodies' which impose duties on both the city council and NHS Brighton and Hove with regards to service users accommodated in registered care homes or hospitals respectively. Both organisations are required to operate a system to receive requests for authorising deprivations of liberty, arranging for the statutory assessments if deprivation is thought to be taking place and for agreeing deprivations of liberty as required. Both organisations are required to have systems to review deprivations of liberty and appoint representatives and Independent Mental Capacity Advocates as required.

3.4 Brighton & Hove City Council is both a Managing Authority and a Supervisory Body. This is due to the in-house residential care that is provided across service user groups in the city.

3.5 As the legislation imposes this duty on both the city council and NHS Brighton and Hove it was felt beneficial to run the service jointly and to pool allocated financial resources accordingly. Without these approaches two separate systems for receiving referrals, assessing possible deprivations of liberty and authorisation would have to be created. A further new statutory role has been created; that of Best Interests Assessor. With separate systems two sets of staff would have to be commissioned to undertake Department of Health (DoH) approved training at Brighton University.

3.6 Brighton & Hove City Council already had the operational skill mix required to meet the Best Interests Assessors requirements, the administrational infrastructure at the Access Point in Adult Social care, familiarity with registered care homes across the city and an operational understanding of the duties imposed under the Mental Capacity Act. A single point of entry across the city, regardless of location will be better for service users, carers and efficiency of service provision.

3.7 The DoH has estimated that 80% of DOLS activity will be generated by registered care homes as Managing Authorities and 20% for those in hospitals. Without a joint system; staff trained via NHS Brighton and Hove may well not receive enough work to maintain a satisfactory standard of competence.

3.8 Partnership working with NHS Brighton and Hove allows for better monitoring of the DOLS activity across the city by way of performance indicators. It allows the city council to capture all DOLS referrals, queries and authorisations especially with NHS partners such as Sussex Partnership NHS Foundation Trust, Brighton and Sussex University Hospital NHS Trust and Southdowns NHS Trust. Many of the Best Interests Assessors are city council staff seconded under Section 75 agreements and it is likely that many of the service users who will be subject to DOLS will be under the care of mental health or learning disability services. There is the possibility of this legislation effecting Delayed Transfers of Care so joint working with colleagues in acute hospitals is key to the policy success.

3.9 Early indications suggest the Care Quality Commission will be monitoring DOLS activity for both statutory bodies and registered care homes. Partnership working will support a robust performance structure.

3.10 Although partnership working is the proposed model it is important to stress that final responsibility for authorisation for a deprivation of liberty cannot be transferred from NHS Brighton and Hove to the city council or vice versa. If the service user is accommodated in the hospital then NHS Brighton and Hove must authorise and in a care home then the city council must take the final decision.

3.11 It has been suggested there will be a peak of referrals and enquiries about DOLS in April 2009 as the safeguards become statute. To manage this peak demand the DOLS regulations have doubled the time scales for assessments only for April 2009 to 14 days for urgent authorisations and to 42 days for standard authorisations. In Brighton and Hove we are proposing two Best Interests Assessors be seconded into dedicated posts for a period of three months supported by the Implementation Officer to manage the proposed demand.

3.12 To support the implementation process and ensure that the council and NHS Brighton and Hove meet statutory duties the IMCA contract with Advocacy Partners has been extended to provide the IMCA role and that of Paid Representative.

3.13 The above proposal will be reviewed at the end of three months and the DOLS implementation will be reviewed after six months locally to ensure there is a structure to support the on-going work. The Department of Health has committed to a formal review a year after implementation and has suggested that DOLS authorisations will reduce from an initial peak as care planning and service provision adapts to prevent deprivation of liberty.

3.14 National Guidance from Care Service Improvement Partnerships (CSIP) recommends that the authorisation for deprivations of liberty is agreed at the level of senior management to ensure a robust system of accountability. It is proposed that for Brighton & Hove City Council the agreed signatories for authorising deprivations of liberty be the Director of Adult Social Care and Housing, and nominated deputies at Assistant Director and Heads of Service level. For NHS Brighton and Hove (PCT) the proposed signatory would the Chief Executive with the following Directors nominated deputies:

- Strategy
- Governance and Development
- Finance
- Delivery
- Joint Director of Public Health

- Deputy Director of Finance
- Deputy Director of Commissioning

4. CONSULTATION

4.1 During the run up and since the implementation of the Mental Capacity Act 2005 in October 2007 there has been a Local Implementation Network (LIN) in Brighton and Hove that meets monthly to discuss issues relating to this legislation. This is a format replicated across England and Wales on the suggestion of the DoH and their local representatives from The Care Services Improvement Partnership (CSIP). Since April 2008 the LIN's focus has included DOLS and all local stakeholders have been invited and minutes circulated.

The membership of the LIN can be found at Appendix 1

In addition a stakeholder event was held in September 2008 entitled a DOLS 'Think Tank' and attended by multi-agency partners from the NHS, council and the private and voluntary sector.

The consultation has been extended to colleagues in the voluntary and charitable sectors. Extensive awareness training has taken place and continues to do so; this has been taken up by colleagues in the private sector with whom the city council contract services. Their feedback has been noted and acted upon.

The Implementation Officer has written to all care home providers across the city, both private and in-house provision, explaining about DOLS, their statutory responsibilities and offering to meet and discuss. In addition he is providing targeted training sessions for Sussex Partnership NHS Foundation Trust and Brighton & Sussex University Hospital Trust staff.

