Brighton & Hove City Council

Adult Care & Health Committee

Title:	**Adult Care & Health Committee**
Date:	**17 June 2013**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Councillors:	Jarrett (Chair), Phillips (Deputy Chair), K Norman (Opposition Spokesperson), Meadows (Opposition Spokesperson), Barnett, Bowden, Marsh, Mears, Summers and Wakefield
Co-optees	Geraldine Hoban (Clinical Commissioning Group), Dr George Mack (Clinical Commissioning Group) and Janice Robinson (Clinical Commissioning Group)
Non-voting Co-optee	Colin Vincent (HealthWatch)
Contact:	**Caroline De Marco** Democratic Services Officer 01273 291063 caroline.demarco@brighton-hove.gov.uk

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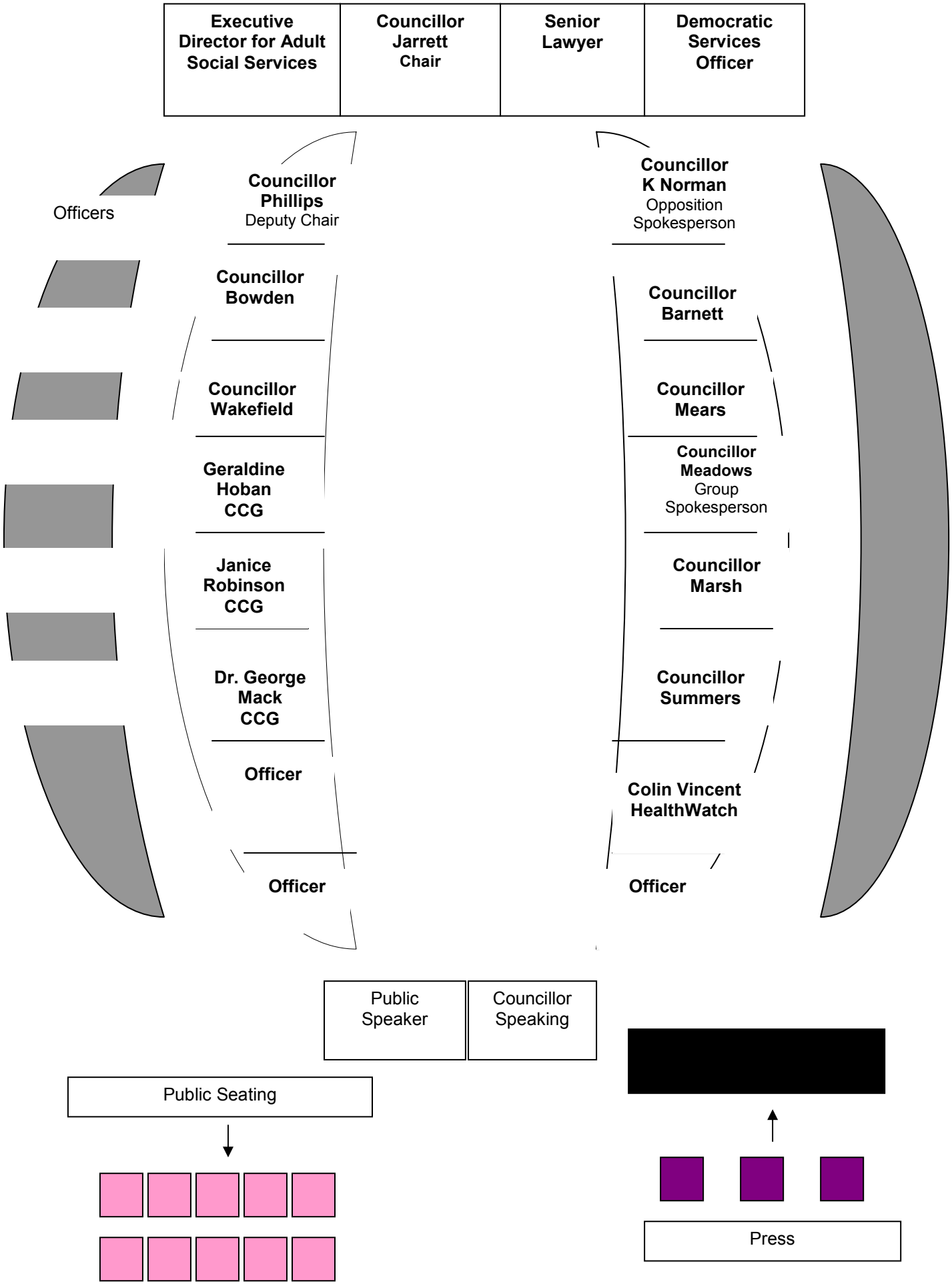
Democratic Services: Adult & Care & Health Committee



AGENDA

PART ONE **Page**

1. PROCEDURAL BUSINESS

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

(b) Declarations of Interest:

(a) Disclosable pecuniary interests not registered on the register of interests;
(b) Any other interests required to be registered under the local code;
(c) Any other general interest as a result of which a decision on the matter might reasonably be regarded as affecting you or a partner more than a majority of other people or businesses in the ward/s affected by the decision.

In each case, you need to declare
(i) the item on the agenda the interest relates to;
(ii) the nature of the interest; and
(iii) whether it is a disclosable pecuniary interest or some other interest.

If unsure, Members should seek advice from the committee lawyer or administrator preferably before the meeting.

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

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

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

2. MINUTES **1 - 16**

To consider the minutes of the meetings of Adult Care & Health Committee held on 18 March 2013 and the Joint Commissioning Board held on 25 March 2013 (copies attached).

Contact Officer: Caroline De Marco Tel: 01273 291063

3. CHAIR'S COMMUNICATIONS

4. CALL OVER

(a) Items 7 to 14 will be read out at the meeting and Members invited to reserve the items for consideration.

(b) Those items not reserved will be taken as having been received and the reports' recommendations agreed.

5. PUBLIC INVOLVEMENT 17 - 18

To consider the following matters raised by members of the public:

(a) Petitions: to receive any petitions presented to the full council or at the meeting itself;
(b) Written Questions: to receive any questions submitted by the due date of 12 noon on the 10 June 2013 (copy attached);
(c) Deputations: to receive any deputations submitted by the due date of 12 noon on the 10 June 2013.

6. MEMBER INVOLVEMENT 19 - 20

To consider the following matters raised by councillors:

(a) Petitions: to receive any petitions submitted to the full Council or at the meeting itself;
(b) Written Questions: to consider any written questions;
(c) Letters: to consider any letters;
(d) Notices of Motion: to consider any Notices of Motion referred from Council or submitted directly to the Committee (copy attached).

PART A - JOINTLY COMMISSIONED (SECTION 75) BUSINESS

7. CONSTITUTIONAL MATTERS 21 - 28

Report of Monitoring Officer (copy attached).

Contact Officer: *Mark Wall* *Tel: 29-1006*
Ward Affected: *All Wards*

8. COMMUNITY SHORT TERM SERVICES - AN UPDATE 29 - 58

Report of Chief Operating Officer, Brighton and Hove Clinical Commissioning Group (copy attached).

Contact Officer: *Anna McDevitt* *Tel: 01273 574841*
Ward Affected: *All Wards*

9. SUSSEX INTEGRATED END OF LIFE AND DEMENTIA CARE SUSSEX PATHWAY (JUNE) **59 - 108**

Report of Chief Operating Officer (copy attached).

Contact Officer: *Simone Lane* *Tel: 01273 574776*
Ward Affected: *All Wards*

PART B COUNCIL COMMITTEE BUSINESS

10. UPDATE ON THE EMBRACE PROJECT **109 - 130**

Presentation by Keith Beadle, from the Fed, Centre for Independent Living.

11. ADULT CARE & HEALTH FINANCE REPORT **131 - 150**

Report of Director of Finance (copy attached).

Contact Officer: *Anne Silley* *Tel: 01273 295065*
Ward Affected: *All Wards*

12. DAY ACTIVITIES REVIEW PROGRESS REPORT **151 - 158**

Report of Executive Director of Adult Social Services (copy attached).

Contact Officer: *Anne Richardson-Locke* *Tel: 01273 290379*
Ward Affected: *All Wards*

13. CONNAUGHT DAY SERVICE **159 - 172**

Report of Executive Director of Adult Care & Health (copy attached).

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

14. EXTRA CARE HOUSING UPDATE **173 - 208**

Report of Executive Director Environment, Development & Housing/Executive Director of Adult Social Services (copy attached).
Ward Affected: *Queen's Park*

15. ITEMS REFERRED FOR COUNCIL

To consider items to be submitted to the 18 July 2013 Council meeting for information.

In accordance with Procedure Rule 24.3a, the Committee may determine that any item is to be included in its report to Council. In addition, any Group may specify one further item to be included by notifying the Chief Executive no later than 10am on the eighth working day before the Council meeting at which the report is to be made, or if the Committee meeting take place after this deadline, immediately at the conclusion of

the Committee meeting

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

Date of Publication - Friday, 7 June 2013

ADULT CARE & HEALTH COMMITTEE	Agenda Item 2a Brighton & Hove City Council

BRIGHTON & HOVE CITY COUNCIL

ADULT CARE & HEALTH COMMITTEE

4.00pm 18 MARCH 2013

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Jarrett (Chair) Councillor Jones (Deputy Chair), K Norman (Opposition Spokesperson), Meadows (Opposition Spokesperson), Barnett, Marsh, Mears, Powell, Wakefield and Wilson

PART ONE

43. PROCEDURAL BUSINESS

43A Declarations of Substitute Members

43.1 There were no substitutes.

43B Declarations of Interests

43.2 Councillor Jones declared a personal but non prejudicial interest in Item 50 – Adults Section 75 Review as he is an employee of Brighton & Sussex University Hospitals NHS Trust**.** Councillor Norman declared a personal but non prejudicial interest in item 49 – Sussex Integrated End of Life and Dementia Care Sussex Pathway as his wife is a trustee of the Martlets Hospice.

43C Exclusion of the Press and Public

43.3 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.

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

44. MINUTES

44.1 Councillor Mears was pleased to note that some financial information had been submitted to the committee. She stressed that the committee could not operate without sufficient financial information.

44.2 Councillor Powell referred to paragraph 38.19. She asked for feedback on Councillor Hawtree's request for more information on some care agencies who were not paying the living wage to their staff. The Chair replied that a brief survey would be carried with providers in May. He would report back on the survey at the June meeting.

44.3 **RESOLVED** – That the minutes of the meeting held on 28 January 2013 be agreed and signed as a correct record.

45. CHAIR'S COMMUNICATIONS

Weather Conditions

45.1 The Chair referred to the bad weather the previous week. Despite the snow, a service had been delivered to the most vulnerable in the city. Meanwhile, the hospitals were experiencing pressure at the current time and the council was doing all it could to prevent further pressure.

45.2 The Chair thanked staff and members of the public who had helped to provide services during the bad weather.

45.3 Councillor Norman mentioned that most years the Adult Care & Health team and volunteers went out in 4x4 vehicles to help deliver services.

46. PUBLIC INVOLVEMENT

(a) Petitions

46.1 The Committee noted that there were no petitions from members of the public.

(b) Written Questions

46.2 The Committee noted that there were no written questions from members of the public.

(c) Deputations

46.3 The Committee noted that there were no deputations from members of the public.

47. ISSUES RAISED BY COUNCILLORS

47.1 The Committee noted that there were no petitions, written questions, letters or Notices of Motion received from councillors.

48. FINANCE REPORT

48.1 The Committee considered a report of the Director of Finance which set out the forecast outturn position for the 2012/13 financial year at Month 9 for Adult Social Care and NHS Trust Managed S75 Budgets as reported to Policy & Resources on 14 February 2013.

The report also provided information on the agreed 2013/14 budget for Adult Care & Health and NHS Trust Managed S75 Budgets set by Budget Council on 28 February 2013.

48.2 The Head of Business Engagement drew attention to paragraph 3.4 which related to NHS controlled S75 Partnership performance - being a projected underspend. More detail was contained in Appendix 1. The Targeted Budget Management reports would be brought to Adult Care & Health Committee roughly quarterly. Paragraphs 3.5 to 3.8 related to the budget for 2013/14. A colour pie chart showed the breakdown of net spend across Adult Care & Health. The largest area was community care (£41,806,000). Adults Provider was £13,706,000. S75 community Care was £8,582,000. Commissioning was £5,203,000 and S75 Staffing and other costs £3,968,000.

48.3 The Head of Business Engagement drew attention to the table on page 24 of the agenda, showing Adult Services - summary breakdown 2013/14 (net budgets). This included a breakdown of community care in Brighton & Hove and out of area. 65 to 70% of placements were in Brighton & Hove. Most of the out of area placements were in East and West Sussex. A budget book would be made available to members within the next month.

48.4 The Head of Business Engagement stated that she would bring regular monitoring reports to the committee relating to Adult Social Care and Public Health. She would provide trend information shown against savings agreed by budget council.

48.5 Councillor Meadows thanked the Head of Business Engagement and welcomed the budget information. She referred to Appendix 1, page 19 which mentioned a risk of £400,000 against extra care housing. She asked for more details about the risk. Councillor Meadows referred to the net reduction in residential client numbers of 6WTE. She asked if there would be redundancies.

48.6 Councillor Meadows queried the overspend for under 65's of £186,000 (page 20) and referred to the high cost of community care out of area (page 24). She asked what steps were being taken to reduce the cost.

48.7 The Head of Business Engagement explained that in relation to extra care housing, it was not expected that £400,000 savings could be made this year. However, it had been possible to cover the shortfall through the savings made against community care and deliver within budget. The net reduction in residential client places would not impact on staff numbers.

48.8 The Head of Assessment Services explained that the £186,000 overspend for under 65's related to people with complex needs. There were currently a number of placements outside the city and the strategy was to look for alternatives in order to bring these clients back to the city.

48.9 Councillor Mears thanked officers for the financial information. She referred to the General Fund budget for 2013/14 agreed at Budget Council on 28 February and queried whether the £400,000 figure had been originally intended for sheltered housing in 2012.

48.10 Councillor Mears referred to the Budget Strategy for Adult Social Care & stated that this needed to be presented as a report to the Committee.

48.11 Councillor Mears referred to the Section 75 budget and expressed concern that the council had had to pay the shortfall in the past. With regard to Learning disabilities Councillor Mears asked for a more detailed paper at a future meeting.

48.12 The Head of Business Engagement explained that the £400,000 had come from reducing residential placements. The savings of £1,640,000 in 2013/14 for Supported Living and Extra Care Housing were in addition to the £400,000. This did not just relate to extra care housing and included other accommodation options. She agreed that it might be necessary to give a more detailed briefing on this matter.

48.13 The Head of Assessment Services stated that the £400,000 was met out the Community Care Budget.

48.14 Councillor Norman commented that the table on page 24 showing the Summary Budget Breakdown 2013/14 was very useful. He asked if officers could expand on the Extra Care Steering Group, and on the current position regarding troubled families.

48.15 The Head of Assessment Services explained that the Steering Group was a joint housing and adult social care officer group. The troubled families work had just commenced and looked at families who cost most to the public purse. The work would target households where there were issues such as joblessness and anti social behaviour.

48.16 Councillor Marsh considered that the troubled families work should be extended to families without children. She asked for an update. The Head of Assessment Services replied that initially the work was targeted at families with children. However the government had given local discretion to have other groups included in the regime. An application had been made to government which related to the Brighton scene. The government had accepted the application and there would be a three year programme with stages in each year to demonstrate work with families. There would be part direct grant and part payment by results. The Chair stated that there would be an interim report submitted to the next Committee on this matter.

48.17 Councillor Jones stated that he would welcome a report on troubled families. He hoped that there would be a change of criteria whereby people without children might be considered in the regime.

48.18 The Head of Assessment Services explained that a targeted approach would address troubled adults. The criterion was people seeking work, a number of incidents of anti social behaviour and problems that were a considerable cost to the public purse.

48.19 Councillor Meadows referred to page 31 relating to the stretch target saving of £500,000 being attached to the community care budget. She asked for more details. Councillor Meadows referred to the Joint Commissioning provider arrangements and asked for details of savings and asked how many staff were involved and in what way. She referred to page 32 in relation to services provided during the day for older people and

older people with mental health needs. Councillor Meadows was concerned that a 2 tier system was being proposed.

48.20 The Head of Assessment Services explained that the £2.2m savings in relation to the community care budget was the continuation of a strategy adopted this year. The aim of the stretch target was to further reduce the spend on the budget. The £2.2m savings included the £500,000. With regard to the Joint commissioning provider arrangements, 6 or 7 staff were affected. The changes would be carried out in a way that avoided redundancies. There was a report on Day Services later on the agenda.

48.21 The Chair stated that there was no intention of having a 2 tier day service system in terms of quality. Some people would have building based services and others would receive a different type of service.

48.22 **RESOLVED -** (1) That the forecast outturn at month 9 for Adult Social Care and NHS Trust Managed S75 Budgets be noted.

(2) That the agreed budget for Adult Social Care and NHS Trust Managed S75 Budgets for the 2013/14 financial year be noted.

49. SUSSEX INTEGRATED END OF LIFE AND DEMENTIA CARE SUSSEX PATHWAY

49.1 The Committee considered a report of the Chief Operating Officer, Clinical Commissioning Group which requested approval of the Pan Sussex Integrated End of Life and Dementia Care Pathway. The pathway had been developed through multi-agency and multi-disciplinary stakeholder group collaboration across Sussex as part of the End of Life Care in Dementia Regional Innovation Funded project for NHS Sussex. It was part of the Joint Dementia Plan for Brighton and Hove. The Brighton and Hove CCG Strategy Group supported implementation of the pathway as agreed at the meeting on 8 January 2013.

49.2 Councillor Marsh stated that she had mixed feelings about the word pathway. She welcomed a strategy that treated people as early as possible; however she questioned whether the best medicines would be available for early on set dementia. Certain medicines that were seen as effective were not available. Councillor Marsh made the point that sometimes people with dementia were robust and end of life could be a long way off. She would be worried if the plan had anything to do withdrawal of fluids and nutrition.

49.3 The Commissioning Manager explained that she had brought along copies of the consensus statement on the Liverpool Care Pathway. This had been supported by the Alzheimer's Society. They stated that in no way should fluids or nutrition be withdrawn from patients. The Commissioning Manager was happy to circulate this paper for discussion. There was robust training and support for the pathway. The new memory assessment service would provide early diagnosis and support. The Commissioning Manager stated that she had spoken to patients' groups regarding early on set dementia. The pathway was considered appropriate.

49.4 The Chief Operating Officer stressed that part of the strategy was to diagnose early in order to provide effective treatment as early as possible.

49.5 Councillor Barnett stated that she believed the Liverpool Pathway did withdraw fluids and food. She had observed this happening in her own family.

49.6 The Chief Operating Officer replied that within the pathway there was a full discussion with people about what the pathway meant for the person and the family. Councillor Barnett made the point that dementia was often diagnosed too late for the person to be involved in decisions about their future.

49.7 Councillor Mears stated that she did not support the pathway in any way and wanted to see a revised report she was happy with. She considered the Liverpool Pathway involved the removal of fluids and food. She was not happy with the tone of the report and considered that the emphasis should be how people were cared for. Councillor Mears was concerned that the membership of the Brighton and Hove Stakeholder Group only had one lay member. She referred to page 38 of the agenda – Appendix 1 Summary of Pathway – Section 5 - which stated "Implement Liverpool Care Pathway as appropriate."

