Overview & Scrutiny

Title:	**Health Overview & Scrutiny Committee**
Date:	**27 July 2011**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Rufus (Chair), Barnett, Bennett, Follett, Turton, Marsh, C Theobald (Deputy Chair), Phillips, Brown (Non-Voting Co-Optee) and Hazelgrove (Non-Voting Co-Optee)
Contact:	**Giles Rossington** **Senior Scrutiny Officer** 29-1038 Giles.rossington@brighton-hove.gov.uk

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AGENDA

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17.	**MINUTES OF THE PREVIOUS MEETING** Draft minutes of the meeting held on 15 June 2011 (copy attached)	3 - 8
18.	**CHAIR'S COMMUNICATIONS**	
19.	**PUBLIC QUESTIONS** No public questions have been received	
20.	**NOTICES OF MOTION REFERRED FROM COUNCIL** No Notices of Motion have been received	
21.	**WRITTEN QUESTIONS FROM COUNCILLORS** No questions have been received	
22.	**HOSC WORK PROGRAMME 2011-12** Report of the Strategic Director, Resources on HOSC work planning (copy attached)	9 - 20
23.	**BRIGHTON & HOVE LINK: RECENT REPORTS** Recent reports from the Brighton & Hove Link for information. The LINk reports focus on: a) healthcare for the Polish community in Brighton & Hove; b) car parking at the Royal Sussex County Hospital (copies attached). Claire Stevens, the BHLINk host manager will be able to answer members' questions	21 - 70
24.	**IMPLEMENTATION OF THE HEALTH & SOCIAL CARE BILL** Report of the Strategic Director, Resources, providing an update on implementation of key areas of the Health & Social Care Bill, including: (1) the transfer of public health responsibilities to local authorities; (2) transition from LINks to Healthwatch; (3) creation of a local Health and Wellbeing Board (copy attached)	71 - 74

25. 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

26. ITEMS TO GO FORWARD TO COUNCIL

To consider items to be submitted to the next Council meeting for information

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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 - Tuesday, 19 July 2011

Agenda Item 16

To consider the following Procedural Business:

A. Declaration of Substitutes

Where a Member of the Committee 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

4.00PM 15 JUNE 2011

COMMITTEE ROOM 1, BRIGHTON TOWN HALL

MINUTES

Present: Councillors Rufus (Chair); Barnett, Bennett, Turton, Marsh, C Theobald (Deputy Chair) and Phillips

Co-opted Members: Hazelgrove (Older People's Council) (Non-Voting Co-Optee), Brown (Brighton &Hove LINk) (non-voting co-optee)

PART ONE

1. PROCEDURAL BUSINESS

1A Declarations of Substitutes

1.1 There were none.

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 09 February 2011 be approved and signed by the Chairman.

3. CHAIR'S COMMUNICATIONS

3.1 The Chair congratulated the scrutiny team on its recent performance in the Centre for Public Scrutiny National Scrutiny awards – the team won the national award for ‘innovation’ and were runners up in ‘team of the year’.

3.2 The Chair drew members’ attention to a letter he had received from the Director of Adult Social Services concerning city residential care homes managed by the Southern Cross organisation. Members expressed concerns about matters including:

- Reports that Southern Cross planned to cut significant numbers of its staff nationally. Cllr Turton told members that he feared that these cuts would largely fall on direct care provider posts with a detrimental impact upon the care that residents received. Committee members therefore wished to know whether there were any cuts planned at the Southern Cross homes in the city; if so whether these cuts related to managerial or to care provider posts; and, if the latter, what steps Adult Social Care was taking to ensure that residents of these homes did not experience a drop in the quality of their care.

- Potential difficulties in finding suitable alternative placements for residents of the Bon Accord care home. Jack Hazelgrove, representing the Older People’s Council, noted that this home provides specialist placements for people with mental health issues. Members were keen to know how, in general terms, the council planned to re-house residents with particular health needs should this prove necessary.

- The fragility and opacity of the care home system in general. Mr Hazelgrove made the point that a system which relied heavily on a range of independent sector providers was seemingly very vulnerable to crises caused market forces or unwise provider business practices; and that it was difficult for stakeholders to assess the level of risk within this system with the very limited information available on the financial viability of providers etc. Members therefore sought assurance as to how the council ensured that this system was managed safely.

3.3 The Chair agreed to communicate these concerns to the Cabinet Member for Social Care and to the Director of Adult Social Services

4. PUBLIC QUESTIONS

4.1 There were none.

5. NOTICES OF MOTION REFERRED FROM COUNCIL

5.1 There were none.

6. WRITTEN QUESTIONS FROM COUNCILLORS

6.1 There were none.

7. ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH

7.1 Dr Tom Scanlon, Brighton & Hove Director of Public Health, presented his 2010 annual report to the committee. Dr Scanlon told members that the 'theme' for this year's report was 'community resilience'. Rather than simply audit the city's public health needs (much of this work is now done by the local Joint Strategic Needs Assessment: JSNA), the report focuses on community 'assets' - the areas where we do well as a city or across specific communities - and outlines how we might begin better utilising these assets to help address areas of concern or underperformance.

7.2 In response to a question from Cllr Phillips on teenage pregnancy rates, Dr Scanlon told members that latest figures had shown a flattening of recent years' decrease. This was not surprising, as there is likely to be some year on year fluctuation of figures even if the long term trend is downwards, given the small numbers being analysed. Provided the city maintains its twin focus on sexual health/contraception services coupled with addressing the broader 'causes' of teenage pregnancy – educational attainment, family environment etc – Dr Scanlon was confident that figures would continue to decline in the medium term.

7.3 In answer to a question from Cllr Phillips on sexual health advisory services, Dr Scanlon told the committee that services based at the Morley St clinic had proved very popular. More still might be done by encouraging school nurses to play a bigger part in sexual health advocacy. Cllr Marsh noted that this could be controversial work for school nurses to undertake and that a potential role for non-statutory services (such as the 'Crew Club' and similar organisations) should also be explored.

7.4 In response to a query from Robert Brown (representing the Brighton & Hove LINk) concerning community development workers, Dr Scanlon told members that the potential for using these workers to develop community resilience had not yet been fully explored, but that it was an idea with some potential.

7.5 In answer to a question from the Chair concerning how the council should best use the Director of Public Health's report, particularly in the context of the current financial pressures, Dr Scanlon told the committee that his report served as a warning against making cuts to services without properly assessing their impact on communities across the city. Services which were apparently discrete might in fact be closely connected with the health of communities and a key element in community resilience. Their removal might therefore be much more damaging than anticipated unless efforts were made to replace an outgoing statutory service with community-centred alternatives. Dr Scanlon wanted this concept of protecting and enhancing community resilience to be a key part in commissioning decisions.

7.6 The Chair thanked Dr Scanlon for his presentation and invited him to take part in HOSC work planning for the coming year.

8. HEALTHCARE IN BRIGHTON & HOVE

8.1 This item was introduced by Andrew Demetriades, Area Director, NHS Brighton & Hove (NHSBH), and by Dr Xavier Nalletamby, Chair of the transitional Brighton & Hove GP Commissioning Consortia (GPCC).

8.2 Mr Demetriades outlined recent developments to the national and local NHS following progress of the Health & Social Care Bill; Dr Nalletamby sketched the process via which local GPs had agreed to form a transitional GPCC. Dr Nalletamby stressed that city GPs were very conscious of potential ethical issues which might arise if GPs were required to act as both gatekeepers and commissioners of NHS-funded healthcare services – i.e. that as GP commissioners they might be seen as wanting to restrict access to services for financial reasons, when, as GPs, they might wish to refer patients into those services for clinical reasons.

8.3 Dr Nalletamby also emphasised that GP commissioning could not be undertaken effectively without positive public involvement, and that the GPCC was committed to engaging with local residents (although matters of importance to the public would have to be balanced against lower profile but key services such as mental health).

8.4 In answer to a question from Cllr Turton on likely statutory guidance concerning the relationship between the GPCC, the local Health and Wellbeing Board and Healthwatch, Mr Demetriades told members that although he did anticipate some guidance on this issue, it was likely that a good deal would be left to local determination. Work is ongoing with partners from across the local health economy to create a local Health and Wellbeing Board which is responsive to the needs of the local authority, of the GPCC and of local people.

8.5 In response to a query from the Chair concerning the amount of autonomy the GPCC would have, Dr Nalletamby told members that he was optimistic that GP commissioning would make a significant difference locally. If GP powers were too restricted, local GPs would not engage with the GPCC.

8.6 The Chair thanked Mr Demetriades and Dr Nalletamby for their contributions.

9. PRIMARY CARE TRUST LEGACY REPORTS

9.1 Members discussed the issue of Primary Care Trust Legacy Documents.

9.2 RESOLVED – that the report be noted and a watching brief kept on this issue.

10. MENTAL HEALTH ACCOMMODATION STRATEGY

10.1 This item was introduced by Dr Richard Ford, Executive Director of Commercial Development, Sussex Partnership NHS Foundation Trust, and by Jane Simmons, Head of Commissioning, Adult Social Care.

10.2 In response to members' questions, Dr Ford told the committee that this pilot was intended to encourage better 'step-down' with service users moving to less intensively supported accommodation when appropriate and thereby freeing up spaces for more needy patients and reducing the use of acute hospital beds. This would help people live independent lives and enable the local health economy to better manage the costs of supplying housing support to people with mental health problems.

10.3 In answer to a question from the Chair on whether the initiative was designed to produce savings, members were told that this was the case, although given the considerable pressures on the service this would probably equate to avoiding an overspend rather than making actual savings. There is no intention to reduce community care budgets, but rather to manage them more efficiently so the maximum number of people can benefit from the resources available.

10.4 Members thanked Dr Ford and Ms Simmons and agreed to receive a progress report in 6 months time.

11. SUSSEX PARTNERSHIP NHS FOUNDATION TRUST: UPDATE

11.1 This item was introduced by Dr Richard Ford, Executive Director of Commercial Development, and Dr Mandy Assin, Clinical Director, Sussex Partnership NHS Foundation Trust. Dr Ford and Dr Assin briefed the committee on developments at the Trust, including the renovation of Mill View hospital, the 'Under One Roof' initiative and improved services for people with dementia.

11.2 Dr Assin told members that a priority with regard to dementia was achieving better early diagnosis, so that people could be effectively supported in the early stages of illness. Appropriate support at this stage can help people with dementia and their families live high quality lives. Cllr Turton told members that there was an excellent and easy to use toolkit for identifying possible dementia available on the Alzheimer's Society website.

11.3 In answer to a question from Mr Hazelgrove on waiting times for non-urgent treatment, Dr Ford told the committee that this issue did need to be addressed, and that he trusted the ongoing re-design of 'access' services would be successful in reducing waits. However, waiting times for non-urgent mental health services are still considerably lower than waits for physical services.

11.4 In response to a query from the Chair on Mill View beds, Dr Ford told members that long term scenarios included moving the recently established 'vulnerable' ward from the Nevill hospital into Mill View at some point in the future. However, Dr Ford assured members that this would not be contemplated until improvements in community-based services had reduced the demand on acute beds at the Mill View/Nevill sites to a degree which would justify a reduction in bed numbers.

11.5 The Chair thanked Dr Ford and Dr Assin for their contributions.

12. LETTERS TO THE CHAIR

12.1 Members discussed letters that had been sent to the Chair by city commissioners regarding plans to change the way services are delivered for: a) long term conditions; and b) short term services.

12.2 Members agreed to take more detailed reports on these issues when the new service models have been drafted.

13. HOSC WORK PROGRAMME 2011-12

13.1 Members considered the work programme report.

13.2 RESOLVED:

(1) that a sub-group of the committee be formed to formulate a draft work programme, and that this draft work programme be presented to the next full committee meeting for endorsement;

(2) that Councillors Rufus, Marsh and a Conservative group representative should sit on this sub-group, as should Mr Robert Brown, representing the Brighton & Hove LINk.

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

14.1 There were none.

15. ITEMS TO GO FORWARD TO COUNCIL

15.1 Members agreed that the Director of Public Health’s annual report should be referred to full council for information.

The meeting concluded at 18:30

Signed Chair

Dated this day of

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

Subject:		**HOSC Work Programme 2011-12**		
Date of Meeting:		**27 July 2011**		
Report of:		**The Strategic Director, Resources**		
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 In order to put together a HOSC work programme for the next year, we have asked city Councillors and key city partners to contribute ideas to the draft HOSC work programme (see **Appendix 1** to this report for work programme suggestions).

1.2 Organisations consulted include: NHS Brighton & Hove, Brighton & Sussex University Hospitals Trust, Sussex Community Trust, Sussex Partnership NHS Foundation Trust, Brighton & Hove Older People’s Council and the Brighton & Hove Local Involvement Network.

2. RECOMMENDATIONS:

2.1 That members:

(1) Note the suggestions for HOSC work programme items (Appendix 1); and

(2) Agree a 2011-12 work programme

3. BACKGROUND INFORMATION

3.1 It is not our intention here to assign dates to the scrutiny of any particular item. Once items have been chosen, scrutiny support officers will liaise with the relevant NHS trusts, council departments etc. to determine the most appropriate dates for these items.

