Brighton & Hove City Council

Overview & Scrutiny

Title:	**Health Overview & Scrutiny Committee**
Date:	**21 March 2012**
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

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

AGENDA

Part One **Page**

69. PROCEDURAL BUSINESS **1 - 2**

(copy attached)

70. MINUTES OF THE PREVIOUS MEETING **3 - 10**

Draft minutes of the meeting held on 16 November 2011 (copy attached)

71. CHAIR'S COMMUNICATIONS

72. PUBLIC QUESTIONS

No public questions have been received

73. NOTICES OF MOTION REFERRED FROM COUNCIL

No Notices of Motion have been received

74. WRITTEN QUESTIONS FROM COUNCILLORS

No questions have been received

75. LONG TERM CONDITIONS **11 - 24**

Report of the Strategic Director, Resources, on plans to improve services for people with Long Term Conditions (copy attached)

76. SUSSEX TOGETHER **25 - 26**

Presentation from Amanda Philpott, NHS Sussex on NHS plans to work more closely across Sussex (see attached)

77. IMPLEMENTATION OF THE HEALTH & SOCIAL CARE BILL: UPDATE **27 - 52**

Report of the Strategic Director, Resources, on local implementation of the Health & Social Care Bill (2011)

78. MENTAL HEALTH: ACUTE BEDS

Update on plans to reduce acute bed capacity at Mill View hospital (for main meeting)

79. LETTERS TO THE CHAIR **53 - 56**

A letter has been received from NHS Sussex regarding the future of the Sussex Orthopaedic Treatment Centre (SOTC) (copy attached)

80. 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

81. ITEMS TO GO FORWARD TO COUNCIL

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

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

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

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

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

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

Date of Publication - Tuesday, 13 March 2012

Agenda Item 69

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.

Agenda item 70

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00PM 25 JANUARY 2012

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

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

Co-opted Members: Hazelgrove (Older People's Council) (Non-Voting Co-Optee)

PART ONE

54. PROCEDURAL BUSINESS

54A Declarations of Substitutes

54.1 Cllr Gilbey attended as substitute for Cllr Turton.

54.2 Cllr Marsh sent her apologies.

54B Declarations of Interest

54.3 There were none.

54C Declarations of Party Whip

54.4 There were none.

54D Exclusion of Press and Public

54.5 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.

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

55. MINUTES OF THE PREVIOUS MEETING

55.1 RESOLVED – That the minutes of the meeting held on 16 November 2011 be approved and signed by the Chairman.

56. CHAIR'S COMMUNICATIONS

56.1 There were none.

57. PUBLIC QUESTIONS

57.1 There were none.

58. NOTICES OF MOTION REFERRED FROM COUNCIL

58.1 There were none.

59. WRITTEN QUESTIONS FROM COUNCILLORS

59.1 There were none.

60. SUSSEX COMMUNITY TRUST

60.1 This item was presented by Clodagh Warde-Robinson, Acting Chief Executive of Sussex Community Trust (SCT). Ms Warde-Robinson outlined recent developments at the trust, including the establishment of three locality teams, plans to work more closely with colleagues in public health to deliver services based on population need, developing closer working relationships with Adult Social Care and with 3rd sector providers, and seeking to introduce pathways which cut across sectoral and organisational boundaries to give the best possible care to service users. The trust does face some major challenges, including managing its estates, maintaining effective IT systems, dealing with commissioner 'block contracts', and reducing its vacant posts.

60.2 In response to a question from the Chair about plans to link more effectively with Public Health teams, members were told that understanding population heath needs was key to developing effective community services which continued to meet evolving health requirements. This is not an exclusive conversation: other relationships – e.g. with the local medical school – are equally vital.

60.3 In answer to a question from Mr Brown on how the Trust would cope with the requirement to make savings, the committee was told that the focus would need to be on running services more efficiently. A move away from block contracts to tariff-based

commissioning would be helpful here as the block contract system does not encourage efficient provision.

60.4 In response to a query from Cllr Barnett on care for the frail elderly, members were informed that this was a priority for SCT and one of the Sussex Together priorities. The aim is to support frail elderly people in the community wherever possible, using intermediate beds and home in-reach services, and liaising closely with GPs and acute providers. For this client group, hospital admissions can easily lead to a loss of independence, with a severely negative impact both on individuals and the local health economy.

60.5 The Chair thanked Ms Warde-Robinson for her contribution.

61. LETTERS TO THE CHAIR

61A The committee discussed a letter sent by Sussex Community Trust (SCT) regarding SCT plans to remove residential beds from the Chailey Heritage site.

61.1 The SCT Acting Chief Executive, Ms Warde-Robinson told members that there was little or no demand for these beds which have been effectively de-commissioned by commissioners.

61.2 Mr Brown noted that the BHLINK had not been formally contacted about these plans; Ms Warde-Robinson promised to rectify this.

61.3 Members agreed that they did not consider SCT's plans for Chailey Heritage to constitute a 'substantial variation' in services, and that there was therefore no need to consult formally with the HOSC.

61B The committee discussed a letter sent by Sussex Community Trust (SCT) regarding SCT plans to enter into a strategic partnership with Care UK.

61.4 Ms Warde-Robinson explained that the proposed partnership would enable SCT to understand better how the private sector works, particularly in terms of contracting and contract management. Any service partnership with the private sector would be led by SCT; the focus of this partnership would be on supporting services around Redhill rather than Brighton.

61.5 members asked to be kept updated on progress.

62. BREAST FEEDING

62.1 This item was introduced by Lydie Lawrence, Clare Jones and Lynda Watson from the city Public Health team.

62.2 In response to a question from the Chair regarding breastfeeding rates beyond 6-8 weeks, members were told that it was very difficult to collect data for this, as there is no prescribed contact point with new mothers which would support such collection – e.g. at

6 months. Locally, public health staff have worked with health visitors to collect robust data at 6 weeks, but there is little prospect of getting data for later ages. There is some national and international data for feeding at later ages, although some of this (e.g. WHO statistics) focuses on exclusive breastfeeding, whereas locally, most women, breastfeeding after 6 months are probably doing this in conjunction with bottle feeding.

62.3 In answer to questions from Cllr Carol Theobald on local feeding rates, the committee was told that rates had improved in recent years, with 80+ of new mothers in the city breast-feeding. It was difficult to say whether the average length of time that new mothers fed for had also increased, but this was likely.

62.4 In response to a question from Mr Brown as to whether cuts in funding were likely to impact on the service, members were told that funding was secure for 2012/13, although the service would always have to justify continued funding by its performance. However, reductions in the Sure Start programme were bound to impact upon breast-feeding rates.

62.5 In answer to a question from Cllr Gilbey on how best to encourage mothers to feel comfortable feeding in public, the committee was told that there were a number of means of conveying the message that there is no inappropriate place to breastfeed. These could potentially include 'sticker' campaigns for cafes etc, although it is doubtful whether the impact of this type of activity justifies the input required, and it can work perversely: i.e. by giving the impression that only business which have chosen to opt into a scheme offer suitable environments for breastfeeding. There is a very significant role to be played here by employers, particularly be the council and NHS trusts, in terms of supporting their employees to breastfeed.

62.6 In response to a question from the Chair on what was being done to spread local good practice, members were informed that a good deal has been done, including networking via the South East Infant Feeding Network (now discontinued) and the Baby Friendly Initiative.

62.7 The Chaired thanked the presenters for their contribution to the meeting and the committee offered their congratulations to the service for its excellent performance.

63. SHORT TERM SERVICES

63.1 This item was introduced by Geraldine Hoban, Chief Operating Officer, Brighton & Hove Transitional Clinical Commissioning Group (CCG).

63.2 Ms Hoban told the committee that it was important to improve short terms services (STS) in the city, making best use of the capacity available and moving away from the traditional bed-based service to a more flexible system better able to respond appropriately to demand. It had been decided not to go out to tender for STS at this time, but instead to encourage more integrated and effective workers from the current providers. This would include creating a single integrated management team from 2012/13.

63.3 Asked by the Chair why this policy was being adopted, Ms Hoban told members that there were currently too many providers in the city using too many different models of

care. The new arrangements would not necessarily reduce the number of providers, but they would ensure that provision was effectively integrated. If for some reason this did not occur, the option to go to tender for a new provider remained.

63.4 In response to a question from Mr Brown regarding the repatriation of community beds, Ms Hoban told members that the aim was to provide as many services as possible within the city. However, going forward these would not necessarily be bed-based services – the intention was to improve community based services so as to be able to reduce the number of beds in the future – by 12 beds or so.

63.5 The Chair thanked Ms Hoban for her update.

64. CARERS' STRATEGY

64.1 This item was introduced by Tamsin Peart, Performance and Development Officer, Adult Social Care.

64.2 Ms Peart outlined achievements over the past 12 months including the appointment of a schools worker to support young carers and the introduction of a city 'carer's card'. Priorities for the coming year included supporting working carers, supporting young adult carers, dementia, and developing relationships with the new city primary care teams.

64.3 In answer to a question from the Chair on the scheme for supporting carers in work, members were told that a key facet of this was encouraging employers to offer flexible working which could allow people to carry on working whilst providing care. This did not necessarily require additional resources to implement.

64.4 The Chair thanked Ms Peart for her contribution and reminded members about the carers' challenge for 2012.

65. MENTAL HEALTH: ACUTE BEDS

65.1 This item was introduced by Geraldine Hoban, Chief Operating Officer, Brighton & Hove Transitional Clinical Commissioning Group (CCG); Dr Richard Ford, Executive Director of Strategic Development, Sussex Partnership NHS Foundation Trust (SPFT); and Samantha Allen, Service Director, SPFT.