49.8 Councillor Jones broadly welcomed the proposals. He thought it was a good pathway but acknowledged that there were issues that arose towards the end of life. He welcomed early intervention with the emphasis on the person who needed care. He stressed the importance of early diagnosis and directing people to appropriate services and medication. Treatment worked best in the early stages. However, he considered that it would be useful to have more information about the Liverpool Care Pathway.

49.9 The Chief Operating Officer stressed that the pathway was about early support for people and their families. Discussions would be held at an early stage.

49.10 Councillor Norman agreed that it was important to work with people in the early stages of dementia. The only mention of the Liverpool Pathway was on page 38 of the agenda and if this caused a problem he suggested the reference to the pathway should be removed. Councillor Norman stressed that the Liverpool Care Pathway was only as good as the people who used it and should not be used without education and training. Councillor Norman thought that the pathway was a good step forward to help people in the last stages of their lives. It did not suggest withdrawing anything from a person.

49.11 Councillor Meadows agreed that there were good proposals in the report, particularly in relation to early intervention and diagnosis. However, she had witnessed her father being given a sponge on a stick rather than fluids and had seen how distressing this could be. Councillor Meadows was concerned about how the pathway would be implemented. She was unhappy with the word implement and stated that if this word was left out she might be able to support the strategy. The emphasis should be on discussion with the person and their family. Councillor Meadows considered that the Older Peoples Council should be consulted about the proposals and noted that they were not mentioned in the report.

49.12 Councillor Wilson questioned what happened when someone entered the pathway at a late stage and could not make a decision.

49.13 The Commissioning Manager replied that the aim was for people not to be in that position. The emphasis was on early intervention and for a decision to be made in conjunction with carers or families on what they would like to happen.

49.14 Councillor Wilson stated that it might have been more palatable if there had been mention of the pathway earlier in the document. She was concerned that the pathway might be implemented at a late stage.

49.15 Councillor Marsh considered that there should be more weight on the patient service user.

49.16 Councillor Powell considered that words were very important and needed to be clear and agreed. She referred to Appendix 1 – Phase 3 and asked for this to be reworded as not everyone had a family.

49.17 The Chair noted that the committee appeared happy with the work proposed for early diagnosis. However, he suggested that a decision on the report be deferred in order to consider the concerns expressed by members. The Chair suggested that the Chief Operating Officer and the Commissioning Manager should meet with him and the Opposition Spokespersons to discuss a way forward for a revised report. A draft of the revised report could be circulated to all members of the committee.

49.18 Councillor Mears stated that she was concerned that the Older Peoples Council had not been consulted and did not appear aware of the consultation in the city. The Commissioning Manager stated that she would check exactly who had been consulted and would ensure that the Older People's Council were consulted as appropriate.

49.19 **RESOLVED -** (1) That it be agreed to defer consideration of the proposals to the next meeting of the Committee on 17 June 2013 in order for a revised report to be submitted which considers the concerns expressed by members of the Committee.

50. ADULTS SECTION 75 REVIEW

50.1 The Committee considered a report of the Chief Operating Officer, Clinical Commissioning Group which outlined revisions to the Adults Section 75 Agreement between the Council and the Clinical Commissioning Group which need to come into effect on 1 April 2013 in order to reflect the changes in law.

50.2 The report explained that from 1 April 2013 the Clinical Commissioning Group would become the accountable body for commissioning the majority of healthcare provision in the City. Joint Commissioning agreements with the Council therefore needed to be revised in order to reflect the new commissioning landscape and changes to legal responsibility for Public Health functions that transfer solely to the Council.

50.3 The Chief Operating Officer stated that paragraph 3.3.1 of the report set out the changes to service areas to be jointly commissioned. The intention was to have an agreement for a three year period. There would be a non pooled budget. A detailed schedule would be submitted to the Joint Commissioning Board which would be updated annually.

50.4 The Senior Lawyer explained the proposals for new governance arrangements for the Joint Commissioning Board. It was proposed to have the Joint Commissioning Board on the same day as Adult Care & Health Committee, immediately prior to the committee. There would be one vote for the CCG and one vote for the Council. There was a question as to whether to involve the whole of the Adult Care and Health Committee or whether to have a Sub-Committee to sit on the Joint Commissioning Board.

50.5 Councillor Meadows expressed concern that the proposal was to maintain a separate Joint Commissioning Board, now that the section 75 business had decreased. She considered that the section 75 business should be considered within the Adult Care and Health Committee.

50.6 Councillor Meadows noted that there was still a health element to a number of the Section 75 functions. She considered that health money should be attached to these services. She stated that she would like to know how much health money was being used to support the council's budget. Councillor Meadows asked how staff were affected by the arrangements.

50.7 The Chief Operating Officer replied that the support grant for HIV/AIDS would need to be used by the Public Health Team led by Tom Scanlon. HIV/AIDs was now solely commissioned by the Council. However, there were a range of services that had a duel aspect. There were no proposals to make changes to staffing.

50.8 The Chair stated that £18 million would come across to the Council with the public health functions.

50.9 Councillor Mears welcomed the revisions in the Section 75 agreement but had areas of concern. She considered that the Section 75 budget should be submitted to the Adult Care & Health Committee. It needed to be a regular report. Councillor Mears referred to paragraph 5.1 (financial comments) and asked for more information on the respective contributions. With regard to the JCB, Councillor Mears agreed that changes needed to be made around saving time and cost cutting. She considered that it would be more practical to have one meeting which would add to clarity and make decision making simpler. It did not make sense to have the JCB before Adult Care & Health Committee.

50.10 The Head of Business Engagement informed Members that £16m of the Adult Social Care budget related to Section 75. She confirmed that it would be possible to identify the Section 75 budget in the finance report submitted to the Committee.

50.11 The Chair stated that there was a need to talk to the Opposition Spokespersons as to what they wanted to see happen with the review of Section 75. These views would be fed into the constitutional review.

50.12 The Chair thanked the Chief Operational Officer for her work with the Joint Commissioning Board and stated that he was pleased that she was continuing to work with the CCG.

50.13 **RESOLVED -** (1) That the requirement to revise the Section 75 Agreement to reflect changes in the law be noted.

(2) That the revisions to the Section 75 Agreement be agreed in order to comply with the changes in the law.

(3) That the proposals for amendments to the arrangements for future meetings of the Joint Commissioning Board be noted.

51. DAY ACTIVITIES REVIEW

51.1 The Committee considered a report of the Director of Adult Social Services which provided an update of progress on the Day Activities Review which included day activities for all vulnerable adults. The report highlighted the need to make the best use of all day centre buildings, resources and staff in order to offer effective and responsive day services across the City and also offer value for money. The report also provided an update on the future of Buckingham Road and Connaught Day Centres.

51.2 Councillor Marsh referred to direct payments and personal budgets and asked what strategies were being put in place to facilitate the take up of personal budgets by making the process easier.

51.3 The Head of Assessment Services reported that the council's record in relation to personal budgets was good (70%). The figure for direct payments was less high. Personal budgets could be used for council services. People had the choice of whether to have direct payments or a personal budget. There was a need to support people with a learning disability to take up personal budgets.

51.4 Councillor Mears referred to paragraph 8.2 in relation to capital funding for day centres. She asked if this had been considered in the budget process and whether any budget had been identified.

51.5 Councillor Mears referred to paragraph 9.2 in relation to consultation. She would like to see a report on the outcome and views expressed in the engagement with providers, service users, carers and advocates carried out since the last meeting. Councillor Mears further referred to paragraph 10.2 in relation to in house services. She asked for a more detailed breakdown of the in house budget figures.

51.6 The Commissioner, Learning Disabilities & Older People explained that Budget capital funding for day centres had not been identified yet, and that she would send Councillor Mears more information about the more recent engagement. The Head of Business Engagement stated that she could provide figures on day centres in the finance report to the next meeting.

51.7 Councillor Jones referred to the timescales involved in finding alternative accommodation for the Connaught Day Centre and asked if another site had been identified. The Commissioner, Learning Disabilities & Older People replied that officers were working with colleagues in education to identify a site. Councillor Jones asked officers to let him know when a site was identified.

51.8 The Chair asked officers to send members a progress update on this matter before the next committee meeting.

51.9 The Chair referred to the Fed' Embrace Project (paragraph 8.7) and stated that this was a valuable resource. The Head of Commissioning & Partnerships informed the Committee that she would arrange for someone from the Federation to give a presentation to the Committee. Councillor Mears suggested having posters in libraries to advertise this resource. Members agreed this was a good idea.

51.10 **RESOLVED -** (1) That the progress of the Day Activities Review and the next steps proposed be noted.

(2) That the presentation of a further progress report at the next meeting in June be agreed.

The meeting concluded at 6.18pm

Signed Chair

Dated this day of

BRIGHTON & HOVE CITY COUNCIL

JOINT COMMISSIONING BOARD

5.00PM 25 MARCH 2013

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Brighton & Hove City Primary Care Trust representatives:
Denise Stokoe (Chair) and Dr George Mack;

Council representatives:
Councillor Rob Jarrett (Deputy Chair);

Co-opted Members:
Colin Vincent, LINk

Apologies: Janice Robinson (Brighton & Hove CCG), Councillor Ken Norman and Councillor Anne Meadows

PART ONE

33. PROCEDURAL BUSINESS

33 (a) Declarations of Substitutes

33.1 There were none.

33 (b) Declarations of Interests

33.2 There were none.

33 (c) Exclusion of Press and Public

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

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

34. MINUTES OF THE PREVIOUS MEETING

34.1 George Mack drew attention to some typing errors. Paragraph 27.6 should have referred to a *peer* review. Paragraph 28.3 – third line should read "…people *with* learning disabilities."

34.2 Colin Vincent referred to paragraph 24.6 relating to the NHS 111 service and stated that he had not yet received a briefing sheet on this service. The Chief Operating Officer informed Mr Vincent that she had sent him a briefing sheet via the LINk office. She would send another copy direct to his home address.

34.3 Mr Vincent mentioned that there had been a media report that had reported some confusion about the NHS 111 service. He asked for an update on how the service was operating in the city.

34.4 The Chief Operating Officer reported that the NHS 111 service went live about 10 days ago. There were teething problems around the technical ability to share information amongst organisations. There had also been a concern about capacity in call centres. The technical problems had been resolved and extra capacity had been added to call centres. The service was now running very smoothly. The national launch of the service would take place in a couple of weeks. There would be some focused work locally to ensure people were made aware of NHS 111. A full report on the service could be produced for a future meeting.

34.5 **RESOLVED** – That the minutes of the Joint Commissioning Board Meeting held on 28 January 2013 be agreed and signed as a correct record subject to the amendments detailed in paragraph 34.1 above.

35. CHAIR'S COMMUNICATIONS

Clinical Commissioning Group Authorisation

35.1 The Chief Operating Officer informed the Board that officers had provided additional information to the NHS Commissioning Board to demonstrate that five areas of concern had been addressed. Four out of the five concerns had been cleared by the NHS Commissioning Board. Only one condition remained outstanding relating to a shared finance officer role. This matter would be resolved. The CCG had already been formally authorised by the NHS Commissioning Board and were in place to go live on 1 April 2013.

HealthWatch

35.2 Colin Vincent informed the Board that the LINk would be superseded by HealthWatch on 1 April 2013. HealthWatch would carry on the work of the LINk with a few additions. The successor organisation was keen to continue to have a representative on the Joint Commissioning Board. Mr Vincent was advised to inform the Community and Voluntary Sector Forum that they should contact the Democratic Services Officer with regard to the HealthWatch representative.

36. PUBLIC QUESTIONS

36.1 There were none.

37. FINANCIAL PERFORMANCE REPORT MONTH 10

37.1 The Board considered a report of the Director of Finance, NHS Sussex and Director of Finance, BHCC which set out the financial position and forecast for the partnership budgets at the end of month 10.

37.2 The Head of Finance, Business Engagement, BHCC drew attention the table in 3.1 of the report which showed the forecast outturn variance by client group.

37.3 The Senior Lawyer asked the Board to note that the two councillors not present at the meeting had been sent the agenda and were able to note the content of the report.

37.4 **RESOLVED -** (1) That the forecast outturns for the s75 budgets as at month 10 be noted.

(2) That the update on budget planning for 2013/14 for the health and social care arrangements agreed by Budget Council and NHS Sussex Board be noted.

38. SUSSEX INTEGRATED END OF LIFE AND DEMENTIA CARE SUSSEX PATHWAY

38.1 The Board noted that this item had been withdrawn from the agenda. The Adult Care & Health Committee held on 18 March 2013 had agreed to defer consideration of the proposals to the next meeting of the Committee on 17 June 2013 in order for a revised report to be submitted which reflected the concerns expressed by Members.

39. DAY ACTIVITIES REVIEW

39.1 The Board considered a report of the Director of Adult Social Services that provided an update of progress on the Day Activities Review which included day activities for all vulnerable adults. The report highlighted the need to make the best use of all day centre buildings, resources and staff in order to offer effective and responsive day services across the City and also offer value for money. The report also provided an update on the future of the Buckingham Road and Connaught Day Centres.

39.2 The Chair observed that many aspects of the service were being reviewed but there remained some uncertainty particularly with regard to the Connaught and Buckingham Road Day Centres.

39.3 The Commissioner, Learning Disabilities and Older People acknowledged that there had been anxiety about the future of these services. There had been regular newsletters and day centre workers are working with current service users to identify alternative locations for activities. At the moment it was known that Education required the Connaught Road building from January 2014. In house staff were working on a specification for an alternative building and are working with carers and service users to ensure that any alternative sites meet the needs of the service users.

39.4 Councillor Jarrett informed the Board that he had spoken to the Chair of the Children and Young People Committee about the Connaught Centre. A timetable regarding Education's move to the Connaught Centre would be available as soon as possible.

39.5 Councillor Jarrett mentioned the "It's Local Actually" service. This was a recognised service for anyone referring people for activities. It was a useful resource and Councillor Jarrett recommended that Board members looked at the Fed Website. http://www.thefedonline.org.uk/services/out-and-about/its-local-actually

39.6 The Senior Lawyer informed the Board that the Day Activities Review report had been fully debated and noted at the Adult Care & Health Committee, on 18 March 2013. Members of the committee in attendance on 18 March included Councillors Meadows and Norman who were unable to attend the Board meeting today.

39.7 **RESOLVED –** (1) That the progress of the Day Activities Review and the next steps proposed be noted.

(1) That it be noted that there will be a presentation of a further progress report to the next meeting.

40. BRIGHTON AND HOVE CCG COMMISSIONING PLANS 2013/14

40.1 The Board considered a presentation from Geraldine Hoban, Chief Operating Officer, Clinical Commissioning Group. The presentation explained that the CCG had three key commissioning plans. The Joint Health and Wellbeing Strategy (JHWS), the Strategic Commissioning Plan (SCP) and the Annual Operating Plan (AOP).

40.2 The presentation set out the background to developing the plans, challenges facing the NHS and details of local budget and spend.

40.3 The Chief Operating Officer set out the local challenge in saving £10.3m from existing services and budgets, whilst increasing the quality of services, driving up the use of innovation, increasing productivity and focusing on prevention of ill health and promotion of wellbeing.

40.4 The Chief Operating Officer informed the Board of an amendment in the presentation. The CCG had a budget of £350m not £400m.

40.5 The presentation detailed the clinical priorities identified in the JSNA. These were cancer, diabetes, musculoskeletal conditions, dermatology, dementia, healthy weight & good nutrition, and emotional health & wellbeing, including mental health.

40.6 The Chief Operating Officer explained that in addition to the specific clinical pathways there were also a number of service areas identified as priorities. These were community care, integrating physical and mental health, primary care, urgent care and care for vulnerable groups.

40.7 The Chief Operating officer stressed that there would be a focus on Quality and outcomes and concluded that the CCG plans were aligned to the Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy, were clinically led, balanced

financially, and were delivered through joint working with local partners with strengthened Section 75 Agreements and a continued focus on quality and outcomes.

40.8 Councillor Jarrett mentioned that he would be interested in seeing the result of a pilot at the Royal Sussex County Hospital. He thought that having liaison nurses was a wonderful idea. They had recently introduced themselves to the Learning Disability Partnership Board. This was a very positive step.

40.9 Colin Vincent asked for clarification regarding the CCG budget. The Chief Operating Officer explained that the NHS Commissioning Board budget for Brighton & Hove would be £150m. The CCG budget was £350m. There had been an increase of £7m not a cut in the budget. However, it was felt that a further £8m was required for the CCG's plans for services. The CCG would look to make the £8m through the efficiency programme.

40.10 Colin Vincent referred to the recent government announcement that in 2013/14 the total budget for local public health services would be just under £2.7 billion. He asked if the CCG would benefit from this money. The Chief Operating Officer replied that the CCG and Local Authority would benefit from the funding and would be working closely together.

40.11 The Head of Assessment Services concurred and informed the Board that the council were working on plans for using the transfer of funds.

40.12 **RESOLVED** – That the presentation be noted.

41. ADULTS SECTION 75 REVIEW

41.1 The Board considered a report of the Chief Operating Officer, Clinical Commissioning Group which outlined revisions to the Adults Section 75 Agreement between the Council and the Clinical Commissioning Group which needed to come into effect on 1 April 2013 in order to reflect the changes in law.

41.2 The report explained that from 1 April 2013 the Clinical Commissioning Group would become the accountable body for commissioning the majority of healthcare provision in the City. Joint Commissioning agreements with the Council therefore needed to be revised in order to reflect the new commissioning landscape and changes to legal responsibility for Public Health functions that transfer solely to the Council.

41.3 The Chief Operating Officer stated that schedules for the jointly commissioned areas had been updated. A new 3 year agreement had been drawn up. There would be a non pooled fund.

41.4 The Senior Lawyer explained that there would be an amendment to the council's constitution that would propose that the timing of the Joint Commissioning Board and Adult Care and Health Committee coincide. The Joint Commissioning Board would meet first to consider the Section 75 business. The proposal was being made to avoid the situation whereby reports were being considered on several occasions by the same people and would make the decision making process more efficient. The report had been agreed by the Adult Care and Health Committee and would be submitted to full Council for approval. The terms of reference for the Joint Commissioning Board would

be updated. The CCG and the local authority members would continue to each have one block vote.

41.5 George Mack referred to Schedule 4 – Excluded Functions. Paragraph 3.1 should refer to Schedule 2 not 4.

41.6 The Senior Lawyer informed the Board that in her opinion the Local Authority single vote on this item had been taken by the whole of the Adult Care & Health Committee on 18 March. The Committee had approved the recommendations.

41.7 **RESOLVED -** That the requirement to revise the Section 75 Agreement to reflect changes in the law, be noted.

(1) That the revisions to the Section 75 Agreement be agreed in order to comply with the changes in the law.

(2) That the proposals for amendments to the arrangements for future meetings of the Joint Commissioning Board be noted.

The meeting concluded at 6.05pm

Signed Chair

Dated this day of

ADULT CARE & HEALTH COMMITTEE	Agenda Item 5B Brighton & Hove City Council

WRITTEN QUESTIONS FROM MEMBERS OF THE PUBLIC

A period of not more than fifteen minutes shall be allowed at each ordinary meeting for questions submitted by a member of the public who either lives or works in the area of the authority.

The following written questions have been received from members of the public.