3.2 It is inevitable that additional topics will be presented to the committee in the course of the year, particularly given the febrile condition of health policy at the moment. Members may therefore wish to choose a limited number of items for examination, rather than risk overloading HOSC agendas.

3.3 Some items listed in **Appendix 1** relate to ongoing pieces of work – i.e. where HOSC had previously asked for a follow-up report on an issue (e.g. breast cancer screening) or where the committee is tracking a process over time (e.g. local NHS trust Foundation Trust applications).

4. CONSULTATION

4.1 Work programme suggestions have been collated after consultation with the key city partners detailed in point 1.2 above.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are none directly: examination of issues agreed by committee members will be supported within the annual Scrutiny team budget. Individual topics for scrutiny may have substantial financial implications, but these will be picked up as appropriate by the relevant reports.

Legal Implications:

5.2

Equalities Implications:

5.3 The HOSC is empowered to “scrutinise matters relating to the health of the Authority’s population and contribute to the development of policy and service to improve health and reduce health inequalities” (**Constitution: 6.1.**2.61). When determining the 2011-12 HOSC work programme members may therefore wish to consider whether the services/plans they choose to examine contribute to reducing health inequalities.

Sustainability Implications:

5.4 None directly, although some health-related issues (e.g. patient journeys for healthcare, carbon footprint of NHS facilities etc.) may have sustainability implications and these should be dealt with in full if these issues are scrutinised.

Crime & Disorder Implications:

5.5 None directly, although some health-related issues (e.g. re: drugs and alcohol services) may have crime & disorder implications and these should be dealt with in full if these issues are scrutinised.

Risk and Opportunity Management Implications:

5.6 When choosing work programme topics, members should consider whether these present ‘good value’ in terms of opportunities to improve local services. For example, although a certain degree of focus on national policy is inevitable, members may wish to examine local policies which can be locally amended rather than national policies which can not.

Corporate / Citywide Implications:

5.7 Members may wish to consider corporate priorities and those of our key partners (e.g. NHS Brighton & Hove) when determining the 2011-12 work programme.

SUPPORTING DOCUMENTATION

Appendices:

1. Suggestions for 2011-12 HOSC work programme

Documents in Members’ Rooms:

None

Background Documents:

None

Appendix 1

HOSC Work Programme 2011-12: Ideas for Scrutiny

1 Issue: PCT Annual Operating Plan (AOP)

Referred By: PCT
Date: Autumn 2011
Notes: The PCT publishes an annual AOP which sets out its high level commissioning intentions for the forthcoming 12 months. This represents an important opportunity for HOSC members to inform themselves about and interrogate PCT commissioning plans. Given the complexity of PCT AOPs, members may wish to take this item as part of a workshop session or via a sub-group rather than as a standard committee item.
Recommendation: Schedule as a workshop event – the AOP is a complex document and does not lend itself to effective scrutiny via a regular committee meeting.

2 Issue: Brighton & Sussex University Hospitals Trust (BSUH) 3T Development progress report

Referred By: BSUH
Date: Sep 11
Notes: 3T is an initiative which will see a major redevelopment of the Royal Sussex County Hospital (RSCH) site in Eastern Road as a regional specialist care centre, with increased focus on trauma, teaching and tertiary services. Plans for this very significant project have been presented to the HOSC on several occasions, with the committee updated on any significant developments in the initiative.
Recommendation: Schedule as committee item for September 2011

3 Issue: Accessibility of RSCH site following 3T development

Referred By: Cllr Janio
Date: Sep 11
Notes: This suggestion refers to patient/visitor access to the RSCH site. There are long term issues with access to the site, particularly in terms of access by private car/parking/parking charges etc, and fears that these problems may be exacerbated by the 3T development.
Recommendation: Schedule for September 2011 to coincide with 3T update (see item 2 above).

4 Issue: BSUHT Foundation Trust (FT) application

Referred By: BSUH
Date: Autumn 11 and Spring 12
Notes: It is Government policy to encourage/require NHS trusts to apply for FT status as soon as they can. BSUH's FT application is ongoing and the trust has updated the HOSC on its application on several occasions already (HOSC is not a statutory consultee on FT applications, but it is considered good practice to involve stakeholders in this way).
Recommendation: Schedule as committee item after discussion with BSUH

5 Issue: South East Coast Ambulance Trust (SECamb) FT application

Referred By: SECamb
Date: TBC
Notes: see notes for Item 4 above
Recommendation: Schedule as committee item after discussion with SECamb

6 Issue: Sussex Community Trust (SCT) progress on merger/B&H services

Referred By: SCT
Date: TBC
Notes: In 2010 South Downs Health NHS Trust, the Brighton & Hove NHS provider of community care services integrated with West Sussex community care services (formerly managed by NHS West Sussex) to form SCT. The Trust came to HOSC to explain the rationale for the merger, plans to improve services etc. There is an update on these plans scheduled for 2011-12.
There are also policies currently under review (including Short Term Services and Long Term Conditions) which may have a significant impact upon SCT. It may therefore make sense to wait until new policies have been agreed and then discuss with SCT how these plans impact upon its operations.
Recommendation: Schedule as committee report(s) after discussion with SCT

7 Issue: Mental Health Re-Commissioning

Referred by: Sussex Partnership NHS Foundation Trust (SPFT)/NHSBH
Date: TBC
Notes: There has been considerable activity in recent months re: re-configuring/re-commissioning city mental health (MH) services. Initiatives include SPFT's 'Under One Roof' and 'Better By Design' plans, and city commissioner's plans re-design MH access services and reconfigure acute MH beds across the city. This is ongoing work and the HOSC will require regular updates on this, as it will on the recently announced MH accommodation pilot.
Recommendation: Schedule as committee report(s) after discussion with SPFT/NHSBH

8 Issue: Breast Screening

Referred By: legacy item
Date: TBC
Notes: Breast cancer screening for city residents is commissioned by the PCT from BSUH. In recent years there have been problems with local breast screening performance, caused by issues re: recruitment, moving over to a digital imaging service etc. HOSC requested an update on these services in 2010, and then asked for a follow up to see whether recent improvements had in fact been maintained.
Recommendation: Schedule in Autumn 2011 (if screening is now back on course, a letter confirming this may be sufficient; if there are still problems with the service then this will require a formal report to committee).

9 Issue: Health & Social Care Bill: Legislative Progress

Referred By:
Date: TBC
Notes: Members might be usefully updated on recent changes to the Health Bill following the 'pause' for consultation, the NHS Future Forum report on this consultation and the Government's response to the Future Forum.
Recommendation: Update paper for committee in Autumn 2011

10 Issue: Health & Social Care Bill: BHCC Implementation

Referred By:
Date: TBC
Notes: There are three main areas of the Health Bill which will require action by the council: (1) the transfer of public health responsibilities

from the PCT to BHCC; (2) the establishment of a new patient and public involvement organisation, Healthwatch, to replace LINks; (3) the creation of a local Health and Wellbeing Board (HWB) to co-ordinate the local health economy and agree the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy. Work is currently ongoing in all these areas.
Recommendation: Include with updates on 9) above.

11 Issue: GP Quality (and access to GP appointments)

Referred By: Cllr Peltzer Dunn
Date: TBC
Notes: Although GPs work to standardised contracts, GP practices are competitive small business with considerable variations in terms of size, buildings etc. Historically, there is a significant variation in terms of general quality of GP practices across the city, as well as large differences in the individual performance areas – including quick access to appointments (but also opening times, patient satisfaction, prescribing etc.) NHS Brighton & Hove is directly responsible for contracting with a quality assuring city GP practices and can share this information with the HOSC
Recommendation: Schedule as committee item after discussion with NHSBH/city GPs

12 Issue: Continuity of Care For People With Mental Health/Substance Misuse Problems Coming Out of Prison

Referred By: Cllr Deane
Date: TBC
Notes: A very high percentage of the prison population have mental health and/or alcohol/substance misuse issues. Left untreated these problems are likely to create difficulties when people are released from custody – e.g. further criminal/anti-social behaviour, worsening MH or physical health problems. However, it is not clear that there is an effective system in place for ensuring that health professionals are made aware of the release of people with severe health problems; there is not necessarily routine sharing of information between prison doctors and GPs etc. There may be particular local issues here, given that B&H has major problems with ASB, chaotic substance misuse etc.
Recommendation: More scoping is required to ascertain what the exact issues are here and how there might be local influence on this matter (offender health is commissioned at a regional/national level as a specialised commissioning contract rather than by individual PCTs)

13 Issue: Maternity (esp. post partum care at RSCH)

Referred By: Cllr Buckley
Date: TBC
Notes: This referral was focused on care for mothers after giving birth at RSCH, particularly in terms of the policy of rapid discharge following straightforward births. However, members may wish to look in more depth at maternity/perinatal services in general (this had been scheduled for 2010-11, but was postponed as the hospital trust was recruiting a new head of midwifery. This could well include discussion about having a local Midwife Led Maternity Unit (MLU) and about effectively supporting women who choose to have a homebirth.
Recommendation: Request report from BSUH/NHSBH on this issue to specifically include discussion of a local MLU. Involve mothers who have recently given birth in these discussions. NB: the committee is not necessarily seeking to criticise maternity care in the city; if there is evidence of really successful local services the HOSC would appreciate the opportunity to help publicise these successes.

14 Issue: Nutrition in Residential Care

Referred By: Cllr Barnett
Date: TBC
Notes: This referral is concerned with food quality and nutrition in nursing and residential homes. This is an issue that has recently been addressed by B&H LINk and members may wish to speak with the LINk and read their report before deciding whether to take action, perhaps in terms of further exploration of key LINk findings.
Recommendation: Talk with LINk before taking further action.

15 Issue: End of Life Care

Referred By: Cllr Wealls
Date: TBC
Notes: This referral particularly concerns dignity in death re: services at RSCH, but might usefully be extended to look at local End of Life services – this is a PCT priority for the coming year, as well as being a national priority area.
Recommendation: workshop event, including PCT, BSUH, local hospices etc

16 Issue: Health Impact of Noise Nuisance

Referred By: Cllr Duncan
Date: TBC
Notes: this referral is particularly concerned with the potential impact of alcohol-related noise nuisance (e.g. late licensing, house parties etc). This is an interesting idea, but will require planning with Licensing/PH
Recommendation: to be considered alongside item 17 (below)

17 Issue: Alcohol Issues

Referred By: Cllr Duncan/Cllr Powell
Date: TBC
Notes: These referrals relate particularly to problems caused by a culture of excessive drinking and its impact on city A&E services (inc lack of a separate children's entrance to A&E), police capacity, problems caused by 2003 Licensing Act etc. These are very significant issues, but there is already a good deal going on here, including the ongoing Intelligent Commissioning Pilot on alcohol issues, a planned (but currently paused) scrutiny panel on alcohol-related hospital admissions, the recent scrutiny report on children and alcohol etc. Members may therefore want to be careful in defining precisely which issues interest them (e.g. looking specifically at the pressure on A&E and possible steps to alleviate this).
Recommendation: HOSC Chair to talk to Cabinet members with responsibility for public health, crime & disorder and IC pilots to see what potential there is for exploring alcohol-related issues without duplicating the work of other bodies. Chair to write to the Chair of OSC asking her to provide an update on the progress of the Intelligent Commissioning alcohol pilot.

18 Issue: Quality/Annual Patient Survey

Referred By: NHSBH/BSUH
Date: TBC
Notes: The committee is likely to be interested in the quality of local healthcare providers, particularly with regard to providers who are struggling to reach an acceptable standard. The Annual Patient Survey is potentially a useful tool in assessing the quality of local NHS trusts (as patient experience is one of the three key areas via which the NHS measures quality). Members may therefore wish to look at the survey results when they become available (and potentially also staff survey information, CQC reports etc)
Recommendation: workshop looking broadly at issues of quality across the local health economy, including patient satisfaction with services.

20 Issue: Cervical Screening/Screening

Referred By: Cllr Phillips
Date: TBC
Notes: The referral for this item was specifically about the cervical screening programme, but this could be broadened to include different screening initiatives (excepting breast screening which is an ongoing performance issue and should be dealt with separately). This item could look at how successful screening is across the city as a whole; whether there are significant differences in uptake across communities/groups of interest (e.g. relatively deprived communities, BME or LGBT groups etc); and if so, what responses are planned.
Recommendation: Committee report

21 Short Term Services

Referred By: NHSBH/ASC
Date: TBC
Notes: City commissioners are currently reviewing the way that city short terms services are configured (short term services are essentially services which bridge the gap between hospital and home – e.g. intermediate care beds, rehabilitative homecare etc). A major aim of this review will be to reduce the number of delayed transfers of care in the city (i.e. delays in discharging patients from hospital), so this item could include focusing on this issue. As a number of short term services are provided by SCT, it may make sense to programme this alongside item 6): SCT services/integration update.
Recommendation: Committee report once Joint Commissioning Board (JCB) has agreed a new short term services strategy

22 Air Quality and Health

Referred By: Cllr Rufus
Date: TBC
Notes: This item seeks to examine the impact poor air quality can have on health, its effects across the city, what contribution it makes to health inequalities in Brighton & Hove, and what steps can be taken to combat it.
Recommendation: Committee report involving Public Health team.