65.2 Ms Hoban told members that a phased reduction of beds at Mill View would commence in April 2012. This would be overseen by a Clinical Taskforce to be chaired by Dr Becky Jarvis (the CCG mental health lead clinician), which would be established in February.

65.3 Dr Ford told the committee that there had been a spike in demand in January 2012 which had stretched services and required some out of area placements – these patients had now been repatriated.

65.4 Ms Allen told members that the January spike was predicted, as there was typically increased demand at this time of year. However, this did not mean that it was an easy thing to find sufficient capacity to cope, and it was sometimes inevitable that out of area placements were used. It was nonetheless important to note that there had been no out

of county placements, in line with the Trust's commitment to offer people a Sussex bed, even in peak periods. Dr Ford added to this, telling members that, if necessary, the trust would 'spot purchase' a Sussex private bed from a reputable, CQC-registered provider rather than place a patient outside Sussex. However, this was rarely required as there was capacity within SPFT to deal with most spikes in demand without recourse to private sector beds.

65.5 In response to a question from Mr Brown on the number of out of area placements recently, Ms Allen told the committee that there had been four in January, the first time in recent months that placements out of area had been needed. SPFT had responded to this spike in activity by postponing the scheduled transfer into Mill View of older people with functional mental health problems (from the Nevill hospital) until demand had reduced.

65.6 In answer to a query on pressures caused by a lack of suitable accommodation for homeless people with mental health problems (particularly in light of the imminent closure of St Patrick's Night Shelter), Ms Allen told members that the trust did have in-patients from the local homeless population, and that a lack of accommodation could potentially present a problem here, but that this was currently being dealt with via the revamp of the mental health accommodation strategy.

65.7 The Chair thanked Ms Hoban, Dr Ford and Ms Allen for their contributions.

65.8 RESOLVED – That there should be a further update on this issue at the next committee meeting to include any work done by the Clinical Taskforce.

66. HOSC WORK PROGRAMME 2011-12

66.1 This was noted.

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

67.1 There were none.

68. ITEMS TO GO FORWARD TO COUNCIL

68.1 There were none.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	**Agenda Item 75** Brighton & Hove City Council

Subject:		**Long Term Conditions**		
Date of Meeting:		**March 21 2012**		
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 term 'Long Term Conditions' refers to medical conditions which cannot be cured, but which may be managed through medication and/or therapy. There is no definitive list of Long Term Conditions, but they are typically held to include conditions such as diabetes, asthma and coronary heart disease.

1.2 Long Term Conditions represent a considerable drain on NHS resources, in terms of both primary and acute sectors, and can have a very significant detrimental impact on the lives of service users. In recent years, attempts have been made to begin managing Long Term Conditions better, improving the quality and consistency of community-based care with the intention of reducing reliance on hospital services, particularly in terms of un-planned admissions, and of enable patients to live more independent lives.

1.3 The attached papers from the Brighton & Hove Transitional Clinical Commissioning Group (CCG)/NHS Sussex (see **Appendices 1, 2 and 3**) contains information about a planned re-design of how the local health economy manages Long Term Conditions. The changes are intended to empower service users to better understand and manage their own conditions, to re-focus services on high quality community provision – either in terms of services delivered directly to people's homes or accessed via clusters of GP surgeries – and to reduce reliance on costly and often unnecessary hospital care.

2. RECOMMENDATIONS:

2.1 That members:

(1) Consider and comment on the proposals contained in the appendices to this report.

3. BACKGROUND INFORMATION

3.1 Please see information provided by the Brighton & Hove CCG/NHS Sussex – **Appendices 1, 2 and 3**.

4. CONSULTATION

4.1 This report was complied after consultation with the Brighton & Hove Transitional Clinical Commissioning Group (CCG)/NHS Sussex.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None directly to this report for information. Some services for people with Long Term Conditions require co-ordination of health and social care services and are therefore jointly commissioned/provided. Therefore final decisions about these matters may have financial implications for the Council.

Legal Implications:

5.2 None directly to this report for information.

Equalities Implications:

5.3 None directly to this report for information.

Sustainability Implications:

5.4 None directly to this report for information.

Crime & Disorder Implications:

5.5 None directly to this report for information.

Risk and Opportunity Management Implications:

5.6 None directly to this report for information.

Corporate / Citywide Implications:

5.7 None directly to this report for information.

SUPPORTING DOCUMENTATION

Appendices:

1. Paper provided by Brighton & Hove Transitional Clinical Commissioning Group (CCG)/NHS Sussex
2. Further information provided by the CCG (listed as Appendix A to the CCG paper)
3. Further information provided by the CCG (Listed as Appendix B to the CCG paper)

Documents in Members' Rooms:

None

Background Documents:

None

Appendix 1

HOSC March 2012

Briefing on Integrated Primary Care Teams

1.The Development of Integrated Primary Care Teams – Background and Rationale for Change

The purpose of this paper is to outline the work that has taken place to implement new Integrated Primary Care Teams to support patients with a range of long term conditions and the frail elderly within the community.

Following previous information regarding this work presented to HOSC in June and November 2011, this paper is intended to provide an update of progress since the implementation of the new teams in January 2012.

The reconfiguration of these community teams was included within the Long-Term Conditions (LTC) commissioning plan and is one of the key Priority Transformation Programmes supporting the delivery of QIPP. The new service model is based on stakeholder feedback and examples of national best practice.

Previously, there were many different teams, supporting patients within the community. These teams had been commissioned at various times and had not developed in an overall coherent way.

- District Nurses;
- Community Matrons;
- Care Home Support Team;
- Medical Review Pharmacist;
- Community Phlebotomy (Phase 2 of the development);
- Community Physiotherapy

These teams have now been reconfigured into new multidisciplinary teams aligned to small clusters of GP Practices (Integrated Primary Care Teams) able to manage the full spectrum of needs patients with long term conditions have. The teams will also support the frail elderly and provide the same level of care to those in care homes or who are housebound. These teams are providing flexible, appropriate and tailored levels of support to patients in conjunction with primary care to enable the patient to develop, establish and achieve their own goals. Dedicated carers support will also be included within these teams from April 2012.

This new model was developed by a clinically led project board with patient and LINK representation. It was supported by a stakeholder event in July 2011, previous HOSC meetings, locality meetings and by the Clinical Commissioning Executive and Board. It was approved for implementation at the Integrated Delivery and Governance Committee in November 2011.

Further background information and detail on the model are included in Appendix A

A briefing and diagram outlining the service model is attached in Appendix B

2. Consultation

This new model was developed by a clinically led project board with patient and LINK representation. It was supported by a stakeholder event in July 2011, previous HOSC meetings, locality meetings and by the Clinical Commissioning Executive and Board. It was approved at the Integrated Delivery and Governance Committee in November.

Sussex Community Trust carried out a full staff consultation process in October 2012 which included all staff affected by the service change, prior to the recruitment process.

3.1 Implementation – March 2012 Update

The new Integrated Primary Care Team service went live on 23 January 2012 with the previous community teams outlined above (current exception of Community Phlebotomy which is to be included in Phase 2) forming new Integrated Teams aligned to small clusters of GP practices.

Locality meetings were held in December 2012 to enable representatives of the new community teams to meet with their aligned practices to begin to build relationships and establish effective ground rules for working.

Since January the focus of implementation has been

- Team formation and development
- Establishment of relationships, agreements on working practices and communication methods
- Alignment of patient caseloads and agreed approaches to patient prioritisation developed
- Patient and public information leaflets regarding the changes
- Stakeholder communication plan regarding the changes
- Establishment of weekly teleconference with Sussex Community Trust to track implantation and address issues arising
- Transformation of the Project Board responsible for development of the model to one with responsibility for overseeing implementation
- Agreed performance management and data collection framework developed
- Draft evaluation framework developed to enable determination of future commissioning intentions.
- Finalisation of pathways to specialist services to enable effective and streamlined referral processes
- Effective alignment with Adult Social Care to improve the interface between health and social services, reducing duplication and improving patient outcomes.
- Following a tender process for provider of the carer service which did not result in a successful bidder, work is taking place to develop an alternative approach to appoint Carers Support Workers from Adult Social Care who will be aligned to the practice clusters to increase the resource and support available to carers. This additional element of the service will build on the carer support work already carried out by Adult Social Care, ensuring best use of resources, management time and avoiding duplication by both the IPCTs and social care.
- Training is currently taking place with practices and members of the teams on the use of the Urgent Care Clinical Dashboard which will support the proactive identification, prioritisation and effective management of patients at increasing risk to prevent avoidable admissions.

- Staff within the Integrated Primary Care Teams have completed training in motivational interviewing techniques and behaviour change to enable them to better support patients in a more proactive way.

3.2 Implementation- Issues

A detailed risk register has been developed and is reviewed at each Project Board meeting for the implementation of the project with risks addressed and escalated as required.

Since the start date in January there have been a number of issues identified which are currently being addressed

- The difficulties of large scale change which includes the different community teams coming together and these teams establishing effective working relationships with their practice clusters. To progress this, meetings are taking place between teams and their cluster practices to start to build effective relationships and agree processes for ongoing communications and an organisational development plan supports staff training and development.
- Some capacity issues within teams, notably across the West. Whilst most of the posts within the teams across the city have been filled, there are a number of vacancies which are being recruited to currently. Combined with staff sickness, this has on occasion led to capacity gaps and a reduced level of service by the teams. To manage this, staff are being deployed across the service to ensure optimum cover, vacancies are currently being recruited to and ongoing communications with primary care are taking place to advise them of any capacity issues and management plans.
- It has been identified that further work needs to take place to ensure clear and effective pathways, referral processes and communications between the new Integrated Primary Care Teams and specialist, urgent care and hospital discharge services. This is being addressed to ensure that patients are able to move seamlessly between these different services, as appropriate.