(a) Jean Calder

"In January my mother, who has dementia, was admitted to the RSCH with severe dehydration. She had been living in nursing-homes. I believe we need to increase awareness of the dangers of dehydration in residential and home care services and hospitals and have already asked the council to explore the possibility of a city-wide awareness campaign.

Can you tell me what information the Council has regarding older people in receipt of social care services, especially those with dementia, who:

- become dehydrated and require hospital admission or medical care
- die of dehydration or dehydration-related conditions."

NOTICE OF MOTION (REFERRED FROM COUNCIL HELD ON 9 MAY 2013)

INDEPENDENT COMMISSION ON WHOLE-PERSON CARE

"This council notes predictions from the Nuffield Trust which show, unless we improve the way services are delivered, growing social care needs will leave a shortfall of up to £29 billion a year by 2020 in NHS funding.

This council also notes the launch of an Independent Commission led by respected international expert and former Department of Health specialist Sir John Oldham OBE. We trust this Commission will be truly independent and non partisan with genuine cross-party involvement. The Commission will seek to find ways of integrating health and social care to meet the challenge of an ageing population with rising needs for care and growing numbers of people with chronic illnesses like cancer, diabetes and dementia.

This council believes in the principle of organising services around the needs of patients, rather than patients around the needs of services, with teams of doctors, nurses, social workers and therapists all working together and care being arranged by a single person. Integrated care will lead to better outcomes and greater efficiency for the whole system.

This council supports a greater focus on preventing people getting ill and more care being provided directly in people's homes so they avoid unnecessary hospital visits, and integrating social care services between the NHS and local authorities.

This council resolves to support the principle of "whole person care".

This council requests the appropriate council committee, to make a positive contribution towards pursuing the goal of integrating health and social care between the NHS and local authorities."

ADULT CARE & HEALTH COMMITTEE/SECTION 75 JOINT COMMISSIONING	**Agenda Item 7** Brighton & Hove City Council

Subject:		**Constitutional Matters**		
Date of Meeting:		**17 June 2013**		
Report of:		**Monitoring Officer**		
Contact Officer:	Name:	**Mark Wall**	**Tel:**	**29-1006**
	E-mail:	mark.wall@brighton-hove.gov.uk		
Key Decision:	No			
Wards Affected:	All			

For General Release

1. SUMMARY AND POLICY CONTEXT

1.1 To provide information on the committee's terms of reference.

2. RECOMMENDATIONS

2.1 That the committee's terms of reference, as set out in Appendix A to this report, be noted.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The Council meeting on 28 March 2013 agreed a revised constitution for the City Council. The new constitution came into force after the conclusion of the Annual Council meeting on 23 May with the exception of any amendments relating to the terms of reference of the Health & Wellbeing and the Financial Regulations and Standards Financial Procedure which came into effect on 1st April 2013.

The Adult Care & Health Committee – Terms of Reference

3.2 The Council agreed that the Joint Commissioning Board be abolished as a separate meeting and that its business be brought into the Adult Care & Health Committee. This will be managed as a two part agenda, starting with the jointly commissioned (Section 75) business when the CCG will meet concurrently with the Council committee (in the same way as the JCB). The second part of the meeting will be limited to the Council committee business. The updated terms of reference for the Adult Care & Health Committee are set out in Appendix 1. An extract from the report "Review of the Constitution" relating to the Joint Commissioning Board is attached as Appendix B.

Membership

3.3 The councillor membership of the committee is set at 10. Councillor Members attend the whole of the meeting. There will be three voting members of the

Clinical Commissioning Group and one non voting Health Watch representative who will attend the jointly commissioned (Section 75) section of the meeting.

3.4 The arrangements for substitute Members to attend meetings of Committees/Sub-Committees, as set out in the Council Procedure Rules 18 to 24, apply to meetings of the Adult Care & Health Committee.

Quorum

3.5 The Quorum for councillors at the Adult Care & Health Committee will be 3 members (see Rule 21 Quorum of Committees and Sub-Committees – Part 3.2 of Council Procedure Rules).

3.6 The Quorum for CCG voting members during the jointly commissioned (Section 75) business will be at least two members.

Voting

3.7 Normal voting rules as set out in the Council Procedure Rules (Rule 29 Voting - part 3.2 – Council Procedure Rules) apply for councillors during the section of the meeting dealing with council committee business.

3.8 During the section of the meeting dealing with jointly commissioned (Section 75 business) each relevant body (Brighton & Hove CCG and Brighton & Hove City Council) will have one vote in passing a resolution. The CCG members and council members will have to decide separately how to use their block vote. The CCG members should decide by a majority. Council members will use normal voting rules (as set out in the constitution) in reaching their decision on how to use their block vote.

Programme Meetings

3.9 Ordinary meetings of the Adult Care & Health Committee are scheduled to take place on the following dates during 2013/14:

Monday 17 June 2013
Monday 23 September 2013
Monday 25 November 2013
Monday 20 January 2014
Monday 17 March 2014

3.10 Meetings of the Committee will be held in the Council Chamber, Hove Town Hall and will start at 4.00 p.m.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 All Council Members considered and approved the new consitution on the revised constitution on 28 March 2013. CCG voting members and officers were consulted on the proposals.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are no specific financial implications arising from this report. It is expected that the overall effect of the introduction of the new constitution will be cost neutral.

Finance Officer Consulted: Name Michelle Herrington Date: 4/06/13

Legal Implications:

5.2 The Council's constitution complies with the requirements of the Localism Act 2011, the Local Government Act 2000, the Local Authorities (Constitutions) Direction and relevant guidance.

5.3 The Revised s75 Agreement approved by JCB in March 2013 will need to be updated to reflect the changes to the Constitution and abolition of the JCB as a separate board.

5.4 There are no adverse Human Rights Act implications arising from this report.

Lawyer Consulted – Sandra O'Brien Date 4/06/13

Equalities Implications:

5.5 There are no equalities implications arising from the report.

Sustainability Implications:

5.6 There are no sustainability implications arising from the report.

Crime & Disorder Implications:

5.7 There are no crime & disorder implications arising from the report.

Risk and Opportunity Management Implications:

5.8 There are no risk and opportunity management implications arising from the report.

Public Health Implications:

5.9 There are no pubic health implications arising from the report.

Corporate / Citywide Implications:

5.10 There are no corporate or city wide implications arising from the report.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 The Joint Commissioning Board could have remained a separate Board but it was considered that the previous arrangements involved an unacceptable level of duplication, with the same reports being taken to both Joint Commissioning Board and Adult Care & Health Committee. Having two

separate agendas with meetings running in succession was also considered cumbersome.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The recommendations are being put forward in line with the requirements of the constitution.

SUPPORTING DOCUMENTATION

Appendices:

1. (A) Adult Care & Health Committee Terms of Reference.

   (B) Extract from report submitted to full council on 28 March 2013 – Item 110 Review of Constitution

Background Documents

1. The Constitution

APPENDIX A

Amended Scheme of Delegation to Committees, Sub-Committees and Advisory Bodies

APPENDIX ONE

DELEGATIONS TO COMMITTEES AND SUB-COMMITTEES – AMENDED SECTIONS

ADULT CARE & HEALTH COMMITTEE AND JOINT COMMISSIONING BOARD

Explanatory Note

This Committee is responsible for adult social services, public health in relation to adults, and joint commissioning and delivery of a number of social care and health services with the Health Service- ~~see the section below relating to the Joint Commissioning Board which oversees these arrangements.~~

The Council and the Clinical Commissioning Group have entered a Partnership Agreement under Section 75 National Health Service Act 2006 ('the Section 75 Agreement') covering the joint commissioning of adult social care and health services. The Committee therefore divides its agenda between
business to be considered jointly with the Clinical Commissioning Group (Part A) and Council business (Part B). The joint meeting of the Adult Care and Health Committee and the Clinical Commissioning Group (Part 1) is known as the Joint Commissioning Board and is where decisions are made concerning the commissioning and provision of services on behalf of the parties to the Section 75 Agreement. It is also the senior forum for the discussion of policy and strategy across the partnership as a whole and is responsible for setting the strategic direction of these services. Fuller details of the governance arrangements relating to the adult social care and health partnership are set out in the Section 75 Agreement.

Delegated Functions

1. Adult Social Services
(a) To exercise the social services functions of the Council in respect of adults;
(b) To exercise all of the powers of the Council in relation to the issue of certificates to blind people; the issue of badges for motor vehicles for disabled people and the grant of assistance to voluntary organisations exercising functions within its area of delegation;
(c) To exercise the functions of the Council in relation to the removal to suitable premises of persons in need of care and attention.

2. Public Health
To exercise the Council's functions in respect of public health relating to adults –

APPENDIX A

Amended Scheme of Delegation to Committees, Sub-Committees and Advisory Bodies

~~DELEGATIONS TO COMMITTEES AND SUB-COMMITTEES – AMENDED SECTIONS 11/09/12~~

(i) including but not limited to:
- sexual health
- physical activity, obesity, and tobacco control programmes
- prevention and early detection
- immunisation
- mental health
- NHS Healthcheck and workplace health programmes
- dental public health
- social exclusion
- seasonal mortality;

(ii) which transfer to the Council under the Health and Social Care Act 2012.

3. Partnership with the Health Service

(a) To exercise the Council's functions under or in connection with the adult services partnership arrangements made with health bodies pursuant to Section 75 of the National Health Service Act 2006 ("the section 75 Agreements").

(b) To meet concurrently with the Clinical Commissioning Group as the Joint Commissioning Board in order to discuss and develop jointly commissioned services in relation to adults

4. Learning Disabilities

To discharge the Council's functions regarding Learning Disability.

NOTE

(a) All the above functions shall be exercised subject to any limitations in the section 75 Agreements.

(b) Policy issues which are relevant both to this Committee and the Children & Young People Committee may be considered by either of those Committees or by the Policy & Resources

APPENDIX B

Extract from report submitted to full council on 28 March 2013 – Item 110 Review of Constitution.

Joint Commissioning Board (JCB)

3.17 The need for a separate JCB meeting was flagged up as an issue at the time of the adoption of the new constitution and the work of the JCB and the Adult Care and Health Committee has been reviewed to consider whether there is duplication or benefit in holding two separate meetings. The Clinical Commissioning Group (CCG) have expressed a desire to continue to have a public forum in which they participate in relation to jointly commissioned services but it is acknowledged that the current arrangements involve an unacceptable level of duplication, with the same reports being taken to both JCB and Adult Care and Health Committees.

3.18 It is proposed that the JCB is abolished as a separate meeting and that its business is brought into the Adult Care and Health Committee. This will be managed as a two part agenda, starting with the jointly commissioned (Section 75) business when the CCG will meet concurrently with the Council committee (in the same way as the JCB). The second part of the meeting will be limited to the Council committee business. The updated terms of reference for the Adult Care and Health Committee are set out in Appendix 1.

ADULT CARE & HEALTH COMMITTEE MEETING JOINTLY COMMISSIONED (SECTION 75) BUSINESS	Agenda Item 8 Brighton & Hove City Council

Subject:		**Community Short term services – an update**		
Date of Meeting:		**17 June**		
Report of:		**Geraldine Hoban – Chief Operating Officer**		
Contact Officer:	**Name:**	**Anna McDevitt**	**Tel:**	**01273 574841**
	Email:	**annamcdevitt@nhs.net**		
Key Decision:	**No**			
Ward(s) affected:		**All**		

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The Community Short Term Services (CSTS) are a collection of services that work closely together to provide rehabilitation and crisis care to people that enable them to either remain at home rather than going to hospital or enable them to be discharged from hospital following an episode of care. Providers of services include Brighton & Hove City Council, Sussex Community Trust, South East Health, Highgrove nursing home and Age UK.

1.2 This report

- provides a general update on Community Short Term Services
- provides an update on the areas highlighted for next steps in the January report
- and draws attention to ongoing issues that need resolution where decisions will need to be made over coming months.

1.3 In the update provided to the JCB in January 2013 the following areas were highlighted as priorities for next steps for Community Short Term Services:

- ensuring the robustness of the current bed and community based models
- ensuring the right balance between bed and community based services
- ensuring the right skill mix to meet levels of need and identifying options for supporting people with dementia
- developing a formal framework for clinical responsibility for people using the service
- implementing a more robust process for quality assurance
- integrating of the community rapid response elements of the service with a view to creating a single service by April 2013
- implementing the single point of access to the service
- working up options for the most effective way of providing the home care element of Community Short Term Services
- evaluating both the service and the delivery mechanism and making recommendations to Committee about next steps

2. RECOMMENDATIONS:

2.1 The Adult Care and Health Committee is asked to note this general update on the Community Short Term Service.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 *General update*

3.1.1 Since last October the bed and community side of CSTS have been under enormous pressure and have been the focus of much attention in the local health economy wide discussions about system pressures. There have been a number of external factors that have contributed to the pressure in CSTS:

- the long and bad winter has increased demand for beds
- the increase in the number of people admitted to hospital has put pressure on the health system
- the acuity and dependency levels of patients being discharged to beds has increased and put extra demands on the staff
- the absence of ward based therapy for patients whilst in RSCH has exacerbated patients needs for therapy when they finally get into a community bed – again this has placed additional pressure on the service

3.1.2 In addition Knoll House has not been operating at its 20 bed capacity since 1st March. It has only had 12 beds open for admissions since 8 April. Consequently the CCG has spot purchased an additional 15 beds from the Victoria Nursing Home Group as well as additional therapy and nursing input to make up for the reduced number of beds at Knoll House and the general extra demand for beds.

3.2 *Knoll House*

Knoll House provides 20 beds to support people with short term rehabilitation needs when they leave hospital, or to prevent hospital admission. Last year the model of service was changed from a clinically led service managed by Sussex Community Trust, and the management responsibility returned to Brighton & Hove City Council. BHCC has taken forward a major improvement programme which includes dealing with previous safeguarding concerns, addressing the Care Quality Commission (CQC) improvement plan, implementing a new more robust management structure, improved partnership documentation and communications, and recruiting and inducting a permanent staff group- 14 new staff have been recruited. Knoll House is operating at a reduced capacity of 12 beds whilst these actions are being taken forward. It is anticipated that the service will return to full capacity within the next 2-3 months once the CQC improvement plan has been fully actioned, and the new cohort of permanent staff have been inducted.

3.3 *Service model and skill mix*

3.3.1 Sussex Community Trust has conducted a review of the nursing needs of the patients in the CSTS beds. In addition we have commissioned one of our public health consultants to carry out a needs assessment for the bed based part of the service which will also inform the appropriate skill mix needed.

3.3.2 At Committee in March 2013, members approved plans to develop an additional 20 beds at Craven Vale for short term services. Careful consideration needs to be given to an appropriate staffing model at Craven Vale to ensure people are adequately supported by the CSTS.It is clear that there will need to be some beds with 24 hour nursing in the system going forward and as it stands neither Cravenvale or Knoll House is in a position to offer this. Discussions between senior officers (both commissioners and providers) are taking place about this.

3.3.3 We are confident that the number of beds and community provision are appropriate. The System Improvement Plan that now exists to support the required improvements in A&E, includes changes to therapy input and the way patients are managed when they first attend A&E, and will have an impact ultimately on CSTS. Other areas that have implemented changes to frailty pathways in hospital have seen a significant reduction in the demand for bed based rehabilitation with the majority of patients going home with support. And as highlighted in the January report our bed numbers are consistent with the recommended number for a city like ours.[1]

3.3.4 In addition it has become more apparent that there are an increasing number of people with dementia who require community short term services. Many of these people need 24 hour nursing as well as requiring some rehabilitation. As a result, commissioners are considering how such provision can be developed.

3.3.5 The needs of service users being transferred from hospital are increasingly complex. Considerable work has been done to ascertain the staffing requirements to support people safely to ensure their needs are met. This includes work to ensure we have the right skill mix in place, the right balance between community and bed based services and agree on how best to use the community bed services.

3.4 *Clinical responsibility*

It was agreed with GPs in the CCG that clinical responsibility for patients whilst they are supported in their own homes are the responsibility of the patients own GP. When patients are in either Knoll House, Craven Vale, or Highgrove the roving GP service is clinically responsible for the patient and will liaise as necessary with the patients own GP. And if a patient being supported by the Community Rapid Response Service (this service is provided for the first 72 hours within the CSTS) needs clinical input this will first be sought from the patients' own GP and failing this the roving GP will be contacted. The RGP is expected to liaise with the patients' own GP.

[1] National Audit for Intermediate Care 2012

3.5 *Quality assurance*

Discussions have begun across the CCG/BHCC to develop a robust quality assurance process for all community short term services to ensure that people are well supported in their journey through all the different elements of the services. There is an intention to undertake this work jointly, with the appropriate health & social care professionals involved in monitoring the quality of services. Reports on quality will be presented to the Short Term Services Board on a regular basis. The expectation is that going forward there will be clinical involvement in this meeting also.

3.6 *Service integration and single point of contact*

Since the beginning of April it has been possible for referrers to the CSTS to only make one referral and for patients to only be assessed once if multiple services are required. This was one of the recommendations of the Short Term Services Review. Referrals are made via the NHS Professional Support Line. There is still further work to do to ensure a more streamlined process for patients accessing beds with CSTS.

3.7 *Home care*

A multi agency piece of work is underway to look at the arrangements for commissioning home care. Specifically the task and finish group will:

- clarify the pathways for services users/ professionals, in both accessing and moving on from the service
- clarify the commissioning arrangements for home care to ensure that resources are used optimally and flexibly
- clarify the roles and responsibilities of the different elements of home care services operating in (and relating to) Community Short Term Services

This group will report into the Short Term Services project board in June.

3.8 *Service Developments*

3.8.1 Over recent months providers are reporting that people are being discharged with increasingly high levels of need. This change in needs has been dealt with in a reactive way by the providers, for example by increasing the levels of staffing and changing the skill mix within parts of the CSTS. It is important to understand whether these increased demands are temporary and can be managed as they currently are, or whether there needs to be a change in way the services are delivered, and in the model of staffing. This has had an impact on people who use the service whose discharge from hospital may have been delayed, and on relationships between providers where responsibilities have been unclear.

3.8.2 The priorities of the Provider Management Board (PMB) for 2013/14 include

- Improving the experience and outcomes for people using the CSTS
- Understanding the change in demands for CSTS and providing a co-ordinated and planned response to ensure that hospital discharges are managed more effectively
- Provide better clarity about roles and responsibilities to ensure effective partnership working.
- developing a common understanding of the role of the service and improving relationships between partner organisations
- addressing operational issues, including the assessment process
- Ensuring that Knoll House returns back to full capacity
- Improving data collection and reporting about the whole system

Commissioners will continue to work closely with the PMB to monitor the work plan.

3.8.3 There is a willingness amongst providers to make the service work and to support patients as best that providers can. Despite difficulties over the winter, the service has supported an enormous amount of patients and has delivered a high quality service. Significant improvements have been made at Knoll House and this should not be underestimated.

3.8.4 One of the key challenges for the providers will be developing a common understanding of the role of the service. Given the complexity of some of the patients entering short term beds, it is increasingly important to ensure that their needs can be safely met in a care home environment. Commissioners are in agreement that the service is intended to support patients with rehabilitation needs, and admission to a bed is dependent on the patients' potential to improve their capacity to manage.

3.8.5 This scope of the service is clearly defined in the service specification which will be cleared by the STS project board and will be the mandate for the CSTS.