Brighton and Hove LINk Report on the Polish Community in Brighton and Hove

Agreed June 22nd 2011

"I'm so pleased someone is trying to help us."
Polish resident

Juan Moreno – LINk volunteer
Magda Pasiut – LINk volunteer
Claire Stevens – LINk Manager
Dr Anita Rajda-Bolczyk
Prof Krystyna Iglicka, Centre for International Affairs, Warsaw

Acknowledgements

Polish community centre
Father Tadeusz Bialas
Andy Vincent, Stop Smoking Service Manager, Sussex Community NHS Trust (for attending first event)
Mo Cleland, Royal Sussex County Hospital, Brighton Sussex University NHS Trust (for attending first event)

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Circulation of Report

"Health is a vital part of any culture and it can be difficult for people from different backgrounds to integrate and adapt their health practices and needs when they arrive in another country."
University of East London (UEL) Dr Marta Rabikowska,
Senior Lecturer in Media and Advertising

Aims

1) to engage with the Polish community (as a seldom heard from community) to find out their experiences of health and adult social care which will be fed back to commissioners and providers to improve services

2) raise awareness and improve understanding of the health services available

3) raise awareness among the Polish community of the LINk

Background Research

Estimating the population size of the Polish population in Brighton and Hove

According to the 2001 Census the population of Brighton and Hove is 256,300. According to a report in the Argus newspaper in 2006, there were more than 1,500 Polish people living in Brighton and Hove. It is estimated that the main age range of Polish people to the UK is 18-35 years.

The main movement from Poland to the UK:

- 150,000 people settled in Britain after the Second World War
- 1980s - birth of the Solidarity movement
- 2004-2008, 451,433, Poland joined the European Union in 2004

It is very difficult to estimate the size of the Eastern European community living in Brighton & Hove both because of the lack of available official data at the local level and the out of date figures of the last Brighton and Hove census carried out in 2001, which in turn do not correspond to the changes in international migration to and from UK experienced since 2004 after the accession of new countries to the European Union (EU). Furthermore, the 2011 census figures have not been released yet.

According to Home Office statistics, 204,895 Poles had registered to work in the UK and pay tax. In addition, it is important to note that as a November 2010 report from the Office for National Statistics (ONS) explains, there is no single source that exists for the purpose of measuring migration. Instead surveys and administrative sources are used by the ONS both separately and in combination to provide the best available estimates (Gillingham, ONS: 2010: 4). For more information on population size etc please see *Additional Information* at the end of this report.

According to Prof Krystyna Iglicka (2011) the fertility rate in 2009 for England and Wales for women born in the UK was 1.84, while for women born outside the UK, but living here 2.48. Polish women in Britain since 2008 (after women from Pakistan) have the highest number of children born in this country (more than women from India and Bangladesh). It has to be noted here that in 2005 Polish women were on 9th position, while prior to 2005 the number of births to Polish mothers had more distance places in this ranking. In addition, according to estimates by Iglicka, after 2004 the population of Polish children in the UK (at the age of 0-14 years) reaches 130 000. However, Poland has one of the lowest fertility rate in the European Union. In 2008, fertility rate in this country reached only 1.31. Iglicka argues that, the high fertility rate of Polish women in the UK is not the outcome of culture differences but the fact that in the UK more Polish nationals are living in the UK than is being showed by official statistics. As well as transformation from large labour migration into an underestimated long-term

migration, with a strong desire to settle in the UK, they have children because there are better living conditions for families than in Poland.

Employment

The most common areas of employment for the Polish community in Brighton and Hove is likely to be:

- Health care services
- Catering and hospitality
- Cleaning
- Care services

It is also probable like most new migrants Polish residents have more than one job.

About the Polish Health System

Poland is the largest country in Central and East Europe with a population of 38.2 million. Poland joined the European Union in 2004. The health system in Poland is funded by public and private health contributions, although social health insurance contributions are the main public source of health care financing. Health insurance contributions are compulsory.

There is a rigid divide between and inpatient and outpatient specialised care, the latter being mostly based on private medical practices in urban areas or independent health care institutions in other areas. There has been a decrease in infant mortality and more resources put into health promotion and illness prevention. There are 2.3 doctors (most are specialists rather than primary care doctors) per 1,000 of the population and there is also a trend towards healthcare professionals choosing to work overseas. Unofficial payments to doctors is also common.

According to the WHO Regional Office for Europe Health for All database, June 2005 Poland has 4.7 beds per 1,000 of the population, the UK has 2.4.

There is a lack of beds in nursing homes and hospices to and community services and residential care is not sufficient to meet demand so many are are cared for in hospitals.

Health Profile

The main causes of death in Poland are cardiovascular disease (50%) cancer (24%), injuries and poisoning (10% for men and 4% for women). Dental care is largely provided by private dentists. Poland has a high level of immunisation against measles.

Indicator	Source	Poland	UK
Women at first childbirth years old	United Nations Development Programme	24.5	29.1
Smoking prevalence, males > % of adults	World Development Indicators database	40%	27%
Heart disease deaths per 100,000 people	World Health Organisation, WHO	80.9	122
Suicide rate - Males per 100,000 people ()	Annual figures: WHO databank	24.7	11
Digestive disease deaths per 100,000 people	World Health Organisation, WHO	26.7	22.1
Average life expectancy years	World Health Organisation, WHO	75	78.9

Services Offered Specifically for Polish Community in Brighton and Hove

- **NHS Brighton and Hove (PCT)** commission spoken language interpreters for all NHS appointments where one is requested/required and written translations in Polish are available on request.

- Anti-natal classes in Polish

- According to Sussex Community NHS Trust there were 994 requests for verbal interpretation last calendar year in Brighton and Hove. Polish was in the top five 70 (7% of the total). The majority of requests for interpreters for the Polish community were in connection with health visiting.

- **Sussex Partnership NHS Foundation Trust** all their published literature carries an access statement in the 9 languages most commonly used by people using our services. One of these is Polish. The statement offers to translate the publication on request.

  The rough sleeper street services team has been delivering a specialist service to A2/A8 nationals. The aim of the service is to reduce rough sleeping, criminal activity and hospital presentations. There is a 1.5 post to assertively engage this group, both workers have 9 languages between them and are Polish and Czech.

What the LINk did

The LINk:

- held a focus group to which 15 people attended. We invited other healthcare professionals to attend. The Brighton and Hove smoking cessation team and a community midwife also attended. We gave each participant a £5 Asda voucher and served Polish snacks to encourage participation
- attended two other events at the Polish community centre (a Polish GP and a Polish interpreter helped to provide translations)
- funded a lunch for 60 Polish residents
- put up posters in Polish shops and other community venues, English language schools, workplaces etc
- published an article in a local Polish magazine
- added information and resources in Polish to our website: http://www.bhlink.org/your-issues/informacje-w-j-zyku-polskim.phuse
- translated our LINk leaflet into Polish
- collated resources in Polish and these were distributed at community events
- requested the local health service services leaflet in Polish from the Primary Care Trust (PCT)
- promoted during Mass in Polish and Radio Free (in Polish) and newspapers

In total the LINk engaged with 120 of the Polish community in Brighton and Hove.

Resources in Polish collated and distributed by LINk:

- Antibiotics
- Breast Awareness
- Flu Vaccine
- Help with Costs
- Hepatitis C
- Measles, Mumps and Rubella
- The NHS Constitution
- Help to Stop Smoking
- Swine Flu Vaccine
- Tuberculosis
- Tuberculosis for your Baby
- Vaccinations from 3 years +
- Pregnancy and maternity rights for Polish rights

We liaised with Father Tadeusz Bialas, a Polish priest from Mary Magdalen Catholic Church. The Polish language mass has a congregation of 300.

Findings of the LINk

- difficulty understanding the NHS as very different from Polish system
- lack of knowledge about NHS rights
- not everyone was registered with a GP or knew how to do this
- different expectations of the NHS e.g. in Poland childbirth is more medicalised
- levels of English varied and participants appreciated access to health information in Polish
- some participants felt that GPs were too willing to prescribe paracetamol and felt they weren't listened to
- some participants had more confidence in Accident and Emergency as they felt they were treated more seriously (Leaman 2006 confirms this)
- many were unaware they could access a free interpreter
- some did not know that they could access NHS dentistry and that it would be free if they were on specific benefits
- a lack of awareness about cancer screening
- some reported that they were not given enough information on pregnancy and childbirth from the GP and that they could not understand what was said. Some also felt they could have had better access to a midwife. One participant said she was told they if she bled during the first three months there was nothing that could be done to help. This created anxiety and concern which led to some women to choose to return to Poland to give birth
- no participants had any experience in adult social care
- some weren't aware there was free help and support for giving up smoking, cigarettes are much cheaper in Poland, typically €1 per pack of 20 and some bring in cigarettes from Poland to save money. 61% of Polish men and 47% of women in Ireland are smokers (Independent.ie).

Other Research

Although the LINk research did not find any evidence that mental health is an issue for the Polish community in the city it is known through other research that mental health and alcoholism are issues for this community. It is also important to note that loneliness and stress can exacerbate drinking and mental health and that these issues can be more prevalent in new migrant communities as they are away from familiar surroundings and family and friends and likely to face discrimination.. According to research by Bristol City Council et al 20% of the people they surveyed said they had experienced racial discrimination. Shockingly, the Polish embassy stated that a fifth of the 250 Poles who died in Britain in 2007 committed suicide (Shields).

There is some anxiety and shame surrounding preventative examinations such as mammograms and other cancer screenings. According to: "Lung cancer is prevalent in the Polish population and reflects high smoking rates. Cancer is not freely discussed in Poland and take-up rates of cancer screening services are

low.” Project manager North of Tyne Healthy Communities Collaborative – Cancer, Leslie Davie.

Mental Health
The East European Advice Centre found that:

- 21% said that there was someone in their close family who had an alcohol problem.
- Of these, 14% felt that there was no help easily available to them and another 14% knew of potential help that they could get, but did not know how to access it.
- Only 11% said that they were aware of help available for alcoholics and their families in their mother tongue.
- 20% said that they would be too embarrassed to speak to their friends or family if they or someone close to them was suffering from alcoholism.
- 29% admitted that they are unclear about the exact drinking laws in the UK, including the official limit for driving.

Health related Information
Research (Manning) also suggests that immigrant populations obtain much information on health from the media, the Internet, and their friends and relatives. Recent research (Garcia-Retamero et al 2011) examined the levels polish immigrants to the UK have difficulties in understanding treatment risk reduction in both their native and non-native language. It found that they had trouble understanding in either language the way the risks were communicated, which is due to a failure to translate cross culturally not linguistically. They advocated for the use of images, having found that they greatly increased understanding.

Conclusion

The LINk engaged with approximately 120 Polish residents which provided an opportunity to raise awareness of the LINk. We also distributed health information in Polish which was well received which we hope will help provide a greater understanding of the services and support available. We feel confident that the people we approached are now more aware of smoking cessation services and the free interpretation service available for NHS patients.

The LINk did not come across any residents who accessed social care although this is likely to be because the newer Polish residents are younger and not in need of these services.

The LINk would like to see more work done to promote smoking cessation among the Polish community e.g. the smoking cessation leaflet in Polish more widely available and perhaps a drop-in session in Polish for smokers.

As male suicide in Poland (see page 8) is more than double that of the UK and with the increased likelihood of social isolation, poverty and racism compounding the issue it is important that the community are aware of the mental health services available and are encouraged to access these.

Recommendations

1) Information on Brighton and Hove City Council website and NHS Trusts websites produced in Polish, see good practice example: http://mylifemychoices.wigan.gov.uk/health-information-in-polish.aspx)

2) DVD or other information format with information for the Polish community on emergency services, see good practice example: http://www.swast.nhs.uk/news/24-7/swamb24712.pdf

3) Accident and Emergency Department at Royal Sussex County Hospital (and other relevant organisations) has multiple copies use the Emergency Multilingual phrasebook: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4073459.pdf

4) Information in Polish on smoking cessation is promoted widely due to higher prevalence within Polish community e.g. drop-in session for Polish community

5) Information on mental health in Polish widely available and information in Polish is proactively distributed to the community.

6) Information on cancer screening event could be a useful way of raising awareness among the Polish community. Ensuring information is available in Polish on cancer screening is available. Good practice example: http://www.chroniclelive.co.uk/lifestyle/2010/06/14/reaching-out-to-the-community-72703-26648310/

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Rocio Garcia-Retamero PhD and Mandeep K. Dhami PhD, 2011
Pictures speak louder than numbers: on communicating medical risks to immigrants with limited non-native language proficiency

Additional Information

Official data at the national level proceeds from six main sources: the *International Passenger Survey* (IPS); the *Long-Term International Migration* (LTIM) index; the *Worker Registration Scheme* (WRS) launched in 2004 for the EU Accession countries; the National Insurance Number (NINo) allocations to overseas nationals; the *Labour Force Survey*; the *Annual Population Survey*; and the *Higher Education Statistics Agency* (HESA). For a thorough analysis on the strengths and limitations of these data sets please consult Emma Gillingham's report (Gillingham, ONS 2010: 4-9).

Most of the statistical data for Eastern Europeans often refer to the A8 and the A2 countries. A8 is used to indicate the eight accession countries of 2004 (Poland, Czech Republic, Latvia, Hungary, Lithuania, Estonia, Slovakia and Slovenia), and A2 for those countries which accessed the EU in 2007: Bulgaria and Romania. Some reports refer to A12 (the twelve EU Accession countries), grouping A8 and A2 country nationals together with Cyprus and Malta.

