Overview & Scrutiny

Title:	**HEALTH OVERVIEW & SCRUTINY COMMITTEE**
Date:	**30 SEPTEMBER 2009**
Time:	**4PM**
Venue	**COUNCIL CHAMBER, HOVE TOWN HALL**
Members:	**Councillors:** Peltzer Dunn (Chairman), Alford, Allen (Deputy Chairman), Barnett, Harmer-Strange, Hawkes, Kitcat, Rufus **Co-optees:** Robert Brown (Brighton & Hove LINk); Jack Hazelgrove (Older People's Council)
Contact:	**Giles Rossington** **Senior Scrutiny Officer** 29-1038 Giles.rossington@brighton-hove.gov.uk

	The Town Hall has facilities for wheelchair users, including lifts and toilets
	An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter and infra red hearing aids are available for use during the meeting. If you require any further information or assistance, please contact the receptionist on arrival.
	FIRE / EMERGENCY EVACUATION PROCEDURE **If the fire alarm sounds continuously, or if you are instructed to do so, you must leave the building by the nearest available exit. You will be directed to the nearest exit by council staff. It is vital that you follow their instructions:** • **You should proceed calmly; do not run and do not use the lifts;** • **Do not stop to collect personal belongings;** • **Once you are outside, please do not wait immediately next to the building, but move some distance away and await further instructions; and** • **Do not re-enter the building until told that it is safe to do so.**

AGENDA

Part One	Page

15. PROCEDURAL BUSINESS **1 - 2**

(copy attached).

16. MINUTES OF THE PREVIOUS MEETING **3 - 8**

Draft minutes of the meeting held on 08 July 2009 (copy attached).

17. CHAIRMAN'S COMMUNICATIONS

18. PUBLIC QUESTIONS

The closing date for Public Questions is noon on 22 September 2009.

19. NOTICES OF MOTION REFERRED FROM COUNCIL

No Notices of Motion have been received.

20. WRITTEN QUESTIONS FROM COUNCILLORS

Two Councillor Questions have been received.

a) from Councillor Brian Pidgeon:

Over the past few days a leaflet from NHS Brighton & Hove has been delivered to every household in the city.

The leaflet, introduced by Darren Grayson, the Chief Executive of NHS Brighton & Hove, contains lots of very useful information, informing people how to make best use of local services, giving tips on healthy living, and outlining how the PCT uses its resources to improve the health of city residents.

The last page of the leaflet contains instructions on how to get a translation of this material: the information can be provided in seven different languages.

However, nowhere in the leaflet is it mentioned that NHS Brighton & Hove has made provision for blind or visually impaired people, by having the information available in large print, in Braille or in audio format.

Is it the case that NHS Brighton & Hove does not think that blind people are entitled to basic information about the healthcare they have paid for through their taxes? Or is it once again the case that blind people have been overlooked by the very organisation which should be most concerned with their needs?

If provision has been made for blind people to access this leaflet, can the Chief Executive of NHS Brighton & Hove explain how people are meant to

find out about it? If no provision has been made, I call on the Chief Executive to apologise to the city's blind community for this omission, and to promise that all future NHS Brighton & Hove publications will be as accessible for blind people as they rightly are for people whose main language is not English.

b) from Councillor Jason Kitcat:

1. What are the clinical reasons GPs are being recommended to prescribe
Tamiflu to all patients with suspected swine flu?

2. As 'flu friends' are not being asked to pay for Tamiflu it is free for patients. This is in contrast with the usual prescription charge policy. What has this free dispensing cost the PCT so far? How is it being funded?
What is the per unit charge the NHS are paying for Tamiflu?

3. As someone who experienced severe headaches when taking Tamiflu I was worried to learn the level of side effects experienced elsewhere. For example in Japan the Ministry of Health & Welfare has instructed doctors not
to give Tamiflu to patients aged 10 to 19 due to extreme behavioural side-effects. At least 18 children in Japan have died as a result of irrational behaviour. The US Food & Drug Administration have also issued a
warning about Tamiflu's potentially fatal neuropsychiatric side-effects.

Japan uses 60% of the world's Tamiflu so are experienced in its use, however
the UK did not issue similar warnings in its use. Two studies by the UK's Health Protection Agency (published in Eurosurveillance) found that 51% of
the 248 children aged 11 to 12 studied had side-effects including nausea, headaches and stomach aches. A study of 85 London pupils also found more
than half had side-effects when given Tamiflu as a preventative measure including 18% reporting a neurophsychiatric side-effect.

Given that the efficacy of Tamiflu type drugs (neuraminidase inhibitors) are
still debated by clinicians and that their advertised benefits of a slightly reduced period of illness are hard to detect in most patients; one must question the cost-benefit of using Tamiflu.

Does the PCT believe that the financial costs, the potential side-effects, the impact on individual health outcomes and wider public health outcomes
been correctly balanced?

21. FLU PANDEMIC UPDATE **9 - 66**

Update on local preparations for the swine flu pandemic by Dr Tom Scanlon, Director of Public Health, Brighton & Hove (copy attached).

22. BRIGHTON & SUSSEX UNIVERSITY HOSPITALS TRUST (BSUHT) FOUNDATION TRUST APPLICATION **67 - 70**

Report of the Director of Strategy and Governance on BSUHT plans to become an NHS Foundation Trust (copy attached). Duncan Selbie, Chief Executive of BSUH, and Mary Goode, Deputy Company Secretary of BSUH, will present this item.

23. SOUTH EAST COAST AMBULANCE TRUST (SECAMB): FOUNDATION TRUST APPLICATION **71 - 74**

Report of the Director of Strategy and Governance on the South East Coast Amulance Trust (SECamb) application for NHS Foundation Trust status. Geraint Davies, SECamb Director of Corporate Affairs and Service Development, will present this item (papers attached).

24. AD HOC PANEL ON THE GP-LED HEALTH CENTRE: NHS BRIGHTON & HOVE RESPONSE TO HOSC RECOMMENDATIONS **75 - 80**

Report of the Director of Strategy and Governance (copy attached).

25. HEALTH OVERVIEW & SCRUTINY COMMITTEE (HOSC) WORK PROGRAMME **81 - 94**

Report of the Director of Strategy and Governance (copy attached).

26. CARERS' STRATEGY **95 - 144**

Report Of the Director of Adult Social Care and Housing on the development of a city carers' Strategy (copy attached).

27. ITEMS TO GO FORWARD TO CABINET OR THE RELEVANT CABINET MEMBER MEETING

To consider items to be submitted to the next available Cabinet or Cabinet Member meeting.

28. ITEMS TO GO FORWARD TO COUNCIL

To consider items to be submitted to the 08 October 2009 Council meeting for information.

The City Council actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public. Provision is also made on the agendas for public questions to committees and details of how questions can be raised can be found on the website and/or on agendas for the meetings.

The closing date for receipt of public questions and deputations for the next meeting is 12 noon on the fifth working day before the meeting.

Agendas and minutes are published on the council's website www.brighton-hove.gov.uk. Agendas are available to view five working days prior to the meeting date.

Meeting papers can be provided, on request, in large print, in Braille, on audio tape or on disc, or translated into any other language as requested.

For further details and general enquiries about this meeting contact Giles Rossington, 01273 29-1038, email giles.rossington@brighton-hove.gov.uk) or email scrutiny@brighton-hove.gov.uk

Date of Publication – 22 September 2009

Agenda Item 15

To consider the following Procedural Business:

A. Declaration of Substitutes

Where a Member of the Commitee is unable to attend a meeting for whatever reason, a substitute Member (who is not a Cabinet Member) may attend and speak and vote in their place for that meeting. Substitutes are not allowed on Scrutiny Select Committees or Scrutiny Panels.

The substitute Member shall be a Member of the Council drawn from the same political group as the Member who is unable to attend the meeting, and must not already be a Member of the Committee. The substitute Member must declare themselves as a substitute, and be minuted as such, at the beginning of the meeting or as soon as they arrive.

B. Declarations of Interest

(1) To seek declarations of any personal or personal & prejudicial interests under Part 2 of the Code of Conduct for Members in relation to matters on the Agenda. Members who do declare such interests are required to clearly describe the nature of the interest.

(2) A Member of the Overview and Scrutiny Commission, an Overview and Scrutiny Committee or a Select Committee has a prejudicial interest in any business at a meeting of that Committee where –
(a) that business relates to a decision made (whether implemented or not) or action taken by the Executive or another of the Council's committees, sub-committees, joint committees or joint sub-committees; and
(b) at the time the decision was made or action was taken the Member was
(i) a Member of the Executive or that committee, sub-committee, joint committee or joint sub-committee and
(ii) was present when the decision was made or action taken.

(3) If the interest is a prejudicial interest, the Code requires the Member concerned:
(a) to leave the room or chamber where the meeting takes place while the item in respect of which the declaration is made is under consideration. [There are three exceptions to this rule which are set out at paragraph (4) below].
(b) not to exercise executive functions in relation to that business and

(c) not to seek improperly to influence a decision about that business.

(4) The circumstances in which a Member who has declared a prejudicial interest is permitted to remain while the item in respect of which the interest has been declared is under consideration are:

(a) for the purpose of making representations, answering questions or giving evidence relating to the item, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise, BUT the Member must leave immediately after he/she has made the representations, answered the questions, or given the evidence;

(b) if the Member has obtained a dispensation from the Standards Committee; or

(c) if the Member is the Leader or a Cabinet Member and has been required to attend before an Overview and Scrutiny Committee or Sub-Committee to answer questions.

C. Declaration of Party Whip

To seek declarations of the existence and nature of any party whip in relation to any matter on the Agenda as set out at paragraph 8 of the Overview and Scrutiny Ways of Working.

D. Exclusion of Press and Public

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

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

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

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

08 JULY 2009

THE COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillors Garry Peltzer Dunn (Chairman), Alford, Allen (Deputy Chairman), Barnett, Hawkes, Janio, Kitcat, Rufus.

Co-opted Members: Robert Brown (LINk), Jack Hazelgrove (Older People's Council).

PART ONE

1. PROCEDURAL BUSINESS

1A Declarations of Substitutes

1.1 Councillor Tony Janio announced that he was attending as substitute for Councillor Steve Harmer-Strange.

1B Declarations of Interest

1.2 There were none.

1C Declarations of Party Whip

1.3 There were none.

1D Exclusion of Press and Public

1.4 In accordance with section 100A(4) of the Local Government Act 1972, it was considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in section 100I (1) of the said Act.

1.5 **RESOLVED** – That the Press and Public be not excluded from the meeting.

2. MINUTES OF THE PREVIOUS MEETING

2.1 **RESOLVED** – That the minutes of the meeting held on 20 May 2009 be approved and signed by the Chairman.

3. CHAIRMAN'S COMMUNICATIONS

3.1 Following recent critical media reports on city breast cancer screening services, the Chairman asked NHS Brighton & Hove and Brighton & Sussex University Hospitals Trust (respectively, the commissioners and the providers of city breast screening services) to address the committee on this issue.

3.2 Councillor Sven Rufus had also asked a Councillor Question on breast screening (see **Item 6** on this agenda). Cllr Rufus agreed that his questions should be taken together with the Chairman's.

3.3 Dr Peter Wilkinson, Deputy Director of Public Health at NHS Brighton & Hove, and Kate Parkin, Director of Screening at Brighton & Sussex University Hospitals Trust , presented a paper and answered members' questions.

3.4 Dr Wilkinson told the committee that the key local issue was a shortfall in radiographers. This longstanding problem had been aggravated by the recent (mandatory) move from 'one' to 'two view' screening, which provides an improved screening service, but requires more radiographer input. This issue is being addressed, and improvements have been made, with the new screening centre providing a more attractive environment to recruit staff into, but there are still recruitment problems. It is anticipated that the development of a school of radiography as part of the University medical school will address this problem in the medium term.

3.5 In answer to a question as to whether the slippage in the screening regime may have had adverse consequences for any individuals, Dr Wilkinson told members that this was extremely difficult to ascertain, but there was a risk that someone with breast cancer could have been diagnosed later than they should have been due to delays in screening.

3.6 The Chairman noted that, although he was partly reassured by the explanation for why breast screening services had been performing poorly and by NHS trust plans to improve matters, he considered it necessary to revisit this issue in several months time in order to make sure that the anticipated improvements had in fact been made.

3.7 **RESOLVED –** that the committee should receive an update report on city breast cancer screening in 6 months time.

4. PUBLIC QUESTIONS

4.1 A Public Question was asked on behalf of Mr Ken Kirk, and the committee debated the issues raised.

4.2 A member argued that requiring Primary Care Trusts to launch a full public consultation exercise every time they put a service out to tender would be disproportionate, particularly given the fact that corporate involvement in the local health economy was relatively minor and did not appear to be growing particularly quickly.

4.3 Another member agreed that full public consultation might not be appropriate in many instances, but argued that the Primary Care Trust (PCT) could still make some effort to involve the public in these issues, perhaps by allowing people to email their views on particular services to the PCT. For significant contracts, full public engagement was essential.

4.4 The Chief Executive of NHS Brighton & Hove told members that the PCT was committed to public engagement whenever appropriate, but that the technical and/or confidential nature of aspects of tender processes might preclude full public involvement in some instances.

4.5 The Chairman noted that one of the major roles of the committee was to ensure that local Primary Care Trusts consulted appropriately. It was the committee's view that NHS Brighton & Hove did generally follow best practice in terms of public involvement in its work, and he was therefore not minded to accede to the questioner's request to write to local Primary Care Trusts urging them to consult more broadly.

5. NOTICES OF MOTION REFERRED FROM COUNCIL

5.1 There were none.

6. WRITTEN QUESTIONS FROM COUNCILLORS

6.1 The question from Councillor Rufus was considered alongside Item 3 (Chairman's Communications).

7. RE-PROVISION OF HEALTHCARE SERVICES IN COMMUNITY SETTINGS

7.1 This Item was introduced by Darren Grayson, Chief Executive of NHS Brighton & Hove.

7.2 In response to a question about plans to provide anti-coagulation clinics in community rather than acute hospital settings, Mr Grayson told members that non-specialist services would eventually be moved out of the Royal Sussex County Hospital. Mr Grayson could not confirm whether these services would continue to be provided at Hove Polyclinic, but promised to pass this information on to the committee.

8. REVISION OF THE CITY WORKING AGE MENTAL HEALTH COMMISSIONING STRATEGY

8.1 This Item was introduced by Simon Scott, Strategic Commissioner for Mental Health for NHS Brighton & Hove and Brighton & Hove City Council.

8.2 Mr Scott told members that Brighton & Hove had high levels of suicide, drugs and alcohol related deaths, severe anxiety and depression, and people drinking at dangerous levels. Local spending on these areas is considerably higher than national

averages, but more can be done to further improve city services: hence the need to revise the Working Age Mental Health Commissioning Strategy.

8.3 **RESOLVED –** that the committee approves the proposed process for the development of the Working Age Mental Health Commissioning Strategy.

9. AD HOC SCRUTINY PANEL REVIEW OF THE BRIGHTON & HOVE GP-LED HEALTH CENTRE

9.1 The report of the ad hoc panel on NHS Brighton & Hove's procurement of a GP-Led Health Centre was introduced by Cllr Trevor Alford, the panel Chairman. Cllr Alford praised officers of NHS Brighton & Hove for the open and transparent way they had worked with the panel on this issue. Another panel member, Cllr Kevin Allen agreed with this, stating that NHS Brighton & Hove had established robust procedures for this procurement and had adhered to these procedures throughout the tender process.

9.2 Cllr Jason Kitcat, who also sat on the panel, agreed that NHS Brighton & Hove had properly followed procurement procedure, but was critical of national policy in this instance, believing that it unfairly discriminated against smaller providers.

9.3 Terry Needle, Director of Quality and Assurance at NHS Brighton & Hove, told members that the GP-Led Health Centre was now operational, although uptake of its services had thus far been quite slow.

9.4 The Chairman asked for a verbal update from NHS Brighton & Hove on the performance of the GP-Led Health Centre for the next committee meeting (September 30 2009). The Chairman also requested that a visit to the facilities be arranged for HOSC members.

9.5 **RESOLVED –**

(1) That the ad hoc panel report be endorsed and passed on to NHS Brighton & Hove for comment and action and to Full Council for information;

(2) That there should be a verbal update on the GP-Led Health Centre at the next (30.09.09) Committee meeting;

(3) That a visit to the GP-Led Health Centre should be arranged for HOSC members.

10. PROVIDERS IN THE LOCAL HEALTH ECONOMY

10.1 **RESOLVED –** As key information was missing from the report presented at this meeting (08.07.09) it was agreed to bring an amended version of the report back to a later committee meeting.

11. HEALTH OVERVIEW & SCRUTINY COMMITTEE (HOSC) WORK PROGRAMME

11.1 The Chairman informed members that he intended to schedule an item on the 30.09.09 committee agenda which would enable the HOSC to agree a 2009-2010 work programme.

11.2 HOSC members would be asked to contribute their work programme ideas in advance of the September meeting, as would all other Brighton & Hove Councillors, partner organisations (e.g. the Brighton & Hove Local Involvement Network and the Older People's Council) and local NHS trusts.

12. CARE QUALITY COMMISSION: REPORT FOR INFORMATION ON CHANGES TO THE QUALITY ASSURANCE REGIME FOR HEALTH AND SOCIAL CARE

12.1 This item was introduced by Terry Needle, Director of Quality and Assurance at NHS Brighton & Hove.

12.2 In response to a question concerning HOSC involvement in the work of the Care Quality Commission (CQC), members were told that there was an opportunity to respond to the current consultation on the CQC. Once the CQC has been established there will also be the facility for third parties (including HOSCs) to feed information to the CQC on an ongoing basis (i.e. whenever they have concerns or informed comments to make about the performance of local healthcare providers).

13. ITEMS TO GO FORWARD TO CABINET OR THE RELEVANT CABINET MEMBER MEETING

13.1 There were none.

14. ITEMS TO GO FORWARD TO COUNCIL

14.1 There were none.

The meeting concluded at 5:30pm

Signed Chair

Dated this day of

# HEALTH OVERVIEW AND SCRUTINY COMMITTEE	**Agenda Item 21** Brighton & Hove City Council

Subject:		**Pandemic Flu Preparations**		
Date of Meeting:		**HOSC 30th September 2009**		
Report of:		**The Director of Public Health**		
Contact Officer:	Name:	Dr. Tom Scanlon	Tel:	01273 545391
	E-mail:	Tom.scanlon@brighton-hove.gov.uk Tom.scanlon:bhcpct.nhs.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The attached paper outlines preparations for the pandemic flu in Brighton and Hove with particular regard to a second wave / surge in flu activity.

2. RECOMMENDATIONS:

2.1 The HOSC are asked to note the report

3. BACKGROUND INFORMATION

3.1 Pandemic swine flu first appeared in the UK in April 2009. A peak of activity (150 cases /100,000) occurred in early July. The first wave is now over as was predicted.

3.2 A second wave is anticipated in the autumn which, in the light of winter weather and the potential for increased transmission could be more severe. The PCT, City Council and Health partners across the city have and continue to jointly plan to deal with the pandemic.

3.3 The antiviral centre continues to operate and antiviral medication will be a central plank of dealing with any second wave. When appropriately administered, antivirals are known to be effective in reducing the duration of the illness in individuals and therefore reducing transmission in the community.

Initially antivirals were prescribed to contacts now they are restricted to patients with the flu and a judgement is made between patient and doctor as to whether antivirals will help.

The costs of antiviral medication is being borne by central government.

Early side effect profiles following administration of antivirals suggest that side effects may be greater than originally anticipated. These are largely gastro-intestinal and short lived. Between 20 and 30% appeared to suffer from nausea or abdominal pain.

Around 20% of those who have had severe complications or who have died following contracting swine flu in the UK were patients who were otherwise completely healthy. A total of 70 people died in the first wave of swine flu in the UK.

3.4 A vaccine campaign will start in the autumn targeting those members of the community most at risk of severe complications following a flu infection. These include those at risk or seasonal flu complications and pregnant women. In addition those people living with relatives who are immune-suppressed and front line workers delivering healthcare will also be offered the vaccination.

4. CONSULTATION

4.1 The MART-flu (Management and Response Team for Pandemic Flu) is the city-wide organisation concerned with planning the city's response to the pandemic and this is where discussion and consultation take place. All key statutory organisations are represented on the MART-flu.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The vaccine will be provided free of charge with GPs paid a fee of just over £5 for each vaccine administered. Healthcare organisations will be expected to vaccinate their own staff. A large number of Council staff are likely to require vaccination.

Legal Implications:

5.2 N/A

Equalities Implications:

5.3 No inequalities issues have been identified with regard to flu planning at this stage.

Sustainability Implications:

5.4 N/A

Crime & Disorder Implications:

5.5 The antiviral drugs are stored in a secure location.

Risk and Opportunity Management Implications:

5.6 There is a possibility that the city's resources will be stretched to the extent that key services will be prejudiced. Plans are in place for example for the identification of vulnerable groups / patients / clients who require frequent care.

Corporate / Citywide Implications:

5.7 The pandemic is a city-wide responsibility and under a memorandum of understanding statutory organisations are all contributing to the efforts to minimise the effects of the pandemic.

SUPPORTING DOCUMENTATION

Appendices:

None

Documents in Members' Rooms:

None

Background Documents:

1. Powerpoint slide summary of swine flu pandemic
2. Paper presented to the PCT Board to provide assurance.
3. Updated planning assumptions from the Strategic Health Authority

SHA Planning Tool for H1N1 Pandemic Influenza
Version 2 – September 4th 2009

Brief Introduction and Guidance for Users

Purpose

The aim of this spreadsheet is to help NHS planners explore the consequences of different assumptions about the H1N1 influenza ("Swine Flu") pandemic, in terms of its possible effect on the population of England as a whole, or of any specific SHA or PCT. This will help generate scenarios for the potential demands on NHS services. Much of its earlier development was undertaken by East of England SHA, whose contribution is gratefully acknowledged.

This version supersedes that circulated in August, and differs in two ways:

(a) The population is now split into broad age cohorts, to which different inputs can be applied

(b) The spreadsheet is set up with an initial scenario to replicate the revised Planning Assumptions (designed to set out a "worst reasonable case") issued by Cabinet Office and Department of Health on September 3rd and reproduced in Annex A below.

Overview of inputs

Inputs are entered on the first ("set up") sheet of the spreadsheet. Each of the following variables can be set as an overall average and for each of four age groups (under 5s, 5-15, 16-64, and 65+).

- the Clinical Attack Rate, i.e. the percentage of the population becoming ill with H1N1 influenza during the planning period: these are the *clinical cases*.
- the percentage *of these clinical cases* who may:
  - suffer complications (typically sufficient to require a GP consultation)
  - require hospitalisation, and the percentage *of those hospitalised* who would require intensive care (if capacity existed)
  - die, due directly or indirectly to influenza.

These, and other key factors, are defined in more detail in the Planning Assumptions appended**.**

- In addition, there is the optional facility to input a percentage of clinical cases *identified* during the course of the pandemic. This percentage is not estimated in the Planning Assumptions. However, it is included as a feature in the spreadsheet in case users wish to consider scenarios involving different proportions of cases being identified.