4. Next/Future Steps

2012-13 is a transitional year towards the full implementation of the service from 2013 onwards. Learning from this transitional year will inform the final service and specification.

Dedicated carers support will be available within the teams from April 2012. Community Phlebotomy will also be included within the scope of the teams. Data collection and monitoring will commence in March 2012 to ensure that the service is meeting agreed outcomes and key performance indicators.

The Prevention sub group which sits under the Project Board will develop pathways into prevention services to further support the service by September 2012 and the end of life services review which is due to conclude by autumn 2012 will improve access to effective and tailored end of life services.

The project board which has overall responsibility for implementation will continue to meet monthly throughout the implementation of the service and will oversee the evaluation of the service. A draft evaluation framework is currently in development and a full evaluation of the service will take place by autumn of 2012 to inform future commissioning intentions and the final version of the service specification.

Appendix 2 (A)

THE RECONFIGURATION OF COMMUNITY TEAMS
HOSC 21 MARCH 2012

1.Background on the proposed model for the reconfiguration of existing community teams

Previously there were many different teams, supporting patients within the community. These teams commissioned at various times and had not developed in an overall coherent way.
The teams included within the reconfiguration are

- District Nurses;
- Community Matrons;
- Care Home Support Team;
- Medical Review Pharmacist;
- Community Phlebotomy (Phase 2 of the development)
- Community Physiotherapy

The aim of the reconfiguration is to deliver efficiencies alongside improvements to patients and carer outcomes and experience and the support to primary care to manage this cohort of patients

2. Service Model

These teams have been reconfigured into new multidisciplinary teams each with dedicated carers support aligned to small clusters of GP practices (Integrated Primary Care Teams) which are able to manage the full spectrum of needs patients with long term conditions have. The overall objective of the teams is to provide flexible, appropriate and tailored levels of support to patients and their carers, in conjunction with primary care to enable the patient to develop, establish and achieve their own goals

Key features of the new model

- There are eleven practice clusters in total, informed by a public health needs analysis which clustered practices of similar age profile, deprivation indices and factors such as registered Nursing and Care Home populations . These proposed clusters have been supported by localities.

- The teams will operate 7 days a week, providing care between 8am and 8pm.Out of these hours care will transfer to South East Health Ltd.

- The practice remains the hub of care and effective working between practices and the dedicated teams will enable a more integrated and flexible approach to delivery of care on a day to day basis.

- The patient level data (real time information about those accessing urgent care services and risk of future admission to hospital score for patients within the practice) held within the Urgent Care Clinical Dashboard which is now embedded in each practice will enable the teams and practices to identify and direct resources appropriately and collectively agree the management plan for patients proactively.

- Patients with complex needs will have a dedicated care co ordinator and care plan reflecting their needs in order to support self care and identify anticipatory care requirements. This information will be shared with consent of the patient with all relevant parties involved in the patients care

- This care co-ordination also facilitates streamlined referral into and discharge from specialist services when required,(instead of patients remaining on a number of different caseloads for long periods of times) and planned alignment of Adult Social Care Teams to localities will improve joint working between health and social care, reducing duplication.

- The teams provide support to the registered population regardless of setting of care, therefore providing housebound and those in care home, meeting with an equitable service.

- Dedicated wound care and continence service, (which visits people at home) developed to support a key proportion of the existing district nursing activity where the intervention is short term or the only intervention being received by the nurse.

Integrated Primary Care Teams

The skill set of each of the 11 teams includes the following core competencies to ensure the effective management of the full range of patient needs is met

- Advanced Physical Assessment skills
- Independent prescribing and case management
- Care co-ordination
- Nursing staff
- Allied Health Professionals
- Community medication review pharmacist
- Generic support workforce
- Administrative support

Each team has a clinical lead and will be overall managed by one of 3 Clinical Service Managers covering the 3 localities across the city. City wide leadership comes from the newly appointed Head of Service for Brighton and Hove. Staff within the team receive line management and clinical supervision from the grade above.

Ongoing training requirements will be identified through the appraisal, personal development planning process, wider organisational development plan and feedback via the ongoing performance and quality monitoring of the new teams which includes feedback directly from Primary Care.

Transitional Year 2012/13
The new model begun to be implemented in an incremental fashion from January 2012 onwards. 2012-13 is be a transitional year and will be subject to full evaluation to inform future commissioning intentions.
A service specification has been developed and performance against this specification will form part of the evaluation for future service delivery.

The evaluation framework is based on the agreed KPIs and quality outcomes for the new service. This outcome based evaluation is based on the NHS Quality Outcomes Framework and key outcome indicators are reflected additionally in CQUINS and the

Annual Operating Plan. Performance of the service will be monitored by commissioners in conjunction with the Commissioning Support Unit (through regular contract performance meetings) and include staff, primary care, patient and carer feedback. Key aspects of this evaluation will include

- Performance against service specification
- KPIs and outcomes achieved
- Patient/carer and staff satisfaction
- Delivery of agreed efficiencies
- Effective working with specialist services

This evaluation will be led by clinicians and commissioners and be carried out by the third quarter of transitional year 2012-13. The outcomes of this evaluation will inform future commissioning intentions and determine the final service specification.

3. Current Progress

A multidisciplinary clinically led project board has overseen the development of the new model and the service specification. This group has now evolved into a project board which is responsible for overseeing the full implementation and successful delivery of the new service.

To maximise effectiveness of the new model, a number of underpinning processes and systems have been developed. These include:

- Proactive patient identification through a predictive risk tool and real time information about patients accessing urgent care services brought together in one place through the Urgent Care Clinical Dashboard.

- Care planning and coordination; basic care plan developed in template form compatible with a range of GP systems now being trialed within practices across the city.

- Clear and effective pathways between the MDT team and the existing specialist services to ensure duplication of care is minimised and patients receive care from the right person and the right time. These have covered four main areas Urgent care, End of Life Care, Disease specific and Adult Social Care

- Further work is underway to explore the opportunity of future community mental health teams being clustered to align to the new teams.

- Alignment of Dementia programmes, particularly Dementia Care Home Support team development again to minimise duplication and ensure one clear service model.

- Funding and model for dedicated carers support agreed and service now being developed

- Health promotion and prevention; clear pathways to effective health promotion and prevention services to support effective self care and maximise patient outcomes, including alignment with services provided by the community and voluntary sector.

4. Impact on Primary Care

The redesign of existing community teams not only has a positive impact on the outcomes for patients within the city but also within primary care establishing stronger working relationships between practices and their linked community teams,

reducing crisis episodes for patients and the subsequent draw on already stretched primary care resources.

The new model is being implemented in an incremental fashion throughout the transitional year and the redesign of these teams means a significant amount of change, not only in structure but ways of working for existing community staff but also primary care.

Key to all of this will be the success of practices and community teams working together effectively. Team meetings are currently taking place to establish relationships and effective systems and processes to support coordinated working.

As part of the evaluation process , practices will be asked through satisfaction surveys to feedback on progress of the new model, issues and areas where best practice have been identified and could be shared. Lessons learnt will also be captured to inform the final service specification in addition to applying these to the way in which future services are developed across the city.

Appendix 3 (B)

Reconfiguration of Community Teams Briefing

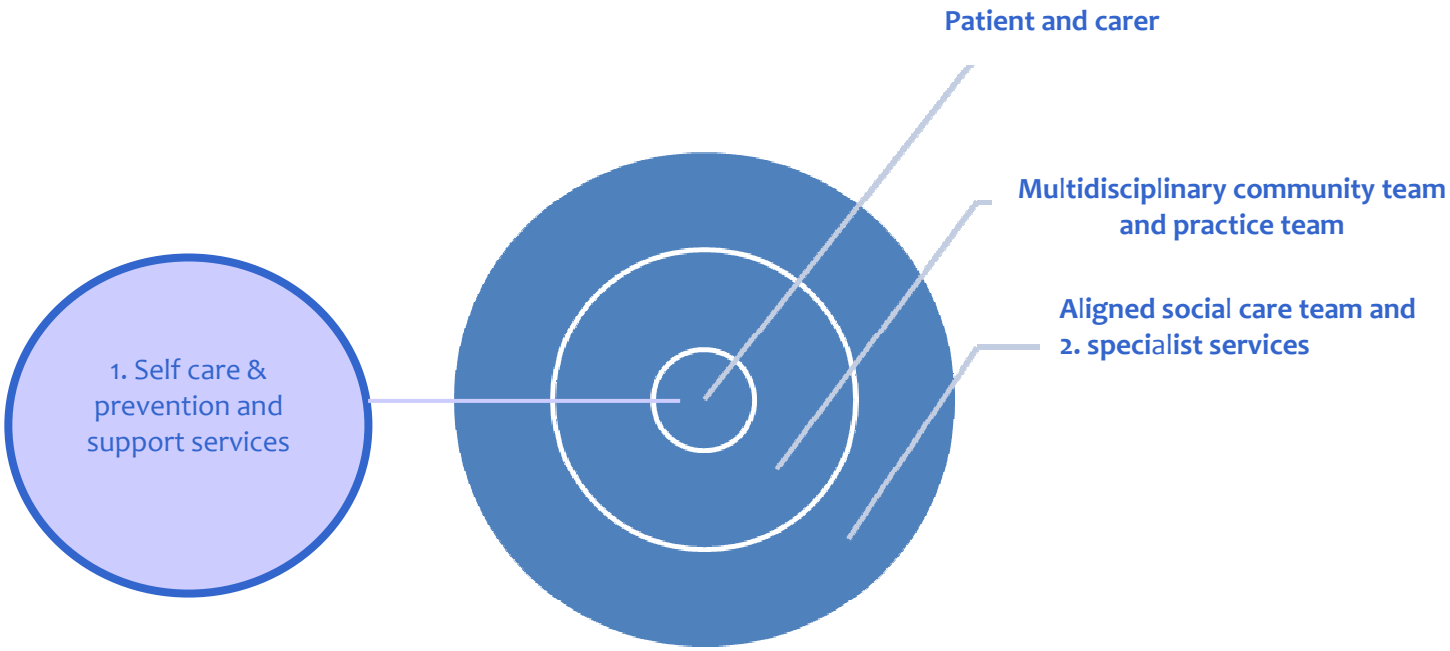
Background

NHS Sussex (Brighton and Hove) and Sussex Community Trust have reconfigured a number of community teams that support patients with a range of needs; such as long term conditions and frail, older people.