5. FINANCIAL & OTHER IMPLICATIONS:

<u>Financial Implications:</u>

5.1 Notional funding to cover the costs of implementing DOLS has been included in the Area Based Grant. The total funding earmarked for 'Mental Capacity Act Grant' for 2009/10 is £152,000 and for 2010/11 is £145,000. In addition, some funds are being paid to PCTs and for NHS Brighton & Hove it is expected that approximately £50,000 will be available to fund DOLS in 2009/10 with a similar amount for 2010/11. It is proposed that Brighton & Hove City Council and NHS Brighton & Hove will pool this funding.

5.2 DOLS will require additional staffing and this is detailed in the main body of the report. The Best Interest Assessors function will look to be absorbed within existing posts, but it is likely that there will be a need for at least one dedicated post for the first 6 months to cover

the expected peak in activity. Due to the uncertainty surrounding activity levels it is very difficult to assess exactly how much DOLS will cost, but it is expected that this can be managed within the grant funding outlined above.

Finance Officer Consulted: Name Mike Bentley Date: 12/02/09

Legal Implications:

5.3 The recommendations contained in paragraph 2 of the report will put structures in place which will enable the Council to comply with its statutory responsibilities in respect of the deprivation of liberty provisions under the Mental Capacity Act 2005, as amended. The body of the report sets out in detail the main provisions of this new legislation. These provisions come into force on 1 April 2009.

Lawyer Consulted: Serena Kynaston Date: 13/02/09

Equalities Implications:

5.4 An Equalities Impact Assessment will be carried out prior to the 1st April 2009 when DOLS comes into statutory force. It has not taken place to date due to the availability of training dates. There is a national Impact Assessment carried out by the Department of Health which will reflect local themes.

5.5 The DOLS legislation has been produced to safeguard some of the most vulnerable groups in society by legal means which are currently lacking. It will place a new focus on their human rights and the lawfulness of arrangements made for their care.

Sustainability Implications:

5.6 There are no sustainability implications.

Crime & Disorder Implications:

5.7 There are no crime and disorder implications

Risk and Opportunity Management Implications:

5.8 Brighton & Hove City Council and NHS Brighton and Hove has a statutory obligation to enact the safeguards (as both a Managing Authority and Supervisory Body) and ensure there is a robust process in place to meet the anticipated demand. This will ensure that the city council is not put at risk financially or in terms of public image, reputation or breach of the law.

The city council must ensure that those nominated signatories are clear about their responsibilities and those of the council as the routes of appeal are via the Court of Protection and / or Judicial review which would be both considerably expensive and potentially tarnish the council's reputation.

The city council and NHS Brighton and Hove should be aware that in certain circumstances, deprivations of liberty may need to be authorised for some people known to the council and whilst alternative means of providing the care in a less restrictive manner are explored and developed.

Corporate / Citywide Implications:

5.9 The DOLS safeguards will affect service users across the city both in registered care homes and hospital. In addition they will affect service users living in other local authority areas in care that has been commissioned by Brighton & Hove City Council or NHS Brighton and Hove. The council remains responsible for service users who are 'ordinary resident' of Brighton & Hove City Council.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 It was considered running separate services between the council and NHS Brighton and Hove but for the reasons stated above it was felt to be beneficial to all parties for one system of assessment and referral to be implemented.

6.2 There were no other options considered because the safeguards are statutory legislation to which the council and NHS Brighton and Hove must respond.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The council and NHS Brighton and Hove have a statutory duty to meet the Deprivation of Liberty Safeguards and deliver the appropriate service with suitable resource allocation to make the process viable. The proposed signatories have a suitable level of seniority and expertise in these areas to meet the requirements and safeguard the council from legal challenge.

SUPPORTING DOCUMENTATION

Appendices:

1. Membership of DOLS Local Implementation Network]
2. DOLS Process Flowchart Draft Feb 09

Documents In Members' Rooms

1. None

Background Documents

1. Deprivation of Liberty Safeguards Code of Practice, Mental Capacity Act 2005

2. Impact Assessment of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards to accompany the Code of Practice and Regulations. May 2008

Appendix 1

Membership of DOLS Local Implementation Network:

Ambrose Page: Contracts Manager, BHCC
Angie Emerson, Head of Income and Payments, BHCC
Colin Lindridge, Associate Director, OPMH, SPT
Edwina Sabine- Specialist Social Worker, Mental Capacity Act, BHCC
Hilary Priestly- Senior Lawyer, BHCC
Jane Simmons- Head of Partnerships- Brighton & Hove PCT
Jen Allan- IMCA
John Child- DOLS Implementation Officer, BHCC
Julie Knight- BSUH
Karen Lillington- Associate Director, BSUH
Karen Swirsky, Southdowns NHS Trust
Matt Hutchison, BSUH
Melinda Stone, Lawyer, BSUH
Michelle Jenkins, Safeguarding Adults Manager, BHCC
Mike Dennis, Contracts Manager, BHCC
Naomi Cox, Integrated Services Manager, LD Services BHCC
Rachel Stone, BSUH
Rosie Key, Southdowns NHS Trust
Sara Fulford- Reg 26 Officer, BHCC
Sarah Lines, Resource Centre Manager, BHCC
Serena Kynaston, Lawyer, BHCC
Terry Pegler, Professional Lead Social Work, SPT
Tim Wilson, Training and Development Manager, BHCC
Wendy Vodrey, Sussex Police

DoLS End to End Process

Version 1.1	DRAFT	February 2009