The *assumed start of the (renewed) pandemic curve* must also be specified as "Week 1" in the box provided in the set-up sheet. This is explained further below. The default setting provided in the spreadsheet is the first Monday in September (7th), though this can be changed by the user.

Outputs

Given the above inputs, the model will calculate and show projected numbers of clinical cases, identified clinical cases (if defined) and cases leading to complications, hospitalisation, demand for ICU cases and death due to H1N1 influenza. These can be displayed for each age group or for the overall population covered.

When the output sheet for any given SHA is selected, the user can access results both for the SHA as a whole and for each constituent PCT population (the populations themselves are shown in the grey cells on each line). Graphs for projected timings over the course of the pandemic are also produced. Which projection to display in detail, for which population, can be chosen by clicking on the appropriate menus.

A reminder of the inputs for the scenario being used also appears in a box on all output sheets.

Initial scenario

The model is set up with one initial scenario labelled "Planning Assumptions", corresponding to the "worst reasonable case" within the revised planning assumptions attached. These cover the period up to mid-May 2010 – i.e. the "normal" winter period for seasonal flu.

- *Clinical Attack Rate*: 30% of population overall:
    - 50% in those aged 15 or under
    - 15% in those aged 65 or over
- [The input column for *identified clinical cases* is left blank in this scenario, as explained above.]
- *Complications*: 15% of clinical cases in overall population, with distribution by age compensating for the differential in Clinical Attack Rate, i.e.
    - 9% in those aged 15 or under
    - 30% in those aged 65 or over
- *Hospitalisation rate*: 1% of clinical cases in overall population, with distribution by age compensating for the differential in Clinical Attack Rate *except for* the under-5s, i.e.
    - 1% in those aged under 5
    - 0.6 % in those aged 5-15
    - 1% in those aged 16-64
    - 2% in those aged 65 or over
- *ICU cases (cases requiring Intensive Care):* 25% of those hospitalised, across all age groups (see further note below)
- Case fatality ratio: 0.1% of clinical cases in overall population, with distribution by age compensating for the differential in Clinical Attack Rate, i.e.
    - 0.06% in those aged 15 or under
    - 0.11% in those aged 16-65 and
    - 0.2% in those aged 65 or over

These assumptions are summarised in the table below, which appears as the first scenario in the set-up sheet. Note that some of the values appear directly in the planning assumptions, whereas others are mathematically implied (for example, if the Clinical Attack Rate is specified for the

overall population and for those aged up to 15 and over 65, this implies a value for the remaining population aged 16-64).

Planning assumptions

	Clinical Attack Rate	Identified Clinical Cases	Complications / Extra GP Consultations	Hospitalisation	ICU Cases	Deaths
Age group	% of pop	% of Cases	% of Cases	% of cases	% of hospitalised	% of Clin. Cases
Population average	**30%**		**15%**	**1.00%**	**25%**	**0.1%**
Under 5	50%		9%	1%	25%	0.06%
5-15	50%		9%	0.6%	25%	0.06%
16-64	28%		16%	1%	25%	0.11%
65+	15%		30%	2%	25%	0.20%

These inputs should be read in conjunction with the planning assumptions appended. This scenario **is not a prediction of what will happen.** Rather, it is considered as a "reasonable worst case" against which to plan during the period covered, given evidence available so far from the UK and across the world.

Any planning for future periods should be based on the standard reasonable worst case assumptions promulgated in pre-pandemic planning.[1]

Exploring other scenarios

Because there are many scientific uncertainties, the spreadsheet can also generate up to three further, user-defined scenarios, to explore the consequences of alternative inputs – for example, if the infection is "milder" than assumed in the reasonable worst case, with a lower percentage of cases requiring hospitalisation, and/or a lower case fatality rate. These are generated by adding the necessary figures to the blank tables in the "set up" sheet.

Note that in entering assumptions for any given scenario, the user should:

- enter a value for the population average, and
- enter values for the under 5s, 5-15, and 65+ age groups.

The figure for the remainder of the population (16-64) will then be calculated automatically, so that the required population average is reached. This calculation takes account of the relative numbers in each age group within the national population. For most plausible scenarios, this value will be close to the population average (given that this age group contains a large proportion of the overall population).

Note that results for SHA and PCT populations take account of the age distributions in each area. So, for example, if over-65s are assumed to have a low Clinical Attack Rate, this will reduce case numbers more in SHAs or PCTs whose populations have a higher proportion in this age group.

The results of all calculations are displayed in rounded form, for example to prevent results appearing as fractions of a person. Figures shown may therefore be subject to "rounding errors", so that (for example) adding the number of cases shown for each age group in a population may

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080734

give a very slightly different figure to that calculated for the whole population. In addition, certain SHAs have populations that do not exactly correspond to the sum of those in their respective PCTs, due variation in geographical boundaries. (Further details of the population figures used are shown on the sheet in the model labelled PCT Pops (2009 projections".)

All scenarios can be saved and modified at any time. However, the initial scenario is supplied "locked" and should remain unchanged unless and until the advised planning assumptions change.

Points on specific features

Percentage of clinical cases identified

Not all clinical cases will be reported, especially if symptoms are mild. Conversely, it is difficult to distinguish H1N1 cases from other influenza-like illnesses. The percentage of cases likely to be identified is speculative at present, but can be set to any value (or none) in user-defined scenarios. If no inputs are entered, all outputs for "identified clinical cases" will appear as zero, by default. Note that all subsequent calculations for complications, hospitalisations and deaths are based on the actual numbers of cases assumed in the scenario, not identified cases. So specifying the proportion of cases identified is optional, and will have no effect on any other calculations.

Complications /GP consultations

As a rough guide, the advised complication rate (15% of clinical cases) provides an indication of demand for GP consultations: these are patients whose symptoms are severe enough to warrant interventions such as prescription of antibiotics. However, some patients with complications might require more than one consultation. In reality, the interplay between case numbers and demand may also be more complex than allowed for here: for example, demand for GP consultations might go up disproportionately if hospitals became overloaded.

ICU cases

The definition of "Intensive Care" used is explained in the Planning Assumptions. Note that these assumptions specify that up to 25% of those hospitalised at any given time may require intensive care. The initial scenario in the spreadsheet specifies 25% of hospitalised cases requiring intensive care: this is somewhat different. Evidence so far suggests that the minority of hospitalised cases who require intensive care typically have stays in ICU that are rather longer than the overall average stay for those hospitalised. *This means that the 25% in the spreadsheet is likely to be somewhat higher than the rate implied by the Planning Assumptions*. Further data on relative stays should allow a better estimation of this figure.

Local timing and shape of the pandemic

The assumed start date for a renewed and sustained growth in cases must be specified as "Week 1" in the spreadsheet. As noted in the Planning Assumptions, a worst reasonable case is that of "Week 1" happening in early September. However, this may vary locally, and it will not be possible to tell whether "Week 1" has occurred until some while after the event.

Starting from any given "Week 1", the user can specify more or less steeply-peaked pandemic curves, for any given overall Clinical Attack Rate. These are explained in more detail in the Planning Assumptions (under "Peak Clinical Attack Rate"), and the same three graphs shown there are used in the spreadsheet.

Timing of hospitalisations and fatalities

As noted above, the spreadsheet can be used to display graphical projections of clinical cases appearing each week in a given population, or the *number of cases leading to* complications, hospitalisation, ICU cases or deaths. Hospitalisations, ICU cases and deaths will successively "lag" behind the appearance of clinical cases. In particular, deaths will typically occur some significant time after appearance of symptoms – perhaps several weeks. The graphs in the spreadsheet provide projections of when clinical cases leading to death would appear in any given scenario, **not when the deaths themselves would occur**. The peak in deaths would occur significantly after the peak in cases.

Caveats

This spreadsheet is intended as a relatively-simple planning aid. It does not attempt to capture all the key features of a pandemic, or the potential effect of interventions such as vaccination. Some more sophisticated planning tools were developed prior to the current outbreak, and previously circulated to SHA and PCT planners / leads via the Pandemic Flu Virtual Forum.[2]

This planning tool may be updated further as more information becomes available. Comments and suggestions as to how it can be improved are also welcome at any time.

Contact:

Dr Peter Bennett
Head of Analysis, Health Protection
Department of Health
Wellington House, 133-155, Waterloo Road
London SE1 8UG
020 7972 4438
peter.bennett@dh.gsi.gov.uk

[2] Other SHA or PCT staff needing to access the Virtual Forum should contact their respective Flu Lead / Flu Planner in the first instance.

ANNEX A
Planning Assumptions for the current A(H1N1) Influenza Pandemic

3 September 2009

Purpose

These planning assumptions relate to the current A(H1N1) pandemic and are appropriate for use until the end of the 2009/10 "seasonal flu" season – i.e. ***until Mid-May 2010****. They provide a common agreed basis for planning across all public and private sector organisations. Working to this common set of assumptions will avoid confusion and facilitate preparedness across the UK.*

These planning assumptions are based on analysis and modelling of data from both inside and outside the UK. They supersede the previous planning assumptions (dated 16 July). ***Modifications reflect the latest evidence on the severity of the current A(H1N1) strain. While considerable uncertainties remain, this evidence is sufficient to exclude some of the most severe possibilities included before.*** *The planning assumptions will be subject to further review and possible change as further new data become available on the current pandemic strain of influenza.*

The assumptions contain a number of parameters, each taken at their 'reasonable worst case' value. In some cases, it has been possible to revise these values downward given the evidence now available. Even despite these reductions, when taken together they continue to represent a relatively unlikely scenario. They should therefore not be taken as a prediction of how the pandemic will develop. Planning against the reasonable worst case will ensure plans are robust against all likely scenarios. Response arrangements must be flexible enough to deal with the range of possible scenarios up to the reasonable worst case and be capable of adjustment as they are implemented.

Because they are based on the reasonable worst case, these Planning Assumptions take no account of the possible effect of vaccination against the pandemic strain until we can be more certain about the timing of delivery and licensing of the vaccine on order. The magnitude of any such effect also depends critically on timing: a large effect on total numbers of cases would only be expected if a substantial proportion of the population could be vaccinated before the pandemic has peaked. Nevertheless, targeted vaccination of at-risk groups may be highly beneficial in preventing more serious illness amongst vulnerable groups.

As further UK and international surveillance data emerge, we will be looking to develop and extend these planning assumptions. ***It is possible that the virus may mutate, becoming more virulent, and it is important to remain prepared for the full range of possibilities.*** *Therefore, any planning for future periods beyond Spring 2010 should be based on the standard reasonable worst case assumptions promulgated in pre-pandemic planning as set out in the 'National Framework for responding to an influenza pandemic' Chapter 3*[3]*.*

General: Timing, duration and geographic spread of the pandemic

[3] Located at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080734

The number of cases over the summer have been relatively small (with an estimated peak of the order of 100,000 clinical cases per week according to HPA calculations),[4] as compared with the numbers that could occur during the course of a full pandemic. It remains possible that case numbers could rise to many hundreds of thousands of cases per week.

Since the last week of July the rate of new cases has slowed considerably. Nevertheless, the exponential growth seen previously may resume, for example, when schools reopen. Transmission may also increase as we enter our normal 'flu season'. It is unclear whether the pandemic would thereafter unfold as a single extended 'wave' or multiple waves separated by periods of reduced case numbers. However, early, sustained exponential growth could lead to a substantial growth in the number of cases. A substantial peak could not, however, happen until October. Such a peak could be much higher than that seen in July. By the end of the planning period (May 2010), up to 30% of the population could have experienced symptoms of pandemic Swine Flu. These are potentially in addition to those experiencing the effects of seasonal flu.

As has already been seen, variations in how the pandemic unfolds from one local area to another is possible, therefore, where appropriate, planning assumptions are shown both across the UK and for local areas where different[5].

Summary of the Planning Assumptions

The table below summarises the key planning assumptions as regards infection with the current A(H1N1) pandemic strain of influenza. As noted above, this represents a "reasonable worst case" for which to plan for the period up to mid-May 2010, not a prediction. The figures shown are explained in more detail in the supporting text below. All apply both across the UK and to local areas except where specific local assumptions are shown.[6] The figures shown can be expected to vary for different age groups within the population: this is also explained in more detail below.

Planning assumptions to mid-May 2010: potential effects of A(H1N1) infection for the general population	
Clinical Attack Rate	up to 30% of population
Peak Clinical Attack Rate	nationally, up to 6.5% of population per week
	locally, 4.5%-8% of population per week
Case Complication Ratio	up to 15% of clinical cases
Case Hospitalisation Ratio	up to 1% of clinical cases, of whom up to 25% could require intensive care at any given time
Case Fatality Ratio	up to 0.1% of clinical cases
Peak Absence Rate	up to 12% of workforce

Clinical Attack Rate

[4] Estimation of the number of A (H1N1) cases in the UK is subject to significant uncertainty and bias due to problems estimating a number of key parameters (such as proportion of those with symptoms accessing the different treatment routes and swab positivity rate).
[5] Throughout this document, a "local area" refers to a population of about 100,000 to 750,000. "National" refers to the UK population of about 62,300,000.
[6] At present, the local assumptions differ from those for the UK only as regards the peak clinical attack rate. However, this may change as more evidence becomes available.

Description: The proportion of the population who *become* ill with influenza, totalled over the period covered. (These are the *clinical cases*.)

Assumption:
In total, up to 30% of the population may experience influenza-like-illness following infection with the A(H1N1) strain within the planning period.

Commentary:
This is an average over all ages in the population. The final Clinical Attack Rate among children under 16 may reach 50% during this period, with significantly lower rates than 30% in older people (of the order of 15% in those over 65).

All the above figures refer to people experiencing symptoms. The proportion of the population infected with the A(H1N1) virus (the serological attack rate) may finally be as high as 60%. This is because in addition to those who develop clinical symptoms, a similar number may be infected but show no or insignificant symptoms.

The peak Clinical Attack Rate

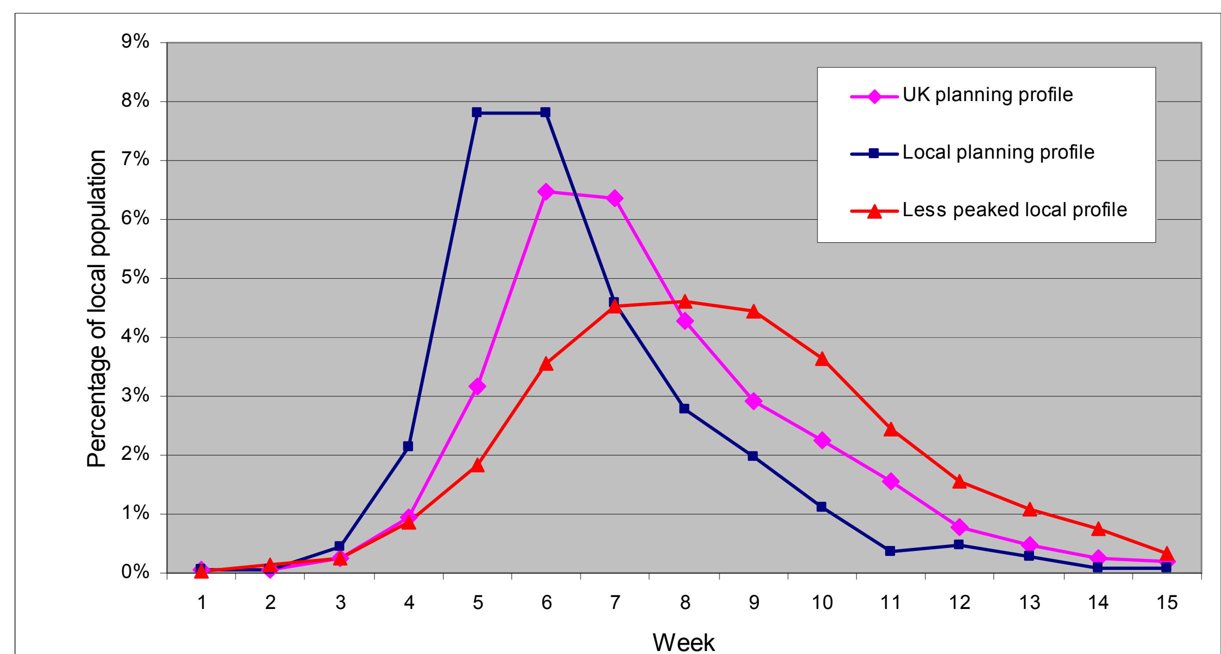
Description: The proportion of the population who *become* ill in the peak week.

Assumptions:
- *Nationally*, up to 6.5% of the UK population may become ill with influenza in the peak week of the pandemic.
- Up to 8% of the population *in any given locality* may become ill with influenza per week in the peak week of a local epidemic.
- These peak rates might be sustained for a fortnight.

Commentary:
The maximum 8% figure for a *local area* is higher than the UK planning assumption of 6.5% because local outbreaks may not be synchronised. Indeed, if the UK epidemic is extended over a relatively long period, local epidemics may have peak Clinical Attack Rates substantially higher than the UK epidemic as a whole. This is due to the UK epidemic curve being a composite of the local curves, which may vary in profile (see below), timing, and to some extent Clinical Attack Rate. As both highly-peaked and more lengthy epidemics pose challenges, planning should take account of the full range of possibilities.

The graph below illustrates three possible profiles for local epidemics, one following the UK planning profile exactly and the others demonstrating possible local variations. Each has a total Clinical Attack Rate of 30% (represented by the area under each curve).

Figure: Local Planning Profiles: Proportion of Local Population Becoming Ill per week



Once again, these should be regarded as illustrative curves to aid planning, not predictions. Forecasting the timing of 'Week 1' of the UK epidemic is not possible at present. Because of the low numbers in early weeks as compared to "background" levels of influenza-like-illness, it will not be possible to tell whether 'Week 1' has been reached from case data alone (except in retrospect).

However, a 'reasonable worst case' at present is that exponential growth in cases might resume when schools re-open (possibly augmented by effects of seasonality). In that case, 'Week 1' could be in early September. Based on the national profile shown, case numbers would then peak in mid to late October. It is also possible that the exponential growth could be more rapid than seen previously, leading to a peak at the start of October. However, 'Week 1' of the local epidemic curve may vary from local region to local region.

Case Complication Ratio

Description: The proportion *of those ill with influenza* who are expected to require additional treatment, such as the prescription of antibiotics (but not necessarily hospitalisation, see below).

Assumption: The complication ratio may be up to 15% of clinical cases (as defined above) during the planning period.

Commentary:
Complication rates appear to be higher, *as a proportion of those who become ill*, in the children under 5, clinical at-risk groups and older people. Conversely, older people may be less likely to become ill with this infection, but are more likely to suffer from complications if they do become ill.

Although evidence on these points is still accumulating, it is reasonable at present to

suggest that with the possible exception of the very young, age differentials in Clinical Attack Rates and Complication Ratios roughly cancel each other out. Thus:

- those over 65 will be about half as likely to become ill with this infection (Clinical Attack Rate of 15% rather than 30%), but have approximately double the complication ratio (30% of clinical cases rather than 15%).
- those under 16 may have a Clinical Attack Rate of up to 50%, but a correspondingly lower complication ratio.

The resulting proportions of all age groups suffering complications from A(H1N1) infection would therefore be comparable.

Case Hospitalisation Ratio and need for Intensive Care

Description:

- the proportion of those ill with influenza who (if capacity exists) should be hospitalised,

and

- the proportion of those hospitalised who would need intensive care[7] (if capacity exists).

Assumption: Up to 1% of clinical cases during the planning period may require hospitalisation. Of these, up to 25% could require intensive care at any given time.

Commentary:
Whilst hospitalisation rates for seasonal influenza are typically in the range 0.5 - 1.0% of those who become ill, current experience in the UK with the A(H1N1) virus suggests that planning should continue on the basis of the assumption given above.

Similar comments apply to age groups as above for complications, *except that* there is some evidence of higher hospitalisation rates amongst children under 5. At present, it is unclear whether this reflects relative severity of symptoms, or a more precautionary approach to hospitalisation. This is a priority area for further investigation, and any further information will be incorporated into planning assumptions when available.

Case Fatality Ratio

Description: The proportion of those ill (*clinical cases*) who die due to influenza, totalled over a complete outbreak of infection.

Assumption: For A(H1N1) infections during the planning period, the eventual Case Fatality Ratio (CFR) could be up to 0.1% of clinical cases.

Commentary:

[7] In this context, "Intensive Care" refers to Level 3 Critical Care, with facilities for mechanical ventilation. To date, it appears that most UK patients requiring Critical Care have required ventilation at some point. Therefore, the assumption that up to 25% of patients hospitalised may require Intensive Care at any given time (rather than only Level 2 Critical Care) is a reasonable worst case. Like all other planning assumptions, this will be reviewed as more evidence becomes available.

This may be regarded as precautionary in the light of what has been seen so far, but the Case Fatality Ratio may increase in the autumn (e.g. due to a higher incidence of bacterial co-infection, viral evolution or host susceptibility factors). The figure of 0.1% is therefore appropriate at present for planning purposes.

Case Fatality Ratios are particularly difficult to estimate. To do so requires knowledge of (a) the total number of cases, including those that are very mild, and (b) the number who die because of influenza but whose deaths have been recorded as due to an underlying condition made worse by influenza. Both these factors are difficult to ascertain. The delay between the onset of illness and report of death must also be taken into account when calculating this ratio. Simply comparing known cases with known fatalities at any given point in a pandemic can give a seriously misleading estimate of the CFR.

To date, the evidence suggests that similar comments with regard to age groups apply as for complication rates. That is, the effects of differing Clinical Attack Rates and Case Fatality Ratios roughly cancel each other out. There is thus no marked difference between any age groups (including the under-5s) in the overall fatality rate due to this infection.

To put the numbers in perspective, the combination of "reasonable worst case" 30% Clinical Attack Rate and 0.1% Case Fatality Ratio would result in a total number of deaths of about 20,000, or about 1/30th of the total expected each year from all causes (about 600,000).

Absence from work due to illness

Description: The proportion of the workforce who may be absent from work at the peak of the local epidemic because they are ill themselves or because they are looking after ill children.

Assumption: Absence rates for illness may reach 12% of the workforce in the peak weeks of the planning period.

Commentary:
This estimate refers to absence over and above that for "normal" holiday leave and non-Swine Flu illness. Current data, and analysis of previous pandemics, suggests an average unavailability for work of approximately 10 calendar days for clinical cases without complications, and 14 for those with complications[8].

Based on analysis of previous pandemics, this includes some allowance for a short period of recuperation following recovery from clinical illness in addition to the period with flu symptoms. The best current estimate of the length of symptoms is an average (mean) of 9 days with 25% having symptoms for more than 10 days.

Also included in the assumption is an estimate for those at home caring for ill children, but *not* for any additional absence due to fear of contracting Swine Flu or the need to look after ill dependent relatives or friends other than children.

---

[8] The Planning Assumptions issued on the 16th of July 2009 refer to working days. The estimates for average length of absence remains the same, but are now quoted in calendar rather than working days, in the interest of clarity.