Previously these teams worked separately to support people within the community and often in isolation from primary care. This meant that some people within the community received multiple visits from different community teams, whilst others received few visits - notably those who are housebound or in care homes, leading to a service which is fragmented, inequitable and inefficient.

Long term conditions teams have been brought together with General Practice teams to form new multidisciplinary teams. These teams, termed Integrated Primary Care Teams, link with between two and five practices, to better support patients with a range of needs within the community. The practice remains the centre of care; with the practice population becoming the overall team caseload - enabling equitable support for all patients.

Model



1 Health trainers, information prescriptions, community and voluntary sector support services
2 Hospital care services, specialist teams (diabetes etc), end of life support

Which community teams are involved?

The community teams include the following

- District nurses
- Community matrons
- Care home support team
- Medical review pharmacy
- Community physiotherapy
- Community phlebotomy (second phase of the development)

As well as the compliment of staff above, teams will, from April 2012, have the resource to support carers, and over time be better aligned with social services to improve coordination across health and social care.

Timeframe for full implementation?

The new service model began to be implemented from January 2012. 2012-13 is a transitional year for the full implementation of the service with a final service specification from April 2013 onwards.

What does it mean for patients?

- Improved support to manage a range of needs within the community – where appropriate a dedicated care coordinator
- A jointly developed care plan to maximise patient outcomes
- An equitable service based on patient need, not ability to attend the practice
- Improved coordination between health and social care – less duplication
- Support for patients and carers to manage their own condition/s
- Prevention of avoidable hospital admissions and support with timely discharge

What does it mean for community teams?

- Less isolated working, greater team working
- The opportunity to develop new skills
- Improved patient care and experience
- Access to dedicated resource to support carers
- Greater coordination, communication and stronger relationships with primary care colleagues
- Improved links to specialist services and support

What does it mean for primary care?

- Dedicated support from known community teams to better-manage patients with a range of needs within the community
- Opportunity to have stronger relationships and regular communication with community teams and with social care
- A range of support tools to improve care planning and coordination; including dedicated resource to develop relationships with the community teams and the Clinical Dashboard to support better patient care
- Equitable service which includes housebound patients and those in care homes

What does it mean for specialist services?

- Improved pathways into and out of specialist services
- Clear risk and referral thresholds
- Use of specialist skills and experience more appropriately
- Improved links with community teams and better care coordination

NHS Sussex

Agenda Item 76

Report to the HOSC on the *Sussex Together* Programme

1 Background

Sussex Together is our programme aimed at securing a safe and sustainable NHS service across Sussex to meet the health needs of the population we serve. This programme began in September 2011, has already brought together senior clinical leaders and other professionals from all NHS organisations in Sussex alongside our partners in the Local Authorities and LINKs, to work together to find the best response to the unprecedented challenge we face. Although spending on the NHS will increase year on year, the increase will not match the projected rise in demand as the number of frail, elderly people increases and more people live with long term conditions. The objective of *Sussex Together*, therefore, is to identify the best way to spend the £2.6 billion available to the NHS in Sussex as a whole.

As an indicator of the size of the task ahead *Sussex Together* identified that unless we change we will face a financial challenge by April 2014 of some £440m in order to release sufficient funds to meet rising demand and rising costs within available resources.

2 What has happened so far

September 2011 to November 2011	• Work with providers and commissioners to understand the health system affordability gap by April 2014 • Engaging providers and commissioners in the *Sussex Together* approach • Development of a financial model to allow the impact of proposed service changes to be quantified in terms of closing the health system affordability gap
December 2011 to January 2012	• A series of three Clinical Summits have been run in which senior clinical and managerial leaders of all NHS organisations in Sussex participated, and detailed outputs from each senate have been shared to inform each next step. The summits were focussed on how key clinical services could be run in different ways to improve the value (benefits divided by costs) of services provided • After Clinical Summit 1, four Clinical Design Groups led by local clinicians were given a mandate to propose clinical service models for Sussex that would improve the value of services and help close the system affordability gap. • The models of care were reviewed and developed in Clinical Summits 2 and 3. • In Clinical Summit 3, senior representatives of commissioners, providers and local authorities gave their support to the principles of working proposed by Sussex

Together and the emerging clinical models.

3 Sussex-wide models of care

The clinical design groups led by local clinicians working with managers, colleagues from the local authorities and LINKs, identified and developed high level models of care in the following key areas:

Frail and Elderly – Based on the work done in Coastal West Sussex, a model of care that is easy to navigate and is more efficient, wrapped around the needs of the patient and ensuring care from the right person at the right time. A model that focuses on prevention and proactive management to enable the elderly to enjoy a better quality of life and improving value through reduced reliance on acute bed usage. Better patient experience through care co-ordination avoiding multiple assessments and care providers.

Unscheduled Care – A model of care that provides better out of hospital care, better integration of emergency care, and reduced inpatient care. Better out of hospital care provided through community outreach and nursing home support, extended hours GP services, a single point of access for clinicians, and rapid access outpatient appointments. Better integration of emergency care through aligned out of hours primary care, community services, and A&E.

Planned Care – Through networked care delivery led by centres of excellence and greater consistency in quality of referrals provide an improved model of care. Development of high quality community care to reduce the need for acute intervention.

Other areas (Paediatrics, Maternity, and Medicines Management) – In respect of paediatrics and maternity, it was noted that there was still work to be done to develop proposals to a point where they can be taken forward. A number of initiatives are being taken forward by the medicines management teams, and it was proposed that consideration for their future structure should be undertaken.

Following the Clinical Summits a further clinical design group was identified, that of Dementia, and clinical leads are now being sought to take this group forward.

4 Turning models of care into delivery of care

The Clinical Design Groups are now working on developing more detailed models to share with colleagues across Sussex.

A Clinical Senate is being formed to take forward the work, supported by the *Sussex Together* Team.

The NHS locally will continue to engage partners, patients and the public in discussions and decisions about future models of service, and ensure they are kept fully informed as proposals are turned into action.

Susan Onslow
Sussex Together Programme Manager
NHS Sussex

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	**Agenda Item 77** Brighton & Hove City Council

Subject:	**Implementation of the Health & Social Care Bill (2011): Update**	
Date of Meeting:	**21 March 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 The 2011 Health & Social Care Bill includes several initiatives to be implemented by local authorities, namely:

- the transfer of public health responsibilities from Primary Care Trusts (PCTs) to local authorities
- the establishment of local Health & Wellbeing Boards
- the establishment of local Healthwatch.

1.2 Although the Health & Social Care Bill has yet to be enacted, work is underway to implement many of the measures included in the Bill – e.g. where primary legislation is not required in order to make changes. This report provides an update on progress with regard to the initiatives listed in 1.1 above.

1.3 **Appendix 1** to this report contains details of the model for a local Health & Wellbeing Board agreed by Cabinet in January 2012; **Appendix 2** contains details of plans for a local Healthwatch agreed by Cabinet in January 2012.

2. RECOMMENDATIONS:

2.1 That members:

(1) Note the contents of this report.

3. BACKGROUND INFORMATION

3A Public Health Transfer

3.1 'Public Health' describes services for population health, including screening, vaccination and immunisation programmes, health data analysis, preventative health campaigns and responding to emergency situations. Currently, public health services are either provided by PCTs, commissioned on behalf of PCTs on a regional/national basis or delivered by national organisations (e.g. the Health Protection Agency).

3.2 The Health & Social Care Bill creates a new body, Public Health England, which will take responsibility for much of the regional/national public health work. Responsibility for local services will be transferred to local authorities. Details of this division of responsibilities are still being finalised, as are budget allocations to each local authority area. Formal transfer of public health duties and budgets will take place in April 2013.

3.3 Locally, the PCT's public health team has already been physically transferred to council offices, and work is ongoing to find the best way to accommodate the team within the council's management and governance structures. This is a strategic issue as well as an operational one, as we need to find an effective way of ensuring that population health considerations are factored in to all the Council's key decision-making processes.

3.4 This work is currently being overseen by the Public Health and Wellbeing Project Board: an officer group which includes the Strategic Director, People; the Director of Public Health; the Director of Adult Social Services; and the Chief Operating Officer of the Brighton & Hove Transitional Clinical Commissioning Group (CCG). Ultimately, decisions on how public health responsibilities should be integrated with the Council's other duties will be taken by Members.

3B Health & Wellbeing Board

3.5 Health & Wellbeing Boards (HWBs) are intended to be broad partnerships, bringing together elected members, council officers (Directors of Public Health, Children's Services and Adult Social Services are all mandatory HWB members), the CCG and local Healthwatch to set the high level health and social care agenda for the local area. HWBs are responsible for:

- The local Joint Strategic Needs Assessment (JSNA)
- A local Joint Health & Wellbeing Strategy

- Encouraging co-ordinated working between local health and social care services
- Encouraging public involvement in decision-making around health, public health and social care.

3.6 Each local authority area must have a HWB in place in shadow form by April 2012. HWBs will assume statutory responsibilities in April 2013.

3.7 After extensive consultation with elected members, health partners and stakeholders, a model for a local HWB has been created. This model has been approved by the Council's Governance Committee (10 January 2012), and by Cabinet (19 January 2012), and Full Council (26 January 2012). Details of this model are included as **Appendix 1** to this report.