3.8.6 The PMB approach for managing CSTS was the best fit at the time – we are reviewing other options and it is possible that in the short term a simple change such as bringing in an independent and dedicated manager to oversee the whole of the CSTS might make it easier for the required service improvements to be made.

3.9 *Summary of the ongoing issues and decisions that will need to be made*

Key decisions and issues to resolve for commissioning bodies over the coming months include

- confirming the numbers of beds and community places needed
- deciding how many of these beds need to have 24 hour nursing
- confirming the arrangements for patients who have dementia and rehabilitation needs
- agreeing where these nursing beds should be provided
- reviewing the PMB arrangements and considering other options for proving leadership and oversight of the CSTS both in the short and medium term
- agreeing how the CSTS works more closely with Independence at Home

These matters are all being considered by officers and a further paper will be shared with this committee when decisions are required.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 Age UK (Brighton and Hove) were tasked with carrying out user engagement with people in receipt of CSTS. A copy of the report is attached at annex A.

4.2 The majority of people surveyed were pleased with the care they received from the services, however there are a number of areas which were identified as requiring further work and these include:

- lack of clarity around the arrangements for home care provision
- poor communication between services and with patients
- patients having multiple assessments
- confusion over the arrangements for managing patient medication and a need for more systematic review of a patients medication
- large amounts of documentation for each patient and multiple care plan

The PMB has already put in place a number of changes to the way that they work as a result of this feedback and have developed an action plan that they will oversee to address other issues within their control. Some issues also fall outside the remit of the PMB and will need to be addressed with other organisations.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 Financial Implications:

There are a number of outstanding issues, as discussed in the body of this report, the financial implications of which are currently being worked through and will be reported in due course.

Finance Officer Consulted: Michelle Herrington/Debra Crisp Date: 03/06/13

5.2 Legal Implications

This Report is for noting only so no specific legal or Human Rights Act 1998 implications arise. However both Health and Social Care partners need to ensure that their relative statutory health and community care duties are continued to be met with regard for individuals Human Rights through the commissioning and delivery of this service.

Lawyer Consulted: Sandra O'Brien Date: 24 May 2013

5.3 Equalities Implications:

The reconfiguration of short term services is a key element of the Urgent Care Commissioning Plan which has been subject to a full equalities impact assessment. The new model for short term services will improve equity, creating a new more streamlined, efficient, tailored and effective service which improves patient outcome and experience.

5.4 Sustainability Implications:

The reconfiguration of short term services will develop a new sustainable model of care which will make a positive ongoing contribution to preventing inappropriate admissions and facilitating effective discharge. The development of existing estate within the city will take due account of sustainability implications in line with the LA sustainability principles and duties.

5.5 Crime & Disorder Implications:

There are no crime and disorder implications arising from this work.

5.6 Risk and Opportunity Management Implications:

Commissioning level risks are recorded via CCG systems and monitored by the internal PMO at the CCG as well as at the Short Term Services project board.

5.7 Public Health Implications:

The new service will have an increased focused on prevention and therefore will aim to avoid and reduce the severity of patient illness, improving both patient outcomes in addition to being more efficient. The inclusion of the development of a new integrated rapid response service ensures that patients who do require a more urgent intervention receive this in a timely and more effective way, improving outcomes and reducing the need for long term care

5.8 Corporate / Citywide Implications:

The reconfiguration of short term services will have a positive impact on all wards of the city, reducing inequalities and improving patient outcomes and experience.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 When a further paper is submitted relating to the key areas for decisions as set out in paragraph 4.2, options for solutions will be evaluated.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 No recommendations are being made as part of this report

SUPPORTING DOCUMENTATION

Appendix 1: Older people's experiences of short term health and social care in Brighton and Hove February 2013 by Age UK Brighton and Hove

Older people's experiences of short term health and social care in Brighton and Hove
February 2013

Patient and Service Users' Experiences of Short Term Care Services in Brighton and Hove
Age UK Brighton and Hove
February 2013

Part 1 Executive summary

1. In spring 2012, the Brighton and Hove Strategic Commissioning Group [BHSCG] set up a Short Term Care Partnership Board [STCPB] to work together to 'develop proposals for a new care pathway that ensured an integrated approach to short term care and rapid response services'. The partners are:

- Age UK Brighton & Hove Crisis Service [AUKBH]
- Brighton and Hove City Council, Craven Vale Intermediate Care Service [BHCC]
- South East Health Roving GP and out of hours district nursing services [SEH]
- Sussex Community NHS Trust Rapid Response Service and Intermediate Care Services [SCT]
- The Victoria Nursing Home Group, intermediate care beds [VNH].

2. The BHSCG have supported this piece of research:

'To find out the experiences of people who have recently used short term care services [both users and carers] to help inform the new provider service model for STC. The focus will be on processes, systems, user understanding and satisfaction with their care'.

3. AUKBH have led this piece of work. The fieldwork was undertaken in October and November 2012. Fifteen people were interviewed and 16 case files were reviewed from all partners except those people who had accessed SEH [who were unable to secure agreement from users]. At the time of the research, people were either current users of the services or had been so within the previous 6 months.

4. The majority of people were pleased with the care that they received from the individual services. This was evident from our interviews and an examination of previous patient and user satisfaction surveys carried out by STCPB partners.

5. This research adds detail to those surveys and patients/service users reports. Whilst may good experiences were reported, this report focusses on areas where improvements in the patient/user experience could be made. The headlines of the research have been verbally reported and incorporated into the STCPB new service model, which will start on the 1 April 2013. Some other issues have started to be addressed, such as medications and paperwork.

6. We have drafted this research so that it can inform the baseline information from which the partnership can evaluate whether the new STCPB model delivers improvements that will impact on patients/ service users. It identifies standards and markers that can be used to evaluate future changes.

7.The research was small scale and qualitative, so some issues will have not emerged. Nevertheless, some clear messages have emerged.

7.1 Information and access

7. 1.1 One of the greatest concerns arising was poor information sharing between practitioners and their organisations; and between the practitioners and organisations and the patient/service users and carers. Patients/users highlighted:

- -The number of handovers from one person (or agency) to others which often resulted in confusion for them - and for those delivering the service.
- - Conflicting, unclear or untimely information.

7.1.2 This had led to a lack of understanding by some service users/patients about why they had been referred to the service, who had overall responsibility for their care and what was going to happen to them when the service ceased. In contrast, other people were given a plethora of written information, much of which was service related and not user friendly, and it could not be absorbed by people in crisis.

7.2 Referrals, assessments, admissions avoidance

7.2.1 In parallel, it was not always clear from both the interviews and file reviews why some people had been referred to and accepted by the STC services. This applied to all services routes including those admitted via SECAmb paramedic services. There was evidence to suggest that many of service users/patients medical and social problems might have been predicted, addressed earlier, or differently. They may not have have needed a rapid response service, especially the community based services.

7.2.2 One of the critical factors appeared to be how primary care practitioners intervened. There were a number of examples of people, unable to access primary care services, had turned to A&E; or they were waiting for a referral to see a specialist when a crisis occurred. Others had been seeing their 'own' GP on a regular basis, but had been changed to another GP who they did not know, and they had delayed getting help which had resulted in a crisis. There was a suggestion that some people were admitted to STC services mainly because routine services were not available at the point of need.

7.2.3 It is unclear how long term home care and support services interact with STC services. The experiences of the service users/patients suggests that more prominence to social and informal care solutions - as well as medical and health assessments and support- could be a better longer term solution to people's care needs. The pathway from STC to independence at home services and home care needs to be scoped; as well as the role of social care at home, in avoiding admission to STC.

7.2.3 For those people in bed based services, it was difficult to ascertain their current health or care status because of the plethora of separate assessments carried out by a range of different professionals, with no easily accessible summary. Notes were not patient/user centered. In particular, medication sheets were duplicated, sometimes differently, as well as having long lists of drugs. They had the potential for creating difficulties for staff administering medication: a serious risk area, given the importance of medication for the STC client group.

8. From the research, a number of specific areas for improvement have been identified:

- Clear written information about the care pathway and different services provision and interrelationships needs to be routinely provided
- Written information needs to be followed up with a conversation to clarify any outstanding issues.
- People need to know why they are receiving the STC service, for how long and who will be responsible for their care when this service ceases.
- Medication prescribing and management stood out as a risk area. Most people in bed based care appeared to be prescribed a great deal of medication, suggesting that pharmacy advice (medication review) needs to be factored into the new service.
- Clarity about how the long term care agenda relates to the care of older people, the role of screening, case finding and the active monitoring of older people at risk.
- Two areas that stood out as needing particular focus in respect of aligning care pathways were falls and people with diabetes.

9. The review also identified a range of other issues that have implications for STC partners and other agencies. These include:

- How data is recorded on patient/service users notes. This needs to be reviewed, especially the duplication of assessments, progress reviews and a summary of both clinical and care needs.
- The information recorded did not appear to take a holistic approach or to be person centered
- The criteria for referral to Rapid Response services need to be reviewed and clarified
- Care pathways need to be clarified - from hospital to bed based intermediate care and community based services needs to be clarified.
- The role of primary care in admission avoidance needs clarifying.
- The role of social care and support in admission avoidance and discharge from STC needs scoping and clarification.

10. Many of the issues raised above have informed the new service model. Some, particularly those that impact on other providers will require further consideration by commissioners. It is proposed that the information collected from this review could:

- Inform further work to improve the current service model;
- Provide a baseline to evaluate this current model;
- Provide an opportunity to develop benchmarks for the final STC model.

Patient and Service Users' Experiences of Short Term Care Services in Brighton and Hove
Age UK Brighton and Hove
February 2013

Part 2 Full report

1.Background

1.1 In May 2012, the Brighton and Hove Clinical Commissioning Group [BHCCG] set up the Short Term Services Provider Partnership [STSPP]. The remit of the group was to secure greater integration of services currently providing a rapid response or short term support for people who might otherwise be admitted to hospital or could be discharged from hospital with the right support. The STSSP is a collective of the following organisations:

- Age UK Brighton & Hove Crisis Service [AUKBH]
- Brighton and Hove City Council, Craven Vale Intermediate Care Service [BHCC]
- South East Health Roving GP and out of hours district nursing services [SEH]
- Sussex Community NHS Trust Rapid Response Service and Intermediate Care Services [SCT]
- The Victoria Nursing Home Group, intermediate care beds [VNH].

1.2 The STSPP and the BHCCG commissioned a small piece of research:

'To find out what experiences of people who have recently used short term care services [both users and carers] could help inform the new provider service model for STC. The focus will be on processes, systems, user understanding and satisfaction with their care'.

1.3 It was agreed that AUKBH should lead this piece of work. Patients/service users were to interviewed and files reviewed of all partner organisations except those people who had accessed SEH. This work was not a comprehensive piece of research, but an evaluation of the impact of the service on patients/service users and their carers. Its intention was to capture, from different sources, information about patient and service user experiences that could inform future, improved service delivery. Many good and appropriate experiences were described, but the report concentrates on where improvements could be made.

The research looked at:

* Access to the services
* The assessment process
* Service co-ordination and discharge processes, and
* Any lessons from hand-overs from one service to another.

[See Appendix 1 for research outline and Appendix 2 for questions]

1.4 This report sets out the methodology used and identifies key messages and observations from interviews and data collection. For ease of reference these have been reported as follows:

- Methodology
- The people
- Paperwork, information sharing and communications
- Medication
- Admission avoidance, primary care
- Access to services, assessment processes

2. Methodology

2.1 The research took place in October and November 2012 and focussed on people currently using the services or those who had used them in the last 6 months. Each provider was asked to identify patients/service users willing to be interviewed and case files that could be examined. With the exclusion of SEH , who were unable to obtain permission from users, case files and names of interviewees were provided by members of the STSPP. The STSPP identified the following methods for capturing patient/service user experiences:

- Desk top review of existing pieces of research and evaluations of similar services [DT]
- Case examination exercises [DT]
- Interviews with patients/ service users [I]
- Focus groups [FG].

2.2 Some people interviewed were 'hazy' about their experiences, and their recollections sometimes muddled. Interviewers attempted wherever possible to clarify issues with patients/service users, to ensure that the reports were as accurate as possible. This shows how difficult it is to do qualitative research with older people in crisis and with memory problems. The researchers were volunteers and trained and skilled in this type of interview. [See Appendix 3]

2.3 A Stakeholder event was held on 2 November 2012. This included two patients/service users who had also been interviewed prior to the event. Their stories are used in this report.

2.4 Focus groups were also run by Pensioners Action [PA]. They leafleted blocks of flats housing older people in the West Hove, Ingram Crescent area, and engaged Wardens of neighbouring flats. They were assisted in this by the West Hove Forum and AUKBH West Hove Neighborhood Group to display flyers advertising the Focus Groups. In order to ensure full engagement, a simplified questionnaire was developed for group discussion. From this three people who

attended focus groups and had used STC services in the previous 6 months were interviewed.

2.5 Most of observations in this report are from face to face interviews with people who had used the service and the case files. In all, 16 people were interviewed and 15 people's case notes were reviewed.

2.6 Results of existing surveys were also reviewed, including:

- The ICS User Surveys undertaken by the Sussex Community Trust
- The Derby Outcome measure Survey [An Audit to measure the Effectiveness of the Intermediate Care Services (ICS) in Brighton & Hove using Derby Outcome Measure (DOM) by Saba Shanmughasundaram, Senior Physiotherapist, undertaken in 2011];
- South East Health Experience Questionnaire 2012
- Redesigning short-term services, a stakeholder event, 17th May 2011, 'Participant Post Event Briefing'
- Feedback from Short Term care Stakeholder Event 2 November 2011.

3. The people

3.1 There were four younger people in their 60's, and early 70s, who had complex medical conditions, including alcohol problems and needed bed based care. [A list of participants is in Appendix 2]

The youngest person was 55.

3.2 The prevailing picture was of older people in crisis, often due to a fall, an accident, or more frequently, due to underlying pathology.

Mr A who was an intermediate care resident . He was 66 and was chronically sick, having suffered 3 small strokes in 2006 and still had residual weakness on his left side. He was a diabetic, had stomach ulcers, depression, intermittent claudication, COPD, hepatitis A and prostate cancer. He had had to give up his job and was living alone though had local family support.[V: I and DT]

Many people had diabetes, even if this was not the immediate reason for short term
care. A number of people had been managing relatively independently until they had
a crisis and wanted to remain that way once they had recovered.

11 people were in their 80s.
7 people were in their 90s
The oldest person was 97

Mrs C. had been coping well and was able to get buses into town, until she suffered a chest infection, had a fall , which led to loss of appetite and back pain. The chest infection diagnosed during a GP visit triggered the admission to short term care.[V: DT].

Mr B. was admitted to hospital following a fall, with acute renal failure, dehydration, a urinary tract infection, type 2 diabetes, recent onset atrial fibrillation and heart block and heart failure. [V: DT]

There were few people with severe dementia in our research, probably because the people selected for interview did not have significant memory loss. So, we are not able to comment on dementia in respect of this cohort, though all research and intelligence indicates that this is a serious issue for the delivery of STC services, and more research may need to be done.

A number of the respondents appeared to have a level of depression or anxiety that was affecting their recovery.

Discussion points:
The prevalence of falls as a trigger for crisis, underlines the importance of the falls pathway now in place with the ambulance services, IBIS and CRRS; and the recently funded fast track falls pathway. Integration with the new STC model is imperitive.

The new STC model needs to be well embedded into the Diabetes Pathway.

7

3.3 In many cases it was not clear why people had been referred to the STC rapid response service. In most cases, the patient/service user in a bed based service did not know or understand why they were in this type of provision; and an examination of notes did not always shed light on why the person was in this service rather than another mainstream service. Patients/service users were also unclear when they might be discharged or where to and who would arrange this. This does not mean that the discharge was not being arranged by staff, but users were in the dark or were not clear what was being planned for them - so they could not plan.

4. Paperwork, information sharing and communications

4.1 All the non bed based services appeared to avoid any additional paperwork. For instance, CRRS took referrals directly from DN's and roving GP's in order to speed up the assessment and intervention. Similarly in AUKBH Crisis, there is minimal paperwork.

4.2 Conversely, once admitted to a bed the paperwork becomes voluminous and duplicated. To the review team, it was not easy to see or understand chronologies and the current status of the patient/service user. Different professionals recorded in separate parts of the record. This may be because of demands on reporting standards by the Care Quality Commission but it is not easy to see at a glance the persons historic or current situation. The records did not appear be holistic or person centered. The assessment process was clearly complex. Typically it included physiotherapy assessment, occupational therapy, prevention of falls, night care, continence management, vital signs monitoring, pain management, nursing care, social care as well as medication and medical assessments. The current format must be time consuming for staff to complete and to access relevant information. [We understand this issue is now being addressed with the new 'patient status at a glance' report at Knoll House.]

4.3 In the focus groups there was a great deal of discussion about problems with information sharing between agencies and with the way in which patient/service user or carers felt uniformed.

4.4 Some concerns have been raised in the STSPP that sharing of information may be difficult across agencies because of confidentiality. It was clear in notes that this already happens and most people had signed to agree to have their information shared.

Mrs P was suffering from high levels of anxiety and calling out services inappropriately, then turning them away on their arrival. The paramedics referred her to the Rapid Response Team and support was provided in a way which was described as 'excellent' especially as it happened over a weekend. Information was not shared well initially (which was especially important given Mrs Ps the lack of insight), but followed up later. It would have benefitted Mrs P and the family if her son had been included more in the information-sharing, initially to help her take it in over a longer period [FG].

Mrs O had a fall, bruising herself badly after health service daytime hours. The lady rang her daughter who lives a long way away, and she spoke to a Roving GP, accessed with ease. She was admitted into hospital the following day. There was very poor information-sharing initially, then there was far too much information provided -and in print which was too small.

Discussion points:
Although there are discharge booklets, it was clear that people either had not seen them or were not able to assimilate all the information whilst ill. There is a need to ensure that patients/ service users understand the discharge process. It may be necessary, particularly where people do not have carers or friends to support them to provide an advocate or 'friend' who could help support their discharge, thus ensuring a better experience and making the best use resources.

Paperwork and consistent processes are a priority for the STCPP. This might include a clear chronology, same codes on data, including reasons for admission, disposition, how long the person has waited for the service, where they have come from, where they are going being discharged to.

If the STSPP is branded as a partnership entity, it needs to be clear how it will overcome concerns about confidentiality and have clear policies and protocols.

5. Medication

5.1 Most people in bed based services appeared to be on a plethora of drugs. Given the complexity of peoples health needs, this may be to be expected but, over 10 different drugs was common in those people in bed based care, though not all were prescribed for regular use. There are numerous examples of difficulties with medication throughout this report.

Mrs E. was admitted to a nursing home partly because was she was anxious about self medication. She had 16 medications prescribed [V, DT]

Mr F, who had 15 drugs prescribed and an alcohol problem had been admitted via A and E and ICS after a fall/collapse. [V, DT]

Discussion points:
The volume and complexity of medication taken by patients/service users indicates that the STSPP needs to include how medicines management can be incoprporated in the new service model for STC.

Consideration needs to be given to a piece of research on how prescribing medication management can be improved for patients, staff and carers to reduce risks and improve outcomes for patients.

6. Admission avoidance, primary care

6.1 A number of people did not appear to have seen their GP prior to admission even though there were indications that a crisis was looming.