If schools are closed due to influenza during term-time (due to lack of availability of staff or planned closure), absence rates may increase as parents may need to stay at home to look after children. It has been estimated that this could cause an *additional* 15% of the workforce to be absent. This is based on the proportion of the national workforce with dependent children at home, as evidenced by survey data. This proportion will clearly differ from case to case, and employers should take account of the characteristics of their own workforce.

Meeting:	**NHS Brighton and Hove** **Board Meeting**
Item no:	**/09**
Date:	**15th September 2009**
Board Sponsor:	**Tom Scanlon**
Paper Author:	**Peter Wilkinson**
Subject:	**Pandemic Flu – Board Update**

1. Summary and Context.

The pandemic is changing day by day and at the time of presentation to the Board the situation may be different from the time of writing. An up-to-date report on activity and impact on services will be delivered verbally by the PCT Flu Director on the day of the Board meeting.

This paper outlines the current national situation with regard to Pandemic (Swine) Flu and NHS Brighton and Hove's response to and preparations for the next wave of the pandemic. The PCT's Pandemic Flu Plan and Emergency Plan have already been considered and approved by the Board. The paper also outlines the national pandemic flu preparation requirements for the PCT and the Board.

The NHS Guidance of July 2nd 'Swine Flu Pandemic: From containment to treatment' sets out the requirements of the NHS as a whole and individual component organizations including PCTs and their boards. The general NHS and PCT requirements are outlined below with the response taken.

PCT Board requirements:

The PCT Board is required to ensure:

- The appointment of a full time director level flu lead with a well resourced team for the coming months;
- The provision of high-quality care to flu and non-flu patients for up to five months;
- Capacity constraints likely to result from increased demand and sickness absence are assured;
- That there are preparations for relevant staff vaccination and support for staff;
- Build on existing relationships with local partner agencies to ensure that their role, channels of communication and ways of working during a sustained wave are clear
- That sufficient antiviral collection points to meet the local community's needs are in operation;
- Plans are in place for the introduction of the National Pandemic Flu Service
- That communications with GPs and other local partners are clear and help maintain public confidence

PCT Requirements:

PCTs are required to ensure:

- Effective local communications;
- Support for primary care including a named senior contact for GPs and LMCs;
- Support for local out of hours services;
- Support for vulnerable patients during a pandemic;
- Prompt treatment with antiviral medication;
- The operation of an antiviral centre;
- A responsible person for antiviral medication responsible person;
- Local plans to introduce the National Pandemic Flu Service and where appropriate, an antiviral collection point network;
- Effective and proactive discussions with local partners
- Promotion of the uptake of seasonal flu and swine flu among healthcare staff including primary care staff;
- The provision of assurance to the SHA on resilience testing including winter plans;
- Robust and timely arrangements for reporting to SHA;
- The continuity of essential supplies and services.

2. Recommendations.

The Board is asked to note and approve the PCT's preparations.

The Board is asked and to confirm that it is assured that the PCT is prepared to deal with the surge and the associated workforce issues.

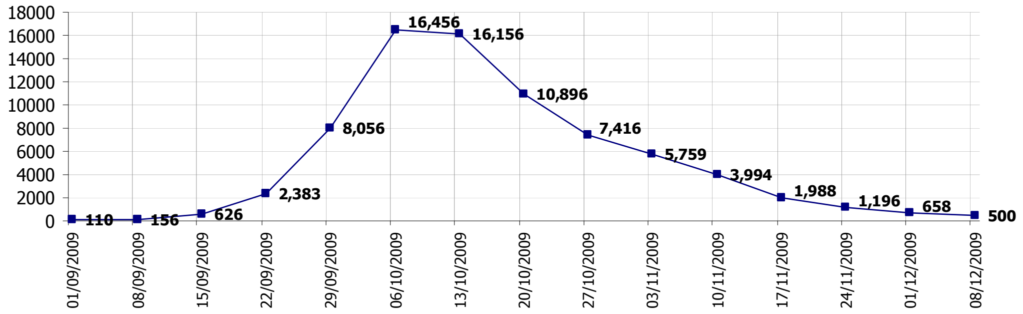
3. Relevant background information

On 11th June 2009 the WHO declared a flu pandemic. The initial UK policy of containment using anti-viral medication to treat cases and close contacts ended on July 2nd 2009 when the UK moved into the treatment phase. From that time there was a rapid increase in the number of possible cases of pandemic flu in England to over 110,000 cases a week, until the week commencing 27th July when the rate of increase began to fall. The number of new cases in England was estimated at 30,000 in the first week of August 2009.

At the end of the containment phase there had been ten confirmed cases of swine flu in Brighton and Hove. Following the move to the treatment phase there has no longer been the requirement to confirm the diagnosis of presumed cases. The number of courses of antiviral medication issued at the Brighton and Hove antiviral collection point peaked at 338 on the 24th July. At the time of writing (August 13th 2009) the number of antiviral courses issued was around 100 on weekdays and 50 to 75 each day at the weekend. In total approximately 5000 courses of antivirals were issued in the first five weeks after the collection point opened.

4. Link to strategic objectives

The DoH worst case scenario planning assumptions and associated projected number of clinical cases in Brighton and Hove during a Pandemic wave is illustrated below. During the two week surge over 2000 residents per day could require treatment with antiviral drugs. At the same time as having to manage the surge organisations will be suffering high absence rates amongst their own staff. It is estimated that the peak absence rate will be 12%.



Planning assumptions to August 31st 2009	
Assumption	
Clinical Attack Rate	5%-10%
Peak clinical attack rate	2-5% per week
Complication rate	15% of clinical cases
Hospitalisation rate	2% of clinical cases
Case fatality rate	0.1% of clinical cases[1]
Peak Absence rate	9% of workforce

Planning assumptions for first major pandemic wave	
Clinical Attack Rate	30%
Peak clinical attack rate	6.5% (local planning assumption 4.5%-8%) per week
Complication rate	15% of clinical cases
Hospitalisation rate	2% of clinical cases
Case fatality rate	0.1-0.35% of clinical cases
Peak Absence rate	12% of workforce

Regarding the management of the surge the current planning guidance suggests that the NHS should plan for a worst case scenario as above. If 2% of cases require hospitalisation then for Brighton and Hove this would be the equivalent of 320 people a week for each of the two peak weeks for Brighton and Hove, and of these 25% requiring critical care. These are worst case assumptions and do not necessarily reflect the current situation where the rates of hospitalisation and critical care are lower.

[1] The 0.1% figure is based on experience outside the UK. Figures up to 0.35%, though unlikely, cannot be currently ruled out from UK data.

5. PCT Response to DoH Requirements

PCT Board requirements: The PCT Board is required to ensure:

- *The appointment of a full time director level flu lead with a well resourced team for the coming months*;

The PCT has appointed Dr. Peter Wilkinson as full-time Flu Director with support from the Director of Public Health and the Emergency Planner. There is a weekly Pandemic Flu Management and Response Team (MART) meeting chaired by the Flu Director with input from across the PCT (public health, medicines management, communications, human resources) BSUH, South Downs, Sussex Partnership Trust, the City Council, Children and Young People's Trust, both Universities, the coroner and out-of-hours services.

The PCT infection control and primary care team are responsible for the stock management and distribution of the Personal Protective Equipment supplied by the Department of Health. The medicines management team is responsible for securing the supply of antiviral medication.

- *The provision of high-quality care to flu and non-flu patients for up to five months*;

The PCT Flu Director has met with the PCT Strategic lead for winter planning to ensure pandemic flu considerations are taken into account in local plans. Potential additional bed capacity is being identified across Sussex.

- *Capacity constraints likely to result from increased demand and sickness absence are assured*;

The PCT has a Pandemic Influenza Human Resources Plan. An internal audit of staff was undertaken to establish how many have caring responsibilities and other factors which may affect their attendance for work during a pandemic. The PCT has ensured its own response and business continuity arrangements. Each directorate and department has identified their own critical and routine functions as part of the PCT's general business continuity process together with the number of staff required to run the critical functions. Home working and flexible working arrangements are to be permitted as appropriate. A designated sickness absence reporting line has been established. A flexibility clause has been inserted into staff contracts to ensure that staff can assist in the response to the Pandemic.

- *That there are preparations for relevant staff vaccination*;

National guidance on vaccination is awaited at the time of writing. PCT staff are unlikely to be in the front line for treatment. Through the MART, provider organisations have identified priority staff for vaccination. A team of vaccinators across the city from different organisations is in preparation.

- *Build on existing relationships with local partner agencies to ensure that their role, channels of communication and ways of working during a sustained wave are clear*

All local statutory agencies are members attend the local flu MART meeting where current operational arrangements and planning for the second wave is reviewed. The BSUH Pandemic Flu meetings are attended by the PCT Director of Flu.

- *That sufficient antiviral collection points to meet the local community's needs are in operation*;

At the time of writing, the PCT is operating a single antiviral collection point (AVC) at Hove Town Hall Chamber. This has capacity to increase and cope with the projected surge. The AVC however may be moved to a smaller facility if the number of residents requiring antiviral medication decreases. This move will be with the proviso of a swift relocation to a larger facility in the event of numbers of affected residents increasing in the winter. There are AVC

facilities in neighbouring PCTs and flu friends do cross PCT borders to pick up medication. Sussex flu directors meet weekly by telephone conference to ensure good cross PCT working.

- *Plans are in place for the introduction of the National Pandemic Flu Service*

The National Pandemic Flu Service is now operational and is incorporated into the processes at the antiviral collection point.

- *That communications with GPs and other local partners are clear and help maintain public confidence*;

A three times weekly e-mail PCT communication is sent to GPs. Feedback from GPs has been very positive. The Argus has visited the antiviral collection point and there have been numerous press releases on the flu since the pandemic began. Public communications are all cleared with West Sussex PCT in its role as lead PCT for emergency planning. To support the antiviral collection point the PCT's PALS team have been operating a helpline.

PCT Requirements:

PCTs are required to ensure:

- *Effective local communications*;

See above

- *Support for primary care including a named senior contact for GPs and LMCs*;

See above.

- *Support for local out of hours services*;

Out of hours services are represented on the weekly pandemic flu MART and relevant issues discussed in that forum.

- *Support for vulnerable patients during a pandemic*;

Through the MART South Downs Health and the City Council have identified and shared lists of vulnerable clients to ensure support in the event of a surge and / or pressures on staffing. A list of medications which might indicate that a patient is vulnerable, and which can be used by GPs to identify vulnerable patients has been sent to all practices.

Arrangements have been made with South Downs and subsequently with the voluntary sector for the home delivery of antiviral medication for people unable to identify anyone to collect the medication on their behalf. Discussions with the voluntary sector are considering other ways in which the sector can contribute to the city's response to the pandemic.

- *Prompt treatment for antiviral medication*;

The antiviral centre operates seven days a week from 8 am until 8 pm and patients can therefore receive medication within the required 12 hour timeframe.

- *The operation of antiviral centre;*

See above

- *A responsible person for antiviral medication responsible person*;

Jane Moffatt, as Medicines Management Team is responsible for ensuring antiviral supplies. The antiviral stock management and re-supply arrangements are being managed by the

PCT's medicines management teams who report on stock levels on a daily basis. Additional storage for pandemic flu vaccines has been secured at South Downs Health NHS Trust.

- *Local plans to introduce the National Pandemic Flu Service and where appropriate, an antiviral collection point network*;

The National Pandemic Flu Service has been activated. A single antiviral collection point may be sufficient for Brighton and Hove although a further four potential points have been identified and agreed with partner organisations.

- *Effective and proactive discussions with local partners*

From a primary care perspective all GP practices have received guidance and templates to assist them in preparing for a flu pandemic. These are being followed up by individual practice visits from PCT staff. Community pharmacies have also been helped to develop business continuity and emergency plans. Discussions have taken place with dental practitioners about arrangements for both routine and emergency dental services to be provided during a pandemic.

- *Promotion of the uptake of seasonal flu and swine flu vaccine among healthcare staff including primary care staff*;

A seasonal flu campaign is being planned by the PCT with increase focus on improved clinical staff uptake through the workings of the MART. Provider trusts are taking action to promote seasonal flu vaccine.

Pandemic specific vaccine is expected to be available for September 2009. However, the vaccination programme is expected to run over many months. The population and workforce groups to be prioritised for vaccination have yet to be decided. Plans are being developed to ensure a pool of vaccinators to support primary care and other services in delivering the vaccination programme.

- *The provision of assurance to the SHA on resilience testing including winter plans*;

See above

- *Robust and timely arrangements for reporting to SHA*;

There is a teleconference twice a week with the SHA that the Flu Director attends. Every week day brief sitreps are sent to the lead PCT.

- *The continuity of essential supplies and services*.

Surge planning is a key component of the weekly MART and there are additional surge meetings within provider trusts attended by the PCT Flu Director. A checklist of resilience planning for critical care in children and adults has been forwarded to the SHA.

6. Link to corporate considerations

To date the PCT has received a small amount of SHA pandemic flu funding. No central guidance has yet been provided regarding the suspension of performance targets in the event of the local health economy workload being overtaken by the operation of an emergency flu response.

6.1 Governance and legal

The governance arrangements for the antiviral collection point are being overseen by South Downs NHS Trust. These include the signing-off of protocols and guidance for staff working at the collection point to issue antiviral medication. Guidance on infection control in relation to patients with symptoms who attend the collection point is also being developed.

6.2 Equalities
No major issues have been identified.

6.3 Consultation
All Category 1 responders and Health organisations (including all GP's surgeries and pharmacies) have been consulted with and involved in flu planning and response measures.

6.4 Risk management
Because the current wave of cases appears to have peaked concern is now shifting to the next wave, which may occur during the winter months and hence is likely to be associated with a greater number of cases. There is also concern that future waves may be more virulent with potentially more serious consequences than those currently being experienced.

Clearly there is a risk that local services may not be able to provide adequate services to meet the needs of the local population during the pandemic. However, the ongoing planning arrangements aim to offset this risk by maximising the support that can be given to the population both in the hospital and in the community.

Pandemic flu will remain on the corporate risk register to ensure that changing circumstances of the Pandemic are reflected in risk management mitigation.

7. Appendices
There are no appendices attached to this report.

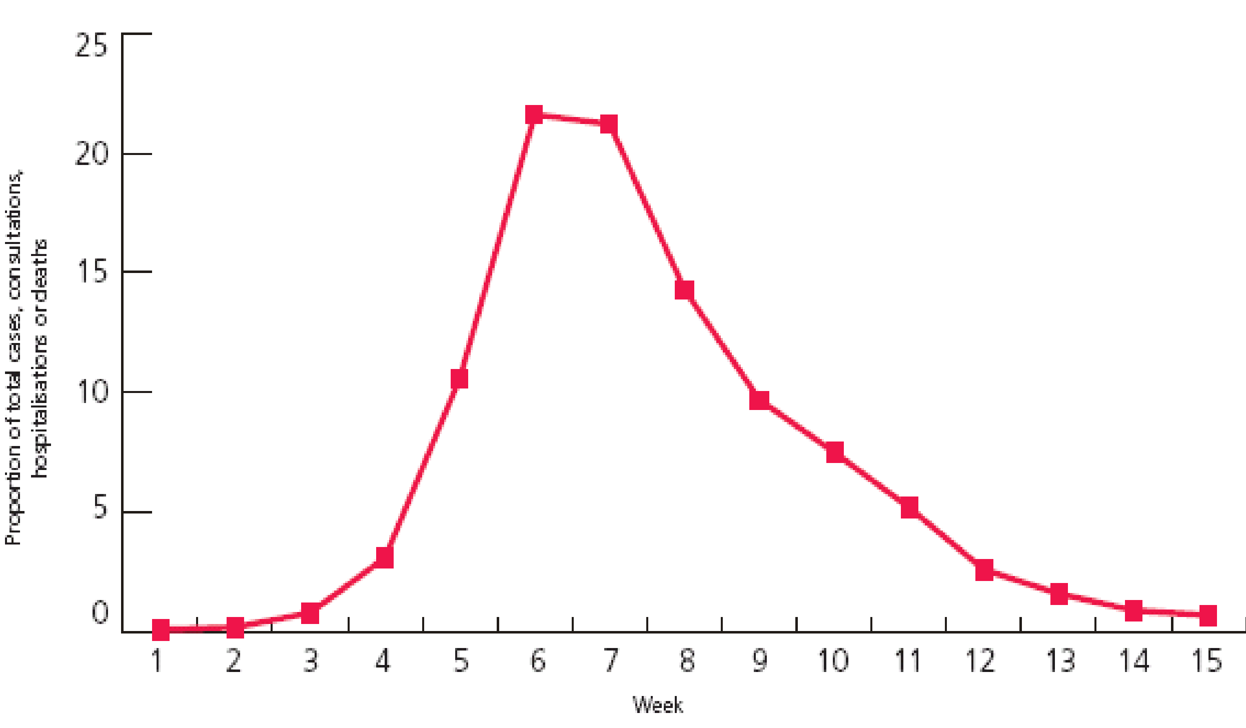
Peter Wilkinson
Pandemic Flu Director August 13th 2009

Pandemic Flu -2009
UPDATE

HOSC
NHS Brighton and Hove
September 30th 2009

Dr. Tom Scanlon
Director of Public Health

Typical single wave flu profile with proportion of new clinical cases, consultations, hospitalisations or deaths by week



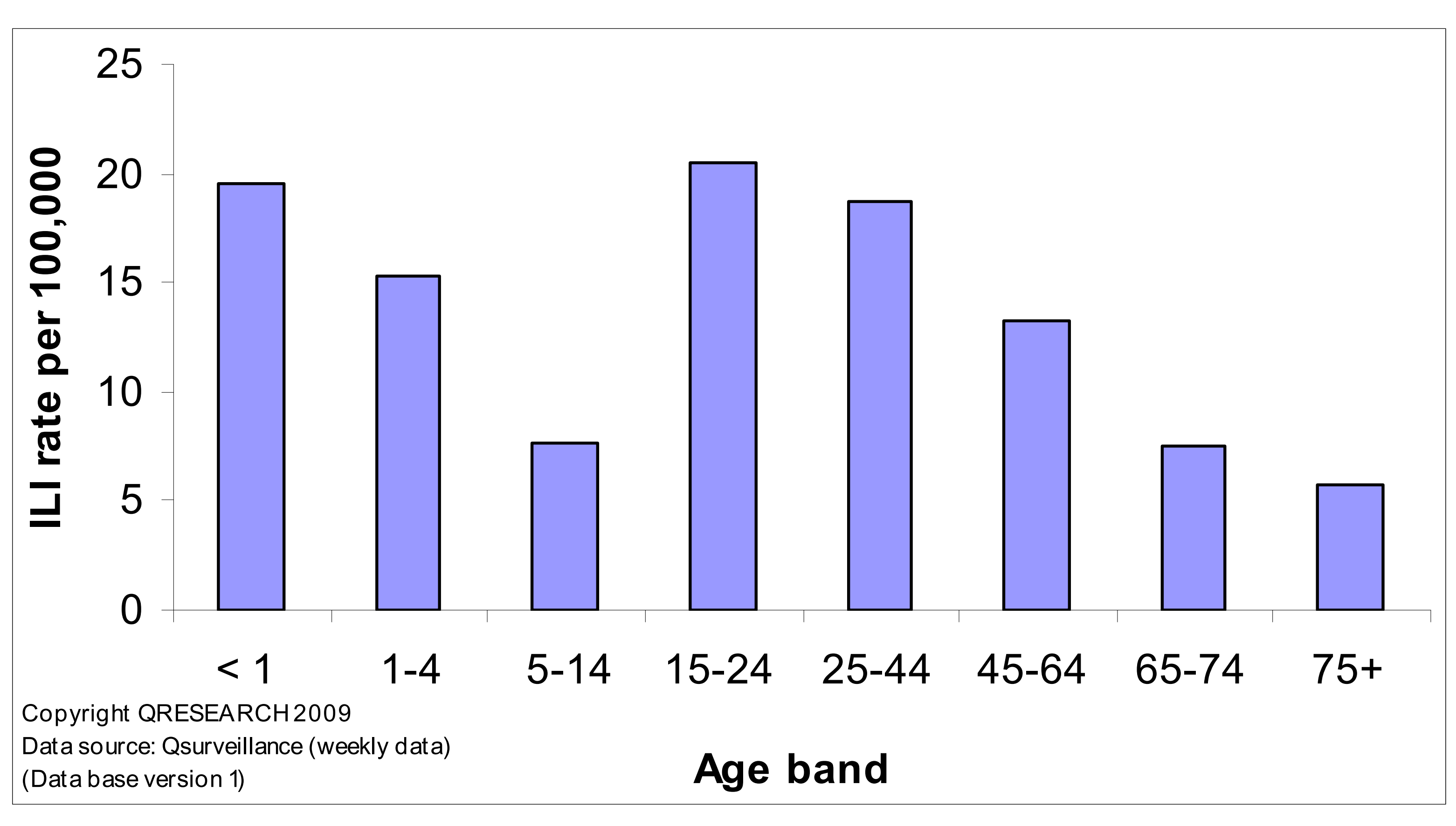
Swine flu progress

- Emerged from Americas therefore early detection and typing
- Came in northern hemisphere summer months
- First UK cases on April 27th – Scottish couple returning from Mexico
- Peaked at Week 28 at 150/100,000 (Seasonal flu of 1999 peaked at 220/100,000 at Week 52)
- First wave now complete
- Not clear if resurgence will occur
- May be less attributable mortality to pandemic swine flu than there was in last year's seasonal flu