3C Healthwatch

3.8 Healthwatch (HW) will be the new body responsible for involving members of the public in health and social care, replacing Local Involvement Networks (LINks). HW will inherit all the current LINk responsibilities, plus some additional duties in relation to signposting NHS services and NHS complaints advocacy. HW also has a mandatory seat on the local HWB.

3.9 HW was originally to be operational in October 2012, but this has now been put back to April 2013. Local authorities may not themselves run a local HW, but are responsible for choosing an appropriate provider and contract managing that provider. The council's Communities and Equalities team will be responsible for this contract management.

3.10 A competitive tender process will be used to identify the local HW provider; details of this were agreed by Cabinet in January 2012, and a copy of the relevant cabinet report is included as **Appendix 2** to this report.

4. CONSULTATION

4.1 No formal consultation has been undertaken.

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:

1. Cabinet report (19.01.12) on Health & wellbeing Boards
2. Cabinet report (19.01.12) on local Healthwatch

Documents in Members' Rooms:

None

Background Documents:

1. The Health & Social care Bill (2011)

Council	Appendix 1
26 January 2012	Brighton & Hove City Council

Subject:		**Brighton & Hove City Council** **Health and Wellbeing Board Development**
Date of Meeting:		10th January 2012 Governance Committee 19th January 2012 Cabinet **26th January 2012 Council**
Report of:		**Directors of Public Health and Adult Social Care, Strategic Director, People**
Contact Officer:	**Name:**	**Terry Parkin** **Tel: 29-0446**
	Email:	**Terry.Parkin@brighton-hove.gov.uk**
Key Decision:	**Yes**	**Forward Plan No:**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT

1.1 The Health and Social Care Bill will require local authorities to establish a Health and Wellbeing Board (HWB) by April 2013. This board will be a formal committee of upper tier and unitary local authorities under Section 102 of the Local Government Act.

1.2 This paper summarises the proposed approach to establishing a Health and Wellbeing Board during the shadow year of 2012-2013 and follows from two longer discussion papers circulated prior to each of the consultation workshops. The purpose of this paper is to seek approval for the approach outlined for the establishment of a Shadow Health and Wellbeing Board (SHWB) in April 2012.

2. RECOMMENDATIONS:

2.1 That Governance Committee recommends to Council the establishment of a Shadow Health and Wellbeing Board from April 2012 as set out in this paper and in accordance with the draft Terms of Reference attached at Appendix One.

2.2 That Governance Committee refers the report to the Cabinet for information.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS

3.1 In Brighton & Hove a decision was reached between officers and elected members *not* to become an early implementer of a Health and Wellbeing Board, but rather to engage in a discussion with partners and stakeholders to work at getting the scope, functions, membership and governance of the Brighton & Hove Health and Wellbeing Board right.

3.2 Two workshops were held to discuss the establishment of a Brighton and Hove Health and Wellbeing Board. The first on 26th July 2011 was used to plan out the scope of the health and wellbeing board. A second workshop on 3rd October was held to discuss the likely make up of the board with regard to three key components: function, membership and governance.

3.3 A national pause was announced in the passage of the Health and Social Care Bill and following further national discussion, led by an NHS Futures Forum, a number of

amendments were made to the Bill. With regard to the establishment of a HWB, these included stronger public engagement, a stronger role for joint commissioning between health and social care, and powers to the HWB to refer to the NHS Commissioning Board the commissioning plans of a clinical commissioning group, if these do not meet the requirement of the health and wellbeing strategy.

3.4 The Bill was passed in the House of Commons on 8th September 2011, and in the face of considerable lobbying from health and nursing groups, passed to the House of Lords on 14th October 2011. It is currently being considered in Committee Stage in the House of Lords and this is a detailed line by line examination of the Bill, which is likely to continue into the New Year.

3.5 A further series of consultation events has taken place including elected members, the health overview and scrutiny committee, the clinical commissioning group, lead commissioners and the LINk.

3.6 This paper and the model proposed reflects the legislative requirements of the Bill, as currently drafted, as well as the local consultation that has taken place prior to and subsequent to the legislation passing through the House of Commons.

Proposed Scope of the Shadow Health and Wellbeing Board

3.7 It is proposed that a Shadow Health and Wellbeing Board be established from April 2012, in advance of the Statutory Board which is likely to be required to be in place from April 2013. The primary purpose of the SHWB will be to prepare the Council, the PCT and the emerging local Clinical Commissioning Group for the statutory roles of the formal Health and Wellbeing Board. The SHWB's focus will be to provide the strategic leadership required to improve the health and wellbeing of the population of Brighton & Hove.

3.8 The SHWB will oversee the production and delivery of a joint health and wellbeing strategy which will be based on the local joint strategic needs assessment.

3.9 The SHWB will monitor the delivery of a series of outcomes covering public health, children and adult social care.

3.10 The SHWB will also review the commissioning plans of the clinical commissioning group with regard to how they address the needs identified in the joint strategic needs assessment (JSNA) and written into the health and wellbeing strategy.

3.11 The remit of the SHWB will be clearly defined and it will seek to concentrate on the strategic leadership and delivery of a number of key outcomes. The board will be 'transformational rather than transactional' and will influence how budgets are spent, rather than oversee a specific health and wellbeing budget.

3.12 The SHWB will have input into wider determinants of health such as housing, economy and education, but this will not be through the SHWB directly overseeing relevant partnerships, but rather having a clear link to groups who lead on this work.Key to this work will be the relationship with the Local Strategic Partnership (LSP) and Public Service Board (PSB) which will emerge in the first shadow year

3.13 Another key relationship that will be established during the first year is the one with children's reporting structures such as the children and young people's trust board (CYPTB) and the local safeguarding board (LSB). It is proposed that these continue in their current format in the first year and that consideration be given to ensuring there is no duplication of roles. In particular, the CYPTB is likely to cease to become a statutory requirement following the removal of the requirement for it to develop and approve a

Children and Young People's Plan. Reporting requirements for the LSB will need to be carefully considered.

3.14 The board will agree a set of health and wellbeing outcomes; these will be strongly influenced by the national public health outcomes framework but also by the joint strategic needs assessment. The national public health outcomes framework and JSNA will then determine the health and wellbeing strategy that the Health and Wellbeing Board will agree and from which the set of outcomes will be selected and agreed.

3.15 The board will also have due regard to the annual report of the Director of Public Health which will be formally presented to the board each year.

3.16 The board will not have a formal role in emergency planning but will be part of the assurance process for making sure that processes are in place to protect the public's health in the event of an emergency.

Governance

3.17 The SHWB will advise the Council, Sussex PCT and the local Clinical Commissioning Group in its shadow year. Once it is formally constituted under the Health and Social Care Act from April 2013, the HWB will be a committee of Council.

3.18 The SHWB will also establish a formal relationship with the Public Service Board and Local Strategic Partnership. There will be overlaps in remit between the board and these groups. During the first shadow year (2012-13) any overlaps will be identified with the aim of removing these before the formal establishment of the board in April 2013. As part of this shadow year the board will plan in a formal board to board meeting with the Public Service Board.

3.19 The SHWB will meet quarterly in the shadow year. A formal 'taking stock' session will take place mid way through the shadow year.

3.20 Meetings will be open and other statutory sectors including provider trusts, community and voluntary sector and members of the public will be able to submit questions to the chair before meetings and at the discretion of the chair during meetings, in accordance with the Council's usual Standing Orders and rules of procedure.

3.21 Key decision-making bodies, such as the Children and Young People's Trust Board, the Local Safeguarding Children's Board and the Joint Commissioning Board will discuss their changing role during this shadow year and report to the SHWB regarding their remit and any changes in their establishment or role. The shadow year will also be used to 'train up' the members of the Health and Wellbeing Board in their new roles.

3.22 When the board is formally constituted under the Health and Social Care Act, it will have formal committee status. Its powers however, will be devolved to the board itself and not through full council, so it will be empowered to take decisions at board level without the need for full council ratification. As a formal committee normal committee rules will apply but draft legislation states that the Secretary of State has the power to disapply any of these by regulation. This would enable the membership of both officers and elected members to participate in decision making.

3.23 A copy of the draft Terms of Reference for the SHWB are attached at Appendix One. These will be reviewed during the shadow year and will need to be revised at the point that the health and wellbeing board is formally constituted under the Health and Social Care Act.

3.24 The consultation has taken place during a period when the City Council is considering a return to a committee structure. However, unlike other committees of the council the HWB will not be proportionately weighted in terms of political party representatives and officers will vote in the same forum as elected members. Further consideration will be given to the structures that will have to sit under the HWB which will ensure full engagement with the public, professionals, the third sector and elected members.

Membership

3.25 There has been widespread support for a small membership, and during the shadow year consideration will be formally given to extending the membership as required. The formal membership of the board will be as follows:

- An elected member from the Largest Political Party will chair the board;
- The Official Opposition and Opposition Parties will also select one member to sit on the board;
- The three Statutory Directors of Public Health, Children's Services and Adult Social Care;
- One lead clinical and one non-clinical member from the Clinical Commissioning Group;
- A member from the Youth Council;
- One member from Healthwatch.

Note: As Healthwatch does not currently have a remit for children and with the likely future changes to the Children and Young People's Trust Board it is important that young people have some representation in health and wellbeing issues that affect their lives, hence the inclusion of a member of the Youth Council.

3.26 Where a discussion is to be held on a particular subject, for example accident and emergency services, other relevant providers, such as in this case Southeast Coast Ambulance Service (SECAmb) will be invited as is relevant.