The information presented here is a brief outline drawn from the ONS' latest *Migration Statistics Quarterly Report* (MSQR), dating November 2010[1], and the Emma Gillingham's report, *Understanding A8 migration to the UK since Accession*, also from ONS and dating November 2010[2]. Both reports combine and analyse the aforementioned data sets to provide the best possible estimates on international migration in the UK. Overall, the figures presented by the report provide an idea of the total size of EU-Accession country nationals, and especially A8 citizens, within the UK. However, they do not offer a breakdown by nationality and/or place of settlement within the UK, albeit some charts and descriptions on international migration movements within the various regions in the UK (see pages 22 and 23 of the MSQR November 2010 for instance). Therefore, all the figures mentioned here is at national level only.

IPS estimates on long-term migration to the UK, 2004-2010

According to the IPS estimates shown in the MSQR (see Figure 1 below), long-term[3] international migration from A8 citizens rose dramatically from 10,000 in March 2004, to over 70,000 in June 2005, and reached its peak in September 2007 with nearly 110,000. From 2007 thereafter immigration numbers have declined with the latest figure for March 2010 at 58,000. Emigration numbers present a slow, but steady, increase between 2004 and 2008, with a peak of over 60,000 in December 2004. From December 2008 onwards, the numbers of those

[1] The report is available at: <http://www.statistics.gov.uk/pdfdir/mig1110.pdf>
[2] The report is available at: <http://www.statistics.gov.uk/CCI/article.asp?ID=2556>
[3] The IPS defines long-term migration according to the UN definition, which means that a long-term migrant is someone who changes their country of residence for at least a year, so that the country of destination effectively becomes the country of usual residence (Emma Gillingham, ONS, November 2010: page 6).

A8 citizens leaving the UK have decreased. The estimated number of A8 citizen emigrants for March 2010 was of 46,000 compared to the 64,000 in March 2009.

Figure 1: IPS long-term international migration estimates of A8 citizens, UK, 2004-2010

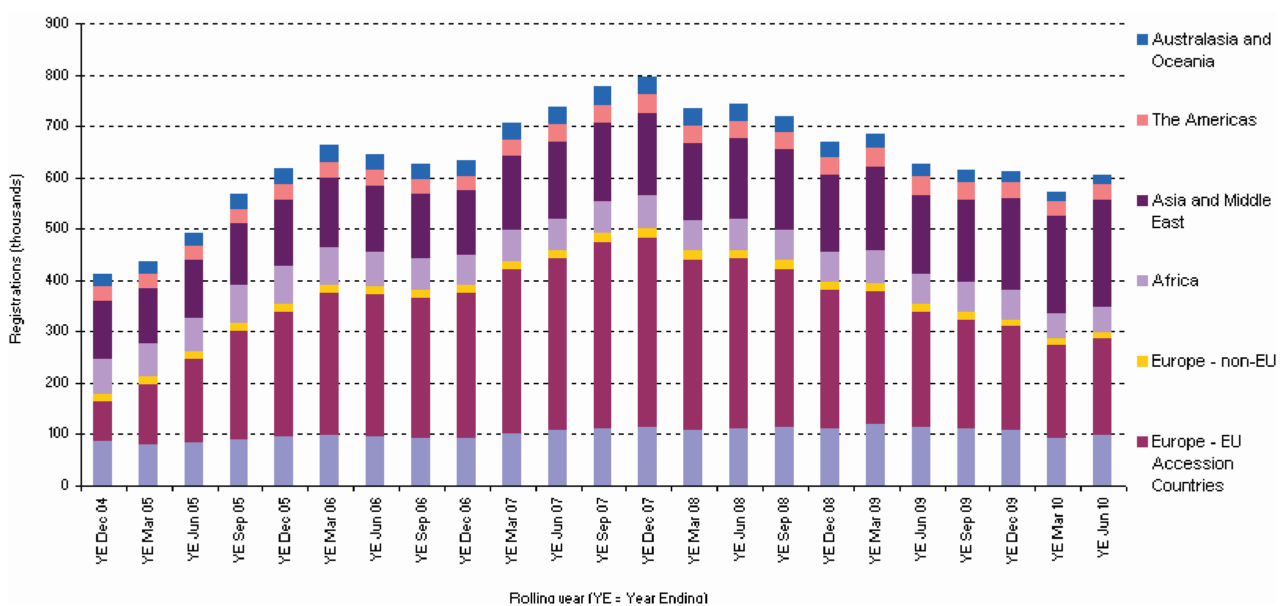
Source: Figure 1.4 Migration Statistics Quarterly Report: November 2010, page 9

The same trend is perceived for net migration when immigration figures are calibrated against emigration numbers between 2004 and 2010; going from under 5,000 A8 country nationals in March 2004 to over 60,000 in June 2005, and over 80,000 in December 2007. From 2007 on, net migration decreases. The latest estimate for March 2010 shows a net migration of just over 10,000.

National Insurance Number (NINo) allocations to overseas nationals and A8 citizens.

Figure 2 below shows the number of National Insurance Numbers (NINo) allocations to overseas nationals. With regards to those NINos allocated to EU Accession countries there is an increase from over 150,000 allocations in December 2004 to over 370,000 in March 2006 and over 470,000 in December 2007. As in Figure 1 for net migration, NINo allocation numbers decrease after 2007 to fewer than 300,000 in June 2010.

Figure 2: National Insurance number allocations to adult overseas nationals by world area of origin, UK, 2004–2010

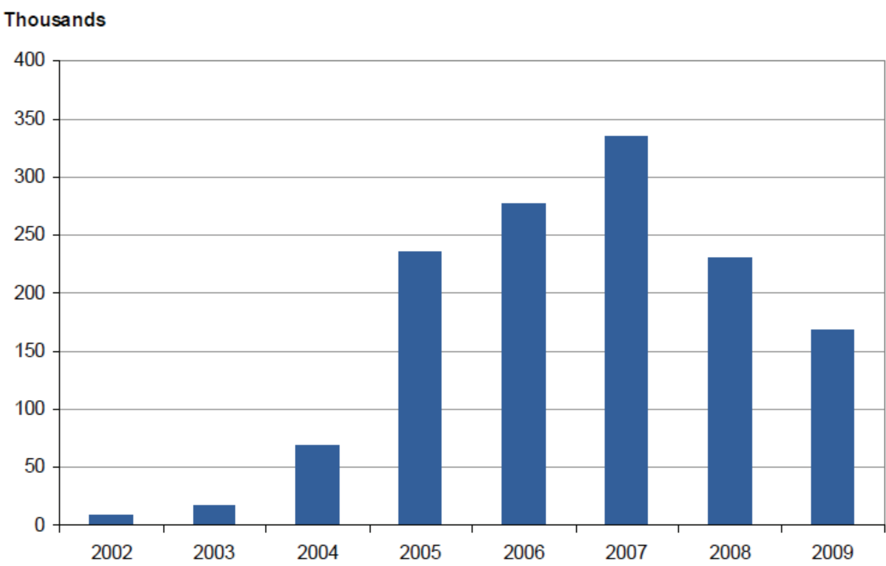


Source: Figure 2.3, Migration Statistics Quarterly Report, November 2010, page 14.
Note: EU Accession countries include A8, A2, Cyprus and Malta.

As shown in Figure 2, after a steady increase the proportion of NINos allocated to Accession nationals as per total of NINo allocations to overseas nationals is in decline. While in December 2007 EU-Accession nationals accounted for 46 per cent of all NINos allocations to adult overseas nationals, this figure has now dropped to 31 per cent.

If we look at the number of NINos allocated to overseas nationals from A8 countries (Figure 3, below), it is possible to perceive the same trend of overall increase in 2004-2007 and rapid decrease thereafter.

Figure 3. NINo allocations to overseas nationals from A8 countries by calendar year of registration, 2002-2009



Source: Gillingham's report, ONS November 2010, page 12

The allocation of NINo to A8 migrants was at a level of 17,000 before accession. In 2004, the number of NINo allocations was over 60,000 and it peaked in 2007 with 335,000. Again, between 2007 and 2009 figures fall with less than 230,000 allocations in 2008 and 168,000 in 2009.

The allocation of NINos is very important and useful to indicate the number of those A8 country nationals who intend to work legally and claim benefits in the UK and therefore allows for an analysis of their impact on both the labour market and the social services.

Nevertheless, these figures are constrained in two main ways. First, they do not provide any indication on the number of immigrants leaving the UK and/or actually resident in the UK. This means that it may count NINo allocations for individuals who have already left the country. Furthermore, there may be a delay between A8 country nationals' entry to the UK and their actual registration for a NINo. According to the ONS report, however, over half of those entering the UK register within the first 6 months of arrival, and around three-quarters of them do it within a year of arrival (Ellingham, ONS 2010: 7-8). Second, the number of people who have been allocated NINos is not the same as the number of those who are working in the UK. This may be because they leave the country or become unemployed.

Nevertheless, NINo allocation numbers can be combined with IPS data which measures the inflows of A8 citizens by main reason for migration. According to the IPS estimates (see Emma Gillingham, ONS, November 2010: Table 2, page 11) between 2004 and 2007 the main reason for A8 citizens migration to the UK was work related. While the numbers of those coming to work was of 37,000 in 2004, this had come to 82,000 by 2007.These figures must be taken with care since the IPS 'work related reasons' category includes those coming with a

definite job, or job offer, and those looking for work, and therefore not necessarily getting a job. Nevertheless, overall IPS estimates clearly reflect the trends shown by the NINo allocations; rapid increase after Accession and decline in numbers in the last years. While those coming for work related reasons amounted 82,000 in 2007, that figure had been reduced to 48,000 in 2008, and almost half, 43,000, the following year (see *Ibid*).

Worker Registration Scheme **(WRS)**

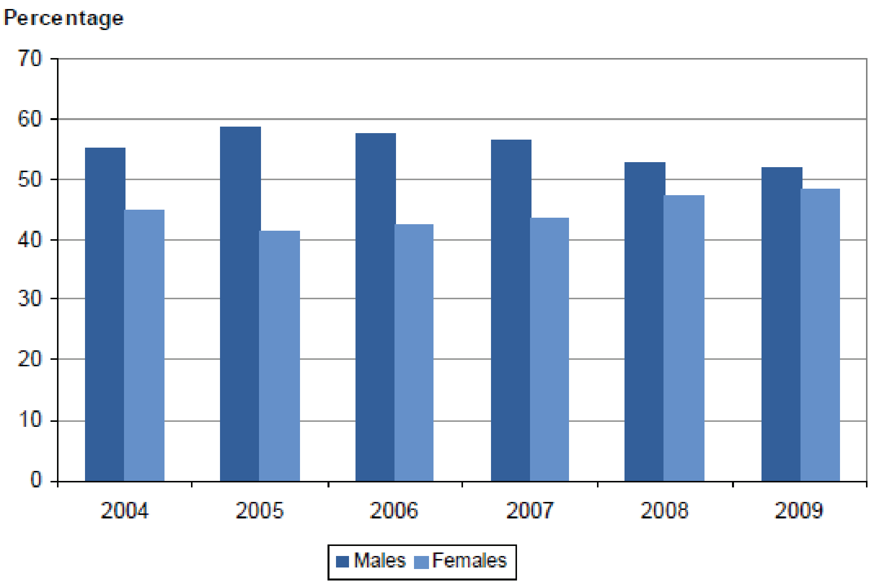
This scheme was launched in before the A8 countries became officially part of the EU in order to measure the potential impact of immigration on the labour market, employment benefits and social services of the UK. The scheme ended on April 30, 2011, meaning that nationals from the A8 countries will now have the same rights to live and work in the UK as the rest of EU nationals. The complete data and analysis proceeding from the WRS can be obtained from the *Accession Monitoring Reports Archive* at the UK Border Agency's website, available at: <*webarchive*.nationalarchives.gov.uk/20090804164037/http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/reports/accession_monitoring_report/

The WRS is a useful source of information as it covers the majority of A8 migrants planning to work legally and claim benefits for at least a month, therefore covering both short and long-term migrants. It is based on place of work rather than place of residence, which according to the Home Office is more accurate (Emma Gillingham, ONS, November 2010: page 8). The main flaw of this data set is that there is no obligation to de-register, which means that WRS can only be used to analyse the inflow of A8 immigrants (*Ibid*).

WRS applications, along with NINo allocations, allow for estimates on A8 citizens migration patterns in terms of sex and age patterns[4]. Estimates show that following accession the majority of A8 immigrants coming to work to the UK were males. However, the proportion between males and females has balanced in the last couple of years (see Figure 4)

Figure 4. Percentage of WRS applications by date of application and sex, May 2004 – December 2009

[4] Note that for estimates migration by sex and age patterns the ONS November 2010 report draws data from other sources as well such as the *Annual Population Survey* or the IPS, and which are not mentioned here for reasons of space (see Emma Gillingham, ONS, November 2010: pages 15-22).