6.2 The ambulance service was a significant feature in people's admission to short term care and paramedics were highly commended. A number of people had successfully used their personal alarm when they had fallen.

6.3 Some of the issues that affect the use of STC services have emerged: relatives living a distance away, a number of different services needing to be accessed, differential responses by routine services over the weekend, the complexity of some of the users problems, and the variability of the severity and urgency of people's needs. The STC services appear to be used for variety of reasons, some of which are not simply to do with the needs of the patient. It is more to do with organisation of other services or the timing at which the person becomes ill or decides to seek help.

6.4 There was reluctance by some people to bother the doctor. This suggested that for a group of people with known complex or changing needs might mean regular monitoring or anticipatory care. This is in place for patients with COPD. There are other case finding and long term care models of continuing support. [See appendix 4.]

Mrs D. who was caring for her husband with dementia and was referred by HERMES to CRRS with severe back pain not being controlled by her drugs and she had been sleeping in a chair. However, she had been booked to go on holiday to Germany. After two visits, she decided she did not need the service. Mrs W needed help but along with a number of other people in this evaluation it was questionable whether there was the need for the rapid response service.

Mrs I. [CV, DT] had been in CV for 2 months. In August she had been admitted to hospital with leg ulcers, discharging pus. She had urinary retention requiring a catheter, blood pressure and heart problems and psychosis.She was known to the mental health services and ICAST. She lived in supported housing, where someone did her shopping. She had no other help at home. Mrs I had been struggling in general and with her mobility. She was prescribed 9 drugs (a number of these were psychotropic).Despite her difficulties, her notes show she was making a good recovery.

Mr K. 55, was referred by HERMES to CCRS. He had a number of serious problems: daily fits because of temporal lobe neuropathy and vertigo, he was under investigation for a brain tumour and was due to be admitted Hurstwood Park within the month. He was on a number of drugs, had alcohol problems, was depressed and had taken a number of overdoses. Carers attended 4 times a day but was still struggling. He had seen his GP 5 times since August. This man had one 30 minute visit as he did not feel he needed any more help.

Mrs H. [CRRS, DT] had been admitted to a bed from ICS. She had been found collapsed at home with acidosis, with incontinence and confusion. She had been fit and independent, until 2 weeks before admission but had declined to see 'her' GP. She was being moved from her regular GP to one she did not know and trust.

Discussion point:
The criteria for access to the new STC need to be reviewed and clearly specified so that the short term care services are appropriately used.

Mrs L, had *been referred after fall. Feeling dizzy and shaky she had been seen by her GP and paramedics who had referred her to CRRS 2 months before. She was under investigation by her GP and had been to the falls clinic but was awaiting an appointment with a geriatrician. She had been offered, but declined, more personal care as she had help from her husband and daughter.* [CRRS:

Mr G., admitted to hospital over a weekend, had been to his GP practice on the Saturday morning. As there was no GP working, the nurse at the practice said because of the severity of his pain he should go to A and E [V, I and DT].

Discussion point:
There was some suggestion that a number of people frequently used the STC services. This needs further examination to elicit whether this suggestion is correct, and whether this a separate, discreet group of people, whose needs may need to asddressed differently.

AUKBH are starting a small peice of work in their service as a way of investigating this suggestion.

Discussion point:
Crisis services are often required because there are delays in referrals to specialist services and investigations. The interactivity between rapid response services and general practice need to be rationised. Some consideration might be given to how the STC agenda links to preventive initiatives in the city, where people have longer term care needs. Case finding programmes may also have a place in avoiding crises. One example is the ' Anticipatory Care Model' in appendix 4.

Ms N broke her hip and was discharged from hospital to a nursing home. She returned home after a 6 month stay. She had input from the Rapid Response team to help her mobilize safely at the home. She seemed to be doing well initially but fell over again within 24 hours and had to be admitted to hospital. Information sharing was poor. The care home had changed her doctor to a Practice near them without Mrs N, her carers or family's knowledge or permission.

Discussion point:
A number of people had used personal alarms to get help, successfully. There may be a need to further promote this service and the key safe service; and to ensure that the community alarm response service is well integrated into the model.

Mrs M. had lost her balance and fallen approximately 3 weeks ago before this interview was carried out. She had pushed her 'call' button and two men came from the alarm service, picked her up, gave her a once over and said 'hospital'. She was diagnosed with a broken rib in A and E, and spent 2 days in MASU. She was well supported by her daughter, carers and her GP. She had not fallen before, but was taking a lot of medication [C V, I].

Discussion point:
It appeared that a number of people still believed that they has their 'own' GP who they had built a relationship with and who they had an understanding of their medical problems. If the GP was changed some patients would not seek help from another practitioner. Some consideration is needed as to how this can be resolved and to manage any necessary changeover of GP.

Discussion point:
Consider which patients, on discharge, need a named case/care manager [unless they already have one].

Discussion points:
In a number of cases, it was not clear where the distinction between long term home support services ended and special short term care services were needed because of a crisis.

There was some suggestion that enhancing regular home care services with some additional support from STC rapid response and crisis services, including clinical overview, might have prevented the need for longer term STC services. The pathways to and from home care needs to be clarified in the new STC model with the default positon being flexible enpough for people stay with their usual carers, unless this is unavoidable.

The threshold for access to community based STC needs some focus and possibly filtering of some people. Consideration might be given to the STS offer ing a 'consultancy' service. This might prevent admission to STC services and provide continuity of home care and general practice services for some service users.

7. Moving forward

Many of the issues raised above have informed the new service model. Some, particularly those that impact on other providers will require further consideration by commissioners. It is only a snapshot. However, the people's stories have highlighted that even when the services are good and where they have good clinical outcomes, that improvements can be made in the experience for them that could be better for both service providers and users. the answers are often in the detail, being more user focussed, communicating better, but other stories suggest the way some services are organised mediate against the best possible care.

It is proposed that the information collected from this review could:

- Inform further work to improve the current service model;
- Provide a baseline to evaluate this current model;
- Provide an opportunity to develop benchmarks for the final model.

Report written by Fran McCabe, Chair AUKBH, with help from Jane Simmons, Bunty Bateman, Ursula Robson and Bea Gahagan.

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Appendices

Appendix 1

AUKBH: Proposal for User Participation
Towards a new service model for Short Term Services and Rapid response Services
17 September 2012 Fran McCabe

Purpose and objectives of the proposal

To find out what the experiences of people who have recently used short term care services [both users and carers] to help inform the new provider service model for STC. The focus will be on processes and systems and user understanding and satisfaction with their care.

Context

A number of pieces of evidence could inform the evaluation.

Existing research. Jane Lodge has been asked for this evidence and will also trawl public health [by end September].
Existing survey data from the partners, including clinical audits. This will need to be made available.
User files and case notes. A small number of recent files should be reviewed.
Questionnaires. Dealing with large numbers of questionnaires will create methodological and logistical problems so is not being considered at present.
Small number of qualitative interviews with recent service users and carers.
Focus groups with recent service users and carers.

AUKBH proposal

We are proposing a small scale evaluation combining 3, 5 and 6 as above. This is feasible in the timescale, which would be to produce a report by 1 December 2012. Trained volunteers would be used to do interviews and AUKBH has a track record and methodology to do this. We will work with Pensioners Action on focus group work. AUKBH would need resources to provide this training, setting up costs, management support, volunteer expenses and report writing. We estimate this will be about 20 days work and we are requesting £2K.

Focus of evaluation

To consider whether the care pathway of the person was effective in relation to helping to keep the person out of hospital or getting them home from hospital timely and safely.

To consider what difference 'a single point of access' might have had.

To consider whether a 'single assessment process' was used and what difference that might have made.

To consider the number and effectiveness of transfers to other services- within the provider group, and beyond- and what processes and protocols might improve them.

To consider what the users and carers are saying about their experience in respect of hospital admissions avoidance, early discharge, being listened to, making a difference to them, understanding and confidence in the system : and their views on what worked well and what might improve that experience.

Methods

Each partner organisation will identify 2 cases [10 in total] for the desk top exercise.
Each partner organisation will identify 2 people who have used STC services in the last 3 months.
AUKBH will set up 2 focus groups in collaboration with Pensioners Action and the Carers Centre.
AUKBH co-ordinate the evaluation and will provide volunteers but other people may wish to volunteer.
Confidentiality issues will be addressed.
The cases selected should be random but include people who have experienced at least one hand over. A particular day might be selected. The evaluation is qualitative and evidence will be cross referenced with existing research

evidence to provide indicators to the provider group so they can ensure their service design meets users and carers needs as well as service requirements.

Evaluation areas

A chronology: what happened, when: in interviews and focus groups, what it felt like as an experience.
Length of time in different parts of the service and speed of handover; and the result.
Observations about what would make difference.

The report

The report would be short and incisive and include:

Evaluation areas;

Observations about how the care pathways affected PI's and implication for different working practices, systems, processes and protocols;

Consistency of evidence from different information sources.

What the STC Provider Group can do itself in the new model;

Implications for other STC associated services.

****

These are the areas to be covered in a desk top exercise, in focus groups and individual interviews.

For use on people who have used the service in the last 3 months [less if possible, but may be a bit longer for focus groups]

Background
Some basis demographic details: gender, age, when used the service.

Access to the service
1. What were the reasons for using the service?
2. Could the reason be described as
   Avoiding hospital admission
   '' '' Readmission
   Help getting out of hospital
   Other
3. Who referred into the service.
4. What service was the entry point?

5. Did you feel that other services had given all the information about you to help the STC service be able to give you the right support?
6. How did [you] person experience first contact/access into the service?
7. What was good? What was bad? what might improve?

The service

8. Which service was used?
9. How long was it before a service contacted you?
10. How long did it take before a service was received?
11. What help did the person have? By whom?
12. What was good? What was bad? What might improve?

Handovers/transfers

13. Was the person referred on to another service?
14. What service? what help? How long did it take? Were there delays?
15. What was good? What was bad? What might improve?
16. What happened at the end of the STC/RR service? Do you still have service? what?

Overall experience

17. What was the best thing about the service? What was the worst? What could improve it?
18. Did you see a doctor at any time during receiving the service?
19. Do you think the service helped to avoid hospital admission, readmission; and speed up hospital discharge; or something else?
20. Did you feel more confident to manage by yourself having had the STC service?

Appendix 2
A profile for each service of service users who took part is shown below

CRRS

Desk Top reviews:

Mrs W	Age 87
Mr S	Age 55
Mrs CF	Age 87

Individual interviews:

Mr PP	Age 77
Mrs JB	Age 88
Mrs EC	Age 84
Mr SK	Age 61
Mr PP	Age 77
Mrs JB	Age 88
Mrs EC	Age 84
Mr SK	Age 61

Craven Vale [CV]

Desk Top reviews:

Mrs S	Age 90
Mr H	Age 79
Mrs BH	Age 83
Individual interviews:	
Mrs EC	Age 90
Mrs NB	Age 65
Mrs DM	Age 79

Victoria Nursing Home [V]

Desk Top reviews:	
Mr A	Age 66
Mrs C	Age 91
Mrs D	Age 91
Mrs AD	Age 91
Mr D	Age 70
Mrs H	Age 88
Individual interviews:	
Mr A	Age 66
RF	Age 70
MN	Age 95

AUKBH Crisis Care[AUK]

Desk Top Reviews:	
Mrs EF	Age 95
DJ	Age 82
Individual Interviews:	
Mr F	Age 88 (also took part in stakeholder event)
Mrs R	Age 82 (also took part in stakeholder event)
Mrs MG	Age 57

Focus Groups

Focus groups were organized by Pensioner Action (PA) on behalf of AgeUK

Mrs X	Age 84, had a fall,.
Mrs Y	Age 89, had anxiety and multiple infections,
Mrs Z	Age 97, broke her hip.

Appendix 3

Key points from a Stakeholder workshop held on 2 November 2012

* Access to information (shared record amongst partners)
* Standard documents / assessments. What does it look like?
* Reduce number of systems.
* Knowing who is working with someone "Patchwork" / Share My Care
* Distinctive Number - people ringing wanting other services
* *A Initial referrals should go through Access number not go direct to services. Must not bypass. But phone must be efficient so no delays.
* Flow - taking on people leaving our services by new providers also needs to be slick too as we are blocked, slow.
* Referrals need to be good; no wasting time assessing again as not good enough. Trusted assessment.
* Repetition of work between teams: DNS do something. ICS go in and see need doing but don't know - so repeat action.

Appendix 4
Anticipatory Care

STAYWELL75+

Phoenix Surgery, Cirencester
PRACTICE ACTIVITY at 25.5.2011

The figures are taken from a 'search' in EMIS that is used to create a 'Patients over 75 list' who are due to be sent their annual health questionnaire. The search picks up all patients in the practice over the age of 75 for the purpose of sending out the questionnaire. The data is formatted into 'birthday months' and then the month being studied is extracted. For the purpose of this exercise, the search was run at the end of April 2011 and the figures below are based on all patients over the age of 75.

There are currently 817 patients over the age of 75 registered with the Phoenix Surgery.

- 117 of these patients are non-compliant and do not respond to the annual health questionnaire.

Of the 700 compliant patients:

- 11 (1.5%) patients have requested to be 'exempted' from the scheme and are therefore coded as such.
- 34 (5%) patients have StayWell Volunteers.
- 40 (5.5%) of patients live in a nursing home. (All patients in a nursing home are sent an annual health review questionnaire which is completed with the nursing staff).
- 23 (3%) patients are due to be sent annual health questionnaires as they are currently coming into the scheme or have just joined the practice.

Overall response rate: **85%**

Benefits

- Phoenix Surgery; the only practice in South Cotswolds below indicative spending target out of eight practices: total weighted population 52,180;
- Partners have maintained programme over 22 years;
- Coordinated case finding on 36 hours per week – 12 administrative coordinator, 12 hours HV for the elderly and 12 hours Community District Nurse.
- Volunteer expenses, cost of postal questionnaires and training of volunteers provided by the Phoenix Charitable Trust, Cirencester and District (£5,200 per year).

There are approximately 18 – 20 visits generated from the returned annual health questionnaires per month.

A great deal of time is also spent working with/for volunteers, organising meetings and ongoing training. Volunteers often call in with concerns about their patients or for advice.

PRACTICE NUMBERS

There are currently 12029 patients registered with the Phoenix Surgery. The over 75's are broken down as follows:

Age Group	75-79	80-84	85-89	90-94	95-100	100-120	Total
Males	138	111	70	16	2	1	338
Females	176	139	115	38	8	3	479
Total	314	250	185	54	10	4	817

Stay Well 75+ outline – taken from www.staywell75.co.uk
Staywell team: Dr. Ian Simpson, lead GP; Tracey Lear, HV for the Elderly, Annabel McEune, Community District Nurse. (David Beales, Originator).
Phoenix Surgery, 9 Chesterton Lane, Cirencester GL7 1XG. Tel: 01285 652056. Practice Manager, Gillie Roberts.

Hampshire Hunt Cottage, Petersfield Road, Ropley, SO24 0EG Telephone: 07950 492286
E-mail: dbeales@heartsandminds.fsnet.co.uk

ADULT CARE & HEALTH COMMITTEE (JOINTLY COMMISSIONED (SECTION 75) BUSINESS)	Agenda Item 9 Brighton & Hove City Council

Subject:		**Sussex Integrated End of Life and Dementia Care Pathway**		
Date of Meeting:		**17 June 2013**		
Report of:		**Geraldine Hoban – Chief Operating Officer, Brighton & Hove CCG**		
Contact Officer:	**Name:**	**Simone Lane**	**Tel:**	**01273 574776**
	Email:	**simonelane@nhs.net**		
Key Decision:	**No**			
Ward(s) affected:		**All**		

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The Pan Sussex Integrated End of Life and Dementia Care Pathway has been developed through multi-agency and multi-disciplinary stakeholder group collaboration across Sussex as part of the End of Life Care in Dementia Regional Innovation Funded project for NHS Sussex. It is part of the Joint Dementia Plan for Brighton and Hove.

1.2 The pathway comprises six phases:

1. Recognising there is a problem (awareness)
2. Discovering that the condition is dementia (assessment, diagnosis & involving the person with dementia in planning for their future care including end of life)
3. Living well with dementia (maximising function & capacity and planning for the future to enhance wellbeing)
4. Getting the right help at the right time (accessing appropriate & timely support. Reviewing advance care plans)
5. Nearing the end of life, including the last days of life (palliative care & ensuing advance care plans are reviews and respected)
6. Care after death (supporting relatives & carers to maintain wellbeing)

The knowledge and skills required by health and social care practitioners in order to successful deliver the integrated dementia care pathway are also identified as are the information needs of people with dementia, relatives and carers.

1.3 The Brighton and Hove Clinical Commissioning Group Strategy Group supports implementation of the pathway as agreed at the meeting on 8th January 2013

2. RECOMMENDATIONS:

2.1 That the revised pathway to be approved for implementation to enable health and social care providers to ensure that the needs of people with dementia are integrated into end of life care planning, service specifications and contractual agreements.

The pathway

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 A *National Dementia Strategy* (NDS) (2009 updated in 2010) aims to **improve end of life care for people with dementia (Objective 12)**

3.2 The *End of Life Care Strategy 2008* key areas for improvement include:

- **identifying people approaching the end of life**
- **advance care planning**
- **rapid access to care**
- **delivery of high quality services in all locations**
- **involving and supporting carers**
- **workforce development**

All of these are included in the integrated pathway.

3.3 The pathway supports the achievement of the following priorities as stated in *The NHS Outcomes Framework 2012/3* - **Domain 2: Enhancing quality of life for people with long term conditions - Domain 4: Ensuring that people with dementia have a positive experience of care** This supports the key priorities of acute hospital admission avoidance; reduced length of stay and enabling people to die in their preferred place of care.

3.4 **Local Context**

The implementation of the integrated end of life care and dementia care pathway is part of the Joint Dementia Plan approved at the Joint Commissioning Board in February 2012.

Dementia is one of the priorities of the shadow Health and Wellbeing Board and it is included in the Joint Health and Wellbeing Strategy which will be ratified once the board is formally constituted in April 2013.

3.5 **Adult Social Care Health Committee March 18th 2013**

This pathway was discussed on March 18th 2013 at the Adult Care & Health Committee and has now been revised, subsequent to its submission to the committee. In response to members concerns re consultation, we can now confirm that 2 members of the Older People's Council and one member of Pensioners Action were part of the LiNK Steering group (now B&H Health Watch).

Revisions have also been made to the pathway in section 5 of the summary and phase 5 of the full pathway the wording "Implement Liverpool Care Pathway (LCP)" has been removed in response to members concerns. After discussion it

was agreed that this level of detail is inappropriate in such a broad pathway, and discussion around the LPC should be solely a clinical discussion in consultation with family/significant others.

The end of life pathway is one component of the work of the Sussex-wide Dementia project, which has also included a wide range of training for health professionals and resulted in the production of 2500 “This is Me” bags. These bags are designed to improve person-centred care as well as providing information, to enable people to make choices about their future care. This resource includes “This is me”, a resource developed by the Alzheimer’s Society, Preferred Priorities for Care, and Planning for your future care: A Guide (Included in the appendix).