3. CONSULTATION

The following people were provided with the opportunity to comment and input into the establishment of the SHWB:

- Members of the staff forums of the city council and clinical commissioning group
- Members of the Overview & Scrutiny Commission
- Political groups
- Individual Cabinet Members
- Corporate Management Team
- Strategic Leadership Board
- The LINk
- NHS Brighton and Hove
- Brighton and Hove Clinical Commissioning Group

4. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

4.1.1 The health and wellbeing board will not hold a service budget. The board will influence budgets and spending decisions through strategic leadership to commissioning and in regard to Joint Strategic Needs Assessments. There will be requirement for some officer support to the board estimated at £30k for which joint funding will be identified by public health, adult social care and children's services.

Finance Officer Consulted: Anne Silley Date: 09/12/11

Legal Implications:

4.2 As set out in the report, the Health and Social Care Bill requires local authorities to establish a Health and Wellbeing Board as a committee of council with specific functions delegated to it. Once the Act and Regulations are in force, a formal committee can be established. This report proposes the establishment of an advisory body – the Shadow health and Wellbeing Board – which will ensure that the Council and its partners are well placed to take on the formal functions of the Health and Wellbeing Board when the Act comes into force.

Lawyer Consulted: Elizabeth Culbert *Date: 08/12/11*

Equalities Implications:

4.3 The council's Equality and Inclusion Policy guides the council's approach to equality, diversity and inclusion. It explains the council's responsibilities and duties, and sets out how the council will meet them. This is a key informant policy of the joint strategic needs assessment of the city which will in turn inform the health and wellbeing strategy adopted by the health and wellbeing board.

Sustainability Implications:

4.4 Sustainability implications for both council operations and city outcomes are incorporated directly into the joint strategic needs assessment of the city and inform the State of the City report.

Crime & Disorder Implications:

4.5 Crime and Disorder implications are incorporated directly into joint strategic needs assessment and formed a key component of the State of the City report.

Risk and Opportunity Management Implications:

4.6 Risks and opportunities for the Council and the city have been considered during the development of this paper and a formal risk assessment was undertaken as part of the work programme of the steering group.

Corporate / Citywide Implications:

4.7 The health and wellbeing board will steer the overarching health and wellbeing priorities for the city and stimulate service level outcomes and business plans, to improve the population's health and wellbeing.

SUPPORTING DOCUMENTATION

Appendices:

1. Draft Terms of Reference of the health and wellbeing board 2012 - 2013

Documents In Members' Rooms

None

Background Documents

None

Brighton & Hove City Council Shadow Health & Wellbeing Board

April 2012-March 2013

Draft Terms of Reference

1. Introduction

The Shadow Health and Wellbeing Board (SHWB) will act as an advisory body to the Council, the Sussex PCT (SPCT) Board and the emerging Clinical Commissioning Group (CCG).

The SHWB will continue to act in shadow form until the formal constitution of the Health and Wellbeing Board (HWB). It is expected that the Health and Social Care Bill will be enacted to enable the new Board to be established in April 2013, when it will become a committee of the Council.

References in this document to the 'Board' are references to the SHWB. These terms of reference will be reviewed prior to the establishment of the Statutory Board.

2. Purpose

The SHWB will lead and advise on work to improve the health and wellbeing of the population of Brighton & Hove, through the development of improved and integrated health and social care services.

In support of this aim the Board will advise the Council, the SPCT Board and the CCG in relation to the following matters:-

1. Providing city-wide strategic leadership to public health, health and adults and children's social care commissioning, acting as a focal point for determining and agreeing health and wellbeing outcomes and resolving any related conflicts;

2. In its shadow year, the SHWB will have regard to the Joint Strategic Needs Assessment (JSNA) for the City. [The HWB will be responsible for preparing and publishing the JSNA once it is a formally established committee under the Health and Social Care Act];

3. Preparing and publishing a Joint Health & Wellbeing Strategy (JHWS) – a high level strategic plan that identifies, from the JSNA and the national outcomes frameworks, needs and priority outcomes across the local population;

4. Receiving the annual CCG commissioning plan for comment. [Once the HWB is a formally established committee under the Health and Social Care Act, it will have the authority to refer the CCG commissioning plan up to the NHS Commissioning Board];

5. Supporting joint commissioning and pooled budget arrangements where it is agreed by the Board that this is appropriate;

6. Promoting integration and joint working in health and social care across the locality;

7. Involving users and the public, including to communicate and explain the JHWS to local organisations and city residents;

8. Monitoring the outcomes goals set out in the JHWS and use its authority to ensure that the public health, health and adults and children's commissioning and delivery plans of member organisations accurately reflect the Strategy and are integrated across the city;

9. Establishing and maintaining a dialogue with the City Council's Local Strategic Partnership Board, including consulting on its proposed strategies and reporting on outcomes in line with the City's Performance and Risk Management Framework.

10. Ensuring robust arrangements are in place for a smooth transition into the Statutory Board by April 2013.

3. Membership

Voting Membership:

- Elected Member from the Largest Political Group (as Chair*)
- One Member each from the Official Opposition and Opposition
- The Director of Children's Services
- The Director of Public Health
- The Director of Adult Social Care
- One lead clinical and one non clinical member from the local Clinical Commissioning Group
- A representative of Healthwatch
- A member from the Youth Council

* The Chair is a fully participating and voting member of the SHWB.

An NHS Commissioning Board (NHSCB) representative will attend, as required, when the NHSCB is established.

A range of partners will be invited to attend the SHWB. This will include the respective chairs of the children's and adults safeguarding boards.

Membership will be reviewed by the SHWB as part of its development of the Statutory Board.

4. Conduct of meetings

1. Meetings of the Board will be in public.

2. The Access to Information Procedure Rules and the Standing Orders of Brighton & Hove City Council will apply with any necessary modifications, including the following:-

    - The Chair will be an elected member of the Largest Political Group;

- The quorum for a meeting shall be a quarter of the voting membership, including at least one elected member from the Council and one representative of the CCG;

- The aim of the Board is to achieve decision making by consensus. Where this is not possible, decisions shall be made on the basis of a show of hands of a majority of voting members present. If there is an equal number of votes, the Chair will have a second or casting vote;

- The Board shall meet four times within a financial year;

- A Special Meeting will be called when the Chair considers this necessary and/or in the circumstances where the Chair receives a request in writing by 50% of the membership of the Board.

5. Communication and Engagement

The SHWB will communicate and engage with local people in how they can achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing. In support of this, the Board will:-

- Develop and implement a Communications and Engagement strategy for the work of the Board, including how the work of the Board will be influenced by stakeholders and the public, including seldom heard groups;

- Represent Brighton & Hove in relation to health and wellbeing issues at a local, sub-regional, regional, national and international level, influencing and negotiating on behalf of the members of the Board and working closely with the LINks/local HealthWatch;

CABINET	Agenda Item 169
19 January 2012	Brighton & Hove City Council

Subject:		**Brighton and Hove City Council Health & Wellbeing Board Development**
Date of Meeting:		**19 January 2012** 26 January 2012 - Council
Report of:		**Extract from the Proceedings of the Governance Committee Meeting held on the 10 January 2012**
Contact Officer:	Name:	**Mark Wall** **Tel: 29-1006**
	E-mail:	mark.wall@brighton-hove.gov.uk
Wards Affected:	All	

GOVERNANCE COMMITTEE

4.00 pm 10 January 2012
COUNCIL CHAMBER, HOVE TOWN HALL

DRAFT MINUTES

Present: Councillors Littman (Chair), A Norman (Deputy Chair), Bowden, Cobb, Cox, J Kitcat, Mitchell, Morgan, Powell and Randall

.

PART ONE

57. BRIGHTON & HOVE CITY COUNCIL HEALTH & WELLBEING BOARD DEVELOPMENT

57.1 The Committee considered a report of the Strategic Director, People and Director of Public Health and Adult Social Care concerning the establishment of a Health and Wellbeing Board. The report summarised the proposed approach to establishing a Health and Wellbeing Board, and sought approval for the approach outlined for the establishment of a Shadow Health and Wellbeing Board in April 2012 as set out in the Terms of Reference.

57.2 An amendment to the draft Terms of Reference was proposed by Council Randall and seconded by Councillor Kitcat. The proposed amendment was circulated to the members. The amendment related to the second bullet point in paragraph 3 'Membership' of the draft Terms of Reference and read:
'*Six additional elected Members which, taken together with the Elected Member as Chair set above, will be allocated to the different groups in proportion to the number of seats they have at Council'.*

Council Kitcat spoke on the amendment and said the six additional members would ensure that there would be a majority of councillors on the Health and Wellbeing Board, which would make the Board as democratic as possible.

57.3 Councillor A Norman noted the proposed amendment and whilst agreeing that it would allow councillors to be more involved, had concerns that a great deal of consultation had taken place and the working group had carefully considered the membership. Councillor Norman suggested it might be more appropriate for the proposed amendment to be considered first by the working group.

57.4 Councillor Bowden supported the amendment as, whilst he did not want the Board to be too big and unwieldy, he felt additional Members on the Board would allow for a more democratic decision making process and would assist officers who may find themselves in a difficult situation having to vote on certain issues.

57.5 Councillor Mitchell had hoped that membership of the Board would be small, but accepted that it was important to protect officers from having to make some decisions. Councillor Mitchell asked whether the Board would be able to monitor and comment on what the partner agencies spent. The Committee were advised that the Board would be able to look at health outcomes for the city, and consider the proposals of how to meet them, but would not be looking at the actual contracts etc.

57.6 Councillor Cobb noted the suggested amendment and stated that she had similar concerns to Councillor Norman, and felt that the working group should have considered them first. Councillor Cobb suggested that another option would be to remove the voting rights of the three Directors (as listed in the Terms of Reference Membership), and allow the Chair to have the casting vote. This would alleviate the need for officers to make decisions.