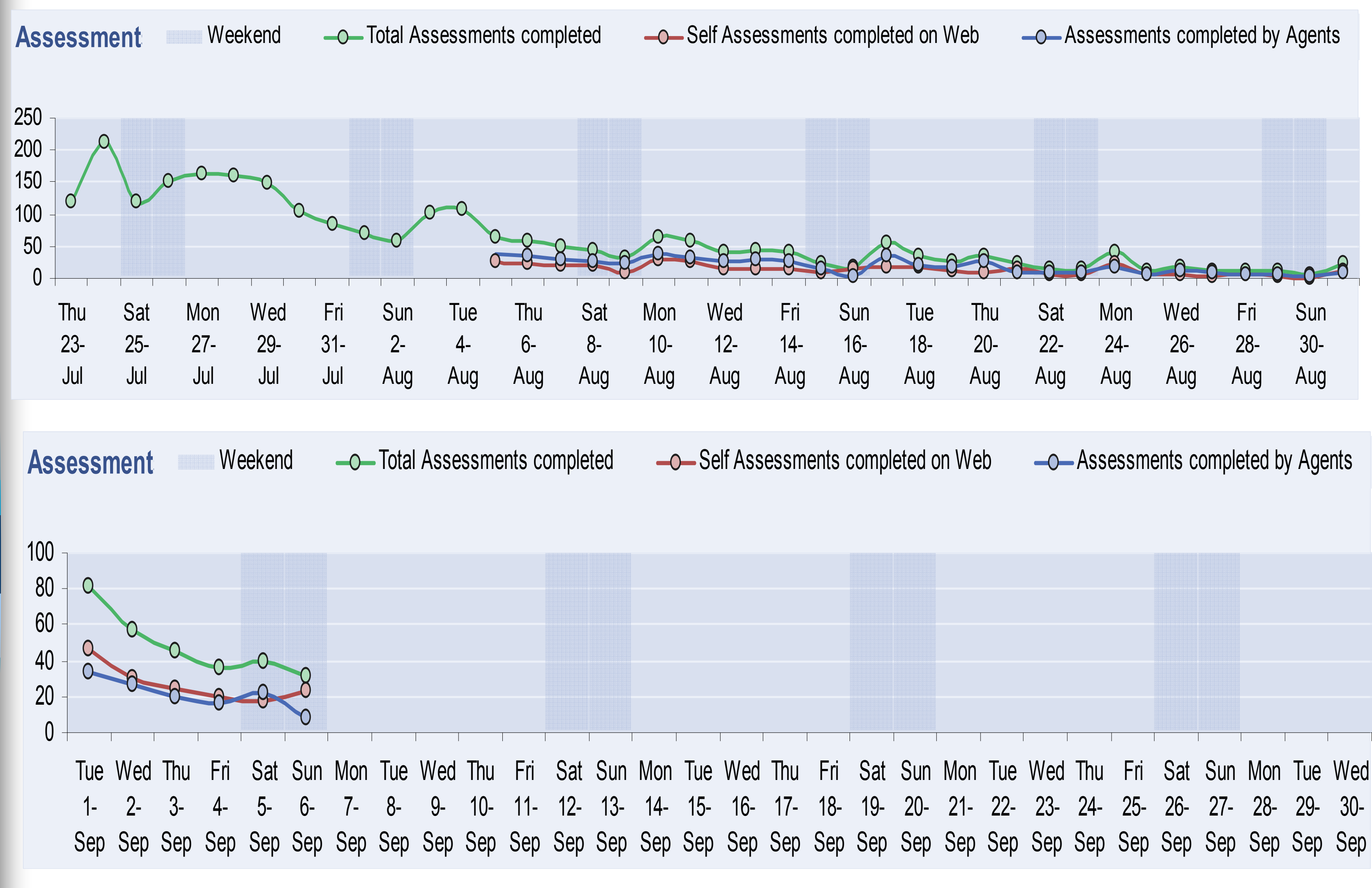
Swine flu features

- Clinically a mild disease in most people
- Severe disease in at-risk groups
- However 20-30% of those severely ill had no co-morbidities
- Questions remain about who should get antivirals
- Typically squeezes out other viruses

Flu surveillance as of August 25th 2009



Antiviral distribution in Brighton and Hove July 23rd – September 6th 2009



Lessons from Australia / NZ

- Population 21 million
- By 11th August: 27,663 confirmed cases, 3281 hospital admissions and 95 deaths
- In NZ 3,208 confirmed cases, 981 hospital admissions, 11% of population infected, 15 deaths
- In 1918/19 pandemic when population 6 million there were 15 000 deaths (95% were from bacterial pneumonia)
- Median age of death 51 years compared with 83 years for seasonal flu
- Pregnant women and obese vulnerable
- This is a new virus and things may change
- Rich countries will be fine, poorer countries will struggle

Monitoring secondary care impact

- Flu-cin (dataset from 5 sentinel hospitals: Liverpool, Imperial College, Leicester, Sheffield and Nottingham (HUB)

- Results available from first 144 hospital admissions (currently > 200 swine flu admissions)

Monitoring secondary care impact - Flu-cin data

- 1% of patients need hospital admission (but subclinical infection rates may be higher than thought)
- 48% of admissions aged 15-44 years
- Co-morbidity in 20% of under 5 years / 90% of > 65 years
- 10% of hospital patients requiring ITU
- Death rate if hospitalised = 3.6%
- Top five co-morbidities: asthma, heart disease, diabetes, COPD and neurological
- Obesity and 3rd trimester pregnancy (x 4 risk of hospitalisation) are also risk factors

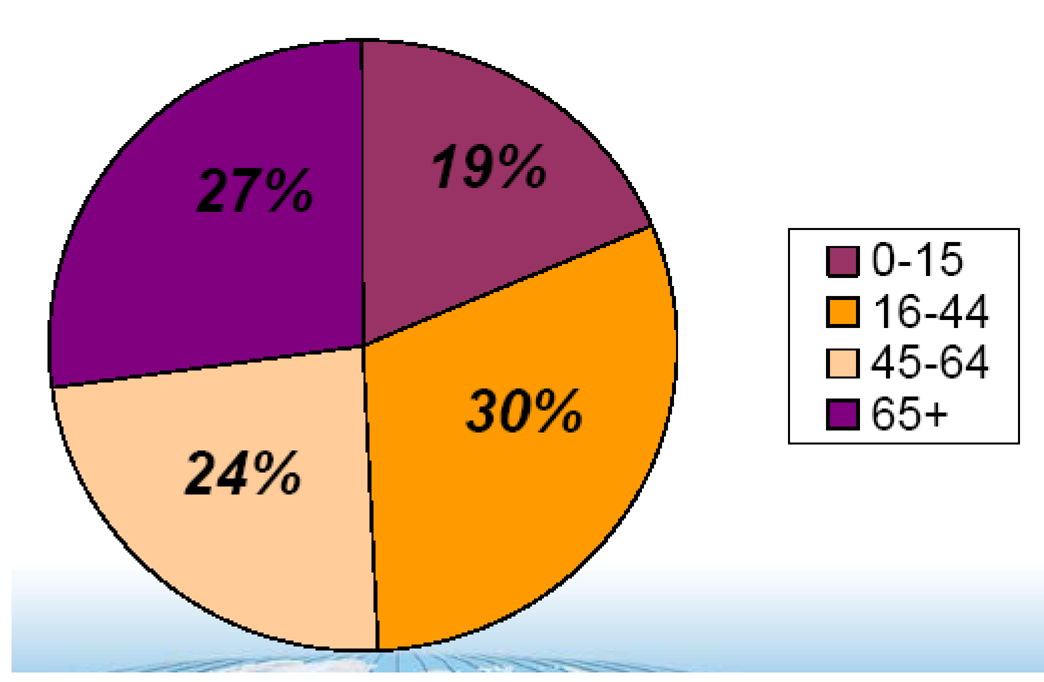
Cumulative number of deaths associated with swine flu in England and Devolved Administrations (03 September 2009)

Number of Deaths

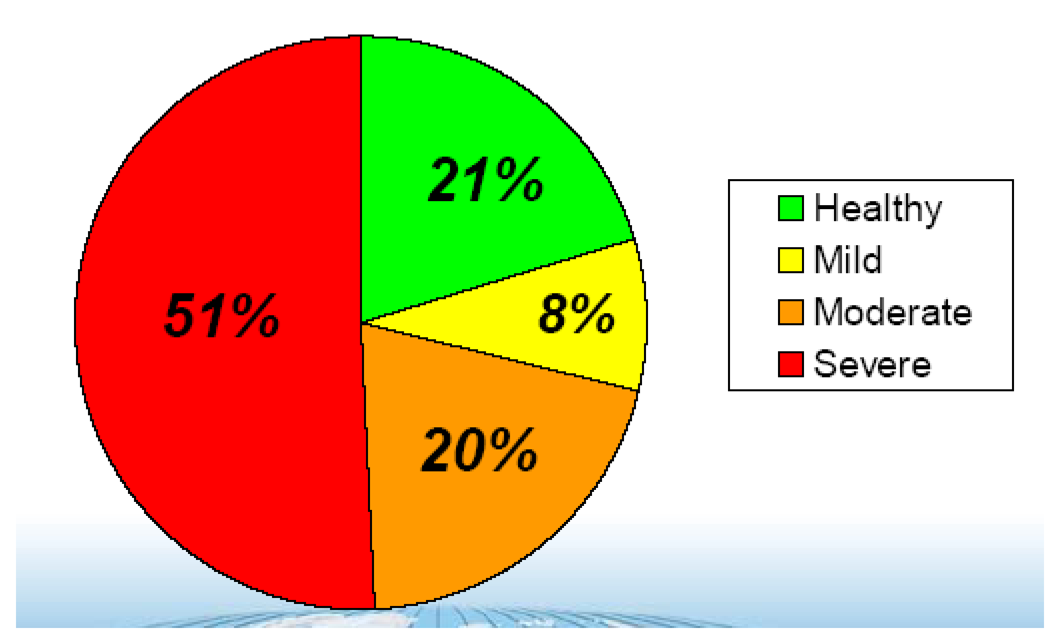
England	61
Scotland	7
Wales	1
N Ireland	1
Total UK	70

- One death has been reported in the Cayman Islands (Overseas Territory)

Age distribution of swine flu deaths in England (as of September 3rd)



Underlying conditions for fully investigated deaths (as of September 3rd)

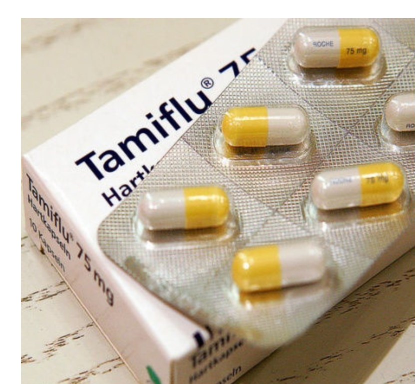


- Fall off in first wave started before school closures
- Susceptibility by age; < 1 year = 1, 15-24 years = 0.55, 25-34 years = 0.44 etc
- 1% of patients need hospital admission
- 48% of admissions aged 15-44 years
- Second wave depends upon how many infected and susceptibility profile of at risk group

Lessons from Eton
Outbreak of swine flu

- Large outbreak in ‘closed community’
- 52% of those with influenza-like illness (ILI) had positive serology for swine flu
- 32% of those with no symptoms of ILI had positive serology for swine flu
- Overall infection rate of 39%
- Presence of fever associated with x 2 chance of positive serology
- Many cases of swine flu may go undetected
- Effects of oseltamivir in the outbreak being analysed

Antivirals



Guidance on use:

- Prevention of a pandemic virus emerging from an outbreak of avian influenza
- Prophylaxis – very limited use
- Treatment of cases / at risk groups

Oseltamivir side effects (% Adults) HPA conference 2009

Adults	SOPC	Placebo	London	SWest	Sheffield
Nausea	10	4	30		31
Abdo pain	2	2	22		8
Diarrhoea	2	1	4		6
Vomiting	1	1	15		6

Oseltamivir side effects (% Children) HPA conference 2009

Children	SOPC	Placebo	London	SWest	Sheffield
Nausea	14		29	33	23
Abdo pain	1		16	21	20
Diarrhoea	1		0	7	6
Vomiting	10		13	11	7

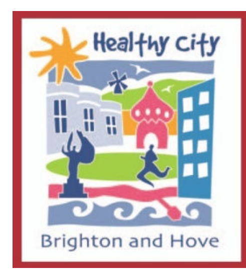
Swine flu vaccination

- Vaccine programme targeted at those at-risk of complications
- Single dose gives 90% protection but two doses gives 95% protection
- Paediatric trials not complete yet
- Limited volume of vaccine available

Pandemic–specific vaccines

- Primary care based vaccination programme
- Guidance just released on September 14th 2009
- Will take place in stages and take several months to complete delivery

Swine flu vaccination



- 6 months to 65 years in seasonal flu at-risk groups (In B&H = 23,000)
- All pregnant women (In B&H = 2,750)
- Household contacts of immuno-compromised (in B&H = 2,600)
- Over 65s in seasonal flu at-risk groups (In B&H = 18,000)
- Front-line staff

Swine flu vaccination

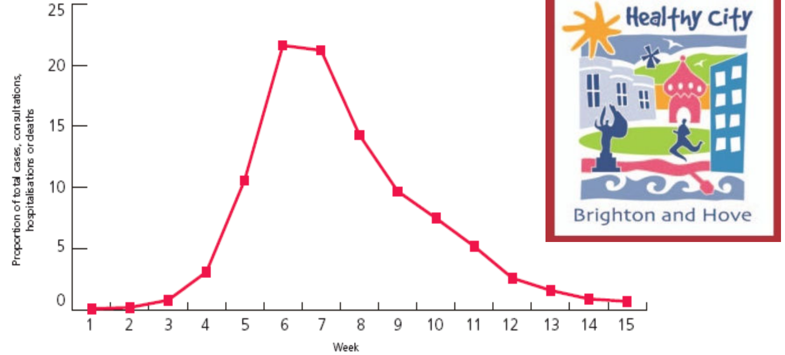
- GPs to receive £5.25 for each H1N1 vaccine given
- 28 QOF points released
- Further QOF changes under discussion
- Routine childhood immunisation data collection for December quarter to be delayed by six weeks
- Practices incentivised to score 3% higher than seasonal flu uptake
- District nurses to vaccinate housebound patients
- LES funding NOT to be withdrawn to pay for vaccine programme

Swine flu vaccination costs in Brighton and Hove

- Seasonal flu vaccine uptake in at-risk groups in B&H in 2008 was 45%, while uptake in over 65s was 71%

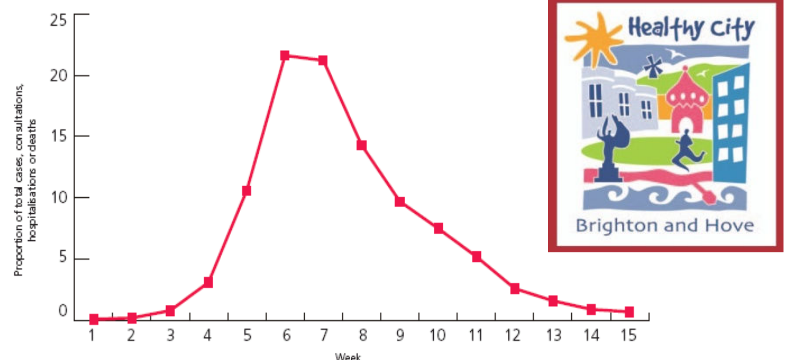
- 50% uptake - £243,000
- 70% uptake - £340,000
- 100% uptake - £480,000
- Vaccine costs to be borne centrally

Surge Capacity



- Prioritisation of services in all sectors of Health and Social Care
- Criteria for admission to and discharge from hospital
- Criteria for continuing care in the community (less than 48 hours or more than 48 hour contact)
- Staff working outside their usual roles and in different locations
- Deployment or retired staff
- ‘Buddying’ of practices and pharmacies
- Host of issues: private schools, homeless people, foreign students, oxygen supplies, PPE supplies, child protection,

Surge Capacity



Revised planning assumptions (September 2009):

- Clinical attack rate - 30%,
- Peak clinical attack rate 4.5–8.0% (mean 6.5%),
- Case complication rate of 15% (equivalent to around 1100 people in B&H),
- Hospitalisation rate of 1% of clinical cases (around 780 people in B&H)
- 25% of hospitalised requiring intensive care
- Case fatality fallen from 0.35% to 0.1%.

Possible impact on the workforce

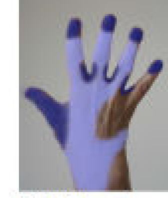
- Up to 50% of the workforce may require time off during the pandemic
- At the peak 15-20% of staff may be absent
- Staff absences will result from caring responsibilities, fear of infection bereavement, and practical issues such as travel problems
- Modelling suggests that smaller units with 5-15 staff should allow for up to 30-35% absenteeism at the peak

Other possible measures

- Coughs and sneezes hygiene campaign – YES
- Restrictions on public gatherings - possible
- School closures – useful <u>local</u> measure during peak
- Restrictions on international travel - no
- Restrictions on local public travel – very unlikely

What should health staff do?

- Adhere to hygiene measures
- Be prepared to work outside of normal role
- Cooperate with planning measures



Back (dorsum)

Front (palm)

- Start making home preparations
  Simple analgesia and flu remedies
  ‘Buddy with friends for transport and for school closures’
- Remember that flu work will take priority

Healthy City
Brighton and Hove

CATCH IT

Germs spread easily. Always carry tissues and use them to catch your cough or sneeze.

BIN IT

Germs can live for several hours on tissues. Dispose of your tissue as soon as possible.

KILL IT

Hands can transfer germs to every surface you touch. Clean your hands as soon as you can.

Flu monitoring and management

- Initially led by Professor Lindsey Davis – National Director of Pandemic Flu since April 2006 (DoH, Prof PH and Epidemiology at University of Nottingham)
- May 2009 - Ian Dalton appointed National Director for NHS flu resilience (Former CEO of NHS Northeast)
- Daily sitrep: flu deaths, antivirals distributed, antiviral stock.
- Weekly teleconferences Sussex
- Twice weekly teleconferences – south east coast
- Weekly MART-flu
- Local 'exclusive' Director-level Flu lead
- Pandemic tool ' to assist in planning' : command and control, governance, cross-sector plans, communications, resilience and business continuity, workforce skills, redeployment and communications, vulnerable groups, flu recovery, finance…
- Board Assurance

Lessons from
Pandemic Influenza in Brighton
1968
Hong Kong Flu H3N2

Impact of Hong Kong flu

- Fewer people died during this pandemic than the two previous pandemics for various reasons
- The pandemic did not gain momentum until near the winter school holidays
- The same virus returned the following years: a year later, in late 1969 and early 1970, and in 1972.

Further information

Health Protection Agency website:
http://www.hpa.org.uk/

Department of Health website:
http://www.dh.gov.uk/en/Publichealth/Flu/PandemicFlu/index.htm

Royal College of General Practitioners
http://www.rcgp.org.uk/clinical_and_research/pandemic_planning/H1N1_Advice_Reference_Table.aspx

Pandemic Flu -2009 UPDATE

HOSC

NHS Brighton and Hove

September 30th 2009

THANK YOU

Dr. Tom Scanlon
Director of Public Health

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	Agenda Item 22 Brighton & Hove City Council

Subject:		**Brighton & Sussex University Hospitals Trust: NHS Foundation Trust Application**	
Date of Meeting:		**30 September 2009**	
Report of:		**The Director of Strategy and Governance**	
Contact Officer:	Name:	Giles Rossington	Tel: 29-1038
	E-mail:	Giles.rossington@brighton-hove.gov.uk	
Wards Affected:	All		

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 Brighton & Sussex University Hospitals Trust (BSUHT) has recently announced that it has begun the process of applying to become an NHS Foundation Trust (FT).

1.2 The statutory powers granted to Health Overview & Scrutiny Committees (HOSCs) by the Health and Social Care Act (2001) do not apply to the FT application process: the HOSC has no formal role in determining whether a trust's decision to apply to become an FT is in the best interests of local residents; nor does the HOSC have a statutory role in determining whether a trust's public/stakeholder consultation in regard to an FT application has been of satisfactory quality and/or scope.

1.3 However, BSUHT has expressed the desire to engage fully with HOSC on this issue, and the trust has consequently requested the opportunity to explain its FT application plans to members. BSUHT has also offered a place on its Foundation Trust Project Board to a representative of the HOSC.

2. RECOMMENDATIONS:

2.1 That members agree Brighton & Sussex University Hospital Trust's plans for its NHS Foundation Trust application.

3. BACKGROUND INFORMATION

3.1 NHS Foundation Trusts are independent public benefit corporations which provide NHS care and which are subject to NHS standards, performance ratings and systems of inspections.

3.2 Foundation Trusts draw a representative public membership from their catchment area. Members then vote for Governors, who will constitute the FT Board of Governors, together with Governors representing the staff and stakeholders.

3.3 The Board of Governors, or Council of Governors, has a very clear and important role. Amongst other functions the Board:

- Holds the Board of Directors to account
- Appoints (or removes) the Chairman and Non Executive Directors and agrees their terms and conditions
- Appoints (or removes) the auditor
- Approves the appointment by the Non Executive Directors of the Chief Executive
- Must be involved with the forward plans of the Trust and be presented with the Annual Plan (or business plan for the coming year).

3.4 FTs have greater autonomy than existing NHS trusts: for instance, they are not performance managed by the Strategic Health Authority or the Department of Health. FTs have considerable flexibility regarding their finances: for instance they may retain any financial surplus and they may also borrow commercially, investing in better and more efficient clinical services where innovation is expected.

3.5 The Department of Health intends that all NHS 'provider' trusts should have sought FT status by the end of 2010. Trusts which have not achieved FT status after this point may be vulnerable to being broken up or taken over by successful FTs.

3.7 In order to become FTs, aspirant trusts must apply (with the approval of their Strategic Health Authority) to Monitor, the FT regulator. The application process is both lengthy and involved, with a particular concentration on a trust's medium and long term financial sustainability (FTs have to meet a considerably higher standard in this respect than do non-FT NHS trusts).

3.8 FTs are accountable to local communities through their Board of Governors. To this end, Monitor requires that aspirant trusts consult widely prior to their formal FT application - not about whether they

become a foundation trust, but on aspects of their FT application, for instance the structure of the Board of Governors. All sections of the community, stakeholders and staff are expected to be consulted.

3.9 An important part of this process consists of a trust determining which communities it actually represents and devising an appropriate governance structure. For some trusts this may be relatively straightforward, but for BSUHT this is bound to present a challenge, as the trust operates major hospitals in Brighton and in Hayward's Heath (providing general acute care for the people of Brighton & Hove and the people of Mid Sussex) as well as offering a range of tertiary services for the whole of Sussex and some very specialist services on a regional basis (i.e. to people in parts of Kent and Surrey as well as the entirety of Sussex). The FT's governance structure must therefore reflect the needs of all these differing constituencies.

3.10 Whilst the HOSC has no formal role in approving an FT application, members may be interested in expressing opinions about elements of BSUHT plans, perhaps particularly in terms of the degree to which the trust intends to maintain a focus on the needs of Brighton & Hove residents via its new governance arrangements.

4. CONSULTATION

4.1 This report has been compiled with the assistance of officers from Brighton & Sussex University Hospitals Trust.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are none to this report for information.

Legal Implications:

5.2 *"There are no legal implications arising from this report."*
Lawyer Consulted: Elizabeth Culbert; Date: 27/08/09

Equalities Implications:

5.3 Foundation Trusts are responsible to their 'members': staff, patients and local residents who elect the trust's Governors and influence the organisation's strategic direction. It is important that a Foundation Trust's membership reflects the entire community, including groups of people who may prove 'hard to reach' via generalist modes of communication. Members may therefore wish to ascertain how BSUHT plans to engage with these groups in order to ensure that trust membership reflects the entire local community.

Sustainability Implications:

5.4 None identified

Crime & Disorder Implications:

5.5 None

Risk and Opportunity Management Implications:

5.6 None identified

Corporate / Citywide Implications:

5.7 None identified

SUPPORTING DOCUMENTATION

Appendices:

None

Documents in Members' Rooms:

None

Background Documents:

None

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	Agenda Item 23 Brighton & Hove City Council

Subject:		**South East Coast Ambulance Trust (SECamb): NHS Foundation Trust Application**		
Date of Meeting:		**30 September 2009**		
Report of:		**The Director of Strategy and Governance**		
Contact Officer:	Name:	Giles Rossington	Tel:	29-1038
	E-mail:	Giles.rossington@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 South East Coast Ambulance Trust (SECamb) has recently announced that it has begun the process of applying to become an NHS Foundation Trust (FT).