To put in context discussions about Advance Care Planning (ACP) good practice is rooted in being guided by an individual’s preference and wishes .In summary, the key points about advance care planning from the good practices guide are set out below:

- No one is obliged to carry out advance care planning
- You may wish to discuss your wishes with your carers, partner or relatives
- Include anything that is important to you no matter how trivial it seems
- If you wish to refuse a specific treatment, consider making an advance decision to refuse treatment
- It is recommended that anything you have written down should be signed and dated
- It is recommended you seek the advice of an experienced healthcare professional if making an advance decision to refuse treatment
- If you make an advance decision that refuses treatment that is life sustaining it must be in writing, signed, dated and witnessed and use a specific form of words
- If you have named someone to speak for you or have a Lasting Power of Attorney, remember to write down their name in your advance care planning documents
- If your wishes are in writing or if you have a Lasting Power of Attorney, keep a copy of the documentation safe and provide copies to those who need to know your wishes e.g. nurse, doctor carer or family member.

- **Remember you can change your mind at any time.**

We would always recommend, and are committed to furthering practioners skills in discussing end of life care. A recent study (Baker et al., 2012) found that advance care plan drawn up in primary care could help reduce unplanned hospital admissions by 52% as more was understood about the person’s wishes: ‘This means that when patients expressed a wish not to be hospitalised it was possible for this to be followed’ (Alzheimer’s Society 2012).

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 The Sussex Integrated End of Life and Dementia Care Pathway has been developed through multi-agency and multi-disciplinary stakeholder group collaboration across Sussex. In Brighton and Hove the following organisations were involved in either the stakeholder group or in consultation:

- Brighton and Hove PCT/CCG
- Brighton and Hove City Council – Adult Social Care
- Brighton and Sussex University Hospital Trust
- Sussex Partnership Foundation NHS Trust
- Sussex Community Trust
- The Martlets Hospice
- The Alzheimer's Society
- The Carers Centre
- The Mediation Centre
- People with dementia, their relatives and carers
- South Coast Ambulance Service
- South East Health (Out of Hours Service)
- Nursing Homes, Residential Care Homes and Domiciliary Care Providers via provider forums
- LiNK Steering group(now B&H Health Watch) 2 member of this group sit on the Older People's council and 1 on Pensioners Action

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The pathway has been analysed by commissioners and no financial implications were identified as all key actions for practitioners to implement were either already within existing plans and budgets or identified as highlighting best practice.

Finance Officer Consulted: :Debra Crisp & Michelle Herrington
Date: 04/06/13

Legal Implications:

5.2 All actions within the pathway and related to implementation are identified as highlighting best practice and flow from the National and Local policy and Guidance described in the body of this Report and are within the current responsibilities of statutory organisations and as described in the Joint Dementia Plan.

As identified in the body of this report consultation has been undertaken with a wide range of interested and potentially affected persons.

In implementing the plan regard must always be paid to individuals' Human Rights enshrined in the Human Rights Act 1998

Lawyer Consulted: *Sandra O'Brien* *Date: 04/06/13*

Equalities Implications:

5.3 This was carried out as part of the Join Dementia Plan

Sustainability Implications:

5.4 This would be included in the existing work as described in the Joint Dementia Plan

Crime & Disorder Implications:

5.5 Nil.

Risk and Opportunity Management Implications:

5.6 The drive to increase the number of people being cared for and dying in their preferred place of care may increase demand for hospice at home and domiciliary care.

Public Health Implications:

5.7 The number of people with dementia who currently have an advance care plan in place early in their condition is limited. This limits the level of forward planning to ensure appropriate and adequate services and support are in the persons' preferred place of care and death. This leads to a higher incidence of unplanned hospital admission and medical intervention as well as earlier admission to residential or nursing home care.

Corporate / Citywide Implications:

5.8 Not applicable

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 The development of an integrate end of life and dementia care pathway was identified as a need in response to both the National Dementia Strategy and the End of Life Care Strategy and reflects the identified needs and consultation locally.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 To ensure the pathway is successfully implemented across Brighton and Hove and fulfil the requirements as described in the Join Dementia Plan.

SUPPORTING DOCUMENTATION

Appendices:

1. The Sussex End of Life and Dementia Care Pathway

2. The Brighton and Hove Stakeholder Group – terms of reference and members, now

3. Additional information on original consultation process

Documents in Members' Rooms

1. None

Background Documents

1. None

Appendix 1a Summary

Pan Sussex Integrated End of Life and Dementia Care Pathway 2013

The Pan Sussex Integrated End of Life and Dementia Care Pathway has been developed through multi-agency and multi-disciplinary stakeholder group collaboration across Sussex as part of the End of Life Care in Dementia Regional Innovation Funded project for NHS Sussex.

The pathway comprises six phases:

1. Recognising there is a problem (awareness)
2. Discovering that the condition is dementia (assessment, diagnosis and involving the person with dementia in planning for their future care)
3. Living well with dementia (maximising function and capacity to enhance wellbeing and planning for future care including end of life)
4. Getting the right help at the right time (accessing appropriate and timely support. Reviewing advance care plans)
5. Nearing the end of life, including the last days of life (palliative care and ensuring advance care plans are reviewed and respected)
6. Care after death (supporting relatives and carers to maintain wellbeing)

Each phase identifies what people with dementia, relatives and carers need; what support is available in Sussex to support that and what has to happen to ensure that the support available meets those needs.

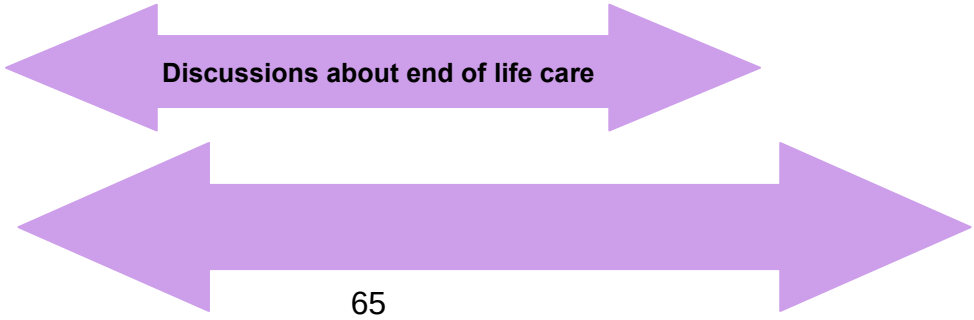
Through this process the knowledge and skills required by health and social care practitioners to successfully deliver the integrated dementia care pathway have been identified, alongside the information needs of people with dementia, their relatives and carers.

The core document is being used to develop:

- flow diagrams to provide an easily accessible guide to the pathway for practitioners
- an information leaflet for people with dementia, their relatives and carers that will describe the pathway and explain what information and support to expect at each phase

The Pan Sussex Integrated End of Life and Dementia Care Pathway

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Phase 6
Recognising there is a problem	**Discovering that the condition is Dementia**	**Living Well with Dementia**	**Getting the right help at the right time**	**Nearing the end of life including care in the last days of life**	**Care after death**



Co-ordination, monitoring and reviewing care and support

Phases		Key Activities for Practitioners
1	**Recognising there is a problem**	**Ensure** information is available to help people to recognise and understand dementia and know what support and options are available **Raise** dementia awareness / education through patient participation groups community groups etc **Involve** others to create dementia friendly communities **Work** to shift the culture and attitudes of both the public and practitioners to one of positive management of the condition and an understanding of the impact of dementia on individuals, their relatives and carers
2	**Discovering that the condition is Dementia**	**Refer** to Memory Assessment Services for early diagnosis & support **Timely** access to information, advice and support (post diagnosis/on-going) **Recognise** and support the information needs of relatives / carers including understanding dementia, impact on daily living and options available **Initiate** a conversation regarding living well and planning future care **Recognise** and support the person's spiritual and cultural needs
3	**Living Well with Dementia**	**Work** with the person, relatives / carers / significant others to support continued wellbeing, promote an active life and inclusion **Include** on Dementia Register to ensure regular monitoring and review **Initiate /review** Advance Care Plan (ACP) discussion in annual dementia review **Be alert** to prompts and cues to initiate *Conversations for Life* (ACP) **Support** completion of *'This is Me'* (or equivalent); give '*This is Me Bag*' to assist communication, understanding and support given **Timely** access to information, advice e.g. benefits, activities, care, respite etc **Normalise** dementia, promote inclusion, awareness and understanding **Recognise** and support person's spiritual and cultural needs
4	**Getting the Right Help at the Right Time**	**Review** ACP /Advance Directive to Refuse Treatment regularly and prior to any intervention **Contingency** plans in place to manage unexpected deterioration **Timely** and appropriate referral to specialists as need arises **Assess** mental capacity as required **Consider** Gold Standards Framework / End of Life Care Register when condition changes / deteriorates **Support** completion of ACP if / when admitted to residential or nursing care **Rapid** access to crisis support (essential to know about local services) **Timely** access to information, advice for relatives / carers about common changes; what to do to avoid crisis; who to contact; care and support options **Promote** use of technology to support independence
5	**Nearing the end of life including care in the last days of life**	**Monitor** and review well-being and progression of dementia **Use** clinical prognostic indicators to recognise the dying phase **Review** ACP, agree and communicate management care plan to all involved **Include** on Gold Standards Framework / End of Life Care Register **Consider** palliative care and refer appropriately **Support** relatives understanding & acceptance of the dying phase **Access** appropriate, sufficient support and funding to enable person to be cared for according to their ACP wishes **Recognise** and support person's spiritual and cultural needs

6	**Care after death**	**Provide** advice and support relatives / carers spiritual and cultural needs **Signpost** relatives and carers to appropriate practical bereavement support **Support** practitioners and others to achieve 'closure', reflect and learn

Appendix 1b Pathway

Pan Sussex Integrated End of Life and Dementia Care Pathway January 2013

The Pan Sussex Integrated End of Life and Dementia Care Pathway has been developed through multi-agency and multi-disciplinary stakeholder group collaboration across Sussex as part of the End of Life Care in Dementia Regional Innovation Funded project for NHS Sussex.

The pathway comprises six phases:

1. Recognising there is a problem (awareness)
2. Discovering that the condition is dementia (assessment, diagnosis and involving the person with dementia in planning for their future care)
3. Living well with dementia (maximising function and capacity and planning for the future to enhance wellbeing)
4. Getting the right help at the right time (accessing appropriate and timely support. Reviewing advance care plans)
5. Nearing the end of life, including the last days of life (palliative care and ensuing advance care plans are reviewed and respected)
6. Care after death (supporting relatives and carers to maintain wellbeing)

Each phase identifies what people with dementia, relatives and carers need; what support is available in Sussex to support those needs and what needs to happen to ensure that the support available meets those needs.

Through this process the knowledge and skills required by health and social care practitioners to successful deliver the integrated dementia care pathway have also been identified as well as the information needs of people with dementia, relatives and carers.

The core document is being used to develop:

- flow diagrams to provide an easily accessible guide to the pathway for practitioners
- an information leaflet for people with dementia their relatives and carers will describe the pathway, what information and support to expect at each phase

The Pan Sussex Integrated End of Life and Dementia Care Pathway

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Phase 6
Recognising there is a problem	**Discovering that the condition is Dementia**	**Living Well with Dementia**	**Getting the right help at the right time**	**Nearing the end of life including care in the last days of life**	**Care after death**

Discussions about end of life care

Co-ordination, monitoring & reviewing care & support

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Phase 6
Recognising there is a problem	**Discovering that the condition is Dementia**	**Living Well with Dementia**	**Getting the right help at the right time**	**Nearing the end of life including care in the last days of life**	**Care after death**

Phase 1 Recognising there is a problem		
NEEDS of people with dementia, their relatives and carers	**SUPPORT available**	**What needs to HAPPEN for support to meet needs**
Greater general public awareness & education regarding dementia (signs, types and ways to live well) to remove stigma and normalise dementia so people feel able to seek advice earlier in the knowledge they will be taken seriously and their concerns listened to and acted upon. **Widely** available information easy to access, clear, factual, practical & prompts people to seek help **One** point of contact to provide consistent advice & guidance **Knowledgeable** and supportive professionals who recognise the signs and symptoms of dementia, including those of early onset, the needs of the relatives /carers, significant others and can signpost to other appropriate support services **Access** to timely assessment and diagnosis with no avoidable delays **Support** & contact through whole process including pre-diagnosis for person, relatives /carers / significant others **Access** to support & dementia education to empower people to be as independent as possible & fully involved in decision making	**Person's** own networks i.e. family, friends, significant others, neighbours, employers; housing providers; wider society and/or community they have regular contact with, **Health** & Social Care professionals they have contact with **Primary** Care: General Practitioner, Integrated Primary Care Team (IPCT) or Neighbourhood Support Team (NST) **Secondary Care:** Acute hospitals **Information** sources e.g. leaflets; internet; media & media campaigns; the NHS Choice; The Alzheimer's Society; Age UK; Carers Centres and organisations	**Increased** public & professional awareness of dementia through wider availability of clear & concise information about dementia **Increased** knowledge, skills & awareness of directly involved professionals of the integrated dementia care pathway: how to access information & support, to improve signposting & consistency of service **Shift** in culture and attitude (clinicians & public) to one of positive management of condition & understanding impact of dementia **Robust assessment system** – including single point of access e.g. a dementia information/helpline line **Counselling** offered early to person with dementia, relatives and carers **Early** & timely access & referral to services to support relatives / carers / significant others **Recognition** by professionals of relative/carer / significant others as partner in care **Offer** routine dementia screening for over 60s **Within** Learning Disability – early assessment /diagnosis to establish baseline as benchmark for ongoing care

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Phase 6
Recognising there is a problem	**Discovering that the condition is Dementia**	**Living Well with Dementia**	**Getting the right help at the right time**	**Nearing the end of life including care in the last days of life**	**Care after death**

Phase 2 Discovering that the condition is Dementia		
NEEDS of people with dementia, their relatives and carers	**SUPPORT available**	**What needs to HAPPEN for support to meet needs**
Timely access to specialist assessment & diagnosis **Honest** & effective communication of diagnosis, prognosis & time to absorb & discuss implications e.g. treatment options, legal considerations; planning future care **Professionals** have positive approach to future & focus on persons' abilities (assets) **To be empowered** & retain control via access to relevant information & support to be make own choices **Appropriate** signposting & referral to enable the person to 'live well with dementia' and maximise their independence. **Appropriate** information sharing by professionals to improve communication & response times **A 'What Next?'** information pack – signposting to support services, etc **Access** to ongoing, appropriate specialist support for treatment / medication etc **Single** source of ongoing support **Access** to Carer Assessment & support **Option** for genetic counselling	**Initial** Assessment by GP, Health & Social Care professionals or acute hospital **Referral** to Memory Assessment Service (MAS) for assessment by Multi-Disciplinary Team **MAS** Dementia Advisors /support workers **GP**, IPCT/ NST **Geriatricians** & other healthcare specialists **Living Well** with Dementia Team / Community Mental Health Team/Community Psychiatric Nurses **Adult** Social Care **Outreach** services e.g. for BME, LGBT groups **Community** Learning Disability Team (CLDT) **Alzheimer's** Society **Dementia UK** Admiral Nurses **Age UK** **Acute** Hospitals Dementia Champions **Counsellors** **Lawyers** & Citizen's Advice re: Lasting Power of Attorney, Wills; employment rights etc **Department** of Work & Pensions (DWP) **Local** Community groups **'ROCK'** – website http://www.sussexpartnership.nhs.uk/service-users/wellbeing/rock	**Increase** professionals awareness & understanding of available sources of support, improve signposting & access to medication & treatment **Requirement** for referral to MAS confirm diagnosis **Access** to counselling for person with dementia **Timely** access to carers assessment **Improved** shared information systems across agencies **Allocated** Key worker e.g. dementia adviser **Support** from appropriate professionals '**One** stop shop' / specialist centre for holistic dementia care **Comprehensive**, timely & accurate information e.g. a "Check list" **Post** diagnostic review to ensure person/carer has understood diagnosis **Place** on dementia or Long Term Conditions Register **Initiate** Advanced Care Planning to facilitate choices **Use** professional patient /carer as means of support

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Phase 6
Recognising there is a problem	**Discovering that the condition is Dementia**	**Living Well with Dementia**	**Getting the right help at the right time**	**Nearing the end of life including care in the last days of life**	**Care after death**

Phase 3 Living Well with Dementia		
NEEDS of people with dementia, their relatives and carers	**SUPPORT available**	**What needs to HAPPEN for support to meet needs**
Holistic assessment of needs & circumstances **Coordinated** services **Regular**, open, honest communication **Opportunities** to talk about concerns & future plans **Advice** & support to enable person to 'live well' **Support** from professionals to start future planning earlier e.g. ACP*, ADRT** LPAs*** **Screening** & management of other health conditions **Early** intervention to resolve issues & enable person to continue 'living well' **Timely** access to treatment / medication to maintain optimum function **Legal** & financial advice for now & future **Dementia** education for person, relative(s) / carers **Opportunity** to record life story 'This is Me' etc **Knowledgeable** & skilled named worker to support, navigate, coordinate, provide continuity & plan **Access** to employment / education for person & carer / significant others	**Own** networks - Family, friends, neighbours, significant others local community, social activities **Primary** Care **-**G.P/ IPCT /NST Community Nurse/ Social Worker; other supporting health & social care professionals **Memory** Assessment Service support, care, treatment, review – signposting to other services. Regular multidisciplinary review with key worker & others (may change during different stages). **Proactive** Care Services **Adult** Social Care – support & access to Personal Budget **Complimentary** therapists **Housing** providers e.g. housing associations; landlords; sheltered & extra-care; Telecare **Living Well** with Dementia Team / Community Mental Health Team/Community Psychiatric Nurses Community Learning Disability Team (CLDT) **Dementia** Specialist Nurse / Admiral Nurse **Crisis** /emergency support & advice e.g. Out of Hours Doctor Service (OOH) / One Call & Rapid Assessment & Intervention Team	**Advance** Care Planning is a routine practice **/** included in annual GP dementia review **Well** written, easy to follow information with contacts **Regular** holistic wellbeing check involving relatives /carers & providing information to maintain optimum physical health **Primary** Care / GP clinics to monitor & promote health & wellbeing & healthy diet to optimise brain function **Professionals** to encourage people to talk & ask questions **Helpline** / **Forum** to share strategies & ideas developed by carers **One** contact point to improve co-ordinated response **Effective** & efficient communication & information sharing between services **Information** available in different formats **Involving** next of kin / carer / significant others **Support** to relatives/carers/ significant others access information & resources **Access** to services based on need not labels

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Phase 6
Recognising there is a problem	**Discovering that the condition is Dementia**	**Living Well with Dementia**	**Getting the right help at the right time**	**Nearing the end of life including care in the last days of life**	**Care after death**