57.7 Councillor Morgan asked for clarification on whether the Board would be looking at issues such as alcohol abuse, mental health etc and whether there would be any overlap with other committees or boards. Councillor Morgan was advised that the Board would be looking at those types of areas, and if there were any overlaps they should become apparent during the shadow year.

57.8 Councillor Powell asked whether it was the intention for the Board to replace the Children and Young People Overview and Scrutiny Committee or the Adult Social Care and Housing Overview and Scrutiny Committee. Councillor Powell was advised that the proposals for the new committees would be agreed in April, and the role of the Health and Wellbeing Board would be looked when proposing the new committees. Councillor Powell asked if there would be a scrutiny function within the Board, and was advised that the Board would be focusing on the health needs of the city and looking at whether those needs were being met.

57.9 Councillor Bowden referred to the suggestion made by Councillor Cobb that the directors on the Board don't have the right to vote and asked if that were legally possible. Councillor Bowden was advised that the directors were required to be full members with equal rights and therefore they would have to be able to vote.

57.10 The Head of Legal and Democratic Services confirmed that it was intention for the arrangements of the shadow board to be as close as possible to the final board. It was

not the intention for the Health and Wellbeing Board to replace other boards or committees, and having the shadow board would allow for any overlaps to be noted.

57.11 Councillor Norman noted that the government recommendations were to have one Member on the Board, and the working group had increased that to three Members. The suggested further increase was on the recommendation of the administration and not the working group and was concerned that to agree an increase at the meeting was inappropriate without it being looked at again by the working group.

57.12 Councillor Kitcat stated that the Health and Wellbeing Board would not be reporting to Council and it was important that councillors came first in any making any decision.

57.13 Councillor Randall confirmed that the suggested change to the membership had been discussed at the recent Leaders Group meeting.

57.14 Councillor Littman noted that there would be 14 members on the Board and therefore all the councillors, representing the political parties, would need to agree for issues to be agreed by the Board.

57.15 A vote was taken on the proposed amendment and the amendment was agreed.

57.16 **RESOLVED:**

(1) That Governance Committee recommends to Council the establishment of a Shadow Health and Wellbeing Board from April 2012 as set out in the report and in accordance with the draft Terms of Reference attached at Appendix One, with the following amendment:

> 'That the second bullet point in paragraph 3 (Membership) reads: 'Six additional elected Members which, taken together with the Elected Member as Chair set out above, will be allocated to the different groups in proportion to the number of seats they have at Council.'

(2) That Governance Committee refers the report to Cabinet for information.

CABINET	Appendix 2 Brighton & Hove City Council

Subject:		**Establishment of a Local HealthWatch**	
Date of Meeting:		**19th January 2012**	
Report of:		**Strategic Director, Communities** **Strategic Director, People**	
Lead Cabinet Member:		**Adult Social Care & Health**	
Contact Officer:	**Name:**	**Michelle Pooley**	**Tel: 295053**
	Email:	**michelle.pooley@brighton-hove.gov.uk**	
Key Decision:	**Yes**	**Forward Plan No: 26657**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 For a number of years successive Governments have encouraged public involvement in health (and latterly social care) matters via statutory engagement vehicles: initially Community Health Councils, then Public and Patient Involvement Forums (PPIF), and currently Local Involvement Networks (LINk). LINks are volunteer-led, but supported by a professional secretariat: the LINk 'host'. The host is contract managed by the city council.

1.2.1 The Health & Social Care Bill (2011) introduces another organisational change, replacing LINks with new statutory bodies called HealthWatch (HW). The Bill requires local authorities to manage the transition from LINks to HW in their areas, and subsequently, to contract manage the local HW.

1.2.2 The Health & Social Care Bill (2011) states, 'A local HealthWatch organisation (LHW) is a body corporate'. For an existing LINk to become a local HW organisation, the LINk would therefore have to become a body corporate.

1.2.3 This report requests delegated authority to award the contract in relation to the new statutory bodies called HealthWatch (HW) once the legislation and necessary Regulations are in force.

2. RECOMMENDATIONS:

2.1 That Cabinet agrees the commencement of a procurement process to appoint a suitably qualified organisation to enable the local HealthWatch to fulfil its proposed statutory duties as set out in the Health and Social Care Bill.

2.2 That Cabinet gives delegated authority for the Strategic Director People to enter into contract on suitable terms on behalf of the council upon completion of the procurement process and once the relevant legislation is in force.

2.3 That Cabinet approve the extension of contract with the current hosts of the LINk to April 2013.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The Health & Social Care Bill (2011) requires local authorities to rethink and reshape how patients and the wider community are engaged in the development and improvement of local care services.

3.2 Statutory support for public involvement in health and social care is currently provided by Local Involvement Networks (LINks). LINks were established in 2008 in every local authority area with social care responsibilities (in accordance with the 2007 Local Government and Public Involvement in Health Act). LINks are volunteer-led organisations that enable local people to have a say in the commissioning and provision of health and social care services. LINks have statutory powers enabling them to hold NHS commissioners and providers and local authority social care commissioners and providers to account. These powers include a right to 'enter and view' premises where care for adults is provided, and a power of referral to the local Health Overview & Scrutiny Committee. The work of LINks is supported by professional administrative staff: the LINk 'host'. Hosts are contracted by the relevant local authority, but must be independent of local authorities and NHS trusts. Currently, host services for the Brighton & Hove LINk are provided by the Brighton & Hove Community & Voluntary Sector Forum (CVSF).

3.3 The new statutory bodies known as a Local HealthWatch (HW) will deliver all LINk services. Local HealthWatch will have additional responsibilities for NHS complaints advocacy and for elements of NHS signposting. HW must also have a seat on the local Health & Wellbeing Board, enhancing its ability to engage with strategic planning and commissioning issues. There will also be a national HealthWatch established as a committee of the Care Quality Commission, and local HW will be able to refer local issues to this body. Other indications, subject to final legislative and national guidance, are that HealthWatch will be:

- a "body corporate" which means a company or other institution that is legally authorized to act as if it were one person;
- an organisation, open to all, using the voices and experiences of the people it serves to encourage high standards of health and care provision and to challenge poor services;
- able to enter and view all publicly funded health and social care services either as unannounced spot checks or at agreed monitoring visits;
- required to promote the voice of local service users and carers in the commissioning of services, and in doing so, champion equality of health and care access and provision;

- able to appoint its own staff to carry out specific roles and will operate as an independent organisation.

3.4 The current proposal as of 3rd January 2012 is for the HW contract to go live in April 2013. However, we are still waiting for detailed guidance on the statutory structure and functions of HW (likely to be included in secondary legislation), and on DH evaluation of the HW pathfinder programme. In the absence of this guidance it would be unwise to engage in detailed transition planning at this point, as key elements of HW are still unconfirmed. However a set of fundamental principles for commissioning are being developed locally.

3.5 The engagement and representation of Young people through HealthWatch is an area of critical importance and is currently the subject of national consultation. In the absence of further information at this stage the proposed arrangements for Children and Young People's representation on the Shadow Health and Wellbeing Board are an important safe guard. These arrangements include Youth Council representation on the Shadow Board.

3.6 The City Council is in discussion with the Clinical Commissioning Group concerning opportunities to either align or jointly commission HealthWatch and the new patient engagement arrangements for the city. Further details and possible options for this work will be brought to future Public Health and Well Being Board Group and / or to the Shadow Health and Wellbeing Board meetings.

Funding.

3.4 Funding for the LINk is provided to local authorities by central Government. Initially this funding was via a specific DH grant, but from 2010 a number of specific grants, including the LINk grant, were rolled into formula funding. Funding for HW will eventually be provided via the Learning Disability and Health Reform grant, although details of this have not yet been published. Each local authority receives a flat sum of LINk funding with additional money in relation to population size. Annual funding for Brighton & Hove is confirmed until the end of the current Spending Review period (March 2015). LINk funding is not ring-fenced, and neither will HW funding be ring-fenced; currently the city council retains some money to cover the costs of contract management, and we expect to do so in the future to reflect the costs of contract managing HW. The Department of Heath has identified that there will be £3.2 million available in 2012/13 for start up costs and will be allocated as part of the Learning Disabilities and Health reform grant.

Timetable.

3.5.1 The Government plans for HW to become operational in April 2013 and includes NHS complaints advocacy services going live in April 2013. This represents a slippage from the original intention for HW to be operational by April 2012, and poses a problem for local authorities as current LINk host contracts run out by April 2012.

3.5.2 The LINk contracts were set nationally at three years, running from April 2008 to April 2011, and renewed for 12 months on a local basis when it became apparent that HW would be replacing LINks in April 2012. It will now be necessary to extend this contract pending completion of the procurement of the new HW contract, planned to take place by April 2013. There would be little value in re-tendering for a contract of twelve month's duration, so it is proposed that the current LINk host contract be extended to enable smooth transition to the new HW. An extension of contract is to be agreed with the CVSF.

3.6 **Transition Planning.**

3.6.1 In order to plan for the transitional arrangements for LINk to HW, the council has set up a HW working group, bringing together council officers (from Policy, Communities and Equality, Scrutiny, Adult Social Care, Procurement), LINk members, the city's voluntary and community sector, GP commissioners, and city NHS trusts.

3.6.2 The HW working Group have given comments and recommendations to the Public Health and Wellbeing Group on principles for procurement. From these, a transitional plan for LINks and a re-tendering process will be developed.