Source: Extracted from Emma Gillingham, ONS November 2010: Figure 7, page 17

As Figure 4 clearly shows, the number of male A8 citizens was clearly larger than that of females; in 2005 around 58% of WRS applications were men by males in compared to 40% that of women. Although the percentage of WRS applications has been overall larger for men, this has seen a considerable decline in favour of an increase in females' applications. While in 2007, the ratio was 55% for men and just over 42% for women, by 2008 men accounted for 53% of applications and women for 47%.

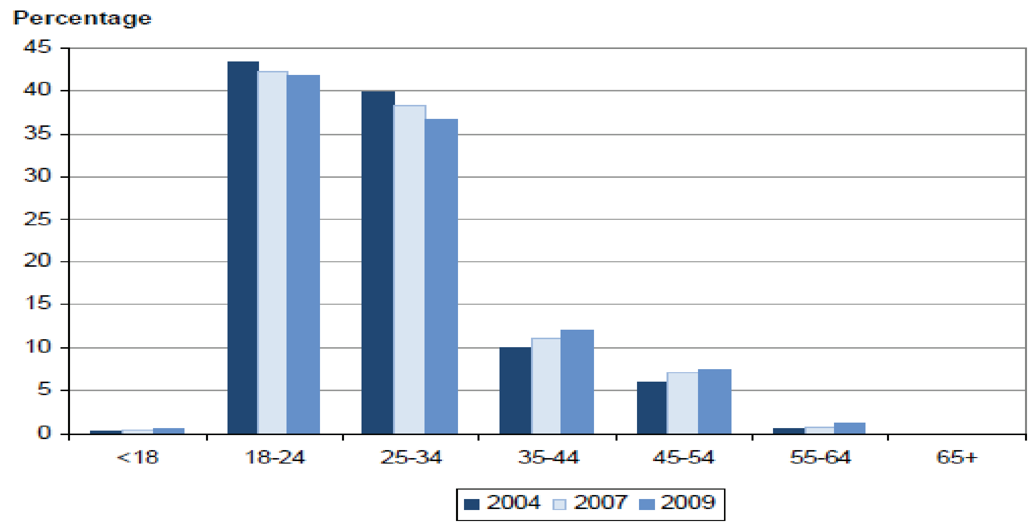
In addition to the increasing numbers of females WRS applications, there has been since Accession an increasing pattern in the number of women of child-bearing age and with it an increase in the number of live births to women born in A8 countries (see Emma Gillingham, ONS, November 2010: Table 5, page 24). Even though the percentage of live birth figures to women born in A8 countries in relation to the total of live births in the UK increased considerably since Accession in 2004, they still constitute a small percentage of total live births. While in 2004 they accounted for 0.5%, by 2009 they had reached 3.7% (*Ibid*).

Most of NINos allocations and WRS applications for the years following Accession show a predominance of young workers between the ages of 18 and 34 years old (see Figures 5 and 6 below). It is clearly visible from the two figures below, that the majority of A8 migrants to the UK are young workers. By 2009, people aged 18-24 years old constituted over 40% of the WRS applications, and those aged 25-34 over 35%.

However, when we compare the younger age categories with the older age groups a slight change in the age structure is appreciated. While the younger categories declined in numbers between 2004 and 2009, the older group

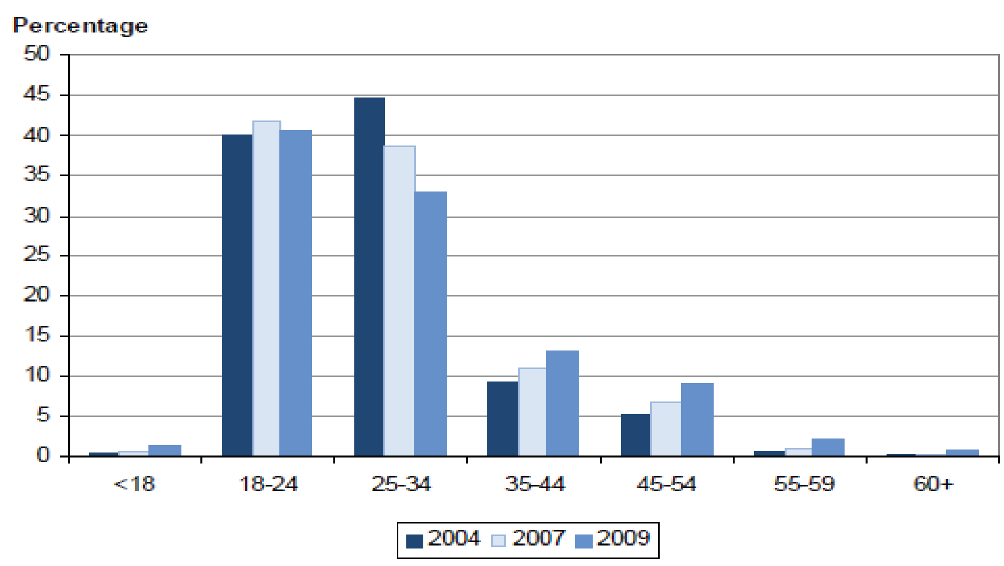
increased. This means that in recent years the age patterns of A8 citizens coming to work in the UK has shifted to older workers.

Figure 5. Percentage of WRS applications by age and date of application, 2004, 2007 and 2009



Source: Extracted from Emma Gillingham, ONS, November 2010: Figure 9, page 20

Figure 6. Age distribution of NINo allocations to A8 nationals in 2004, 2007 and 2009 by calendar year of registration

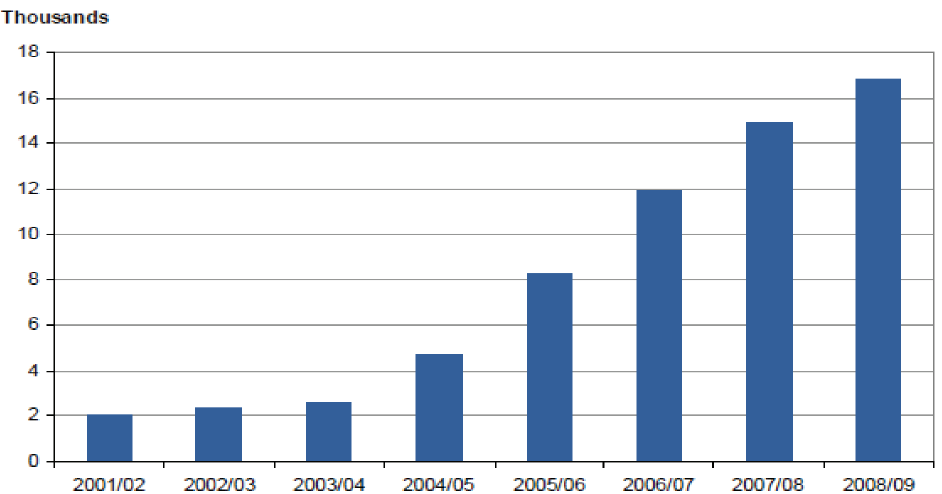


Source: Extracted from Emma Gillingham, ONS, November 2010: Figure 10, page 21

***Higher Education Statistics Agency* (HESA)**

In contrast to NINo allocations and WRS applications which show a clear decline from 2007 onwards in the numbers of A8 citizens migrating to the UK to work, the number of A8 citizens coming to study at UK universities has increased every year since Accession.

Figure 7. A8 student numbers in Higher Education institutions in England and Wales, academic years 2001/02 – 2008/09.



Source: Emma Gillingham, ONS, November 2010: Figure 3, page 13

While for the 2004/05 academic year HESA numbers showed a total of over 8,000 A8 students in the UK, by 2007/08 there were nearly 15,000, and close to 17,000 by 2008/09. As the report indicates this constitutes less than 1 per cent of the total student numbers in England and Wales higher education (0.7% 2008/09).

Circulation of Report

Brighton Sussex University Hospital NHS Trust
Sussex Community NHS Trust
South East Coast Ambulance Service
Health Overview and Scrutiny Committee (HOSC)
Brighton and Hove City Council
Sussex Partnership NHS Foundation Trust
NHS Brighton and Hove
Black Minority Ethnic Community Partnership (BMECP)
Polish Community Centre
GP Consortia Chair
Council of Ethnic Minority Voluntary Sector Organisations

Brighton and Hove LINk Report

Car Parking at
Royal Sussex County Hospital

Mick Lister, LINk volunteer
Sylvia New, LINk volunteer
Claire Stevens, LINk manager

Agreed 22.06.11

Contents

1. Acknowledgements
2. Summary
3. Introduction: information on LINks and background to project
4. Background
5. Methodology: research tools, limitations of research
6. Results
7. Recommendations
8. References
9. Appendices

1. Acknowledgements

LINk enter and view representatives: Mick Lister, Robert Brown, MBE, Roy Pennington, Farida Gallagher.

Geoff Britten. (Transport Co-ordinator. Transport Bureau. Royal Sussex County Hospital, RSCH)

Nina Aynsleigh-Marshall. (Transport Co-ordinator. Transport Bureau, RSCH)

Lee Gander. Patient Transport at Bluebird Community Partnership

Patients, visitors and unpaid carers at the Royal Sussex County Hospital

2. Summary

This study was mainly concerned with looking into accessing the North Car Park at the Royal Sussex County Hospital, Eastern Road, Brighton.
The study did cover other aspects of parking at the hospital, such as parking costs, use of public transport to get to the hospital and patient/public views on improving parking at the hospital.

Two separate surveys and an observation visit were carried out by Enter and View Representatives from Brighton and Hove LINk. The two surveys were carried out on Friday mornings and the observation visit on a Saturday morning. On reflection these were not the best times to carry out a survey as they were not the busiest times at the hospital, in the case of the first survey on a Friday morning 4 day clinics had been cancelled.

Some 62% of people surveyed travelled to the hospital by car, of these 48% parked their car on the street or were dropped off by a friend or relative. Of those people who parked in the North Car Park most said they usually had to queue for between 20-40 minutes before gaining access. Those who parked on the street or were dropped off at the hospital, did so because their previous experience had been that there were no available spaces in front of the Barry Building or there had been long delays in accessing the North Car Park.

As a result of these problems in parking when attending the Hospital either as a visitor or as a patient, people are having to allow extra time when travelling for an appointment or visit. In some cases patients have been late for their appointment through no fault of their own.

Views on hospital parking in this report are based on a relatively low number of questionnaire respondents (77) to 2 separate surveys of whom, 54.5 % were patients.

- In addition a LINk volunteer informally visited the North car park and surrounding roads in order to get an impression of the area.

- The surveys give a very limited picture not least because they were undertaken after 10 am on the morning of 05.11.10, and also on 11.03.11, a Friday afternoon when 4 outpatient clinics had been cancelled so fewer people than usual were in the Outpatients dept.

- The independent visit took place on a Saturday morning 16.04.2011 when there were unlikely to be large numbers of car park users.

- 11 (14 %) of the people in the survey complained of very long waiting times at the car park and therefore having to queue for some time. This contributed to the stress they were already experiencing, especially if they then arrived late for their appointment. This influenced their decision regarding mode of transport to the hospital in future.

- 57% of the people expressing an opinion about car park charges thought that they were unreasonable.

- Only 30% thought that the charges were reasonable, and 13% did not know. However, it must be noted that some people choose to park at the Royal Sussex County Hospital (RSCH) and go into town from there because it is cheaper than parking in the town centre – these users might well say that charges are reasonable.

- The major redevelopment plan for the hospital includes only 200 extra parking spaces. Given that there are already serious parking problems, and the new build will result in more patients, visitors and staff this seems unlikely to be sufficient.

- The proposed 691 vehicle parking spaces across the whole site is below that which would be allowed as a maximum by Brighton and Hove City Council (BHCC) if the full standard entitlement were to be used. With approximately 3,300 staff at any one time, and approximately 600 beds, the parking provision could be increased to 2,250 parking spaces. The total quantum of vehicle spaces being requested for the site as a whole represents just 31% of this total permissible allocation.

3. Introduction

The LINk is a statutory body established in 2008 under the Local Government and Public Involvement in Health Act 2007. It is an independent network of people and groups who help make social and health care better in their local area. The LINk helps people have their say and makes sure that what they say is listened to. The LINk has powers to monitor and investigate issues relating to publicly funded health and social care.

The Department of Health (DH) (Sept 2010) is aware that access to, and charging for hospital car parking is an important issue for patients and their visitors. Some people are unhappy about the principle of being charged to park their vehicle when accessing NHS services, as they believe it contradicts the principle that NHS treatment is free at the point of delivery. Others are unhappy about the level of charges imposed. Provision of spaces and level of charges is currently a matter for individual hospital trusts, taking account of their local circumstances. DH guidance in line with recommendations made by the Health Select Committee advises that concessions should be offered to protect frequent users of NHS services. Concessions may be either reduced rate or free provision, under qualifying criteria set by local managers. This guidance has no statutory provision although Trusts are expected to take account of it.

The LINk elected to undertake this piece of work as a result of a number of individuals raising concerns about access to parking at RSCH. To obtain data direct from patients, carers, staff and visitors, the LINk agreed to undertake 2 surveys in order to collect the views of people whilst they were directly using the services. These were:-

- Based around people queuing at the North car park.
- In the Outpatients department in order to ascertain what proportion of people had come by car and identify those who had experienced difficulty in accessing the North car park in the past.
- A visit by a LINk volunteer was carried out to view the layout of the North car park, its entrance/exit arrangements and the surrounding road network.