1.2 The statutory powers granted to Health Overview & Scrutiny Committees (HOSCs) by the Health and Social Care Act (2001) do not apply to the FT application process: the HOSC has no formal role in determining whether a trust's decision to apply to become an FT is in the best interests of local residents; nor does the HOSC have a statutory role in determining whether a trust's public/stakeholder consultation in regard to an FT application has been of satisfactory quality and/or scope.

1.3 However, SECamb has expressed the desire to engage fully with local HOSCs on this issue, and the trust has consequently requested the opportunity to explain its FT application plans to members.

2. RECOMMENDATIONS:

2.1 That members approve South East Coast Ambulance Trust's preparations for its NHS Foundation Trust application.

3. BACKGROUND INFORMATION

3.1 NHS Foundation Trusts are independent public benefit corporations that provide NHS care and which are still subject to NHS standards, performance ratings and systems of inspections.

3.2 Foundation Trusts have a representative public membership from their catchment area. Members then vote for Governors, who form the Board of Governors together with Governors representing the staff and stakeholders.

3.3 The Board of Governors, or Council of Governors, has a very clear and important role. Amongst other functions the Board:

- Holds the Board of Directors to account
- Appoints (or removes) the Chairman and Non Executive Directors and agrees their terms and conditions
- Appoints (or removes) the auditor
- Approves the appointment by the Non Executive Directors of the Chief Executive
- Must be involved with the forward plans of the Trust and be presented with the Annual Plan (or business plan for the coming year).

3.4 FTs have greater autonomy than existing NHS trusts: for instance, they are not performance managed by the Strategic Health Authority nor the Department of Health. FTs have considerable flexibility regarding their finances: for instance they may retain any financial surplus and they may also borrow, investing in better and more efficient clinical services where innovation is expected.

3.5 The Department of Health intends that all NHS ‘provider’ trusts should have sought FT status by the end of 2010. Trusts which have not achieved FT status after this point may be vulnerable to being broken up or taken over by successful FTs.

3.7 In order to become FTs, aspirant trusts must apply (with the approval of their Strategic Health Authority) to Monitor, the FT regulator. The application process is both lengthy and involved, with a particular concentration on a trust’s medium and long term financial sustainability (FTs have to meet a considerably higher standard in this respect than do non-FT NHS trusts).

3.8 FTs are accountable to local communities through the Board of Governors. To this end, Monitor requires that aspirant trusts consult widely prior to their FT applicants, not about whether they become a

foundation trust, but on aspects of their FT application, for instance the structure of the Board of Governors. All sections of the community, stakeholders and staff are expected to be consulted.

3.9 Whilst the HOSC has no formal role in approving an FT application, members may be interested in expressing opinions about elements of SECamb plans.

4. CONSULTATION

4.1 No formal consultation has been undertaken in relation to this report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are none to this report for information.

Legal Implications:

5.2 *There are none to this report.*

Equalities Implications:

5.3 Foundation Trusts are responsible to their 'members': staff, patients and local residents who elect the trust's Governors and influence the organisation's strategic direction. It is important that a Foundation Trust's membership reflects the entire community, including groups of people who may prove 'hard to reach' via generalist modes of communication. Members may therefore wish to ascertain how BSUHT plans to engage with these groups in order to ensure that trust membership reflects the entire local community.

Sustainability Implications:

5.4 None identified

Crime & Disorder Implications:

5.5 None

Risk and Opportunity Management Implications:

5.6 None identified

Corporate / Citywide Implications:

5.7 None identified

SUPPORTING DOCUMENTATION

Appendices:
None

Documents in Members' Rooms:
None

Background Documents:
None

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	**Agenda Item 24** Brighton & Hove City Council

Subject:		**NHS Brighton & Hove Response to HOSC Ad Hoc Panel Recommendations regarding the Brighton & Hove GP-Led Health Centre**		
Date of Meeting:		**30 September 2009**		
Report of:		**The Director of Strategy and Governance**		
Contact Officer:	Name:	Giles Rossington	Tel:	01273 29-1038
	E-mail:	Giles.rossington@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report presents NHS Brighton & Hove's response to the recommendations made by the HOSC ad hoc panel set up to consider the PCT's procurement of a city GP-Led Health Centre.

2. RECOMMENDATIONS:

2.1 That members note NHS Brighton & Hove's response (see **Appendix 1**) to the ad hoc panel's recommendations.

3. BACKGROUND INFORMATION

3.1 At its 04.03.09 meeting, HOSC agreed to form an ad hoc panel to look at issues relating to NHS Brighton & Hove's procurement of a city GP-Led Health Centre. The panel reported back to HOSC at its 08.07.09 committee meeting, where the panel's recommendations were endorsed by the full committee. The HOSC Chairman subsequently wrote to the Chief Executive of NHS Brighton & Hove, requesting a formal response to these recommendations.

3.2 In essence, the panel's work consisted of examining the process by which NHS Brighton & Hove had contracted for running a city centre GP surgery with extended opening hours. This was part of a national initiative to improve access to primary care, particularly for people who

are not registered with a GP or who are temporarily unable to access their own GP (e.g. commuters, tourists etc).

3.3 Particular concerns included the reputation of the successful bidder for the contract, whether NHS Brighton & Hove had undertaken adequate public consultation in respect of this contract, and whether the competitive tender process favoured particular types of bidder (i.e. large and/or independent sector concerns).

3.4 In general the panel found that NHS Brighton & Hove had acted in accordance with best practice at all stages of the tender, with the contract being awarded to the most competitive bidder, and with an adequate degree of public consultation/involvement. However, the panel did have some concerns and ideas about this tender, and about NHS competitive tenders in general, and these were embodied in a series of recommendations to NHS Brighton & Hove.

3.5 The ad hoc panel's recommendations were:

(1) The Panel recommends that NHS Brighton & Hove pays particular attention to monitoring the GP-Led Health Centre contract, given Care UK's uneven record as a provider of high quality healthcare;

(2) The Panel recommends that HOSC should request a report from NHS Brighton & Hove on its strategy to improve the commercial competitiveness of local health care providers;

(3) The Panel recommends that HOSC requests a comprehensive update on the above issues, to be received after the GP-Led Health Centre has been in operation for twelve months or so;

(4) The Panel commends NHS Brighton & Hove for its constructive approach to sharing information in relation to the GP-Led Health Centre. It is to be hoped that the PCT will be similarly open in terms of other procurements, and will endeavour to place as much information about tenders as possible in the public domain;

(5) When it launches future initiatives, NHS Brighton & Hove should give serious consideration to ensuring that there is a method via which members of the public can present their views, even in situations where full public consultation would not be appropriate.

3.6 NHS Brighton & Hove's formal response to the ad hoc panel recommendations is reprinted in **Appendix 1** to this report . In brief, the PCT has agreed to undertake or is already undertaking all the panel's recommendations. The ad hoc panel report and the NHS Brighton &

Hove response will be presented for information to a future Full Council meeting.

4. CONSULTATION

4.1 No formal consultation has been undertaken in preparing this report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this report for information

Legal Implications:

5.2 *"The Health and Social Care Act 2001 Sections 7-10 and the Overview and Scrutiny Health Function Regulations 2002 set out the legal powers for Local Authority Overview and Scrutiny Committees in relation to health issues and the duties of the NHS to support those powers. The powers of HOSC include reporting to the Secretary of State where it feels that the proposal would not be in the interests of the health service in the area."*

Lawyer Consulted: Elizabeth Culbert; Date: 27/08/09

Equalities Implications:

5.3 None identified

Sustainability Implications:

5.4 None identified

Crime & Disorder Implications:

5.5 None identified

Risk and Opportunity Management Implications:

5.6 None identified

Corporate / Citywide Implications:

5.7 None identified

SUPPORTING DOCUMENTATION

Appendices:

1. NHS Brighton & Hove’s formal response to the ad hoc panel recommendations

Documents in Members’ Rooms:

None

Background Documents:
None

1st September 2009

NHS Brighton and Hove
Prestamex House
171 – 173 Preston Road
Brighton BN1 6AG

Direct Line: 01273 545327
darren.grayson@bhcpct.nhs.uk

Councillor Garry Peltzer Dunn
Chairman
Brighton and Hove Health Overview & Scrutiny Committee (HOSC)
PO Box 2500
Kings House
Grand Avenue
Hove
BN3 2SR

Dear Councillor Peltzer Dunn,

Brighton & Hove GP-Led Health Centre

Thank you for sending me a copy of the Health Overview & Scrutiny Committees ad hoc scrutiny panels report and recommendations into the tendering process of the GP-Led Health Centre. As discussed briefly at the last HOSC, PCT staff were pleased to be involved and to have the opportunity to discuss the tendering process.

The following is the PCTs response to the recommendations detailed in the report:

The Panel recommends that NHS Brighton & Hove pays particular attention to monitoring the GP-Led Health Centre contract, given Care UK's uneven record as a provider of high quality healthcare not going to achieve on a particular indicator.

The Alternative Provider Medical Services (APMS) contract allows stronger contract and performance management. There are more than 40 performance indicators which must be achieved or financial penalties kick in. There is no additional payment for high performance except under the Quality and Outcomes Framework[1].
Care UK is required to notify the PCT if it thinks it is not going to achieve on a particular indicator. Care UK is also required to collate quarterly reports on activity including any issues that arise, such as serious untoward incidents.

The Panel recommends that HOSC should request a report from NHS Brighton & Hove on its strategy to improve the commercial competitiveness of local health care providers.

The PCT is currently revising its procurement strategy and developing a detailed market management strategy. Key to this will be a consideration of how the PCT can support the

[1] Quality and Outcome Framework is a national scheme to reward GP practices that reach the standards laid out in the framework. These cover a range or clinical and organisational standards such as the management of patients with long term health conditions which includes an indicator 'The percentage of patients with diabetes who record a retinal screening in the previous 15 months'

development of all local health care providers, whether those who currently provide services or potential new providers. This will include issues around commercial competitiveness, although the PCT has to balance regard for local provision with compliance with procurement legislation. The market management strategy is intended for completion by October 2009, and the PCT would be more than willing to involve the HOSC.

The Panel recommends that HOSC requests a comprehensive update on the above issues, to be received after the GP-Led Health Centre has been in operation for twelve months or so.

This information can be provided to HOSC when requested. These will be based on the quarterly reports provided by Care UK.

The Panel commends NHS Brighton & Hove for its constructive approach to sharing information in relation to the GP-Led Health Centre. It is to be hoped that the PCT will be similarly open in terms of other procurements, and will endeavour to place as much information about tenders as possible in the public domain.

The PCT takes seriously its role in managing public money, and aims to be open and transparent about all the activities in which it engages. The PCT will continue to make available the fullest possible range of information about procurement activity and outcomes via its website and in response to any queries received.

When it launches future initiatives, NHS Brighton & Hove should give serious consideration to ensuring that there is a method via which members of the public can present their views, even in situations where full public consultation would not be appropriate.

NHS Brighton and Hove will ensure that all significant future initiatives are notified online and comments are invited from the public.

If you require any further information please let me know.

Yours sincerely

Darren Grayson
Chief Executive

cc: Denise Stokoe, Chair, NHS Brighton and Hove

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	Agenda Item 25 Brighton & Hove City Council

Subject:		**Health Overview & Scrutiny Committee (HOSC) Work Programme 2009-2010**		
Date of Meeting:		**30 September 2009**		
Report of:		**The Director of Strategy and Governance**		
Contact Officer:	Name:	Giles Rossington	Tel:	01273 29-1038
	E-mail:	Giles.rossington@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report sets out a number for subjects for potential inclusion in the 2009-2010 HOSC work programme. Some of these subjects represent ongoing HOSC work; others are referrals from Councillors or from local NHS trusts.

1.2 Members are requested to choose subjects from this list (and any additional subjects they may wish to consider) to populate the 2009-2010 committee work programme.

2. RECOMMENDATIONS:

2.1 That members agree a 2009-2010 work programme with reference to the work programme suggestions reprinted in **Appendix 1** to this report

3. BACKGROUND INFORMATION

3.1 Work programmes allow Overview & Scrutiny (O&S) committees to plan effectively, permit officers and partner organisations to prepare timely reports and ensure that the appropriate people are able to attend meetings, and enable the Overview & Scrutiny Commission to better oversee the work of scrutiny (by eliminating pointless duplication etc.)

3.2 In developing the 2009-2010 work programme, HOSC has asked for input from:

(a) HOSC members
(b) All Brighton & Hove City Council Councillors (including members of the Council's Executive)
(c) Senior council officers (e.g. the Director of Public Health and the Director of Adult Social Care and Housing)
(d) Local NHS trusts
(e) The Brighton & Hove Local Involvement Network (LINk)
(f) The Brighton & Hove Older People's Council (OPC)
(g) Key city organisations (i.e. members of the Local Strategic Partnership)
(h) City voluntary sector organisations (via the Community and Voluntary Sector Forum)

3.3 **Appendix 1** to this report lists the ideas for work programme items which have been received. In each instance, there is a brief description of the topic put forward, a suggestion as to the best way to present it, and information on the person or body who referred the idea. In some instances (e.g. where HOSC has previously requested an update on an issue in 6 months or a year's time, or when senior officers from an organisation are only available on a limited number of dates), a provisional date for the item has been suggested. Members are not being asked to determine dates for items which currently have no date attached, as this will require detailed negotiation with our health partners.

3.4 Members are asked to choose an annual work programme from the items suggested (and any other items they may wish to include).

3.5 The HOSC is obliged by statute to consider formal referrals from the Brighton & Hove LINk. The Council's constitution also requires HOSC to consider Notices of Motion referred from Full Council, Councillor Questions and Public Questions. The HOSC is not *obliged* to consider any other referrals or requests for work (e.g. referrals from NHS trusts, the OPC etc.), although there may be compelling reasons for it to do so.

3.6 HOSC members are not required to accept all or any of the recommended topics listed in **Appendix 1** to this report. However, if they do not wish to pursue a topic, members may wish to explain why they have come to this decision, so that this information can be relayed to the referrer.

3.7 The HOSC work programme is only intended as a guide to the committee's plans for the coming year. There are bound to be issues arising throughout the year which the committee wishes to address, and in-year referrals from NHS trusts, the LINk, ward Councillors etc.

4. CONSULTATION

4.1 Informal consultation has been undertaken with the individuals/bodies listed in 3.2 above.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None directly. The HOSC work programme will be delivered within existing officer resource allocations.

Legal Implications:

5.2 *"There are no legal implications arising from this report."*

Lawyer Consulted: Elizabeth Culbert; Date: 27/08/09

Equalities Implications:

5.3 Members should consider equalities issues when agreeing a HOSC work programme (e.g. do the topics chosen reflect concerns of residents from all city communities, and particularly those of communities which may experience health inequalities – i.e. BME communities, LGBT communities, deprived communities, older people)?

Sustainability Implications:

5.4 None directly, but some work programme ideas (e.g. plans to make major changes to NHS estates, or to move services to/from community settings) may have sustainability implications.

Crime & Disorder Implications:

5.5 None directly, but some work programme ideas (e.g. plans to make changes to substance misuse services) may have crime and disorder implications.

Risk and Opportunity Management Implications:

5.6 None identified.

Corporate / Citywide Implications:

5.7 An effective scrutiny function is likely to be one which contributes to broader attempts to improve city services. To this end, members may wish to ensure that the 2009-2010 HOSC work programme is aligned with corporate priorities, Local Strategic Partnership priorities and, particularly, with the NHS Brighton & Hove priorities for service improvement (as detailed in the current NHS Brighton & Hove Annual Operating Plan).

SUPPORTING DOCUMENTATION

Appendices:

1. List of suggested topics for the 2009-2010 HOSC work programme

Documents in Members' Rooms:

None

Background Documents:

1. The NHS Brighton & Hove Annual Operating Plan 2009-2010

Appendix 1

Suggested topics for the 2009-2010 HOSC Work Programme

1 Annual Health Check (2008-2009) Report Back

Suggested Format: report (by HOSC support officers) detailing performance of local NHS trusts, cross-referenced against 07-08 performance and 08-09 average performances across the NHS

Reason: To enable HOSC to keep abreast of general local NHS performance and to identify any particular areas of concern re: the performance of local trusts

Possible Date: 02 December

Referred: HOSC officers

2 Care Quality Commission (CQC) 2009-2010 assessment of NHS trusts – opportunity for 3rd party comments

Suggested Format: report (by HOSC support officers) offering members the opportunity to make comments on local NHS trusts for submission to CQC (or to delegate this responsibility to officers)

Reason: opportunity for HOSC to influence CQC (but may not be worthwhile to make very detailed comments unless there is something of particular concern to members)

Possible Date: TBC

Referred: HOSC officers

3 Patient Experience/Quality/Outcomes

Suggested Format: presentation/report by PCT/BSUH officers
Presentation to include information on: CQUIN, PROMs, real time reporting of patient experience.

Reason: A major facet of current NHS thinking is directed at better capturing patient experience of NHS healthcare and at assessing and recording the outcomes of healthcare interventions – looking at what good a treatment has done rather than just measuring the numbers of treatments undertaken. (At times there may be an objective measure of the success of a procedure – i.e. no further acute admittances etc – but often, outcomes can only be measured by gauging patient opinion – i.e. do you believe that undergoing a procedure improved your health?

– hence the need to take patient experience and outcome reporting together.)

Possible Date: TBC

Referred: BSUH

4 3T Progress Report

Suggested Format: presentation by officers of BSUH

Reason: This is an ongoing piece of work, and a very important one in terms of the local health economy (and the city economy)

Date: 27 January 2010

Referred: BSUH

5 BSUH Foundation Trust application

Suggested Format: presentation by officers of BSUH

Reason: This is an ongoing piece of work, and HOSC should be kept informed of the progress of this application (as with SPFT's FT application)

Possible Date: TBC

Referred: BSUH

6 Immunisation/Vaccination

Suggested Format: report by PCT/Director of Public Health and/or possible ad hoc panel

Reason: city vaccination rates (esp. for MMR) are, in some instances, well below national averages (and well below the threshold needed to grant 'herd immunity' to the general population). There might be value in HOSC looking at this issue re: why the city may not be performing well (if low rates of immunisation are indeed a cause for concern), what steps might be taken to improve performance etc

Possible Date: 27 January 2010

Referred: Cllr Jason Kitcat

7 Dental Services

Suggested Format: report from PCT

Reason: HOSC looked at city dental services in March 2009 and resolved to receive an update in 6 months time

Date: 02 December 2009

Referred: from earlier HOSC meeting

8 Swine Flu

Suggested Format: Ad Hoc Panel/Select Committee.

Reason: To gauge performance of city emergency planning re: flu pandemic and suggest ways in which planning for future eventualities might be improved/ensure that recent good practice is repeated in future emergencies

Possible Date: after pandemic threat has peaked (early 2010?)

Referred: HOSC officers

9 Breast Cancer Screening

Suggested Format: Report/presentation from PCT/BSUH

Reason: HOSC requested a 6 monthly update when it last reviewed this issue (July 09)

Possible Date: 27 January 2010

Referred: from earlier HOSC meeting

10 South Downs Health Trust integration with West (and East) Sussex Community Services

Suggested Format: Report/presentation from SDH

Reason: ongoing monitoring role for HOSC re: significant changes to community healthcare provision across Sussex. Particular need to focus on any potential impact upon city residents and upon BHCC S75 arrangements with SDH

Possible Date: TBC

Referred: from earlier HOSC meeting; suggested by Cllr Mo Marsh

11 Sussex Partnership Foundation Trust development of B&H services

Suggested Format: presentation from SPFT (Richard Ford)

Reason: regular item at HOSC meetings; particular interest re: SPFT plans for city acute dementia beds, and more generally the need to ensure that SPFT services continue to meet the needs of city residents

Possible Date: December 2009

Referred: SPFT; Cllr Kevin Allen

12 Revision of the City Working Age Mental Health Commissioning Strategy

Suggested Format: Report from the commissioners of WAMH services (PCT and BHCC)

Reason: ongoing: HOSC received an initial report on the WAMH revision in July 09, and is due to receive an additional report when the revised strategy has been completed

Possible Date: TBC (Jan/March 2010?)

Referred: city commissioners

13 LINk Update

Suggested Format: Report/presentation from LINk host officers/LINk members

Reason: regular item giving members update on progress of the B&H LINk

Possible Date: Jan 2010?

Referred: regular HOSC item

14 Sussex Orthopaedic Treatment Centre Update

Suggested Format: Report/presentation from PCT/Care UK detailing performance of SOTC (re: areas of concern identified by HOSC in Nov 08)

Reason: Chance for HOSC to determine whether there are still issues re: performance at SOTC (still some areas of concern after last examination of SOTC)

Possible Date: May 2010

Referred: by HOSC members (following earlier scrutiny of this issue)

15 Public Health

Suggested Format: Presentation by Director of Public Health re: his annual report. Possible work (e.g. ad hoc panel) arising from this?

Reason: Opportunity for HOSC to engage with public health agenda (key part of committee remit)

Possible Date: TBC

Referred: Director of Public Health

16 PCT Annual Operating Plan (Strategic Commissioning Plan)

Suggested Format: Report from PCT

Reason: Opportunity for HOSC to examine annual city commissioning plans for coming year

Possible Date: December 2009

Referred: anticipated referral from PCT

17 Ad Hoc Panel Report on the B&H GP-Led Health Centre: 12 Month Update

Suggested Format: Report from PCT/HOSC officers

Reason: Opportunity to assess performance of GP-Led Health Centre in its first year of operation

Possible Date: May 2010 (or first meeting of 10/11 cycle)

Referred: Recommendation from the ad hoc panel report on the GP-Led Health Centre, agreed by HOSC (8 July 2009)

18 Improving the Commercial Competitiveness of Local Healthcare Providers

Suggested Format: Report/presentation by PCT

Reason: The NHS marketplace is increasingly competitive in terms of healthcare contracts going out to commercial tender. If established local healthcare providers (across all sectors: i.e. NHS trusts, 3rd sector, independents) cannot compete effectively with national/international competition, their role in the LHE will dwindle. There is therefore a potential role for the PCT to appropriately support these providers so as to ensure a continuing local presence in the LHE

Possible Date: March 2010

Referred: Recommendation of the ad hoc scrutiny panel on the GP-Led Health Centre (endorsed by HOSC July 08 2009)

19 Alcohol Related Hospital Admissions

Suggested Format: report from PCT/Director of Public Health. Possible further work (i.e. ad hoc panel)

Reason: The Overview & Scrutiny Commission (OSC) recently decided that O&S committees should include relevant red LAA indicators in their work programmes for in-depth investigation. The red indicator which falls within the remit of HOSC is ***NI 39: rate of alcohol related admissions to hospitals***

Possible Date: March 2010

Referred: from OSC

20 Fit For the Future

Suggested Format: report from HOSC officers

Reason: The Joint HOSC on the 'Fit For the Future' plans to reconfigure acute healthcare in West Sussex is due to reconvene in Autumn 2009, when implementation of Fit For the Future resumes (it was suspended pending the merger of Royal West Sussex and Worthing and Southlands hospital trusts). The HOSC will need updating about the end result of this process (should this occur in 2009-10), and may need to take a view on whether it should monitor aspects of the reconfiguration once the JHOSC has been disbanded (e.g. impacts upon B&H residents of changes made at Worthing or Hayward's Heath hospitals).