3.6.3 In brief, the transition plan will identify and address key challenges in the transition process. These include:

- Using feedback from LINk members, the LINk host, the city council's contract manager and organisations that have worked closely with the LINk (e.g. NHS trusts, BHCC Adult Social Care) to highlight areas of good and of relatively weak performance, and planning HW support accordingly;
- Identifying and mitigating against the major risks in transition (e.g. losing volunteer goodwill; ensuring that the LINk is adequately resourced for transition; ensuring that the LINk still represents local people effectively during the transition process);
- Seeking LINk's involvement and support in the development of the Health and Wellbeing Strategy;
- Ensuring that HW is capable of representing all city communities. Further work and clarification, as described above and in the appendix, on the representation of children and young people will be required;
- Ensuring that HW is able to contribute positively to the local Health & Wellbeing Board (including taking a prominent role in public engagement around the city's Joint Health and Wellbeing Strategy).

3.7 Procurement of HW support:

The Health & Social Care Bill requires local authorities to procure independent administrative support for local HW. Given the sums involved for a multi-year contract, this will need to be organised via a competitive tender. To meet the planned deadline of April 2013, the tender process will need to commence in Spring 2012.

The Indicative Procurement Timelines are:

Placement of OJEU	March 2012
Evaluation of Expression of Interests	May 2012
Issue of Invitation to Tender	June 2012
Tender Evaluation	August/September 2012
Clarification's	September/October/November 2012
Contract Awarded	December 2012
Mobilisation and transition finalisation	January – April 2013

Please note that the above timelines may change as a result of DH guidance.

2.4 It is currently proposed that the new contract will subsist for an initial period of three years with the Council having an annual option to extend by periods up to a further 24 months subject to confirmation of funding. Should the budget not be confirmed, the new contract period will be reduced to twelve months with the option of renewing the contract on an annual basis.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 In line with both the community engagement framework and with procurement rules, at this stage in the process, information about the new arrangements for HW and the implications of the delay in relation to the Health & Social Care Bill (2011) have been explained to the current LINk hosts and volunteers. Informal consultation activities have been used in formulating the substantive plans for the LINk to HW transition.

4.2 The HW working Group have given comments and recommendations to the Public Health and Wellbeing Group on principles for procurement. The HW working group, includes representatives from the city council, the local Community & Voluntary Sector Forum, the Brighton & Hove LINk, Sussex Community NHS Trust and Sussex Partnership NHS Foundation Trust.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The Department of Health has indicated an announcement on the provisional funding allocation for the additional functions of local HealthWatch will be made by the end of the year following the consultation on allocation options in July 2011. The funding will be allocated through the specific revenue grant for Learning Disabilities and Health Reform and based on the consultation will be in the order of £120,000, plus an additional £15,000 for start up costs. This will be in addition to the current level of funding allocated to LINk functions of £147,000 which is planned to increase by inflation subject to agreement of the budget strategy for 2012/13.

Finance Officer Consulted: Anne Silley Date: 03/01/12

Legal Implications:

5.2.1 The Health and Social Care Bill is currently in Committee Stage in the House of Lords and there is no clear indication of timing in terms of when Royal Assent may be likely. The requirement to establish HealthWatch as an organisation does form part of the Bill and therefore it will be necessary to await Royal Assent and

commencement of the relevant provisions before completing the procurement exercise in order to ensure that all the relevant statutory requirements and functions, are met. Regulations are proposed which will set out the membership of Health Watch.

5.2.2 The new HealthWatch support contract will need to be procured in accordance with the requirements of the Council's contract standing orders, EU procurement Directives and associated UK Regulations. The indicative timetable indicates adherence to the necessary processes and legal advice should be sought as appropriate.

Lawyer Consulted: Elizabeth Culbert and Sonia Likhari Date: 19/12/2011

Equalities Implications:

5.3. In relation to the extension of contract for the LINk, we would recommend that an EIA is carried out to consider the potential impact of the transition to HealthWatch. Once Cabinet approval has been granted for this proposal an EIA will be completed to inform the procurement process. This will specifically ensure that as many potential organisations as possible are identified that are able to address the needs of the diverse demographic of Brighton and Hove.

Sustainability Implications:

5.4 The setting up of a local HealthWatch will fall within the City Council's Corporate plan (2011) priority area of creating a more sustainable city. Sustainability of health and wellbeing means improving conditions, which influence health, and promote healthy lifestyles, treating illness, providing care and support and reduce inequalities in health. Within the procurement process of commissioning support for Health Watch, effective evidence of sustainability will need to be integrated into this approach with due regard to the One Planet Framework.

Crime & Disorder Implications:

5.5 HealthWatch has a key role in the engagement aspects of the JSNA. Any findings of the wider determinants of heath and wellbeing, including crime and disorder, will be fed into relevant city wide strategies via the B&H Strategic Partnership family of partnerships.

Risk and Opportunity Management Implications:

5.6. Policy development in this area is undertaken with due regard to the council's approved risk management process. A risk register is being maintained by the Project Team, and will inform project actions and future arrangements.

Public Health Implications:

5.7. HealthWatch will be an important mechanism to support the improvements in public health especially through the engagement work of the organisation which will contribute a wider and more effective development of the JSNA which in turn

will enhance the Health and Wellbeing Strategy to ensure that patients and communities have a voice in the development of Health and Wellbeing. HealthWatch will also be a statutory representative on the Health and Wellbeing Board and therefore will enable a much more wider engagement and feedback mechanism to communities to be developed.

Corporate / Citywide Implications:

5.8.1 This commission supports two of the council's corporate priorities, tackling inequality and engaging people who live and work in the city. Local HealthWatch will act to promote the voice of local service users and carers in the commissioning of services and, in doing so, champion equality of health and care access and provision. The chair of a Local HealthWatch organisation will have a seat on the local authority health and wellbeing board ensuring there is a route to influence decisions about local service provision.

5.8.2 The commission of HealthWatch is being lead by the Communities and Equalities Team to ensure the work supports implementation of the Community Engagement Framework and makes links with other commissions and engagement projects aimed at representation, engagement and reducing inequality. As part of this work the Communities and Equalities Team are in discussions with the Clinical Commissioning Group concerning opportunities to either align or joint commission HealthWatch and the new patient engagement arrangements for the city.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 The way that HealthWatch is organised is defined by national government legislation therefore there are no alternative options at this stage.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 That the recommendations are accepted in order to enable this Council to meet its forthcoming statutory duties and comply with European Procurement rules.

SUPPORTING DOCUMENTATION

Appendices:

1. None

2.

Documents in Members' Rooms

1. Not Applicable

2.

Background Documents

1. Health and Social Care Bill (2011)

2.

Dear Colleagues

Sussex Orthopaedic Treatment Centre – assignment of lease

I am writing to update you regarding orthopaedic provision in Sussex.

NHS Sussex has agreed to assign the lease of the Sussex Orthopaedic Treatment Centre (SOTC) facility to Brighton and Sussex University Hospitals NHS Trust (BSUH) for a period of five years from 1st April 2012.

The Interim Contract with Care UK for the provision of elective orthopaedic activity at the SOTC will terminate on 31 March 2012. We are working with Care UK and BSUH to ensure smooth and effective handover of services to ensure continuity in patient care.

The Interim Contract was a temporary contracting arrangement following the cancellation of a procurement exercise last summer and the sole purpose of this contract was to ensure continuity of service while a clinically driven review of the musculo-skeletal (MSK) model was undertaken and a new contracting framework implemented.

Following a review of the available options regarding the premises, the award of the lease to BSUH was identified as the optimal solution in terms of safeguarding the interests of both patients and taxpayers.

In coming to this decision we considered the following issues:

- The building is located on land owned by BSUH on the site of the Princess Royal Hospital, Haywards Heath which is subject to a separate 20 year lease between BSUH and the PCT dated March 2005.

- The facility has always had medical, estates and facilities management links with BSUH and there are advantages in managing the service in a single organisation.

- The SOTC does not have outpatient facilities and the building is not designed for outpatient activity. This means that the facility cannot provide the entire elective orthopaedic pathway. The SOTC facility is critical to the delivery of NHS Sussex's operational and strategic goals relating to the provision of elective orthopaedic services clinically linked to wider trauma and orthopaedic provision.

- There is an interdependency between elective and non-elective activity in respect of clinical governance, sustainability and postgraduate education. NHS Sussex is clear that BSUH needs a reasonable elective orthopaedic flow to sustain high quality trauma services. The combination of routine orthopaedics along with complex work is crucial to maintaining the skills of the specialist surgeons.. 85% of major trauma cases require orthopaedic intervention and all other Major Trauma Centres (21 in England) receive routine orthopaedics along with complex work.

Patient choice
Across Sussex we have a vibrant market for routine elective orthopaedic services, including providers from statutory NHS, commercial and third sectors and there are relatively low barriers to entry. The award of the lease to BSUH does not impact on

the ability of patients to exercise choice. Patients will be able to choose treatment at the Sussex Orthopaedic Treatment Centre or treatment at other sites by other providers.

NHS Sussex has made a separate decision to contract for routine elective services, including orthopaedics, via the Any Qualified Provider (AQP) route – in future this may further increase the choice available to patients. A provider which can meet NHS service quality requirements, prices and other normal contract standards can apply to be added to the list of providers from which patients can make their choice.

A new Sussex musculo-skeletal (MSK) service model has been designed locally, and an implementation project has commenced to convert the design template into a new MSK service. Planning discussions are underway to assess how best to achieve this at a clinical commissioning group level. We currently have a variety of MSK provision across Sussex and the AQP contracting mechanism for elective orthopaedics provides flexibility to support local variations to the new model.

I hope this is a helpful update. We will be working with Care UK and BSUH to support the smooth transfer of the Sussex Orthopaedic Treatment Centre premises and to ensure elective orthopaedic capacity is maintained during the transition.

Kind regards
Amanda

Amanda Fadero
Chief Executive, NHS Sussex

Sally Robson

Executive Assistant

Amanda Fadero, Chief Executive

NHS Sussex

Tel: 01273 574603

e-mail Sally.Robson@BHCPCT.nhs.uk

secure e-mail Sallyrobson1@nhs.net