The LINk enter and view team of authorised representatives are fully trained and all have completed an enhanced Criminal Records Bureau check.

The LINk had already recommended that more information was provided on the BSUHT website on car parking and charges and concessions and this was implemented.

The results were gathered on 05.11.10 and 11.03.11 and 16.04.2011 at the Royal Sussex County Hospital (RSCH) which is part of the Brighton and Sussex University Hospital NHS Trust (BSUHT).

A report by Siobhan Ryan, health reporter for the Argus newspaper also highlighted concerns from staff, patients and residents around car parking at RSCH. (See appendices)

4. Background

BSUHT currently has 480 car parking spaces with 72 dedicated to patients and 73 to hospital staff and vehicles and 335 shared between everyone. The multi-storey has 20 disabled bays located on Level 6 which gives direct access into the hospital and 6 dedicated renal bays for regular renal patients.

The hospital has installed new digital car park signs in Eastern Road which tell people how many spaces there are and how long they will have to wait.

There is limited access to the A&E forecourt with 4 drop-off bays and 2 disabled bays.

At the front of the main hospital site there is a pay and display car park for patients and visitors only - this has 12 disabled bays outside the Physiotherapy Department (Latilla building) and 5 disabled bays by the car park entrance.

Car parking charges apply to all users, including those who are disabled.

The hospital has attendants working at the car parking sites to help ease traffic flow and guide drivers to the right spot.

There is a considerable amount of pay and display parking located in the roads around the hospital including from 2 hours limited parking, 4 hours limited parking and 11 hours parking.

There are several bus stops that serve this site on Eastern Road.
Routes 1, 1A, 7, 14B, 23, 37, 37B, 40X, 47, 52, 57, 71, 73, 90, 94A, N7, N99
All stop outside the hospital.

The redevelopment plans for the southern half of the RSCH will bring the total on site vehicle parking to 691 - approximately 31% of the total amount permissible under BHCC parking standards. This is 200 more vehicle spaces than at present. Additionally, there will be 180 cycle parking spaces. There will also be improved drop-off facilities at a frontal point off Eastern Rd.

Some concessions for car park fees are available on site for the following people: -

- The Sussex Cancer Centre has their own car park for daily visitors (for radiotherapy, chemotherapy, out-patients, etc). They used to charge £1 to park for a day (01273 696955 ext. 4901).

- The Renal department (01273 696955 ext. 7624) does help out some of their patients with parking in the multi-story car park on the RSCH site. Contact extension.

- Disabled patients do not have any sort of discounted parking on either hospital site (RSCH or Princess Royal Hospital in Haywards Heath).

- Some people on benefits can claim back parking fees (see Appendices)

- If a person applies to be a volunteer for the BSUH Trust and gets accepted, they can apply for a BSUH parking permit - and this will be free of charge.

The Patient Transport Department provided the following information on help for disabled patients:

"Due to the high demand for patient transport, we screen booking requests and only grant it to those who meet the criteria. Basically, if the patient has a mental or physical condition that prevents them from being able to use public transport / taxis and this can be verified by their GP or hospital consultant then they will be provided with transport. Patients cannot request transport themselves; If it is their first referral to hospital the GP is responsible for booking/funding transport and for subsequent appointments, the hospital department the patient is attending."

Patient Transport at Bluebird Community Partnership, operate a booking service with Volunteer Car Drivers, any one will qualify for Medical Transport, however it does depend on the availability of the Volunteer Driver. Patients can access the service by calling 01444 417919 after 9.30a.m.

5. Methodology

Results were gathered from questionnaires completed by patients, carers, staff and visitors which are recorded in the Results Section of this Report.

More in-depth observations were recorded by Enter and View representatives. Enter and View is a legal right of the LINk and means the observing of the delivery of health and social care services and collecting the views of people whilst they are directly using those services. It is a legal right of the LINk to be able to enter publicly funded services.

In addition, a LINk volunteer visited the North Car Park on a separate occasion in order to note the layout and occupancy of the bays.

Limitation of results

The total questionnaire survey size was 77 people. Although this gives a good indication of people's experiences with car parking at RSCH, it cannot be seen to be a significant sample. Furthermore the results are based on \`snapshots\` from 2 occasions which may not be typical.

However it does demonstrate representative views of people using the RSCH.

The separate site visit to the North Car Park was undertaken on a Saturday morning when it was unlikely to be very busy.

- People would be less likely to be using it as a cheap place to park while they go to work elsewhere in Brighton.
- There would not be many / any clinics being held in Outpatients.
- Most visitors would be expected to come in the afternoon or evening.

However. this did provide the opportunity for a thorough check on the occupancy of marked disabled and renal parking bays.

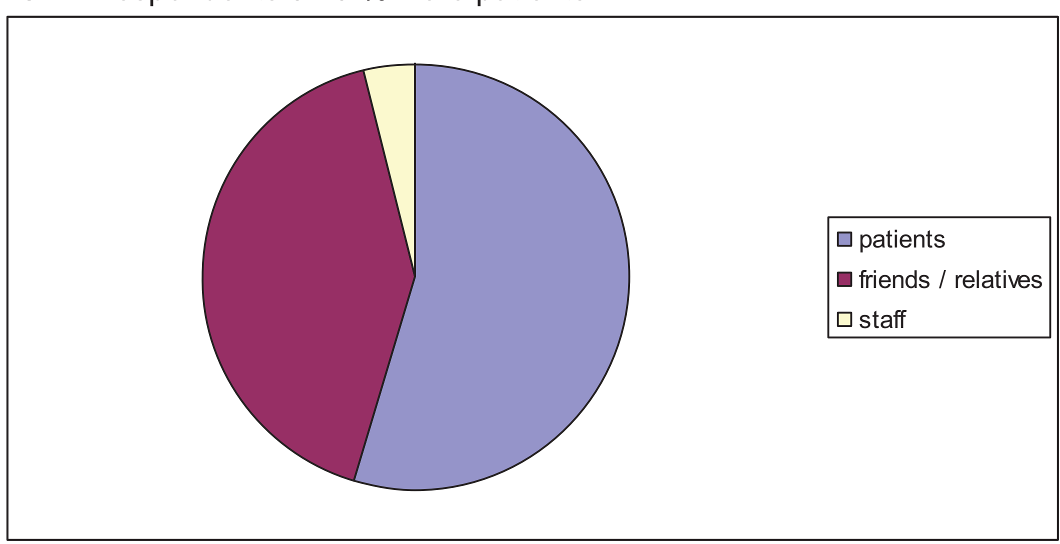
The RSCH Transport Bureau and Transport Coordinator were contacted for further information, as was Patient Transport at Bluebird Community Partnership.

6. Results

Q1. Are you?

a patient	42
non paid carer	0
relative/friend	32
staff	3

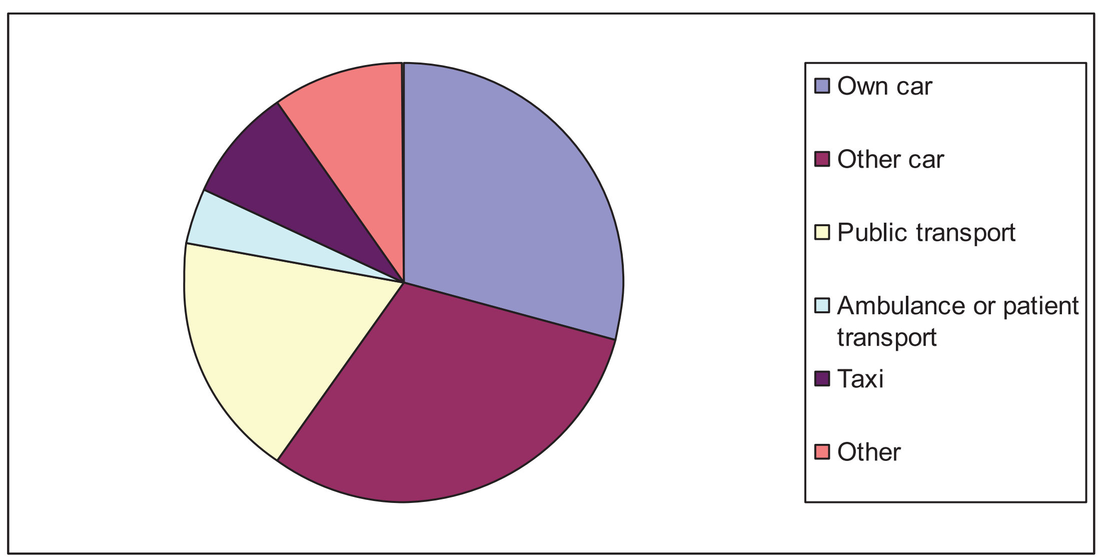
Of 77 respondents 54.5 % were patients.



Q2. Which mode of transport did you use to get here?

Your car	21
Other car	22
Public transport	13
Ambulance or patient transport	3
Taxi	6
Other	7

Approximately 56% (43 / 77) had travelled to the hospital by car on this occasion.



Q3. Are you registered disabled?

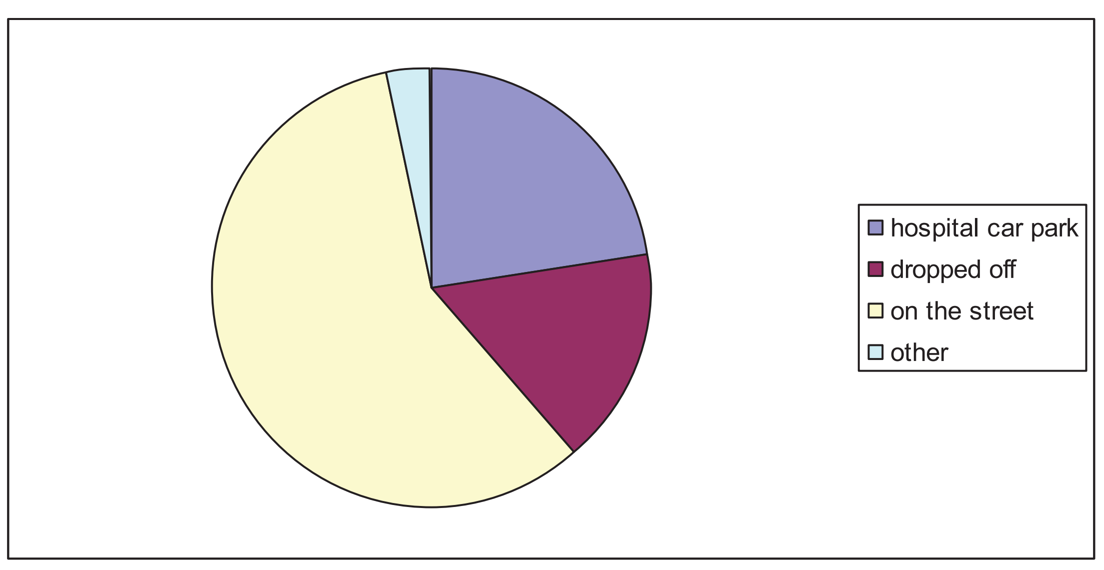
Yes	8
No	63
No response	6

Approximately 13% (8 out of 63) of those who responded were disabled.

Q4. If you came by car, where did you park?

hospital car park	7
dropped off	5
on the street	18
other	1

Approximately 23% (7out of 31) had parked in the hospital car park.



Q5. If you came by car, how long did you wait to park today?

less than 5 minutes	19
5-10 minutes	12
half an hour	4
40-50 minutes	0
an hour	1
more than an hour	0

47 % (17 of 36) had to wait more than 5 minutes to get into the car park.

11 people in the survey (14%) complained of very long waiting times and having to queue.

Q6. Have you been offered any help parking, from parking attendants etc?

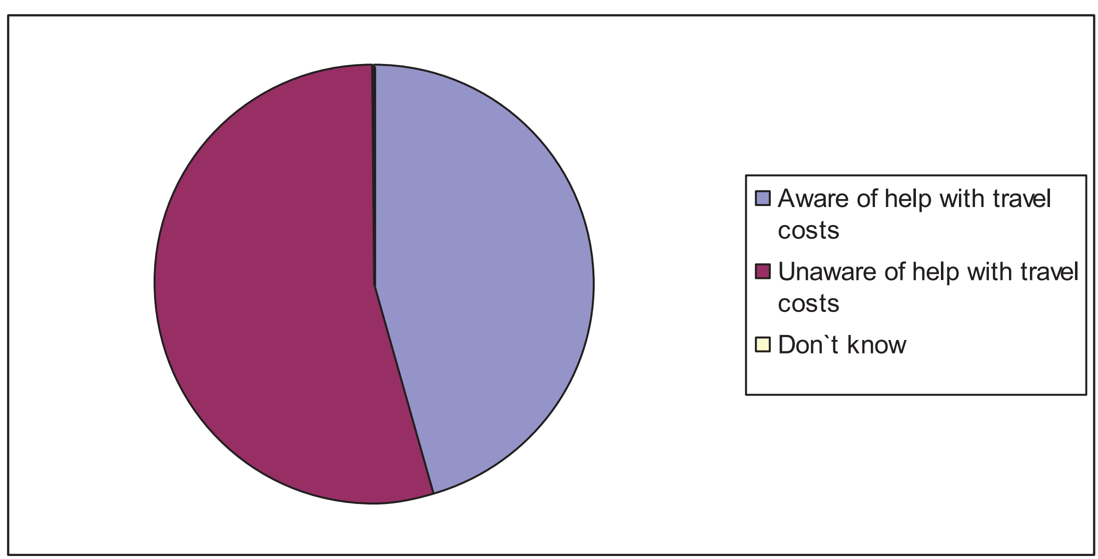
Yes	5
No	31

Most people (86%) had not been offered any assistance with parking.