Possible Date: TBC

Referred: ongoing HOSC/JHOSC work

21 Community/Acute Mental Health Services

Suggested Format: report from PCT/SPFT/ASC. Possible further work (in committee or via ad hoc panel)

Reason: Look at whether current policy of maintaining people with MH conditions in the community has an impact upon other services (e.g. police, housing, ASC) which has not been formally agreed/approved by local partnerships

Possible Date: TBC

Referred: Cllr Anne Meadows

22 Older People's Care/EMI Nursing Care

Suggested Format: Report from PCT/ASC

Reason: Look at provision of healthcare for older people, particularly in terms of nursing care for older people with mental health problems.

Possible Date: TBC

Referred: Cllr Dawn Barnett

23 Discharge From Hospital

Suggested Format: Report from BSUH

Reason: Examine the criteria for discharging patients from acute (hospital) care and the arrangements for following up post-discharge. Also look at potential delays in discharge from acute to community care.

Possible Date: TBC

Referred: Cllr Juliet McCaffery

24 Health Visitors and Midwives

Suggested Format: Report from PCT (and/or providers)

Reason: Examine issues including the staffing levels of health visitors and midwives and arrangements for sharing information across ante and post natal care.

Possible Date: TBC

Referred: Cllr Juliet McCaffery

25 Breastfeeding

Suggested Format: Report from PCT (and/or providers)

Reason: To establish what city support there is for breastfeeding, and how services might be improved, particularly in terms of ensuring that good quality services are available across the city (re: statistics which show considerable variation in breast feeding take up across Brighton & Hove).

Possible Date: TBC

Referred: Cllr Juliet McCaffery

26 Care of the Elderly in Hospital

Suggested Format: Report from BSUH

Reason: Examine provision of elderly acute care in the city, especially given the historic problems with these services (i.e. unsuitable environments at RSCH and BGH; 'temporary' re-provision of city services in Newhaven etc.)

Possible Date: TBC

Referred: Cllr Juliet McCaffery

27 Emergency Planning at BSUH

Suggested Format: Report from BSUH

Reason: Examine BSUH planning for city emergencies: i.e. how the RSCH plans to cope with major incidents, including incidents which directly impact upon the hospital site.

Possible Date: TBC

Referred: Cllr Juliet McCaffery

28 Swine Flu: Hospital Planning

Suggested Format: Report from BSUH

Reason: Examine BSUH planning in context of a worsening swine flu pandemic: i.e. how will the hospital cope with a large number of infected patients? How does it plan to limit infection spreading across hospital site? How does it plan to ensure sufficient staff levels if pandemic returns in a more virulent form in the winter?

Possible Date: TBC

Referred: Cllr Juliet McCaffery

29 Relocation of RSCH Acute Services into Community Settings

Suggested Format: Report from PCT/BSUH

Reason: The 3T rebuild of the RSCH site includes plans to relocate some services (e.g. aspects of outpatient provision) to community settings. It is important that the committee is privy to the details of these plans, as community approval for the development of the RSCH may depend upon assurances that general hospital services for local people remain accessible when they are re-provided in community settings. Transport is likely to be a key issue here.

Possible Date: TBC

Referred: Cllrs Craig Turton, Gill Mitchell

30 South East Coast Ambulance Trust – Ambulance Provision for Amateur Sports

Suggested Format: Report from SECamb

Reason: Concern that it is apparently SECamb policy to require amateur footballers with suspected fractures to be transported to hospital in their private transport rather than by ambulance

Possible Date: TBC

Referred: Cllr Bob Carden

31 Car Park Charges at NHS Trusts

Suggested Format: Report from BSUH

Reason: There is a concern that charges for hospital car parks (particularly at RSCH) may have a serious negative impact upon people who are required to attend hospital regularly and/or people with limited means.

Possible Date: March 2010

Referred: Cllr Garry Peltzer Dunn

Health Overview and Scrutiny Committee	Agenda Item 26

Subject:		**Carers' Joint Commissioning Strategy**		
Date of Meeting:		**30 September 2009**		
Report of:		**Director of Adult Social Care and Housing**		
Contact Officer:	Name:	**Tamsin Peart**	**Tel:**	**29-5253**
	E-mail:	tamsin.peart@brighton-hove.gov.uk		
Key Decision:	Yes	Forward Plan No. (*7 Digit Ref):*		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The draft Carers' Development and Commissioning Strategy 2009 - 2012 sets out the vision for the future development and commissioning of services to support carers in Brighton and Hove for the next three years. It is a joint strategy across Brighton & Hove City Council and NHS Brighton and Hove.

1.2 Two draft strategies are attached. Appendix 1 is the draft consultation document that summarises the background information and suggested priorities for the strategy. Appendix 2 is the draft strategy document in full with more detailed priorities and commissioning implications set out.

2. RECOMMENDATIONS:

2.1 That members consider and contribute to the draft strategy.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 **Local Information**

At the time of the 2001 Census 21,800 people identified themselves as carers in Brighton and Hove. This is 9% of the population and includes almost 500 young carers aged 8-17. Almost 4,000 carers (18%) are caring for more than one person and almost 10,000 (46%) have been caring for five or more years.

3.2 **Strategy Development**

The strategy has been developed by the Joint Commissioner for Carers' Services for Brighton & Hove City Council and NHS Brighton and Hove working together with the Carers Strategy Group. The key principles of the strategy reflect those in the National Carers Strategy published in June 2008. The strategy encompasses all carers including parent carers.

3.3 **Objectives of Strategy**

The overall objectives of the strategy are:

- *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.*

The key priorities and commissioning recommendations set out in the draft strategy propose how these objectives will be met.

4. CONSULTATION

4.1

The Carers Strategy Group is chaired by the Head of Partnerships and Public Engagement at the PCT and includes representatives from the following organisations: Brighton & Sussex University Hospitals Trust, Sussex Partnership Foundation Trust, South Downs Health Trust, the Children and Young People's Trust, Amaze, the Alzheimers Society, the Carers Centre, Crossroads and the universities.

The third sector stakeholder involvement brings a wide range of carers' views to the table through their work both with individual carers and with carers' support groups.

In addition there has been direct consultation with carers on the strategy to date with a focus group of older carers of people with mental health needs, discussion tables at the International Day of Disabled People (December 2008) and the Carers Forum (March 2009) and a meeting with young carers.

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

4.2 The following consultation is planned for the future:

- A city-wide carers' survey has been commissioned from the Carers Centre and will be carried out in June during Carers Week.
- The consultation document is currently posted on the council and PCT websites.
- Carers Focus Group August 2009

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

5. FINANCIAL & OTHER IMPLICATIONS:

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

The City Council's Carers Grant forms part of the Area Based Grant and for 2009/10 the funding available for Carers will be approximately £1 million.

A breakdown of the current allocation of funding for carers' services is detailed in the Strategy at 3.5 and 3.6, page 10.

The National Carers Strategy ***"Carers at the heart of 21st-century families and communities"*** contained a new funding commitment for the provision of breaks to carers. The money is allocated to PCTs to administer, although it is allocated in total at a national level. The amount provided to the PCT for funding is not ring-fenced, or specifically identified in the 'general uplift' awarded to the PCT. However, Carers organisations have calculated the likely PCT 'allocation' and the PCT has agreed that the basis of these figures are reasonable. The suggested allocations for NHS Brighton and Hove are:

- £275K for 2009/10 and
- £546K for 2010/11.

PCTs are required to publish joint plans for the provision of breaks taking account of the new money allocated to PCTs and the existing Carers Grant allocated to local authorities. The additional funding can be used to provide a wide range of services from relief care, leisure services and breaks with the cared for person.

The PCT has set aside specific funding for Carers and Business Cases have been submitted against this. Once approved via the business case process, funding for Carers will be made available, although the PCT will also have to be mindful of the full range of pressures on resources as financial circumstances change moving into 2010/2011.

Finance Officer Consulted: Anne Silley Date: 07/04/09
Jonathan Reid Date: 01/06/09

5.2 Legal Implications:

This report provides details of the local strategy for carers and proposals for the implementation of the National Strategy within Brighton and Hove. The proposals are therefore in keeping with Central Government guidance. The local consultation process must ensure that all parties/organisations likely to have an interest in or be affected by the proposed implementation of the strategy are included in that process, that there is ample time for responses and measures are in place to enable those under disability to participate fully and equally in providing their views.

The proposals for implementation of the Strategy take account of carers and their families ECHR Article 8 Rights (Family Life) and the proposed consultation process ensures fairness in accordance with Article 6.

Layer Consulted: *Sandra O'Brien* *Date: 31/03/09*

5.3 Equalities Implications:

One of the key priorities in the draft strategy is to develop equality of access to services for all carers including BME carers, LGBT carers, parent carers, young carers and older carers.

An Equalities Impact Assessment has been completed and is attached at Appendix 3. This will be published as part of the consultation process for the strategy. The actions arising from this will be integrated into the delivery plan for the strategy.

Sustainability Implications:

Carers belong to every community in the city. Therefore supporting carers is key to the development of sustainable communities.

5.5 Crime & Disorder Implications:

5.6 Risk and Opportunity Management Implications:

Implementation of the Carers Strategy is key to delivering the LAA target NI 135 which is one of the city's agreed top 35 stretch targets: **Carers receiving needs assessment or review and a specific carer's service, or advice and information**

5.7 Corporate / Citywide Implications:

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

7. REASONS FOR REPORT RECOMMENDATIONS

SUPPORTING DOCUMENTATION

Appendices:

1. draft consultation document

2. draft development and commissioning strategy document

3. Equalities Impact Assessment

Documents In Members' Rooms

1.

2.

Background Documents

1. ***Carers at the heart of 21st-century families and communities, Department of Health 2008***

Carers Strategy 2009 - 2012 Consultation Document

Introduction
Brighton & Hove City Council and NHS Brighton and Hove Primary Care Trust are developing a Carers Strategy for the city which will enable us to implement the key principles of the national strategy for carers as well as address local issues in the city. The document will inform decision making and expenditure on carers' services over the next few years. This consultation document outlines some of the key issues for carers in the city with suggested ways of addressing these needs. We welcome comments and contributions to the development of this strategy from carers, service users and professionals.

Definitions:
- A carer spends a significant proportion of their life providing unpaid support to family or friends. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems. Parent carers are people with parental responsibilities (parents, grandparents, foster parents, adoptee parents and others) who also provide additional care, assistance and support to children with learning or physical disabilities, complex health needs or illness, or emotional behavioural difficulties.
- Young carers are children and young people under 18 who provide, or intend to provide, care, assistance or support to another family member. They carry out, often on a regular basis, significant or substantial caring tasks and assume a level of responsibility, which would usually be associated with an adult.
- Sibling carers are children and young people who contribute to the care of their siblings who have additional needs.

Who are carers - nationally?
- 1 in 6 of the population
- 3 in 5 of us at some point in our lives
- 42% of carers are men and 58% women

Who are carers in Brighton and Hove?
- 21,800 in Brighton & Hove
- 24% of people aged 50 to 64 are carers
- Almost 500 aged 8-17 years
- Almost 4,000 caring for more than one person
- Over 10,000 caring for 5+ years
- Over 1,000 carers in Brighton and Hove may sustain a physical injury through their caring role and over 1000 may be treated for a stress related illness
- More than 4,500 carers have been caring for at least 10 years and almost 10,000 for five years or more
- Nearly 4,000 carers look after more than one person

Health Issues

- More than 50% have sustained physical injuries
- 52% treated for stress related illnesses
- 94% manage medication
- 23% manage dressings
- 12% give injections

Who are they caring for in Brighton and Hove?

- One in five people over 65 say they do not have good health, compared to one in ten of the total population
- 18% of population have limiting long-term illness
- 400 adults with a learning disability living in the community
- Over 3,000 people with dementia
- 190 people with young onset dementia
- 2,500 problematic drug users
- 14,500 harmful drinkers
- 2,300 mental health service users aged under 65
- 3,900-5,900 people aged 65+ with depression
- 2,000 disabled under 16 year olds in Brighton and Hove

Key Principles

Integrated & personalised services

Vision: 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. **(Services that are joined up but also meet your needs and those of the person you care for on an individual basis)**

What have carers in Brighton and Hove already told us?
• Information and support provided within NHS settings including hospitals, mental health services and GP practices
• GPs are essential in encouraging their patients to recognise themselves as carers and signposting them to appropriate support
• Confidentiality is a barrier to communication between carers and professionals in mental health services. It needs to be flexible, discussed and negotiated.
• Poor communication between professionals can lead to a poor quality of service
• Dual diagnosis can lead to people falling between two services and not having their needs met
• Mental health service users would benefit from support in daily living skills but this is not always available
• Carers don't always want to manage services directly themselves and need choice and control over the delivery of services including the choice not to manage services themselves
• Carers need to be involved from the beginning of discussions

about Individual • Budgets and any impact on the carer as a result of changes to services needs to be taken into account
• Carers need information and advice about how to access services for the cared for person when that person is self-funding
• Better information about Carers Needs Assessments
• Training for NHS staff in hospitals, primary care and mental health services to increase their awareness of the issues facing carers
• Parent carers whose child has a severe learning disability feel that existing third sector providers are limited in what they can offer as this cohort is such a small minority of all parent carers
• There is no specific support for parent carers whose child has mental health needs
• Good communication between families and professionals is essential at point of diagnosis
• Professionals use too much jargon and language that can exclude users and carers
• Patients need to have all their needs met when in hospital, e.g. existing medication to be given at right time etc
• Services shouldn't be so dependent on one individual that they are unavailable when that individual is ill/leaves etc

Proposed Priorities
1. Provide and further develop appropriate, good quality information
• Information Prescriptions • Fund different media including websites, fact sheets, help lines • Map of Medicine is a web based reference guide for NHS staff to ensure best practice in delivering patient care – a local carers' pathway will be developed as part of this
2. Information Sharing Policy Implementation
▪ Monitor implementation in Sussex Partnership Foundation Trust and develop practice in other areas including primary care and substance misuse services
3. Develop equality of access to services for all carers through targeted information and outreach work across all communities underrepresented in statutory and provider services
• Ensure needs of BME carers identified and addressed • Ensure needs of LGBT carers identified and addressed • Provider services to work towards promoting their services across all communities in the city and ensuring they are open and accessible to all carers • Ensure needs of carers of people with HIV/Aids identified and addressed • Ensure needs of parent carers identified and addressed • Take forward good practice from 50+ Project and ongoing work in East Brighton

4. Offer good quality, timely and proportionate outcome focused carers' needs assessments and reviews
• Increase in number of carers assessments • Increase access to carers' needs assessments/reviews through voluntary sector and NHS services and housing • Development of a self-assessment tool for carers will give carers more choice about how their needs are assessed and may offer facilitated assessments with third sector providers • Holistic joint assessments/reviews to complement development of personalised services e.g. Reablement and Individual Budgets • All services responsible for carers assessments/reviews to develop strategies to meet performance targets • Monitor outcomes of assessment/review through city-wide carers' survey and service specific surveys/evaluation tools
5. Self Directed Support options available to carers
• 30% of carers of adults access carers' services via Self Directed Support by March 2011 • Carers' needs taken account of in the development of self directed support with service users • Appropriate support to voluntary sector providers to ensure sustainability of universal services • Appropriate levels of funding available for direct payments to parent carers
6. End of Life Care
• Link with End of Life Care strategy for Brighton and Hove to ensure carers' needs are included • Provision of appropriate services to carers supporting cared for at end of life • Access to bereavement support services
7. Carer involvement in the development and provision of services
• City-wide carers' survey • Community Engagement Framework - ensure Gateway services are carer aware • Use of Amaze's Compass database • Inclusion of carers on key decision making boards
8. Carers' needs and views taken into account on admission to, discharge from and during stays in hospital as well as in discussion and decisions about diagnosis, ongoing treatments, therapies and services
▪ Care Passports ▪ Support to carers at Millview Hospital ▪ Support to carers at the Nevill Hospital ▪ Support to carers at the Royal Sussex County Hospital ▪ Ongoing support to carers in the community following new diagnosis/hospital discharge
9. Provision of key workers for children and young people with special needs and their carers to ensure services and care are well integrated

A life of their own
Vision: Carers will be able to have a life of their own outside of their caring role.

What have carers in Brighton and Hove already told us?
• Parent carers would like funding for breaks for the whole family
• Carers benefit greatly from the opportunity to go on holiday, some with, others without, the cared for person
• Eligibility criteria for learning disability services means that some cared for people are receiving few or no services but carers are still undertaking regular and substantial caring roles
• Day services for people with dementia following diagnosis
• Assistance with transport to and from hospital
• Peer support
• Media representation of poor quality services can discourage users and put additional pressure on carers
• Some users and carers are reluctant to pay for services putting additional pressure on carers
• Care at home can be more appropriate for people with dementia but there is limited availability
• Support services available within local communities rather than everything being based in city centre
• Sustainability of support groups professional input withdrawn

Proposed Priorities
1. To extend the choice and accessibility of quality break opportunities for carers
• Support a range of voluntary and independent organisations to provide flexible breaks for carers • Use of self directed support to develop flexible breaks and services for carers • Explore need for home-based relief care for carers of people with functional mental health needs • Development of services to meet the needs of people under 65 with dementia including those whose condition has developed beyond early to moderate dementia and whose needs can not be met by the current day service provision. • Development of short breaks for children and young people with special needs to provide respite to parent carers • Accessible leisure opportunities for children and young people with special needs and their parent carers • Funding available for parent carers to increase choice and control through use of Direct Payments
2. Provision of carers' services that support carers in their caring role

• Through development of Self Directed Support • Explore use of Telecare in supporting carers
3. Support to carers wishing to access leisure activities
▪ Extend benefits of Compass card for parent carers and their children
4. Support to carers to plan for the future
• Emergency Back Up Scheme

Income & employment

Vision: Carers will be financially supported so that they are not forced into financial hardship by their caring role.

What have carers in Brighton and Hove already told us?
• Concern about employer's perception if they request flexible working
• Caring responsibilities leading to poor health can be reflected in sickness records and impact on employment opportunities

Proposed Priorities
1. To work with partners and local employers to help carers take up and/or remain in employment.
▪ Introduce target for local employers to have in place a carers policy ▪ Provide training (using the DVD) to local employers to increase understanding about the role of caring and their needs as employees. ▪ Working carers who have had an individual carer's assessment will be encouraged to share this assessment with their line manager as a first step in exploring how caring responsibilities impact on work patterns, and thereby providing an opportunity to begin a meaningful dialogue on what might be done to assist both the employee and the employer.
2. Partnership working with JobCentre Plus
• We will explore ways to engage and work with JobCentre Plus (exploring work opportunities with or without formal qualifications. Refresher course or preparation for work retaining programmes can often give confidence and help update and learn news skills for competing in the employment market)
3. Access to education and training.
▪ Provision of alternate care to enable carers to take up education and training ▪ Develop links with the Learning and Skills Council to provide discounted/free access to courses for carers. ▪ Explore opportunities for working with Connexions (targeting young carers in supporting all 13 – 19 years old on learning,

training and work)

Health & well-being

Vision: Carers will be supported to stay mentally and physically well and treated with dignity.

What have carers in Brighton and Hove told us already?
• Carers worry about how they would manage in a crisis
• Carers, particularly those caring for an adult son/daughter, would like plans to be put in place for the future with input from key professionals to address both care and financial issues

Proposed Priorities
1. Access to support in primary care
• Development of GP Link Worker scheme • Ensure PALS information service includes information relevant to carers • Develop a network of Carers' Advisers based across a range of NHS settings to include acute and community services and provide continuity of support to carers in their own homes following diagnosis/treatment/in-patient care. • Parent Carer Plus: a flexible specialist key worker approach built around informing, supporting and involving parent carers during and after the discharge process from RACH • GP Practices – Carers Advisers working within GP practices to offer a regular presence, advice to practice staff and direct support to carers
2. Access to advice and training
• Continue back care service for carers • "Looking After Me" courses • Pilot Mindfulness Based Cognitive Therapy course through Brighton Buddhist Centre • Dementia training for carers • Develop health care training, e.g. medications, wound management etc
3. Access to emotional support
• Provision of information, advice, support and advocacy • Provision of Insider Guide and Triple P courses to parent carers and development of Resilience Therapy techniques • Increased access to psychological therapies – monitor uptake of new counselling services accessed via GPs by carers and the outcomes for them • Develop transition services to support carers following bereavement/end of caring role and for parent carers during child's transition to adulthood with a focus on

work/education/training and reduction in isolation

Young carers

Vision: 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.

What have young carers in Brighton & Hove said is important to them?
young carers top ten wishes…
The most helpful groups are ones where you can talk about difficult feelings with young people in a similar situation
Carers project worker to support us to engage in new activities and attend activities provided by the Young Carers Project would most help with the difficulties of getting out to do activities and meeting new friends
We don't want to have to do personal care
8-10 year olds **Someone to support us to go out as a family**
Paid domestic help would most reduce the impact of our caring role in the home
16-25 year olds **1:1 confidential support so that we feel informed about our choices and options**
People in authority should let us know they are working for us and speaking up for us
We enjoy cooking to help at home
In an emergency we would like to have a pre-prepared plan of action (made with young person and family) to follow; kept by the school, Young Carers Project etc containing names and phone numbers of people to contact
The best way to raise awareness in schools is in PSHE lessons and sessions for pupils and teachers to understand some of the difficulties faced by young carers

Proposed Priorities
1. Identification and recognition of young carers at point of assessment of cared for person
▪ Appropriate services to cared for person to minimise impact on child(ren) ▪ Support for parents to be parents and family to be a family
2. Joint working between services for adults and services for children
• Joint protocol between adult services and CYPT • Jointly commission young carers assessment services • Family Pathfinder • Transitions Project

3. Ensure needs of young carers of substance misusing parents identified and addressed
▪ Assessment services ▪ support services
4. Support for young carers in schools
• awareness raising in schools with teachers & other staff • awareness raising in schools with pupils • support in schools
5. NHS Services
• Ensure that the development of Carers' Advisers in NHS settings includes recognition of and support for young carers
6. Emergency Back-Up scheme
▪ Expand existing scheme to meet needs of young carers

For further information or to contribute to this document please contact:

Tamsin Peart
Brighton & Hove City Council
G38, Kings House, Grand Avenue, Hove BN3 2SS
tel. 01273 295253
tamsin.peart@brighton-hove.gov.uk

Carers Strategy – draft outline

Contents

1. Foreword

1.1 Definitions

1.2 Vision

1.3 Strategic Vision for Brighton & Hove

1.4 Personalisation

2. The National Picture

2.1 Facts and Figures

2.2 Finances and Employment

2.3 Legislation

3. Assessment of need

3.1 Carers of adults in Brighton and Hove

3.2 Carers of disabled children in Brighton and Hove

3.3 Who are the carers caring for?

3.4 Equalities and Inclusion

3.5 Current Funding streams for carers of adults

3.6 Current funding streams for parent carers

4. Key Principles, Priorities and Commissioning Implications

4.1 Integrated & personalised services

4.2 A life of their own

4.3 Income & employment

4.4 Health & well-being

4.5 Young carers

5. Implementation

1. Foreword

1.1 Definitions:

- A carer spends a significant proportion of their life providing unpaid support to family or friends. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.
- Parent carers are people with parental responsibilities (parents, grandparents, foster parents, adoptee parents and others) who also provide additional care, assistance and support to children with learning or physical disabilities, complex health needs or illness, or emotional behavioural difficulties.
- Young carers are children and young people under 18 who provide, or intend to provide, care, assistance or support to another family member. They carry out, often on a regular basis, significant or substantial caring tasks and assume a level of responsibility, which would usually be associated with an adult.
- Sibling carers are children and young people who contribute to the care of their siblings who have additional needs.