Phase 3 Living Well with Dementia		
NEEDS of people with dementia, their relatives and carers	**SUPPORT available**	**What needs to HAPPEN for support to meet needs**
Timely access to Carers Assessments & referral for to carers support services **Appropriate**, timely advice & access to benefits **Professionals** to know appropriate advice sources **Support** for person, relative(s)/carers / significant others to deal with emotional impact of diagnosis & plans for future **Relatives** /carers to know signs of deterioration & where to seek help & advice **Culturally** sensitive services **Dementia** friendly communities (incl. legal services & banks regarding LPAs***) **Ease** of access to range of integrated services to retain choices & control of their life **Flexible** approach supporting people with dementia in acute hospitals **Rapid** access to emergency / crisis support	Dementia CRISIS Team / South East Coast Ambulance Service (SECAmb) /Acute hospitals **Managing** legal affairs - Lawyer & Office of Public Guardian **Dementia** friendly communities **Support** groups for people with dementia & their families e.g. Alzheimer's Society / Age UK / Voluntary organisations and Charities/Day Care Services /Activity & Lunch Clubs / Specialist groups /clubs / Advocacy Services / Mediation Services **Residential** Care & Nursing Homes / Domiciliary Care **Carers** Support Services **Hospice** @ Home **Benefits Advice** – to access appropriate benefits as well as debt counselling etc **Department** of Work & Pensions (DWP) **Completing** a 'This is Me/This is About me' document and ensuing copy is kept and transferred with person between services **Specialist** medical services e.g. incontinence service, optician, dentist	**Encourage** & support completion of 'This is Me' or equivalent **This is Me Bag** made available to store important information **Access** to high quality respite care **Dementia** friendly communities **Consistent** emergency out of hours support **Appropriate** safeguarding processes in place

*ACP – Advance Care Plan ** ADRT – Advance Directive to Refuse Treatment *** LPA – Lasting Power of Attorney

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Phase 6
Recognising there is a problem	**Discovering that the condition is Dementia**	**Living Well with Dementia**	**Getting the right help at the right time**	**Nearing the end of life including care in the last days of life**	**Care after death**

Phase 4 Getting the right help at the right time		
NEEDS of people with dementia, their relatives and carers	**SUPPORT available**	**What needs to HAPPEN for support to meet needs**
Personalised & crisis plans for timely & appropriate, 24/7 support **Rapid** access to services to avoid crises e.g. timely referral to specialists **Prompt** responses in crisis **Professionals** who understands person & family /carers / significant others needs & limitations, listens & includes **Opportunities** to review Advance Care Plan **Education** of relatives/ carers to recognise changes/ deterioration / end of life **Knowledgeable** & skilled named worker to support, navigate, coordinate, provide continuity & plan **Regular** wellbeing reviews to identify change/deterioration **Access** to holistic assessment, care & treatment / multi-disciplinary team and/or specialist interventions **Prompt** access to services & information in a crisis **Timely** information to support future planning	**Support** wellbeing & decision making in person's best interests - early involvement & information about what is helpful **Own** networks - Family, friends, significant others**,** neighbours, community, local clubs & social activities **Primary** Care **-**G.P/ IPCT /NST /Community Nurse/ Social Worker; other supporting health & social care professionals **Proactive** Care Services **Continuing** Health Care Assessment & Funding **Adult** Social Care – support & access to Personal Budget **Complimentary** therapists **Housing** providers e.g. housing associations; landlords; sheltered & extra-care; Telecare **Living Well** with Dementia Team / Community Mental Health Team/Community Psychiatric Nurses/ Community Learning Disability Team (CLDT) **Dementia** Specialist Nurse / Admiral Nurse **Crisis** /emergency support & advice e.g. Out of Hours Doctor Service (OOH) / One Call / Rapid Assessment & Intervention Team /	**Different** specialists provide right care, right time, right support a) Advance Care Planning b) Contingency / alternatives knowing options & contacts **Listening** to the person with dementia, relatives/ carers / significant others treating as 'partners in their care' **Training** to improve practitioner knowledge, understanding & skills (including decision making skills) of support services available **Information** available in different formats **Access** to appropriate advocacy support **Normalising** life e.g. socialising and enjoying life **Support** services available 24/7 - a Sussex helpline? **Increased** use of technology to support independence e.g. sensor mats; alarms **Access** to specialist practitioners e.g. Psychiatrist/ IPCT/ NST **Annual** Wellbeing checks **Specialist** & 'dementia friendly' wards/ units in general hospitals

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Phase 6
Recognising there is a problem	**Discovering that the condition is Dementia**	**Living Well with Dementia**	**Getting the right help at the right time**	**Nearing the end of life including care in the last days of life**	**Care after death**

Phase 4 Getting the right help at the right time		
NEEDS of people with dementia, their relatives and carers	**SUPPORT available**	**What needs to HAPPEN for support to meet needs**
Access to appropriate rolling respite, home support, day care / activities to support family/carer wellbeing **Information** regarding appointments etc to be sent to family/carer **Support** to access to benefits etc **Prompt** access to additional funding e.g. Continuing Heath Care (CHC)for end of life care **Access** to Carers groups to support relatives and carers	Dementia CRISIS Team / SECAmb / Acute hospitals **Dementia** friendly communities **Support** groups for people with dementia & their families e.g. Alzheimer's Society / Age UK / Voluntary organisations/visiting service & Charities /Day Care Services /Activity & Lunch Clubs / Specialist groups /clubs / Advocacy Services / Mediation Services /Samaritans **Residential** Care & Nursing Homes / Domiciliary Care **Carers** Support Services **Hospice** @ Home **Benefits Advice**, DWP Lawyer & Office of Public Guardian **Specialist** medical services e.g. incontinence service, optician, dentist	**Carers** centre & carers forum **GP** surgeries with touch screen to access websites & someone to help **Empowering** relatives and carers through education & information to recognise needs and access support **Improve** information to raise awareness of support available **Advance** Care Planning is routinely completed upon admission to residential / nursing care homes

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Phase 6
Recognising there is a problem	**Discovering that the condition is Dementia**	**Living Well with Dementia**	**Getting the right help at the right time**	**Nearing the end of life including care in the last days of life**	**Care after death**

Phase 5 Nearing the end of life including care in the last days of life		
NEEDS of people with dementia, their relatives and carers	**SUPPORT available**	**What needs to HAPPEN for support to meet needs**
Early planning to maximise possibility of person being supported in their preferred place of care **Information** & education for family/carers / significant others & professionals about last stages of life **Professionals** who understand & respond to the persons' priorities, wishes & cultural needs **Review** of & respect for, wishes stated in ACP; ADRT etc & support to implement **Treated** with dignity & respect & according to the persons' expressed wishes **Knowledgeable** & skilled named worker to support, navigate, coordinate, provide continuity & plan **Continuity** of medical, social, spiritual, emotional & practical care & support for the person, family /carer / significant others & which facilitates the persons preferences & choices **Access** to good quality end of life care/ palliative care including symptom control **Access** to counselling for family/carers/ significant others if appropriate **Pre-bereavement** care for	**Support** to die in preferred place of care through own networks – family, carers etc **Primary** Care -G.P/ IPCT /NST /Community Nurse/ Social Worker; other supporting health & social care professionals **Health** condition monitored & reviewed through GP's End of Life Care register & Gold Standards Framework meetings **Proactive** Care Services **Continuing** Health Care Assessment & Funding **Adult** Social Care – support & access to Personal Budget **Complimentary** therapists **Residential** Care & Nursing Homes / Domiciliary Care **Carers** Support Services **Hospice** @ Home **Review** of Advance Care Plans Advance Decisions to refuse treatment (ADRT)/ DNACPR by G.P. & IPCT/NST **Holistic** support from Hospice @ Home, Hospice Multi Disciplinary Team 'Just in Case Medications', Advanced Care Nurse Practitioners, MacMillan Community Team Integrated Night Sitting Service, End of life co-ordinators & equipment	**Improve** professionals ability to recognise the normal "Dying Phase" **Continuity** of care through care journey with named healthcare professional with defined responsibility for communicating changes to all involved & who coordinates ACP/ADRT/DNACPR **All** professionals understand persons' emotional & spiritual needs & who to contact for specialist emotional support **Review** of ACP / LPA / ADRT /DNACPR & preferred place of care (PPC) & implemented according to person's wishes **Hospitals** discharge people with clear care advice, information & contact details **Timely** assessment & response for Continuing Care Funding (CHC) to ensure appropriate / increased support to reduce fear of inadequate access to appropriate end of life care **Improve** access to specialist services & equipment **Access** to information, appropriate support / services **Retaining** GP's in nursing homes

family/carer / significant others		

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Phase 6
Recognising there is a problem	**Discovering that the condition is Dementia**	**Living Well with Dementia**	**Getting the right help at the right time**	**Nearing the end of life including care in the last days of life**	**Care after death**

Phase 5 Nearing the end of life including care in the last days of life		
NEEDS of people with dementia, their relatives and carers	**SUPPORT available**	**What needs to HAPPEN for support to meet needs**
Dying with dignity in place of choice	**Spiritual** support from local churches/faith support **Community** Learning Disability Team (CLDT) **Dementia** Specialist Nurse / Admiral Nurse **Crisis** /emergency support & advice e.g. Out of Hours Doctor Service (OOH) / One Call / Rapid Assessment & Intervention Team / Dementia CRISIS Team / SECAmb / Acute hospitals	**Co-ordinated** Teamwork with all services involved **Access** to EOLC Support/Adviser – EOLC register and discussion at Gold Standard framework meetings (GSF) **Emotional** and Social support for family/ carers / significant others e.g. Pre death course; pre bereavement support (including counselling) **Family/carers/** significant others to review funeral arrangements /support options

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Phase 6
Recognising there is a problem	**Discovering that the condition is Dementia**	**Living Well with Dementia**	**Getting the right help at the right time**	**Nearing the end of life including care in the last days of life**	**Care after death**

Phase 6 Care after death		
NEEDS of people with dementia, their relatives and carers	**SUPPORT available**	**What needs to HAPPEN for support to meet needs**
Recognition that the end of life does not stop at the point of death **Ensuing** person's wishes are respected regarding care after death **Empathic** support for family & carer including timely verification of death; out of hours support - emotional, spiritual, practical care & bereavement support with opportunities to talk & grieve **Sensitive** post bereavement support –especially important if there are issues regarding carrying out individuals wishes **Information** & practical support regarding registering death; financial affairs; who to notify & post bereavement support **Named** person to continue supporting family/carers/ significant others for a period **Access** to counselling if appropriate **One** central contact point & information shared by all professionals **Support** & information about bereavement support	**Bereavement** & practical support through family, friends/ significant others **G.P.** & IPCT/NST **Hospice** @ Home Hospice Bereavement Team **Dementia** Specialist Nurse / Admiral Nurse / Advanced Care Nurse Practitioners/ Community Learning Disability Team (CLDT) **Support** within community **Spiritual** support of their choosing; **Carers** Support Groups **Local** bereavement support groups e.g. run by religious & voluntary groups **CRUSE** **Admiral** Nurse support **Practical** support with financial arrangements from: **DWP** Bereavement Service **Funeral** Directors **Carers** Centre **Samaritans**	**Family**/carers encouraged to use bereavement services & care at point of death **Support** available to help with practical arrangements **Recognition** that relatives /carers/ significant others & practitioners may require 'closure' & facilitating this **Funding** for carer groups to recognise need for post bereavement support e.g. Bereavement care – new beginning course - need to include in prospectus funding **Identifying** the carer / significant others and their role – financial, social, psychological **Timely** & appropriate referral to services e.g. counselling/ support groups **Care** co-ordinator to follow up relatives/ carer / significant others - Carers groups – ongoing support / counselling

Appendix 2

End of Life Care in Dementia Project

Brighton and Hove Stakeholder Group

Terms of Reference

Introduction

The overall aim of the End of Life Care in Dementia project is to improve end of life care for people with dementia across Sussex, so that more people with dementia die in their preferred place of death, with dignity, without undue pain and with their advance wishes respected. Specific objectives are:

1. To increase advanced end of life care planning for people with dementia
2. To develop a comprehensive care pathway for people with dementia at the end of life
3. To ensure staff caring for those with dementia and nearing the end of their life are equipped with the skills to deliver safe, high quality care.

Purpose of the Brighton and Hove Stakeholder Group

The aim of the Stakeholder Group is to support the delivery of the End of Life Care in Dementia project aims and objectives within the Brighton and Hove locality.

Functions

The Stakeholder Group will work together to share knowledge, skills and expertise and through this to:

- develop a comprehensive and integrated care pathway for people with dementia at the end of life which includes advance care planning
- develop and agree local joint action plans for implementing the integrated care pathway including arrangements for monitoring and reviewing progress
- develop and agree local protocols to support best practice
- identify learning and development needs related to end of life care in dementia
- contribute to the evaluation of the End of Life Care in Dementia Project

Accountability

The Brighton and Hove End of Life Care in Dementia Stakeholder Group is accountable to the following:

- The End of Life Care in Dementia Steering Group
- Brighton and Hove Clinical Commissioning Group
- NHS Sussex
- NHS South of England

Meetings

At Lanchester House Brighton at 9.30pm-12.30pm
Monday 7th January 2013
Monday 18th February 2013

Membership of the Brighton and Hove Stakeholder Group 10.12.12

Brighton & Hove CCG	Deidre Prower Dr Christa Beesley	Practice Nurse Brighton General Practitioner – Brighton
Brighton & Hove PCT	Kate Hirst Anthony Flint	Dementia Commissioner EoLC Commissioner
Sussex Partnership Foundation NHS Trust	Jeanette Waite James Cadel Anne Fellbaum	Practice Development Facilitator Social Worker CMHT Care Homes InReach Team
Sussex Community Trust	Lesley Oates Sarah Rogers	End of Life Care Co-ordinator Clinical Services Manager EoLC
Brighton & Sussex University Hospitals NHS Trust	Lucy Frost Dr Mark Bayliss Dr Jo Preston Jane Stokes	Dementia Champion Consultant Geriatrician Registrar Elderly Care End of Life Care Facilitator
The Martlets Hospice	Jackie Windsor Imelda Glackin	Education Manager Service Development
Brighton & Hove City Council Social Services	Tim Wilson Kevin Murphy Rosemary Mitchener Naomi Cornford	L&D Officer Independent Sector L&D Lead Care Manager Clinical Quality Review Nurse
Alzheimer's Society	Sophie Mackrell	Support Services Manager
Carers	Sheila Killick	Carers Support Service
Residential and Nursing Homes		Through BHCC Provider Forum
Domiciliary Care Providers		Focus group & BHCC Provider Forum
Learning Disability Provider	Chris Bland	Operations Manager Grace Eyre Foundation
SECAmb	Elizabeth Davis	EoLC Lead
South East Health OOH	Dr Robin Warshfsky	Assistant Medical Director
Voluntary Sector	Alice Sharville	B&H Independent Mediation Service
Lay Member (carers)	Sheila New	

Cc in and will attend as and when required

Eleanor Langridge
10th December 2012
Version 8

Planning for your future care

A GUIDE

Planning for your future care

A GUIDE

There may be times in your life when you think about the consequences of becoming seriously ill or disabled. This may be at a time of ill health or as a result of a life changing event. It may simply be because you are the sort of person who likes to plan ahead.

You may want to take the opportunity to think about what living with a serious illness might mean to you, your partner or your relatives, particularly if you become unable to make decisions for yourself. You may wish to record what your preferences and wishes for future care and treatment might be or you may simply choose to do nothing at all.

One way of making people aware of your wishes is by a process that is called advance care planning.

This booklet provides a simple explanation about advance care planning and the different options open to you. The booklet uses some of the terms contained within the framework of the Mental Capacity Act (2005), so some of the language used may be new to you.

What is Advance Care Planning?

Advance care planning is a process of discussion between you and those who provide care for you, for example your nurses, doctors, care home manager, social worker, family or friends.

During this discussion you may choose to express some views, preferences and wishes about your future care so that these can be taken into account if you were unable to make your own decisions at some point in the future. This process will enable you to communicate your wishes to all involved in your care.

Aspects of Advance Care Planning

These points will be explained in this booklet.

Advance care planning is an entirely voluntary process and no one is under any pressure to take any of the above steps.

Opening the conversation

Having an advance care planning conversation with someone may lead to one or more of the points mentioned in this booklet.

A conversation about advance care planning may be prompted by:

- The wish to make plans just in case something unexpected happens
- Planning for your future or for retirement
- Following the diagnosis of a serious or long term condition or being aware that you may have a limited time to live
- After the death of a spouse, partner or friend.

Not everyone will choose to engage in such a conversation and that is fine. However, talking and planning ahead means that your wishes are more likely to be known by others. This is important for those responsible for making decisions about your care if you lose capacity to make your own decisions because of serious illness.

Explore your options

Advance care planning can occur at any time you choose. Ask your care provider or someone close to you to have the discussion with you. You may want to plan an appropriate time and place for having an advance care planning conversation.

To explore what options are available to you, you and the person with whom you have the discussion may need to seek some support and advice.

You might have strong views about things that you would or would not like to happen. For example, some people may say they would always want to stay at home if they become ill. However this may not be a realistic choice in some circumstances.

An example about exploring options

Ella lives with her daughter, son-in-law and two young grandchildren. She knows she is approaching the end of her life and would like to remain in her home. But Ella also feels that she really must go into a nursing home to save her family any extra work or upset. The idea is causing her a great deal of worry.

Ella has not told her family her wishes so she does not know how they feel about the possibility of looking after her. She has not asked her doctor what support is locally available to help her stay in her own home or if there are any alternatives available to her other than a nursing home.

Discussing and finding out all of the options available might help Ella resolve some of her concerns and make her future plans together with her family.

Identify your wishes and preferences

The wishes you express during advance care planning are personal to you and can be about anything to do with your future care.

You may want to include your priorities and preferences for the future, for example:

- How you might want any religious or spiritual beliefs you hold to be reflected in your care
- The name of a person/people you wish to be consulted on your behalf at a later time; this could be a close family member but can be anyone you choose
- Your choice about where you would like to be cared for, for example at home, in a hospital, nursing home or a hospice
- Where you would like to be cared for at the end of your life and who you would like to be with you
- Your thoughts on different treatments or types of care that you might be offered
- How you like to do things, for example preferring a shower instead of a bath or sleeping with the light on
- Concerns or solutions about practical issues, for example who will look after your pet should you become ill.

If you become unable to make a decision yourself, this information will help those caring for you to identify what is in your best interests and make decisions on your behalf.

Refusing specific treatment

During an advance care planning discussion, you may decide to express a very specific view about a particular medical treatment which you do not want to have. This can be done by making an advance decision to refuse treatment.

An advance decision to refuse treatment (sometimes called a living will or advance directive) is a decision you can make to refuse a specific type of treatment at some time in the future. This is to be observed if you can't make your own decision at the time the treatment becomes relevant.

Sometimes you may want to refuse a treatment in some circumstances but not others. If so, you must specify all the circumstances in which you want to refuse this particular treatment.

There are rules if you wish to refuse treatment that is potentially life sustaining, for example, ventilation. An advance decision to refuse this type of treatment must be put in writing, signed and witnessed and include the statement 'even if life is at risk as a result'.

If you wish to make an advance decision to refuse treatment you are advised to discuss this with a health care professional who is fully aware of your medical history.

An advance decision to refuse treatment will only be used if at some time in the future you lose the ability to make your own decisions about your treatment.

Remember you can change your mind at any time.

Ask someone to speak for you

You may wish to name someone – or even more than one person – who should be asked about your care if you are not able to make decisions for yourself. This person may be a close family member, a friend or any other person you choose.

If in the future you are unable to make a decision for yourself, a health or social care professional would, if possible, consult with the person you named. Although this person cannot make decisions for you, they can provide information about your wishes, feelings and values. This will help the healthcare professionals act in your best interests.

This is not the same as legally appointing somebody to make decisions for you under a lasting power of attorney. We look at that on page 10.

An example of naming someone to speak for you

Sheelagh lives alone and has no living relative. She has always received help and support from her lifelong friend and neighbour Jenny.