Q7. Are you aware that if you are on a low income or benefits you may be entitled to reclaim your travel costs, to and from hospital?

Yes	30
No	36
Don`t know	0

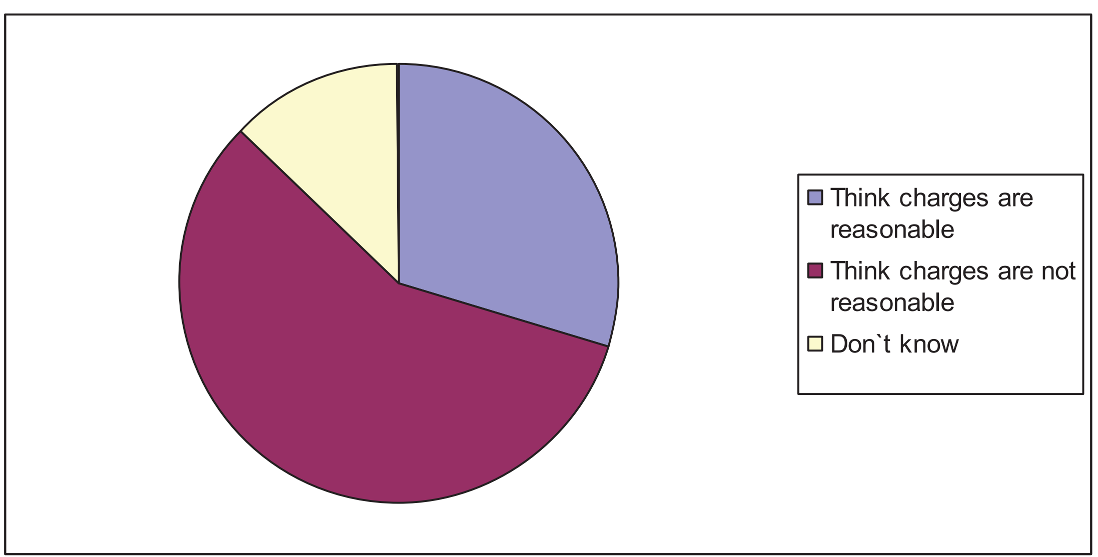
More than half the people surveyed (55%) were unaware that those on low incomes might be able to reclaim travel costs to and from hospital.



Q8. Do you think the car parking charges are reasonable? (0 – 2 hours £2.00, 2 – 4 hours £3.00, 4 – 6 hours £4.00)

Yes	14
No	27
Don`t know	6

57% of the total thought that the charges were unreasonable while only 30% thought that they were, and 13% did not know.

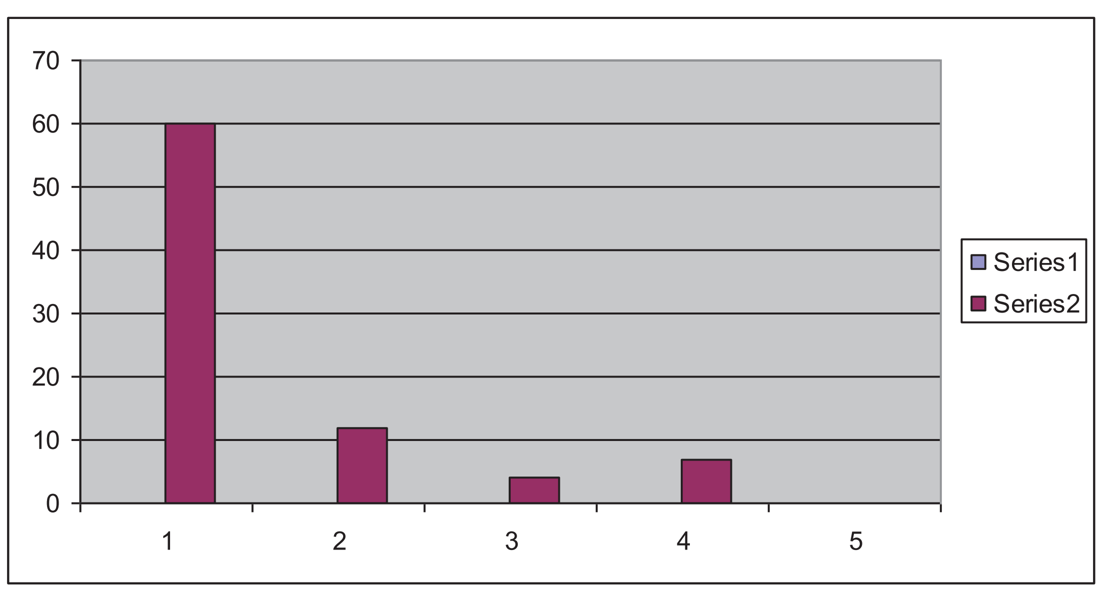


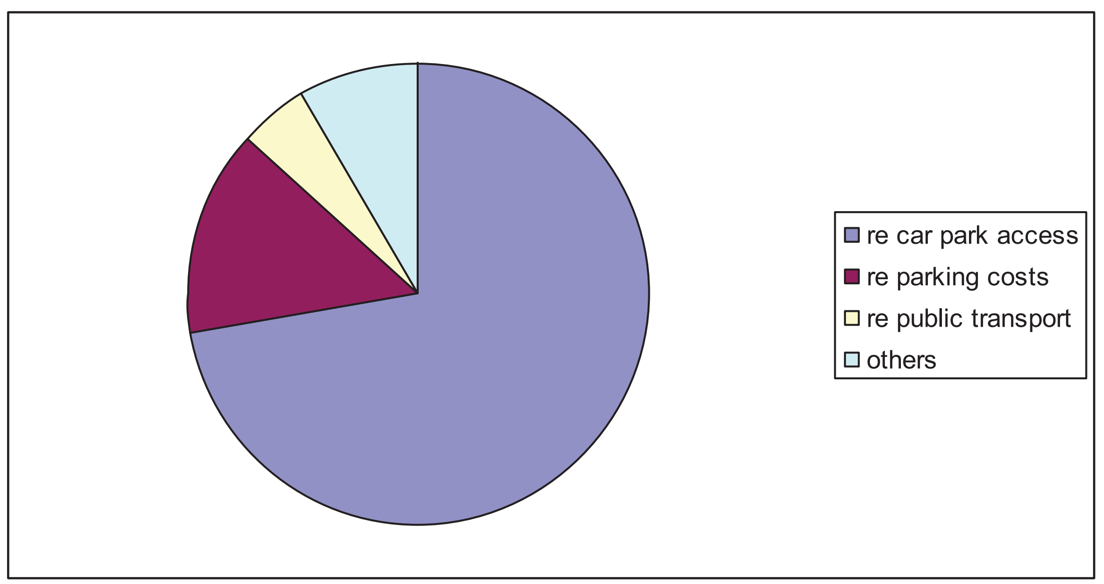
Q9. What do you think could be improved with car parking at this hospital?

This provided an opportunity for people to express their own views, complaints and ideas.

There were 83 suggestions in total - 10 repeated more than once. They were organised into 4 categories:-

1. Car parking access = 60 = approx 72% of the total comments.
2. Parking costs = 12 = approx 15% of the total comments.
3. Public transport = 4 = approx 5% of the total comments.
4. Others = 7 = approx 8% of the total comments.





Observations during informal visit to the North Car Park:

- No Parking attendants were seen during the 90 minutes while the volunteer was present.
- The car park was approximately one third full with many empty spaces.
- 13 Disabled spaces were occupied by cars which were not displaying either a blue badge or a yellow renal patient card. This was despite there being plenty of other empty spaces to choose from. (These spaces are near exit doors for easier access).

7. Recommendations

1. SPACE

The Which? Report states that around ½ of hospital car park users have had a very stressful visit made worse because they could not find a space.
This is borne out by the results of our survey.

The major redevelopment plan for RSCH includes only 200 extra parking spaces.

1a.This number needs to be increased to a more realistic level.

2. **ACCESS to North Car Park**

2a. Create a one way through road in from Bristol Gate along the North Access Rd leaving via Whitehawk Hill. This would allow quicker access and reduce users` frustration. The area of the turning roundabout could then be used for extra disabled parking bays.

If the queue were on the right hand side of the road, trapped drivers who decide to leave can make their escape. This would reduce waiting times. It would also be within the hospital grounds and not clogging up surrounding roads. However, it would involve the cost of switching round the entry/exit barriers and some repositioning of the disabled bays just inside the car park.

2b. Improved signage would help users.

2c. Attendants could go through the queue seeking out blue badge holders in order to `fast track` them in when there are free disabled spaces in the car park.

2d. Provide more disabled parking bays outside the Barry building – some blue badge holders would not then need to queue at the North car park, and they might also be nearer to the departments that they are visiting making access easier for them.

2d. Have someone regularly check the disabled parking bays in the North Car Park and the few outside A&E to move unauthorised drivers on and ensure that those who need the bays can get into them.

2e. Display prominent signs on the wall in front of each disabled bay on the hospital site stating that unauthorised users may be clamped or fined if they ignore them and occasionally do this.

2f. Investigate the possibility of setting up a Park and Ride for staff, patients and visitors. This would relieve pressure at RSCH and the surrounding area (possibly sited at Black Rock or Brighton Race track).

3. CHARGES

Charges must be fair and cover the cost of running the car park but without generating a profit.

3a. Concessions for patients who visit regularly should be reconsidered e. g. renal patients have to spend many hours a week at the hospital and should not have to pay for parking while visiting the dialysis unit.

3d. Concessions should be widely advertised in car parks, patient literature to ensure that patients are aware that they may be entitled to reclaim travel costs.

3e. Reimburse patients for additional parking fees when appointments are excessively delayed or have a fixed rate charge if a way can be found to identify those car park users who are genuinely going to the hospital.

3f. Investigate possibility of concessionary fares on buses for staff.

8. References

- RSCH Website information re transport and parking plus email responses from Geoff Britten and Nina Aynsleigh-Marshall.

- Site map of RSCH

- RSCH site map of car parks.

- Siobhan Ryan; Health reporter comments

- Brighton 3T`s Transport Assessment report: Brighton and Sussex University Hospitals. March 2009.

- Brighton 3T`s Redevelopment Transportation Presentation: Hospital Liaison Group Meeting. 11th October 2010

- Which? campaign for improved hospital car parking.

http://www.which.co.uk/campaigns/food-and-health/hospital-car-parks---have-your-say/get-involved-with-our-car-park-campaign/

- DH document Sept 2010. NHS Car Parking: Response to Consultation

- LINk Report on Car parking charges at District General Hospital, Eastbourne and Conquest Hospital. Hastings. (Issue nos: IR 31 and IR 32)

9. Appendices

9a Questionnaire used at North car park

Tell us what you think about car parking at the Royal Sussex County Hospital

Who is asking these questions?
Brighton and Hove Local Involvement Network (LINk) is the independent Health and adult social watchdog for the city. We are a network of local people (volunteers) and organisations who want to improve local health and social care services. LINks have legal powers and can influence health and social care that is funded by the public.

What will the LINk do with answers to these questions?
Your opinions will be taken seriously, and will help to bring about positive change in the way local services are run.

Who can complete this survey?
Anyone who lives or uses the services in Brighton or Hove.

Do I have to give my name and contact details?
No, you don't have to give your details. However, If you want to be entered

Q1. Are you?
- ☐ a patient
- ☐ non paid carer
- ☐ relative/friend
- ☐ staff

Q2. Are you or your passenger/s registered disabled?
Which mode of transport did you use to get here?
- ☐ your car
- ☐ other car
- ☐ public transport
- ☐ ambulance or patient transport
- ☐ other

Q3. Are you registered disabled?
- ☐ Yes
- ☐ No

Q4. If you came by car, where did you park?
- ☐ hospital car park
- ☐ dropped off
- ☐ on the street
- ☐ other

Q5. If you came by car, how long did you wait to park today?

☐ less than 5 minutes
☐ 5-10 minutes
☐ half an hour
☐ 40-50 minutes
☐ an hour
☐ more than an hour

Q6. Have you been offered any help parking, from parking attendants etc?

☐ Yes
☐ No

Q7. Are you aware that if you are on a low income or benefits you may be entitled to reclaim your travel costs, to and from hospital?

☐ Yes
☐ No
☐ Don't know

Q8. Do you think the car parking charges are reasonable? (0 – 2 hours £2.00, 2 – 4 hours £3.00, 4 – 6 hours £4.00)

☐ Yes
☐ No
☐ Don't know

Q9. What do you think could be improved with car parking at this hospital?

Thank you for taking the time to answer our questions!

If you would like to be kept informed of what improvements or changes will be made as a result of this survey please complete your contact details.