1.2 Vision

The National Strategy for carers 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.*

1.3 Strategic Vision for B&H:

The Carers' Development and Commissioning Strategy 2009 - 2012 will set out the vision for the future development and commissioning of services to support carers in Brighton and Hove for the next three years. It is a joint strategy across Brighton & Hove City Council and NHS Brighton and Hove.
The Strategy recognises the importance of carers as expert care partners in supporting those with care needs to live independently in the

community and aims to reduce the social and health inequalities faced by carers and those they care for.

1.4 Personalisation

Ensuring that carers are an integral part of the Adult Social Care vision for Personalisation will go a long way to meeting the key priorities in the national strategy and the local priorities for carers in Brighton and Hove:

"Our vision is to create an integrated range of effective services and opportunities that deliver timely and appropriate responses to individuals' needs and aspirations and support them in leading fulfilled and healthy lives .Our commitment is to empower 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, we will re-design our service to offer:

- clear advice and information through multi-skilled contact point(s);
- self-assessment and 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 re-enablement for the majority of social care users;
- a robust care management service for those who need it; and
- a professional and effective process to safeguard vulnerable adults.

The new service will work to a set of key principles. It will be a service that:

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

2. The National Picture

2.1 Facts and figures

- Every year 301,000 become carers

- The economic value of the contribution that carers make is estimated at £87 billion in the UK. This is equivalent to the cost of the NHS every year.
- 3 in 5 of us will become carers at some point in our lives
- More than 50% of carers in a Carers UK study had sustained a physical injury since becoming a carer and 52% had been treated for a stress related illness
- More than 80% of carers say that caring has damaged their health
- Nearly 21% of carers caring 50+ hours report that they are not in good health, compared with 11% of non-carers
- a third of carers (35%) without good social support suffered ill-health compared to those with good support (15%) – Office of National Statistics
- In 2000, one in six people aged 16 or over (16 per cent) was caring for a sick, disabled or older person and one in five households (21 per cent) contained a carer. These figures represent around 6.8 million adult carers in 5 million households
- Over 1 in 4 (28%) carers spend at least twenty hours per week on their caring responsibilities and 1 in 10 spent 50 hours or more.
- One in five carers (21%) have been caring for someone for at least 10 years and nearly half (45%) have been carers for 5 years or more.
- 10% of GP patients are carers
- 94% of carers manage medication, 23% manage dressings, and 12% give injections
- 175,000 carers are under the age of 18
- 13 million expect to become carers in the next decade
- 18% of carers look after more than one person
- 1.2 million care for more than 50 hours per week

2.2 Finances and Employment

Carers face a number of barriers to employment. These can be individual barriers, for example a lack of skills and confidence due to isolation in the home. Also they may face labour market barriers such as difficulty of accessing jobs that are sufficiently local or accessible to combine with caring roles. Furthermore, employers are not always attuned to carer needs or to provide flexible working arrangements to enable carers to combine work and caring responsibilities. Even after caring has ceased, former carers encounter problems getting re-employed due to gaps in their employment history.

Key facts to understand the multiple vulnerability of families of children with complex needs or disabilities.

- On average, it costs three times the amount to raise a disabled child compared to raising a child with no disabilities[1]
- Family breakdown - in the general population of Brighton and Hove, 27% of households with children are single parent households (2001 Census), while single parent households form 36% of families on the Compass database. Single parent household nearly all headed by mums, looking after boys.
- Lower income
  a) in the population of households with children in Brighton & Hove, 61% of mums and 86% of dads are in paid work, compared to the Compass families where 16% of mums and 63% of dads are in paid work.
  b) 50% not claiming or unsuccessfully claiming Disability Living Allowance[2].
  c) 55% of disabled children live in or on the margin of poverty
- Greater likelihood of disabled children experiencing neglect and abuse.

Of the under 16s on the Compass, 45% live in parts of B&H that rank in the most deprived 20% nationally (i.e. Super Output Areas among the most deprived 20% of all SOAs in the UK.).

2.3 Legislation

Work with carers is underpinned with three specific pieces of legislation:

- Carers (Recognition and Services) Act 1995
- Carers and Disabled Children Act 2000
- Carers (Equal Opportunities) Act 2004

There is also wider legislation such as The Work and Families Act 2006 and case law.
Guidance relating to carers in included in the NHS Constitution handbook and the NHS Operating Framework 2009/10.
The new Section 242 'Duty to Involve' of the NHS Act 2006 provides the guidelines for involving service users in the design, delivery and monitoring of services.

Further details are outlined in Appendix 1.

3. Assessment of Need

3.1 Carers of adults in Brighton & Hove

- 21800 (9%) people identified themselves as carers in the 2001 Census. Of these, 71% care for between 1-19 hours per week, 10% between 20-49 hours per week and 19%, over 4,000 people, for 50 or more hours per week. However, this is likely to be an

[1] Disabled Children & Child Poverty: briefing paper from Every Disabled Child Matters, 2007
[2] as above

underestimate of the total number of carers across Brighton and Hove. A study for Carers UK (2006) found that 65% of people with a caring responsibility did not identify themselves as a carer in the first year of caring. For a third of them (32%) it took over 5 years before they recognised they were a carer.

- 24% of people aged 50 to 64 are carers.
- Carers Allowance figures provide an additional picture of the number of carers in the area. This is made payable to those who are not in employment or are on a low income providing at least 35 hours of care to a severely disabled person. Across Brighton and Hove there were 1,640 people receiving Carers Allowance in February 2007. This represents an increase of 20% since 2003 highlighting an increase in informal care across the city.
- The economic value of the contribution made by carers is estimated at £222.7 million within the city.
- Around 40% of the working age population providing unpaid care across Brighton and Hove are economically inactive, this figure rises to 70% for those providing care of more than 50 hours per week. People providing care make up 14% of all economically inactive people across the city.

Based on national figures we may expect the following in Brighton and Hove:

- Over 1,000 carers in Brighton and Hove may sustain a physical injury through their caring role and over 1000 may be treated for a stress related illness
- More than 4,500 carers have been caring for at least 10 years and almost 10,000 for five years or more
- Nearly 4,000 carers look after more than one person

3.2 **Disabled children in Brighton and Hove**

The proportion of children in the UK that are disabled is not known. Current
estimates range from 5 to 7%. If we consider the conservative estimate of
5% then we would expect there to be just over 2,000 disabled under 16 year olds in Brighton and Hove.

Both nationally and locally, the numbers are increasing of children born with disabilities (for example following IVF treatment and multiple births), those who develop complex needs following injury or illness, and those surviving due to medical intervention not previously possible. NHS Brighton and Hove (in the Joint Assessment of Children's Services (Brighten Up 2008) acknowledges that there is only poor data about the numbers of such children in the city and wide variations in the quality and quantity of services available to their families.

There are just over 1,000 children with additional needs on the Compass Database held by Amaze, representing about 2% of all Brighton and Hove children (aged 0 to 19 years). Therefore if 5 -7% is the expected

proportion of disabled children, the 2006 data represents less a third of those with additional needs. Of those children we do have information about:-

- 72% of the children were male
- 10%of families have more than one child with special needs
- 50% of families where the main or sole carer does not usually get a night's sleep, rising to 60% where more than one child with SEN
- Disabled children more likely to be living in most deprived neighbourhoods
- 24% of parents think their housing is not adequate to meet the needs of their disabled children
- 50% receive no support from extended family, for example from grandparents
- In about a fifth of families with non-disabled siblings, these children share in care of the disabled child
- Only 4% get support from social services (compared to 15% of all families in Brighton and Hove who have any social services support)
- 55% of children on the Compass have been bullied, and 27% have been involved in bullying. Both these figures rise when related to the children who are excluded from schools.
- A child with special needs is seven times more likely to be temporarily excluded from school, and 13 times more likely to be permanently excluded.

3.3 Who are the carers caring for?

We do not know the exact numbers of carers in the city or who they are caring for. However, considering the numbers of people living in the community with disabilities, health or addiction needs, many of whom are supported by carers, gives an indication of caring roles undertaken in the city.

Older People

At the time of the 2001 Census there were a total of 51,058 people aged 60 years and older living in the city. However, in contrast to national and regional trends, the population of older people in the city reduced to 48,100 by 2008 and is expected to decrease further over the next few years. By 2013 the older population is expected to be at its lowest level with 47,600 people aged over 60 living in the city, a 1% reduction from 2008. We then see an expansion in the older population, and from 2013 to 2028 it is expected to increase by 21%, more than 4 times the rate of younger age groups, to 57,600 people.

Disabled People

The Census 2001 reported that 18% of the total population of Brighton & Hove, 44,600 people, reported having a limiting long-term illness. Of these, 21,500 are aged 18-64.

DWP reported in November 2007 that 5% of the population, 12,390 people, were in receipt of Disability Living Allowance.
The PCT's Public Health report indicates that by 2010 9.6% (16,179) of adults aged 18-64 in Brighton and Hove will have a moderate to serious disability. The majority of these (77%, 12,458) will have a moderate disability, whereas a significantly smaller proportion (23%, 3,721) will have a serious disability. By 2010 there are predicted to be almost 19,000 adults aged 18-64 with some form of severe or moderate disability. It is likely that many of those with a serious disability

Disabled Children

- It is common for more than one member of a family to have a disability. The Brighton and Hove Compass database has 10% of families with more than one child with special needs and 2% with more than two children with special needs.
- 12% of children on the Compass have a main carer who is disabled themselves.
- Over 1,100 children in the city have statements of Special Educational Needs (SEN). Not all disabled children have a severe enough need to receive a statement e.g. only half the children on the Compass with severe juvenile arthritis have a statement.

HIV/Aids

There are over 1,300 people in Brighton and Hove living with HIV/Aids of whom 85% are gay men and the majority of others are African women. There is a year on year increase of 10% in the numbers of people in the city living with HIV/Aids and the highest increase is amongst African women.

Mental Health

- Brighton and Hove has up to 39% higher incidence of serious mental illness compared with England
- There are variations across the city with the highest indices of need in the eastern parts
- Brighton and Hove has nearly twice the national suicide rate and we are unlikely to meet the 2010 national target for reducing suicides
- There are above 30,000 who would be eligible for CBT or talking therapies support at any one time in the city
- We have over 12,000 people on incapacity benefit, of which 53% are classified as having mental health needs, 7% above the national average
- We have the 2nd highest percentage of alcohol related deaths in men in the country
- We have specific high risk groups in the city including the largest identified LGBT community in the UK
- We have the highest rate of problem drug users in the South East
- B&H spends proportionally more on mental health than another other PCT in the south East and is above the national average

At any one time in the city there are:

- Around 1,500 people receiving support from the recovery team because of a SMI
- 4000 discharged from the recovery team but living with a SMI
- Up to 3000+ carers
- 30,000+ who have a need for CBT because of anxiety or depression
- Between 700 and 1,500 people with schizophrenia
- 400 women with post natal depression
- Around 650 referrals form GP's per month into the single access point for mental health issues

	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

Dementia

The expected number of people aged over 65 with some form of dementia in Brighton and Hove should be approximately 3261. Based on national research it is likely that at least 71% of these people have a carer which equates to over 2,300 carers of people with dementia or 10% of all carers in the city.
There are also almost 200 people under 65 with young onset dementia. In new research published in January 2009 in the British Medical Journal half of family carers of people with dementia reported some abusive behaviour towards the person they were caring for and one third report 'significant' levels of abuse.
The paper authors feel that this is unsurprising, as most people with dementia are being cared for by dedicated family or friends, often with little support placing them under enormous strain. The authors recommend giving carers access to respite, psychological support and financial security to help end mistreatment.
A YouGov survey commissioned in 2008 found that 19% of carers sometimes or often feel threatened by the person they care for. Two-thirds said they would like training.

Learning Disabilities

Over 400 adults with learning disabilities live in the community, the majority with, or supported by, family carers. There are 63 young people with learning disabilities who will be 18 in the next 3 years the majority of whom will continue to live at home with family. The national average age for leaving home for all young people is now 24 and it is likely to be that or higher for most people with learning disabilities some of whom will remain in the family home for the long term.

Substance Misuse

There are over 2,500 problematic drug users and over 14,500 harmful drinkers in Brighton and Hove. Supporting carers not only helps carers themselves, but also improves treatment take-up, retention and outcomes for drug users, while bolstering the support they may receive outside of formal treatment.

Cancer
The incidence of cancer in Sussex has remained very stable over the last decade, despite the increase in both population numbers due to further house building, and overall age. Nationally the incidence of cancer is expected to increase by up to a third over the next fifteen years. The impact in Sussex, where we already have such an elderly population, is unknown, but it is encouraging that here is no indication of a rising trend as yet. In 2006 there appeared to be slight increases in cancer deaths in both Brighton and Hastings, although the overall trend continues downwards.

3.4 Equalities and Inclusion

Number of people aged 50 and over providing unpaid care, 2001 Census data

Hours per week caring	All people aged 50 and over	50 to 64	% of carers	65 to 74	% of carers	75 to 84	% of carers	85 and over
1 to 19	7,639	5,215		1,636		685		103
20-49	1,145	690	24%	267	16%	154	10%	34
50 or more	2,598	1.241		667		551		139
Does not provide care	66,060	29,846		16,455		13,534		6,225

- This shows that 17% of the population aged 50 and over provide care compared with 9% of the overall population in the city.

Young Carers

Estimated number and proportion of children (aged 8-17) who are carers in Brighton and Hove, by age and hours caring per week[3]

	1-19 hours	20-49	50+ hours	Total	Total

3 Source: Calculated by Prof Saul Becker, University of Nottingham, from Office for National Statistics Census 2001 data.

		hours		number	%
8-11	77	3	6	86	17.5
12-15	215	15	9	239	50
16-17	128	20	8	156	32.5
All	**420**	**38**	**23**	**481**	**100%**
All as %	87%	8%	5%	100%	

Disability
In the Census 2001, 13% of carers of adults (?) in Brighton and Hove described themselves as not in good health.
Nationally, 5% of carers are permanently sick or disabled.

BME
The 2001 Census estimated that there were just over 14,200 people from non-white ethnic groups across Brighton and Hove - 5.7% of the city's population. However, the population profile of the city is changing:
• 15% of the city's residents were born outside England – well above national and regional levels
• BME groups were estimated to have increased in size by 35% over the period 2001 to 2004 (against a national increase of 13%)

LGBT Population in Brighton and Hove
The 2001 census did not collect information on sexual identity, but anecdotal evidence indicates that as many as 40,000 people identify as LGBT, or 21% of the total population, in Brighton and Hove. The Count Me in Too survey recommended further research in to the specific needs of LGBT carers and carers of LGBT people in the city.

Religion or belief
The 2001census showed that over a quarter of the population of the city stated that they had no religion, the second highest percentage of any authority in England and Wales. 59% of the population stated that they were Christian and 1.36% of the population was Jewish. The Muslim population is around 1.4% and the Buddhist population 0.7%.

Financial impact on carers
Caring clearly has an impact on the life chances of carers, on their financial security in later life, and on their employment prospects. For a person in full time work who has to give up their job to care full-time, the current level of Carers Allowance - £48.65 per week - clearly does not provide financial compensation.
The key role played by carers and the £87 billion saving they make to the economy have not been fully recognized.

An Equalities Impact Assessment is attached at Appendix 2.

3.5 Current funding streams for carers of adults

A significant amount of funding for 2009/2010 is committed through ongoing contracts to third sector providers. These contracts will be reviewed during the coming months to consider how they might need to be changed to reflect the priorities in the strategy and address the personalisation agenda. Current expenditure reflects many of the priorities outlined in the strategy although there are areas of service that are not currently funded and will need new resources or a redistribution of existing resources once the key priorities in the strategy have been agreed. From 2010/2011 resource allocation will be more closely aligned to the agreed priorities in this strategy.

Breakdown of funders for carers of adults 2009/10

	£'000s	%
City Council	949	62
NHS Brighton and Hove	436	28
Sussex Partnership Foundation Trust	148	10
Total	**1533**	**100**

Breakdown of expenditure for carers of adults 2009/10

	£'000s	%
breaks and services	893	58
information, advice, support & advocacy	328	22
service development & assessments	281	18
Community Engagement	31	2
Total	**1533**	**100**

3.6 Current funding streams for parent carers

The Children and Young People's Trust have received Aiming High funding to transform short break services for disabled children. This amounts to £2.2m revenue and £450K capital over three years. The Carers Grant allocation for 2009/10 is approx £203K. The Disabled Children's Strategic Partnership Board meet regularly to discuss the needs of disabled children and their families in the city and inform decisions over expenditure.

4. Key Principles

4.1 Integrated & personalised services

Vision: 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.

Key Priorities from National Strategy
▪ Key to achieving greater integration of services is the use of more effective holistic assessment which enables the person cared for and their carer to identify their needs, what matters to them and how their own outcomes will best be met. In some circumstances, it will also be important that carers have their own individual assessment, to ensure that specific needs around their own health and well-being are identified.

▪ Training carers to enable them to strengthen them in their caring role and to empower them in their dealings with care professionals as expert care partners.
▪ Training and awareness raising for key professionals from health to housing, to provide better services and support for carers and work with them as expert care partners.
▪ Integrated, partnership working between the NHS, social care services and carers
▪ Actively involving carers in diagnosis, care and discharge planning;
▪ Providing greater support for carers at GP practices and acute trusts;
▪ Personalised, targeted information provided to carers

What have carers in Brighton and Hove said is important to them?
• Information and support provided within NHS settings including hospitals, mental health services and GP practices
• GPs are essential in encouraging their patients to recognise themselves as carers and signposting them to appropriate support
• Confidentiality is a barrier to communication between carers and professionals in mental health services. It needs to be flexible, discussed and negotiated.
• Poor communication between professionals can lead to a poor quality of service
• Dual diagnosis can lead to people falling between two services and not having their needs met
• Mental health service users would benefit from support in daily living skills but this is not always available
• Carers don't always want to manage services directly themselves and need choice and control over the delivery of services including the choice not to manage services themselves
• Carers need to be involved from the beginning of discussions about Individual • Budgets and any impact on the carer as a result of changes to services needs to be taken into account
• Carers need information and advice about how to access services for the cared for person when that person is self-funding
• Better information about Carers Needs Assessments
• Training for NHS staff in hospitals, primary care and mental health services to increase their awareness of the issues facing carers
• Parent carers whose child has a severe learning disability feel that existing third sector providers are limited in what they can offer as this cohort is such a small minority of all parent carers
• There is no specific support for parent carers whose child has mental health needs
• Good communication between families and professionals is essential at point of diagnosis
• Professionals use too much jargon and language that can exclude users and carers
• Patients need to have all their needs met when in hospital, e.g. existing medication to be given at right time etc

• Services shouldn't be so dependent on one individual that they are unavailable when that individual is ill/leaves etc

How do we do this already?
• Specialist Carers' Needs Assessments and Reviews provided by the city council and NHS Trusts as well as with third sector providers
• Joint Commissioner for Carers' Services working across Adult Social Care and the PCT
• Joint contracts between Adult Social Care and the PCT with third sector providers for carers' services
• The Federation of Disabled People Direct Payments Advice Service can offer guidance to all carers and users regardless of who is paying for the care
• GP Link Worker – Carers Centre has three years funding to develop services in 15 GP practices with the aim of recognising patients' caring roles, addressing their physical and mental health needs and promoting both third sector and statutory services to further meet carers' needs
• Transition events for young people entering adult services
• Sussex Partnership Foundation Trust has information for carers and staff guidance on managing confidentiality
• Care Passports are used in hospitals and residential care settings. The bright yellow passports take the form of a notebook in which carers can note the special needs of those they care for and can write down questions they wish to ask nurses or consultants. The passport is then kept with the patient and referred to by hospital staff.
• Carers are involved in the selection and training of social work students at the local universities and in delivering carer awareness training in the city council and Sussed Partnership Foundation Trust

Priorities
1. Provide and further develop appropriate, good quality information
• Information Prescriptions • Use of a range of media including websites, factsheets, help lines • Map of Medicine is a web based reference guide for NHS staff to ensure best practice in delivering patient care – a local carers' pathway will be developed as part of this
2. Information Sharing Policy Implementation
▪ Monitor implementation in SPT and develop practice in other areas including primary care, acute services (Brighton and Sussex University Hospitals Trust), community services (Southdowns Health NHS Trust) and substance misuse services
3. Develop equality of access to services for all carers through targeted information and outreach work across all communities underrepresented in statutory and provider services
• Ensure needs of BME carers identified and addressed • Ensure needs of LGBT carers identified and addressed • Ensure needs of carers of people with HIV/Aids identified and addressed

<table>
<tr><td>
Provider services to work towards promoting their services across all communities in the city and ensuring they are open and accessible to all carers
Ensure needs of parent carers identified and addressed
Take forward good practice from 50+ Project and ongoing work in East Brighton
</td></tr>
<tr><td>4. Offer good quality, timely and proportionate outcome focused carers' needs assessments and reviews to meet National Indicator 135</td></tr>
<tr><td>
Increase in number of carers receiving a service following assessment/review from xxx to xx in 2009/10 and xxx in 2010/11.
Increase access to carers' needs assessments/reviews through voluntary sector and NHS services and housing
Development of a self-assessment tool for carers will give carers more choice about how their needs are assessed and may offer facilitated assessments with third sector providers
Holistic joint assessments/reviews to complement development of personalised services e.g. Reablement and Individual Budgets
All services responsible for carers assessments/reviews to develop strategies to meet performance targets through the delivery of both high quality assessments/reviews and services to meet the identified needs of carers
Monitor outcomes of assessment/review through city-wide carers' survey and service specific surveys/evaluation tools
</td></tr>
<tr><td>5. Self Directed Support options available to carers</td></tr>
<tr><td>
30% of carers of adults access carers' services via Self Directed Support by March 2011
Carers' needs integral to the development of self directed support for service users
Appropriate support to voluntary sector providers to ensure sustainability of universal services
Appropriate levels of funding available for direct payments to parent carers
</td></tr>
<tr><td>6. End of Life Care</td></tr>
<tr><td>
Link with End of Life Care strategy for Brighton and Hove to ensure carers' needs are included
Provision of appropriate services to carers supporting cared for at end of life
Access to bereavement support services
</td></tr>
<tr><td>7. Carer involvement in the development and provision of services</td></tr>
<tr><td>
City-wide carers' survey
Community Engagement Framework - ensure Gateway services are carer aware
Use of Amaze's Compass database
Inclusion of carers on key decision making boards
</td></tr>
<tr><td>8. Carers' needs and views taken into account on admission to, discharge from and during stays in hospital as well as in discussion and decisions about diagnosis, ongoing treatments, therapies and services</td></tr>
<tr><td>
Care Passports – evaluate uptake and outcomes of current usage
Support to carers at Millview
Support to carers at the Royal Sussex County Hospital
Ongoing support to carers in the community following new diagnosis/hospital
</td></tr>
</table>

discharge
9. Provision of keyworkers for children and young people with special needs and their carers to ensure services and care are well integrated

Commissioning Implications
▪ Monitor and evaluate the development of the Community Engagement framework and ensure that all Gateway organisations are carer aware and that the needs of BME and LGBT carers and those from other disadvantaged groups are identified consider ways of addressing needs appropriately
▪ Meet National Indicator 135 by providing access to carers needs assessments/reviews through a range of means including development of provision in the voluntary sector, self assessment etc
▪ Ensure carers are represented on decision making boards and panels and they are supported to contribute their knowledge and experience.
• Bereavement support
▪ Contracting arrangements to be adapted to reflect move towards Self Directed Support
▪ Survey of carers' needs
▪ Key workers provided to children and young people with special needs and their parent carers
▪ All services responsible for carers assessments/reviews to develop strategies to meet performance targets

4.2 A life of their own

Vision: Carers will be able to have a life of their own alongside their caring role.

Key Priorities from National Strategy
▪ Carers should have the opportunities and space they need to participate in activities outside their caring role. They should be free to have an identity that is separate from that of the people they support. Carers have the right to expect these freedoms, which others take for granted, and to avoid the social exclusion that may result from having no life outside caring.
▪ Greater emphasis on the provision of planned breaks, which will provide carers with the time to take up the same work, education, leisure and training opportunities as anyone else.

What have carers in Brighton and Hove said is important to them ?
• Parent carers would like funding for breaks for the whole family
• Carers benefit greatly from the opportunity to go on holiday, some with, others without, the cared for person
• Eligibility criteria for learning disability services means that some cared for people are receiving few or no services but carers are still undertaking regular and substantial caring roles

• Day services for people with dementia following diagnosis
• Assistance with transport to and from hospital
• Peer support
• Media representation of poor quality services can discourage users and put additional pressure on carers
• Some users and carers are reluctant to pay for services putting additional pressure on carers
• Care at home can be more appropriate for people with dementia but there is limited availability
• Support services available within local communities rather than everything being based in city centre
• Sustainability of support groups professional input withdrawn

How do we do this already?
▪ Relief care in the home provided by third sector and independent providers
▪ Day service for people under 65 with young onset dementia
▪ Monthly Saturday day service for adults with learning disabilities specifically for carer relief
▪ A wide range of generic, care group specific and neighbourhood based support groups for carers and former carers
▪ Spot Purchase Budget - ring-fenced budget allocated to carers on an individual basis to meet identified need for a break or service following assessment or review.
▪ Emergency Back Up Scheme

Priorities
1. To extend the choice and accessibility of quality break opportunities for carers
• Support a range of voluntary and independent organisations to provide flexible breaks for carers • Use of self directed support to develop flexible breaks and services for carers • Explore need for home-based relief care for carers of people with functional mental health needs • Development of services to meet the needs of people under 65 with dementia including those whose condition has developed beyond early to moderate dementia and whose needs can not be met by the current day service provision. • Development of short breaks for children and young people with special needs to provide respite to parent carers • Accessible leisure opportunities for children and young people with special needs and their parent carers • Funding available for parent carers to increase choice and control through use of Direct Payments
2. Provision of carers' services that support carers in their caring role
• Through development of Self Directed Support
• Explore use of Telecare in supporting carers
3. Support to carers wishing to access leisure activities

▪ Extend benefits of Compass card for parent carers and their children ▪ Appropriate transport is key to enabling carers and cared for to access leisure facilities
4. Support to carers to plan for the future
• Legal advice re discretionary wills and trusts • Emergency Back Up Scheme

Commissioning Implications
▪ Consider equity of access to breaks services in relation to referral routes and charging policies
▪ Consider the quality and cost-effectiveness of break provision
▪ Increase capacity of relief care in the home to meet demand pressures through combination of current providers and Individual Budgets
▪ Explore need for home-based relief care for carers of people with functional mental health needs through piloting of service
▪ Use of Carers Grant and Aiming High monies to meet identified needs of parent carers for breaks and leisure opportunities with their children including through the use of direct payments with appropriate support

4.3 Income & employment

Vision: Carers will be financially supported so that they are not forced into financial hardship by their caring role.

Key Priorities from National Strategy
▪ To ensure that carers have the opportunity to combine paid employment with their caring role through the provision of better services, increased break provision, easier access to training and skills and more flexible working opportunities
▪ Access to good benefits advice
▪ Jobcentre Plus improving the way they work with carers and can provide support to carers in returning to work
▪ Awareness-raising with employers around the right to request flexible working and supporting carers

What have carers in Brighton and Hove said is important to them?
• Concern about employer’s perception if they request flexible working
• Caring responsibilities leading to poor health can be reflected in sickness records and impact on employment opportunities

How do we do this already?
• MACS Money Advice and Casework Service has Big Lottery reaching communities funding to provide assistance with financial issues including bank

accounts; debts - helping with financial statements and negotiating with creditors; benefits - carrying out benefit checks and applications; dealing with utility suppliers.
• Free legal advice surgeries at the Carers' Centre
• Adult Advancement and Careers Service is a pilot project that will offer information to residents and workers and direct delivery co-located advice services in three areas of the city

Priorities
1. To work with partners and local employers to help carers take up and/or remain in employment.
▪ Develop a carers' policy template and promote with for local employers ▪ Provide training (using the DVD) to local employers to increase understanding about the role of caring and their needs as employees. ▪ Working carers who have had an individual carers assessment will be encouraged to share this assessment with their line manager as a first step in exploring how caring responsibilities impact on work patterns, and thereby providing an opportunity to begin a meaningful dialogue on what might be done to assist both the employee and the employer.
2. Access to benefits and money advice
3. Partnership working with JobCentre Plus
• Care Partnership Manager will be appointed April 2009 to the local Jobcentre Plus and we will explore ways to engage and work with them to consider employment opportunities for carers
4. Access to education and training.
▪ Provision of alternate care to enable carers to take up education and training ▪ Develop links with the Learning and Skills Council and local universities to provide discounted/free access to courses for carers. ▪ Explore opportunities for working with Connexions (targeting young carers in supporting all 13 – 19 years old on learning, training and work)

Commissioning Implications
▪ To support parent carers to make successful applications for DLA for their children

4.4. Health & well-being

Vision: Carers will be supported to stay mentally and physically well and treated with dignity.

Key Priorities from National Strategy
▪ Every carer should be supported so that caring does not adversely affect their health.
▪ Services and support to carers should enable them to stay mentally and

physically well throughout their caring role
▪ Short-term, home-based respite established for carers in crisis or emergency situations
▪ The needs of carers should be built into the care planning process for people with long-term conditions
▪ Psychological distress is experienced by many carers and needs to be recognised at an early stage
▪ PCTs should aim to create a more personalised service that provides support for carers by recognising their need for breaks from caring.
▪ Involvement of carers in all care planning from diagnosis to discharge and beyond
▪ Take into account the health of the carer to ensure continuity of care for the person being cared for
▪ Access to information relevant to the care and needs of the person being cared for

What have carers in Brighton and Hove said is important to them ?
• Carers worry about how they would manage in a crisis
• Carers, particularly those caring for an adult son/daughter, would like plans to be put in place for the future with input from key professionals to address both care and financial issues
• Health checks for carers
• Flexible booking arrangements at GP surgeries for carers

How do we do this already?
▪ Good quality information, advice, support and advocacy provided by the third sector offered both as generic service and targeted at specific care groups
▪ Back Care Service providing advice in safe moving and handling and the loan of equipment to all carers
▪ Looking After Me course for carers
▪ Free counselling from Relate for carers
• Access to low cost voluntary sector counselling, e.g. Federation of Disabled People, Age Concern,

Priorities
1. Access to support in NHS services
• Development of GP Link Worker scheme • Ensure PALS information service includes information relevant to carers • Develop a network of Carers' Advisers based across a range of NHS settings to include acute and community services and provide continuity of support to carers in their own homes following diagnosis/treatment/in-patient care. • Parent Carer Plus: a flexible specialist key worker approach built around informing, supporting and involving parent carers during and after the discharge process from RACH • GP Practices – Carers Advisers working within GP practices to offer a regular presence, advice to practice staff and direct support to carers

2. Access to advice and training
• Continue back care service for carers • “Looking After Me” courses • Pilot Mindfulness Based Cognitive Therapy course through Brighton Buddhist Centre • Dementia training for carers • Health care training, e.g. medications, wound management etc
3. Access to emotional support
• Provision of information, advice, support and advocacy • Provision of Insider Guide and Triple P courses to parent carers and development of Resilience Therapy techniques • Increased access to psychological therapies – monitor uptake of IAPT by carers and outcomes • Develop transition services to support carers following bereavement/end of caring role and for parent carers during child’s transition to adulthood with a focus on work/education/training and reduction in isolation

Commissioning Implications
▪ Pilot service in RSCH 2009/10
▪ Continuation of back care service
▪ Continue to fund and develop information, advice, support and advocacy
▪ Provide Resilience Therapy training for carers
▪ Develop transition services to support carers following bereavement/end of caring role and for parent carers during child’s transition to adulthood with a focus on work/education/training and reduction in isolation

Young carers

Vision: 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.

Key Priorities from National Strategy
▪ Protecting young people from inappropriate caring
▪ High quality targeted support is accessible to young carers who need it
▪ Better joined-up, whole-family support to families affected by illness, disability or substance misuse who have young carers
▪ Universal services – schools, GPs, hospitals – have a vital role in providing support, understanding and practical guidance to young carers

What have young carers in Brighton & Hove said is important to them ?

young carers top ten wishes…

The most helpful groups are ones where you can talk about difficult feelings with young people in a similar situation
Carers project worker to support us to engage in new activities and attend activities provided by the Young Carers Project would most help with the difficulties of getting out to do activities and meeting new friends
We don't want to have to do personal care
<u>8-10 year olds</u> **Someone to support us to go out as a family**
Paid domestic help would most reduce the impact of our caring role in the home
<u>16-25 year olds</u> **1:1 confidential support so that we feel informed about our choices and options**
People in authority should let us know they are working for us and speaking up for us
We enjoy cooking to help at home
In an emergency we would like to have a pre-prepared plan of action (made with young person and family) to follow; kept by the school, Young Carers Project etc containing names and phone numbers of people to contact
The best way to raise awareness in schools is in PSHE lessons and sessions for pupils and teachers to understand some of the difficulties faced by young carers

How do we do this already?
▪ Casework and assessments for 8-17 year old young carers
▪ Transitions project for 16-25 year olds
▪ Activities and group work
▪ Targeted support for young carers of substance misusers

Priorities
1. Identification and recognition of young carers at point of assessment of cared for person
▪ Appropriate services to cared for person to minimise impact on child(ren) ▪ Support for parents to be parents and family to be a family
2. Joint working between services for adults and services for children
• Joint protocol between adult services and CYPT • Jointly commission young carers assessment services • Family Pathfinder • Transitions Project
3. Ensure needs of young carers of substance misusing parents identified and addressed
▪ Assessment services ▪ support services
4. Support for young carers in schools
• awareness raising in schools with teachers & other staff • awareness raising in schools with pupils • support in schools
5. NHS Services
• Ensure that the development of Carers' Advisers in NHS settings includes

recognition of and support for young carers
6 . Emergency Back-Up scheme
▪ Expand existing scheme to meet needs of young carers

Commissioning Implications
▪ Jointly commission young carers assessment services with CYPT, consider future of this service from April 2010
▪ Assessment and support needs of young carers of substance misusing parents
• Work in schools to raise awareness with both pupils and staff, contribute to PSHE (personal, social and health education) curriculum, develop guidance for schools, deliver casework to individual young carers and support transition between primary and secondary schools.
• Work in colleges and universities to raise awareness, deliver casework , develop links with student support services, embed young carer training into health and social science syllabi.
• Availability of funding for respite breaks, activities and support groups for young carers

Appendix 1.

Legislation

Carers (Recognition and Services) Act 1995

Where a carer is providing, or intends to provide, substantial care on a regular basis, they are entitled, on request, to an assessment when a local authority carries out an assessment of the person cared for in respect of community care services or services for children.

The results of the carer's assessment should be taken into account when the local authority is making decisions about services to be provided to the user.

Carers and Disabled Children Act 2000

Carers (aged 16 or over) of an Adult

- Right to a Carers Assessment (even if the person they care for refuses Social Services assessment or contact)
- Councils now have the power to provide services to carers
- Councils have the power to charge carers for services
- Direct Payments Schemes for carers
- Voucher schemes so person cared for can purchase services which allow the carers to get a break

People with Parental Responsibility for a Disabled Child

- Right to an assessment
- Direct Payments
- Short term break Voucher Schemes

Carers (Equal Opportunities) Act 2004

Clause 1 Duty to inform carers of their right to an assessment

This introduces new provisions to the 1995 and the 2000 Acts giving local authorities a duty to inform carers that they may have a right to an assessment.

Clause 2 Assessment of Carers

This builds on assessments undertaken through the above Acts so that councils have a duty to consider the wishes of carers concerning employment, training, education or leisure activities and take these into account when providing services.

Clause 3 Co-operation between Authorities

NHS organisations, local education authorities and local housing authorities must give 'due consideration' to requests by the local authority to become involved in planning services for carers or to provide assistance to individual carers.

The Work & Families Act 2006
The Work & Families Act 2006 came into effect in April 2007 and gives employees who are, or expect to be, caring for another adult, the right to request flexible working. As an employer, Brighton & Hove City Council, along with other major employers in the city, has a responsibility to its own employees who are also carers to ensure that it offers appropriate support and consideration in response to requests for flexible working. In policy terms the City Council and its partners have an opportunity to influence and promote best practice amongst employers in the local economic community.

Coleman Case
In November 2008 the Employment Tribunal in London ruled that protection for carers against discrimination "by association with disability" can be given under existing UK law. This means that employers will now have to ensure that carers in their workforce are not treated differently to other employees, and cannot refuse to employ someone because of their caring role. The Tribunal has ruled that the section defining the meaning of direct discrimination in Disability Discrimination Act 1995 should be read so that it says:
"A person directly discriminates against a disabled person <u>or a person associated with a disabled person</u> if, on the ground of the disabled person's disability, he treats the disabled person <u>or a person associated with the disabled person</u> less favourably than he treats or would treat a person not having that particular disability <u>or association (as the case may be)</u> whose relevant circumstances, including his abilities, are the same as, or not materially different from, those of the disabled person <u>or the person associated with the disabled person</u>" (the words underlined being those that the Tribunal has added).

NHS Constitution
The new NHS Constitution (England) calls for the NHS to recognise the huge value of unpaid care given and gives carers prominence as partners in care.
The handbook accompanying the Constitution talks about the need to treat "family members and carers as experts and care partners" and that support mechanisms to enable carers to develop their skills and confidence are "particularly pertinent where carers participate in providing aspects of care such as rehabilitation exercises, wound or drug management and manual handling."

NHS Operating Framework 2009/10
The NHS Operating Framework says:
" The carers' strategy sets out how we can ensure that we support carers. One key requirement is that PCT's should work with their local authority partners and publish joint plans on how their combined

funding will support breaks for carers, including short breaks, in a personalised way." It is understood that Strategic Health Authorities will be monitoring PCT performance with this.

Equalities Impact Assessment Template

Aim of Policy / Scope of Service

Joint Development and Commissioning Strategy for Carers: This Strategy sets out how we will be implementing the key principles of the national strategy in Brighton and Hove and addressing local challenges as well as those faced by carers throughout the UK. There will be a 3 year action plan to underpin the strategy and take forward the implementation of the key priorities.

Different Groups included in scope	Potential Impact on this group	Existing data/information inc. relevant legislation	Data/Information required	Potential actions to minimise negative impact and maximise positive impacts
AGE Older People	Older people often see caring for a partner as integral to their relationship and do not recognise themselves as carers or seek help with this role until they reach a crisis. Older carers of an adult child with a learning disability may need increased support to continue in their caring role and/or to plan for a time when they may no longer be able to provide care. These situations may lead to co-caring.	17% of the population aged 50 and over provide care compared with 9% of the overall population in the city. 52% of carers in the city are aged 50+ There are approx. 48,000 people in the city aged 60+ 1 in 5 people over 65 say they do not have good health, compared to one in ten of the total population		When older people with health and/or social care needs come into contact with services ensure their carers are identified. Co-caring to be recognised and recorded and needs of individual as both user and carer to be identified and addressed appropriately.

AGE Young carers	There are almost 500 young carers in the city aged 8-17 years.	Young carers are at risk of under-achieving academically and of their physical and emotional health being affected.	Improve recognition and identification of young carers within both and universal services such as schools and primary care.	Specialist services e.g. substance misuse and mental health and other universal services such as schools and primary care to recognise and identify young carers and take appropriate action. Age specific young carers survey to be developed alongside city-wide survey.
Disability	Many carers also have their own disability and this needs to be taken into account when addressing their needs as well as those of the cared for. Through the Coleman Case and locally we know that carers often experience discrimination and stigma by association with a disabled person. We know that some disabled people are in a co-caring situation and that some young carers will be caring for 2 disabled parents.	2,738 carers not in good health 18% of general population have a limiting long-term illness.		Develop disability monitoring in all commissioned carers' services and Carers Needs Assessments. Ensure disability monitoring included in carers survey currently in development to ensure specific needs of disabled carers are identified. Continue to provide back care service for carers. Monitor uptake and outcomes of IAPTs by carers.
Ethnicity	Caring varies between ethnic groups. Bangledeshi	The 2001 Census estimated that there were just over	How well does the city's varied BME population find	Ensure ethnic monitoring included in carers survey

	and Pakistani men and women are three times more likely to provide care compared with their white British counterparts *(Source: Who cares wins,statistical analysis of the Census Carers UK, 2001).* We know that many carers/family members visit hospital/residential care daily to provide culturally appropriate food, act as interpreters or just to enable the service user to communicate in their own language. There is an existing inequity that some carers' services are free at the point of delivery whilst other services, accessed through Adult Social Care require that the user is financially assessed and may be charged for the service. We know that the uptake of some of these free services by BME carers is not representative of the local community. Therefore, we need to consider how best	14,200 people from non-white ethnic groups across Brighton and Hove - 5.7% of the city's population, just above the regional figure (4.9%) but well below the average for England (9.1%). No one group dominates the BME population. However, the population profile of the city is changing: • 15% of the city's residents were born outside the UK • BME groups were estimated to have increased in size by 35% over the period 2001 to 2004 • 20% of all new births in 2005 were to mothers born outside the UK Whilst a significant number of BME carers, reflecting the local BME population, access the Carers Centre, very few BME carers use other carers' services in the city such as Crossroads or the Alzheimer's Society.	out about and access health and social care services? How and where should we be providing information and delivering services to meet the needs of BME carers? What changes may be required to existing services or new services developed/ commissioned?	currently in development to ensure specific needs of BME carers are identified. Work with BMECP to address identified needs of BME carers. Address inequity of cost of services.

	to address this inequity.			
LGBT population	The LGBT population may experience additional discrimination which can include: • Not identifying with the term carer • Living in "hidden" relationships • Feeling highly stigmatised • Leading secretive double lives causing isolation and fear • Being frightened to be open about their sexuality to service providers • Service providers being embarrassed and ill informed	Anecdotal evidence indicates that as many as 40,000 people identify as LGBT, or 21% of the total population, in Brighton and Hove	Identify needs of LGBT carers	Ensure sexual orientation monitoring included in carers survey currently in development to ensure specific needs of LGBTcarers are identified.
Gender	There may be a greater expectation that women take on a caring role in a family. In turn, this could lead to male carers not being recognised.	Nationally, 42% of carers are men and 58% women. This is reflected in the figures for carers aged 50+ in the city, 43% of whom are men and 57% women. Less male carers than women access services in the city.	Ensure gender monitoring in all commissioned carers' services.	Ensure gender monitoring included in carers survey currently in development to ensure specific needs of men and women carers are identified. Monitor uptake and evaluate outcomes for the male cancer carers' service.
Religion or	The 2001census showed that	The Carers Grant may be		Ensure carers are informed

belief	over a quarter of the population of the city stated that they had no religion, the second highest percentage of any authority in England and Wales. 59% of the population stated that they were Christian and 1.36% of the population was Jewish. The Muslim population is around 1.4% and the Buddhist population 0.7%.	accessed to support carers practise their religion/belief e.g. transport to day service on Sunday morning to enable carer to attend church, increase in home care service during Ramadan. Spiritual support at End of Life is addressed in the End of Life Care Strategy currently in development.		of services available that may support them to take part in faith activities.

Agreed Action	Timescale	Lead Officer	Review Date
Carers Survey – has been commissioned from the Carers Centre to be carried out through a variety of methods in June 2009. A separate survey will be designed for young carers. Funding for translations/interpreting/accessible formats is available. The survey will include equalities monitoring and will seek to identify key outcomes that would best meet carers' needs.	From June 2009	Tamsin Peart	October 2009
Community Engagement – Gateway Organisations – several third sector organisations have been commissioned to develop user and carer involvement in the development, monitoring and delivery of services. These organisations include the Carers Centre, Spectrum, Mind, the Black and Minority Ethnic Partnership, Age Concern and the Federation of Disabled People. It is expected that these organisations will work together to engage a wide range of communities and address issues such as cares' needs, mental health etc.	January 2009 to March 2010	Martin Campbell	quarterly
	June 2009	Carers Developme	September

Carers Needs Assessment Guidance – ensure this is updated to include reference to support available to address religion/belief activities and that co-caring is recognised and recorded and needs of individual as both user and carer are be identified and addressed appropriately		nt Manager	2009
Male Cancer Carers' Support Service – monitor uptake and report back on outcomes	2009/10	Chris Lau, Director Carers Centre	October 2009
Schools – work with schools to raise awareness of the issues facing young carers with pupils, teachers and other staff	2009/2011	Chris Lau, Director Carers Centre	November 2009
Primary Care – through GP Link Worker scheme encourage identification of carers and ensure signposting/referral to appropriate carers' services	2009-2012	Chris Lau, Director Carers Centre	November 2009
Charging for services – DMT to consider charging issues	June 2009	Tamsin Peart	October 2009