9b. Copy of Questionnaire used at Outpatients Department

Tell us what you think about car parking at the Royal Sussex County Hospital

Who is asking these questions?
Brighton and Hove Local Involvement Network (LINk) is the independent Health and adult social watchdog for the city. We are a network of local people (volunteers) and organisations who want to improve local health and social care services. LINks have legal powers and can influence health and social care that is funded by the public.

What will the LINk do with answers to these questions?
Your opinions will be taken seriously, and will help to bring about positive change in the way local services are run.

Who can complete this survey?
Anyone who lives or uses the services in Brighton or Hove.

Do I have to give my name and contact details?
No, you don't have to give your details.

Q1. Are you?
- ☐ a patient
- ☐ non paid carer
- ☐ relative/friend
- ☐ staff

Q2. Which mode of transport did you use to get here?
- ☐ your car
- ☐ other car
- ☐ public transport
- ☐ ambulance or patient transport
- ☐ other

Q3. Are you registered disabled?
- ☐ Yes
- ☐ No

Q4. If you came by car, where did you park?
- ☐ hospital car park
- ☐ dropped off
- ☐ on the street
- ☐ other

Q5. If you came by car, how long did you wait to park today?

☐ less than 5 minutes
☐ 5-10 minutes
☐ half an hour
☐ 40-50 minutes
☐ an hour
☐ more than an hour

Q6. Have you been offered any help parking, from parking attendants etc?
☐ Yes
☐ No

Q7. Are you aware that if you are on a low income or benefits you may be entitled to reclaim your travel costs, to and from hospital?
☐ Yes
☐ No
☐ Don't know

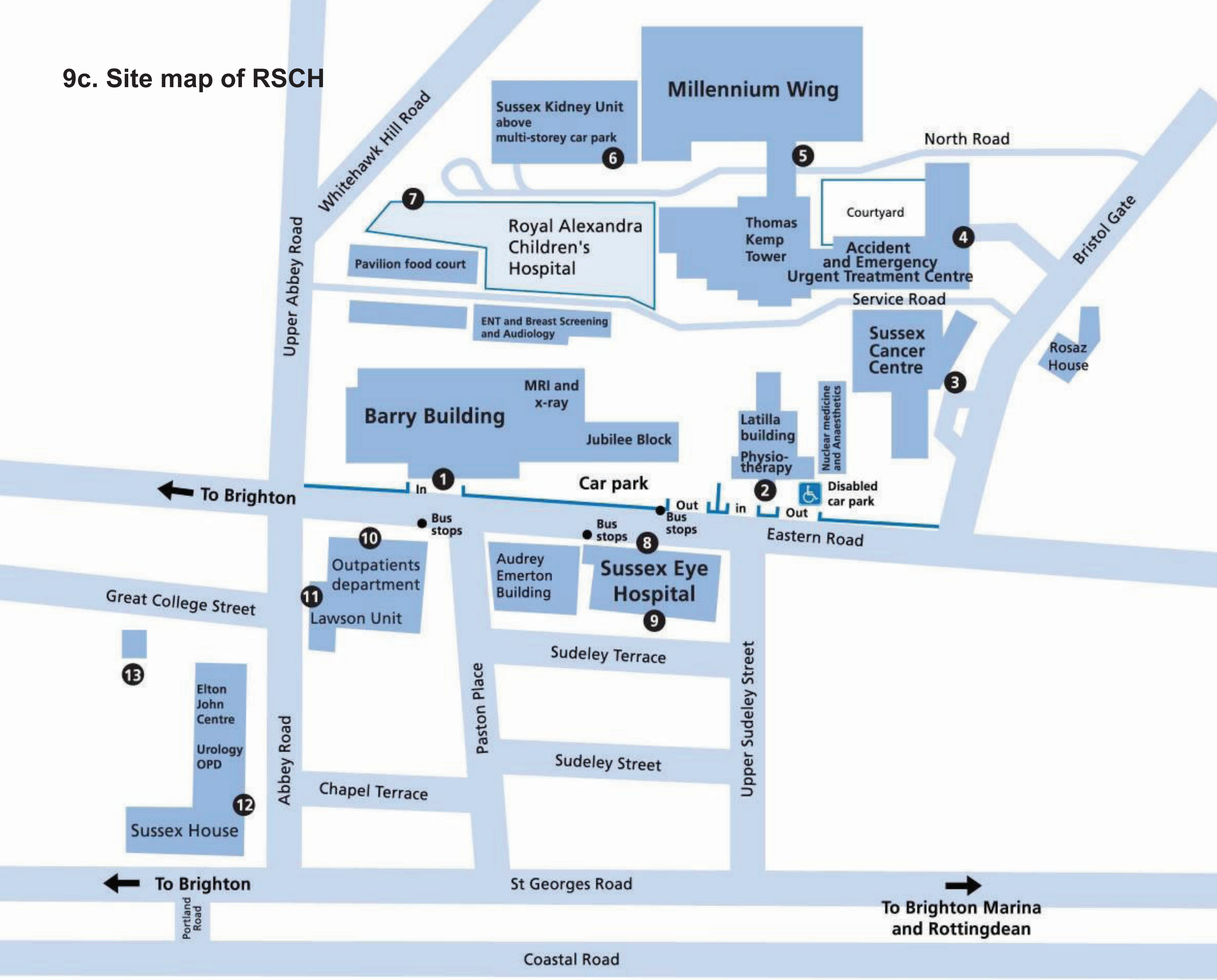
Q8. Do you think the car parking charges are reasonable? (0 – 2 hours £2.00, 2 – 4 hours £3.00, 4 – 6 hours £4.00)
☐ Yes
☐ No
☐ Don't know

Q9. What do you think could be improved with car parking at this hospital?

Thank you for taking the time to answer our questions!

If you would like to be kept informed of what improvements or changes will be made as a result of this survey please complete your contact details.

9c. Site map of RSCH



1. **Main Eastern Road entrance** for most wards, x-ray and MRI, breast unit, ENT and audiology outpatients and cardiology.
2. **Latilla entrance** for physiotherapy and rheumatology oupatients.
3. **Cancer Centre entrance** for chemotherapy and radiotherapy.
4. **Emergency entrance and Thomas Kemp Tower** for accident and emergency, maternity, CT scanning, orthopaedic outpatients.
5. **Millennium Wing** for cardiac surgery, orthopaedic surgery and digestive diseases.
6. **Sussex Kidney Unit** and multi-storey car park.
7. **Royal Alexandra Children's Hospital**
8. **Sussex Eye Hospital entrance for eye inpatients** (via Eastern Road).
9. **Sussex Eye Hospital entrance for eye outpatients** (via Sudeley Terrace).
10. **Outpatients Department** for most medical and surgical outpatients, diabetes, blood tests, colposcopy and genito-urinary medicine.
11. **Lawson Unit.**
12. **Sussex House** for urology (including outpatients), Clinical Media Centre and the Elton John centre.
13. **Sussex House Mobile Breast Screening Unit.** At the back of car park, access via Abbey Road.

9d.
Brighton 3T`s Transport Assessment report: Brighton and Sussex University Hospitals. March 2009
http://tiny.cc/rjf08

9e.
RSCH Website information re transport and parking:
http://www.bsuh.nhs.uk/hospitals/our-hospitals/royal-sussex-county-hospital/#RSCH-parking

9f.
Help with travel costs
http://www.bsuh.nhs.uk/patients-and-visitors/coming-into-hospital/help-with-travel-costs/

9g.
Brighton 3T`s Redevelopment Transportation Presentation: Hospital Liaison Group Meeting. 11th October 2010
http://tiny.cc/2gjo5

9h.
Siobhan Ryan; Health Argus article on car parking
http://tiny.cc/5bfnn

9i.
Which campaign for improved hospital car parking.
http://www.which.co.uk/campaigns/food-and-health/hospital-car-parks---have-your-say/get-involved-with-our-car-park-campaign/

9j.
Department of Healthdocument Sept 2010. NHS Car Parking: Response to Consultation
http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_119457

9k.
East Sussex LINk Report on Car parking charges at District General Hospital, Eastbourne and Conquest Hospital. Hastings. (Issue nos: IR 31 and IR 32)
http://www.thecountylink.net/upload/reportofsurvey-Feb09.pdf

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

Subject:		**Implementation of Health & Social Care Bill: Update**	
Date of Meeting:		**27 July 2010**	
Report of:		**The Strategic Director, Resources**	
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 The Health & Social Care Bill currently making its way though parliament includes several measures to be implemented, in whole or part, by local authorities. This report includes a brief description of these measures, outlining some of the difficulties and opportunities they may present.

2. RECOMMENDATIONS:

2.1 That members note the contents of this report and decide whether they wish to receive more information about any of the matters discussed herein.

3. BACKGROUND INFORMATION

3.1 The 2011 Health & Social Care Bill contains three measures of particular relevance to upper-tier local authorities. These are: (1) the transfer of public health responsibilities from Primary Care Trusts (PCTs) to councils; (2) the requirement for local authorities to manage the process by which Local Involvement Networks (LINks) evolve into new organisations called 'Healthwatch'; (3) the creation of local Health and Wellbeing Boards to bring local authority members and officers together with NHS commissioners and representatives of patients and public to co-ordinate health and social care commissioning across local health economies.

3.2 **(1)** The Health & Social Care Bill announced that many PCT public health (PH) functions will, when PCTs are abolished, be transferred to upper-tier local authorities. Some PCT PH functions will transfer to a new national body, Public Health England, as will some of the responsibilities of national bodies such as the Health Protection Agency.

3.3 Although details of how responsibilities (and budgets) will be split between Public Health England and local authorities are still being determined, many core Public Health teams have already physically moved from PCTs to councils – this is the case in Brighton & Hove. Work is ongoing to determine how the Public Health team best fits within the council's structures.

3.4 **(2)** Local Involvement Networks (LINks) are the current statutory vehicle for enabling members of the public to get involved in decisions about the commissioning and provision of health and social care services. LINks are volunteer-led organisations supported by a professional 'host'. Hosts are commissioned and contract-managed by local authorities; the money for host contracts (and contract management costs) being provided by central Government.

3.5 The Health & Social Care Bill contains measures to replace LINks with new organisations called Healthwatch. Healthwatch will perform the current LINK roles of scrutinising local health and social care services, facilitating public engagement with decision-making about these services, and publicising available services. In addition, Healthwatch will be responsible for sign-posting people to local NHS services and for NHS complaints advocacy (although the latter function may be commissioned from a professional provider under the aegis of the local Healthwatch). Healthwatch is also expected to have a much greater involvement in strategic commissioning than LINks have typically had, and to this end Healthwatch must be a member of local Health and Wellbeing Boards. The Government also intends to establish a national organisation, Healthwatch England, which will work closely with the Care Quality Commission (the national quality regulator for NHS and social care services) and will share information/concerns with local Healthwatch organisations.

3.6 Although Healthwatch will be significantly different to LINks, the Government has stressed that it sees the journey as 'evolution rather than revolution', particularly if a local LINk is performing well. Responsibility for managing the transition from LINks to Healthwatch rests with local authorities.

3.7 In Brighton & Hove, we have recently consulted partners and stakeholders on an options paper for Healthwatch. This sets out three types of models for developing a local organisation: (a) doing the minimum required by statute and employing only central funding; (b) an

ambitious approach, using council/partner funds to grow Healthwatch; (c) a compromise approach which will seek to follow statutory requirements, but will also look to develop informal means of support for Healthwatch and/or commission Healthwatch to carry out specific pieces of work. In the coming months we will seek to develop the preferred option, working together with NHS Brighton & Hove, local GPs, the current LINk host, the city's community and voluntary sector, and current LINk members.

3.8 **(3)** Health and Wellbeing Boards (HWB) will be partnership groups bringing together elected members, local authority officers, GP commissioners and public and patient voices to co-ordinate health and social care commissioning across the local health economy.

3.9 Functions of HWBs include:

- Agreeing a local Joint Strategic Needs Assessment (JSNA)
- Agreeing a local Joint Health and Wellbeing Strategy (JHWS)
- Supporting local joint-working/integration of health and social care services
- Promoting public/user involvement in health and social care
- Ensuring that GP commissioning plans and council commissioning plans accord with the JHWS

3.10 Mandatory HWB members are:

- Local Director of Public Health (DPH)
- Local Director of Adult Social Services (DASS)
- Local Director of Children's Services (DCS)
- Healthwatch
- Representative(s) of local Clinical Commissioning Group(s) – i.e. GP commissioners
- Elected member(s) of the local authority (there is no maximum number set, and elected members may form the majority of a HWB)

3.11 The council is working closely with key partners to develop a local HWB. Key issues include: determining the scope of a local JHWS; deciding who (in additional to mandatory members) should sit on the local HWB; working out how the HWB should interact with other partners, including major health and social care providers; deciding how the HWB should be positioned in terms of city partnership structures.

4. CONSULTATION

4.1 None 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 None to this report for information

Equalities Implications:
5.3 None to this report for information

Sustainability Implications:
5.4 None to this report for information

Crime & Disorder Implications:
5.5 None to this report for information

Risk and Opportunity Management Implications:
5.6 None to this report for information

Corporate / Citywide Implications:
5.7 None to this report for information

SUPPORTING DOCUMENTATION

Appendices:
None

Documents in Members' Rooms:
None

Background Documents:
1. The Health & Social Care Bill (2011)