As Sheelagh gets older she starts to think about what will happen to her if for any reason her health fails. She knows and trusts Jenny well and she decides to ask her to be the person she would like to be consulted and speak on her behalf, should the need ever arise.

Sheelagh is happy that her financial affairs continue to be managed by her solicitor just as they always have been, and discusses that with her solicitor.

Making a Lasting Power of Attorney

You may choose to give another person legal authority (making them an 'attorney') to make decisions on your behalf if a time comes that you are not able to make your own decisions. This can be a relative, a friend or a solicitor.

A Lasting Power of Attorney (LPA) enables you to give another person the right to make decisions about your property and affairs and/or your personal welfare.

Decisions about care and treatment can be covered by a personal welfare LPA. An LPA covering your personal welfare (sometimes called health and welfare) will only be used when you lack the ability to make specific health and welfare decisions for yourself.

There are special rules about appointing an LPA. You can get a special form from the Office of the Public Guardian (OPG) or stationery shops that provide legal packs. The form will explain what to do. Your LPA will need to be registered with the Office of Public Guardians before it can be used (see details on page 14).

LPA has replaced Enduring Power of Attorney.

An example of appointing a Lasting Power of Attorney

Kamal lives with a heart condition and has limited mobility; he has started to think about what might happen in the future if his illness gets worse.

Kamal has always handled the finances and affairs for both himself and his wife. They are both concerned that should anything happen to him, his wife would find it hard to cope with any major decisions or he may become too ill to make decisions about his own care.

To give him and his wife peace of mind they both decide to give Lasting Power of Attorney to their daughter. They both discuss with Farah their thoughts about any possible future decisions which may arise around money, property or healthcare. By doing so their daughter understands their wishes and preferences and can act for them in the way they would choose should the need ever arise.

Farah will only make decisions for her parents if a time comes that they are unable to make decisions for themselves.

Let people know

Advance care planning does not always need to be in writing unless you are making an advance decision to refuse life sustaining treatment. However the professionals involved in your care and members of your family may find it helpful if your wishes and preferences are in writing, signed and dated. It is a good idea to give a copy of your wishes to everyone who needs to know. Remember to keep your own copy safe.

By letting people know about your wishes you may have an opportunity to discuss your views with those close to you.

If you have made an advance decision to refuse specific treatment you must be sure that the people involved in your care know this. Ask your nurse or doctor to help you do this.

Key points about advance care planning

- No one is obliged to carry out advance care planning
- You may wish to discuss your wishes with your carers, partner or relatives
- Include anything that is important to you no matter how trivial it seems
- If you wish to refuse a specific treatment, consider making an advance decision to refuse treatment
- It is recommended that anything you have written down should be signed and dated
- It is recommended you seek the advice of an experienced healthcare professional if making an advance decision to refuse treatment
- If you make an advance decision that refuses treatment that is life sustaining it must be in writing, signed, dated and witnessed and use a specific form of words
- If you have named someone to speak for you or have a Lasting Power of Attorney, remember to write down their name in your advance care planning documents
- If your wishes are in writing or if you have a Lasting Power of Attorney, keep a copy of the documentation safe and provide copies to those who need to know your wishes e.g. nurse, doctor carer or family member.

Remember you can change your mind at any time.

Where to find further information

The following information is found on websites. You may be able to get help to access these through your GP, health or social care worker, your library or at a hospital information centre.

Dying Matters

10 leaflets focusing on having discussions and planning ahead can be found at **www.dyingmatters.org/overview/resources**

Mental Capacity Act

Information about the Mental Capacity Act and the supporting Code of Practice.
www.justice.gov.uk/guidance/protecting-the-vulnerable/mental-capacity-act

Office of Public Guardian

The Office of Public Guardian is there to protect people who lack capacity. Forms and guidance on appointing a Lasting Power of Attorney are available.
www.publicguardian.gov.uk
Tel. 0300 4560300

Preferred Priorities for Care

A document which can be used to help write down preferences and wishes for the future.
www.endoflifecareforadults.nhs.uk/tools/core-tools/preferredprioritiesforcare

The Mental Capacity Act in Practice

Guidance for End of Life Care (2008) – The National Council for Palliative Care.
www.ncpc.org.uk
Tel. 020 7697 1520

Good Decision Making – The Mental Capacity Act and End of Life Care

A summary guidance to introduce people to the MCA and its contents and to explain the importance for End of Life Care decision making.
www.ncpc.org.uk

Advance Decisions to Refuse Treatment website

A training website for professionals which contains a patient section.
www.adrt.nhs.uk

NHS Choices

A website providing information on conditions, treatments, living well and support for carers.
www.nhs.uk

Age UK LifeBook

The LifeBook is a free booklet to document important and useful information about your life, from who insures your car to where you put the TV licence.

www.ageuk.org.uk/home-and-care/home-safety-and-security/lifebook/

Tel. 0845 685 1061 quoting reference ALL 721

Healthtalkonline

A website detailing people's experiences of dying and bereavement, including sections on caring for someone with a terminal illness.

www.healthtalkonline.org/Dying_and_bereavement/

www.endoflifecareforadults.nhs.uk
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Dying Matters
'Let's talk about it'

The University of Nottingham

NHS
National End of Life Care Programme

Preferred Priorities for Care

Preferred Priorities for Care

What is this document for?

The Preferred Priorities for Care (also known as PPC) can help you prepare for the future. It gives you an opportunity to think about, talk about and write down your preferences and priorities for care at the end of your life. You do not need to do this unless you want to.

The PPC can help you and your carers (your family, friends and professionals) to understand what is important to you when planning your care. If a time comes when, for whatever reason, you are unable to make a decision for yourself, anyone who has to make decisions about your care on your behalf will have to take into account anything you have written in your PPC.

Sometimes people wish to refuse specific medical treatments in advance. The PPC is not meant to be used for such legally binding refusals. If you decide that you want to refuse any medical treatments, it would be advisable to discuss this with your doctors.

Remember that your views may change over time. You can change what you have written whenever you wish to, and it would be advisable to review your PPC regularly to make sure that it still reflects what you want.

Should I talk to other people about my PPC?

You may find it helpful to talk about your future care with your family and friends, although sometimes this can be difficult because it might be emotional or people might not agree. It can also be useful to talk about any particular needs your family or friends may have if they are going to be involved in caring for you. Your professional carers (like your doctor, nurse or social worker) can help and support you and your family with this.

When you have completed your PPC you are encouraged to keep it with you and share it with anyone involved in your care. Unless people know what is important to you, they will not be able to take your wishes into account.

Will my preferences and priorities be met?

What you have written in your PPC will always be taken into account when planning your care. However, sometimes things can change unexpectedly (like carers becoming over-tired or ill), or resources may not be available to meet a particular need.

What should I include in my PPC?

You should include anything that is important to you or that you are worried about. It is a good idea to think about your beliefs and values, what you would and would not like, and where you would like to be cared for at the end of your life.

People who should be asked about your care if you are not able to make a decision for yourself

You may have formally appointed somebody to make decisions on your behalf, using a Lasting Power of Attorney, in case you ever become unable to make a decision for yourself. If you have registered a Lasting Power of Attorney please provide their contact details below.

Name:

Address:

Telephone number:

Relationship to you:

Even if you have not registered a Lasting Power of Attorney, is there anybody you would like to be consulted about your care in the event that you are unable to make decisions for yourself? If so, please provide their contact details below.

Name:

Address:

Telephone number:

Relationship to you:

Your preferences and priorities

In relation to your health, what has been happening to you?

What are your preferences and priorities for your future care?

Where would you like to be cared for in the future?

Signature **Date**

Please record any changes to your preferences and priorities here

(Please sign and date any changes)

Further information

You can use this page to make a note of any further information you need or questions you might want to ask your professional carers (like your doctor, nurse or social worker).

Contact details

You can use this page to record contact details of anyone who is involved in your care.

Name	Relationship to you	Contact number
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----------	----------	----------
----------	----------	----------
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This document was given to me by:

Name:

Organisation:

Tel:

Email:

Further information about PPC is available at: www.endoflifecareforadults.nhs.uk

Originated by Lancashire & South Cumbria Cancer Network June 2004 and endorsed by the NHS End of Life Care Programme

Revised December 2007 by the National PPC Review Team

V2.2/2011

Royal College of Nursing

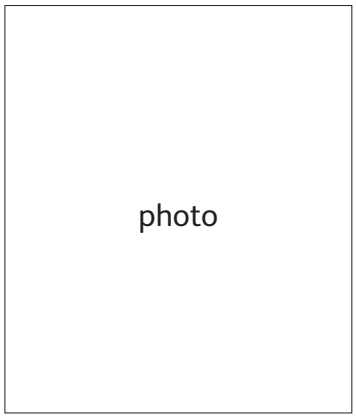
Leading the fight against dementia
Alzheimer's Society

This is me

This leaflet will help you support me in an unfamiliar place

Please place a photograph of yourself in the space provided.

My name



This is me is about the person at the time the document is completed and will need to be updated as necessary.

This is me should be completed by the person or persons who know the patient best and wherever possible with the person themselves.

Please refer to the back page for guidance notes to help you complete **This is me**.

My name: full name and the name I prefer to be known by

I currently live

Carer/the person who knows me best

I would like you to know

My home and family, things that are important to me

My life so far

My hobbies and interests

Things which may worry or upset me

I like to relax by

My hearing and eyesight

My communication

My mobility

My sleep

My personal care

My eating and drinking

My medication

Date completed: By whom:

Relationship to patient:

In signing this document, I agree that the information in this leaflet may be shared with health and care workers.

Guidance notes to help you to complete **This is me**

This is me is intended to provide professionals with information about the person with dementia as an individual. This will enhance the care and support given while the person is in an unfamiliar environment. It is not a medical document.

This is me is about the person at the time the document is completed and will need to be updated as necessary. This form can be completed by the person with dementia or their carer with help from the person with dementia where possible.

My name: Full name and the name I prefer to be known by.

Where I currently live: The area (not the address) where I live. Include details about how long I have lived there, and where I lived before.

Carer/the person who knows me best: It may be a spouse, relative, friend or carer.

I would like you to know: Include anything I feel is important and will help staff to get to know and care for me, eg I have dementia, I have never been in hospital before, I prefer female carers, I don't like the dark, I am left handed, I am allergic to… etc.

My home and family, things that are important to me: Include marital status, children, grandchildren, friends, pets, any possessions, things of comfort. Any religious or cultural considerations.

My life so far: Place of birth, education, work history, travel, etc.

My hobbies and interests: Past or present – eg reading, music, television or radio, crafts, cars.

Things which may worry or upset me: Anything that may upset me or cause anxiety such as personal worries, eg money, family concerns, or being apart from a loved one, or physical needs, eg being in pain, constipated, thirsty or hungry.

I like to relax by: Things which may help if I become unhappy or distressed. What usually reassures me, eg comforting words, music or TV? Do I like company and someone sitting and talking with me or prefer quiet time alone? Who could be contacted to help and if so when?

My hearing and eyesight: Can I hear well or do I need a hearing aid? How is it best to approach me? Is the use of touch appropriate? Do I need eye contact to establish communication? Do I wear glasses or need any other vision aids?

My communication: How do I usually communicate, eg verbally, using gestures, pointing or a mixture of both? Can I read and write and does writing things down help? How do I indicate pain, discomfort, thirst or hunger? Include anything that may help staff identify my needs.

My mobility: Am I fully mobile or do I need help? Do I need a walking aid? Is my mobility affected by surfaces? Can I use stairs? Can I stand unaided from sitting position? Do I need handrails? Do I need a special chair or cushion, or do my feet need raising to make me comfortable?

My sleep: Usual sleep patterns and bedtime routines. Do I like a light left on and do I find it difficult to find the toilet at night? Position in bed, any special mattress, pillow, do I need a regular change of position?

My personal care: Normal routines, preferences and usual level of assistance required in the bath or, shower or other. Do I prefer a male or female carer? What are my preferences for continence aids used, soaps, cosmetics, shaving, teeth cleaning and dentures?

My eating and drinking: Do I need assistance to eat or drink? Can I use cutlery or do I prefer finger foods? Do I need adapted aids such as cutlery or crockery to eat and drink? Does food need to be cut into pieces? Do I wear dentures to eat or do I have swallowing difficulties? What texture of food is required to help, soft or liquidised? Do I require thickened fluids? List likes, dislikes and any special dietary requirements including vegetarianism, religious or cultural needs. Include information about my appetite and whether I need help to choose food off a menu.

My medication: Do I need help to take medication? Do I prefer to take liquid medication?

Dedicated to the memory of Ken Ridley, a much valued member of the Northumberland Acute Care and Dementia Group.

The Royal College of Nursing is pleased to support **This is me**.

To order extra copies call Xcalibre on 01628 529240. For general dementia queries call our Helpline on 0845 300 0336.

alzheimers.org.uk

It's Local Actually
pinpoint an activity

the Fed
centre for independent living

Centre for Independent Living
Embrace Project

Putting people and local services together

Geraldine Desmoulins
Keith Beadle

NHS
Brighton and Hove

Brighton & Hove City Council

City-wide co-ordination

- The Fed was endorsed as The Centre for Independent Living (CIL) at a City-wide Summit in June 2011
- Since then the CIL has brought together key stakeholders to increase choice and control to people in the city
- The Embrace Project has co-ordinated this work by –

  Providing information, particularly on 'grass root' activity which links with each locality in the city

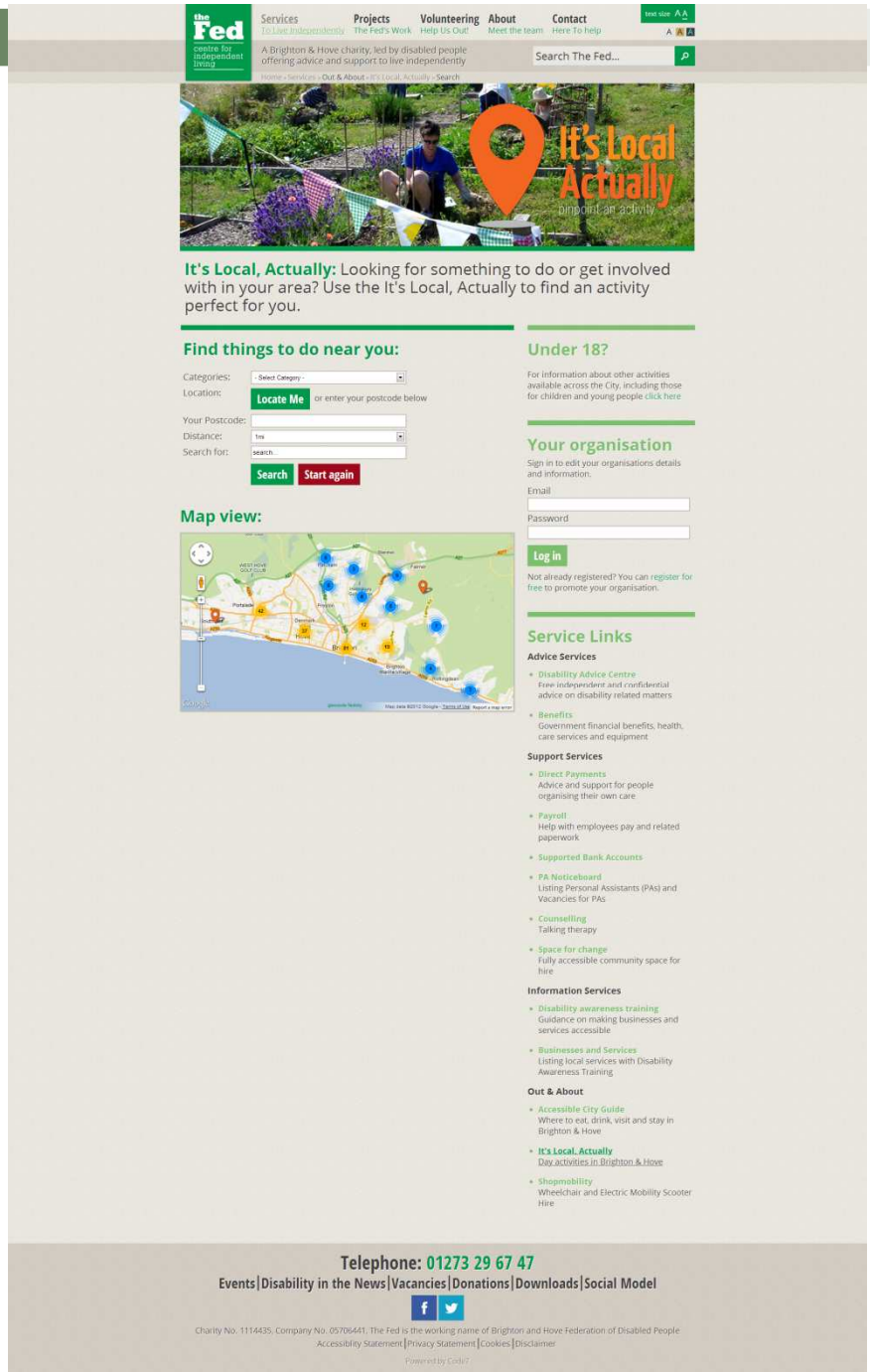
  Providing information to support joined up and collaborative commissioning

  Encouraging and building on community engagement and encouraging community activity

The CIL launched "It's Local Actually" in November 2012

It's Local Actually

pinpoint an activity


the Fed
centre for independent living
Services
To Live Independently
Projects
The Fed's Work
Volunteering
Help Us Out!
About
Meet the team
Contact
Here To help
text size A A
A Brighton & Hove charity, led by disabled people offering advice and support to live independently
Search The Fed...
Home › Services › Out & About › It's Local, Actually › Search
It's Local Actually
pinpoint an activity
It's Local, Actually: Looking for something to do or get involved with in your area? Use the It's Local, Actually to find an activity perfect for you.
Find things to do near you:
Categories:
- Select Category -
Location:
Locate Me
or enter your postcode below
Your Postcode:
Distance:
1mi
Search for:
search...
Search
Start again
Map view:
Under 18?
For information about other activities available across the City, including those for children and young people click here
Your organisation
Sign in to edit your organisations details and information.
Email
Password
Log in
Not already registered? You can register for free to promote your organisation.
Service Links
Advice Services
Disability Advice Centre
Free independent and confidential advice on disability related matters
Benefits
Government financial benefits, health, care services and equipment
Support Services
Direct Payments
Advice and support for people organising their own care
Payroll
Help with employees pay and related paperwork
Supported Bank Accounts
PA Noticeboard
Listing Personal Assistants (PAs) and Vacancies for PAs
Counselling
Talking therapy
Space for change
Fully accessible community space for hire
Information Services
Disability awareness training
Guidance on making businesses and services accessible
Businesses and Services
Listing local services with Disability Awareness Training
Out & About
Accessible City Guide
Where to eat, drink, visit and stay in Brighton & Hove
It's Local, Actually
Day activities in Brighton & Hove
Shopmobility
Wheelchair and Electric Mobility Scooter Hire
Telephone: 01273 29 67 47
Events | Disability in the News | Vacancies | Donations | Downloads | Social Model
Charity No. 1114435. Company No. 05706441. The Fed is the working name of Brighton and Hove Federation of Disabled People
Accessibility Statement | Privacy Statement | Cookies | Disclaimer
Powered by Code7

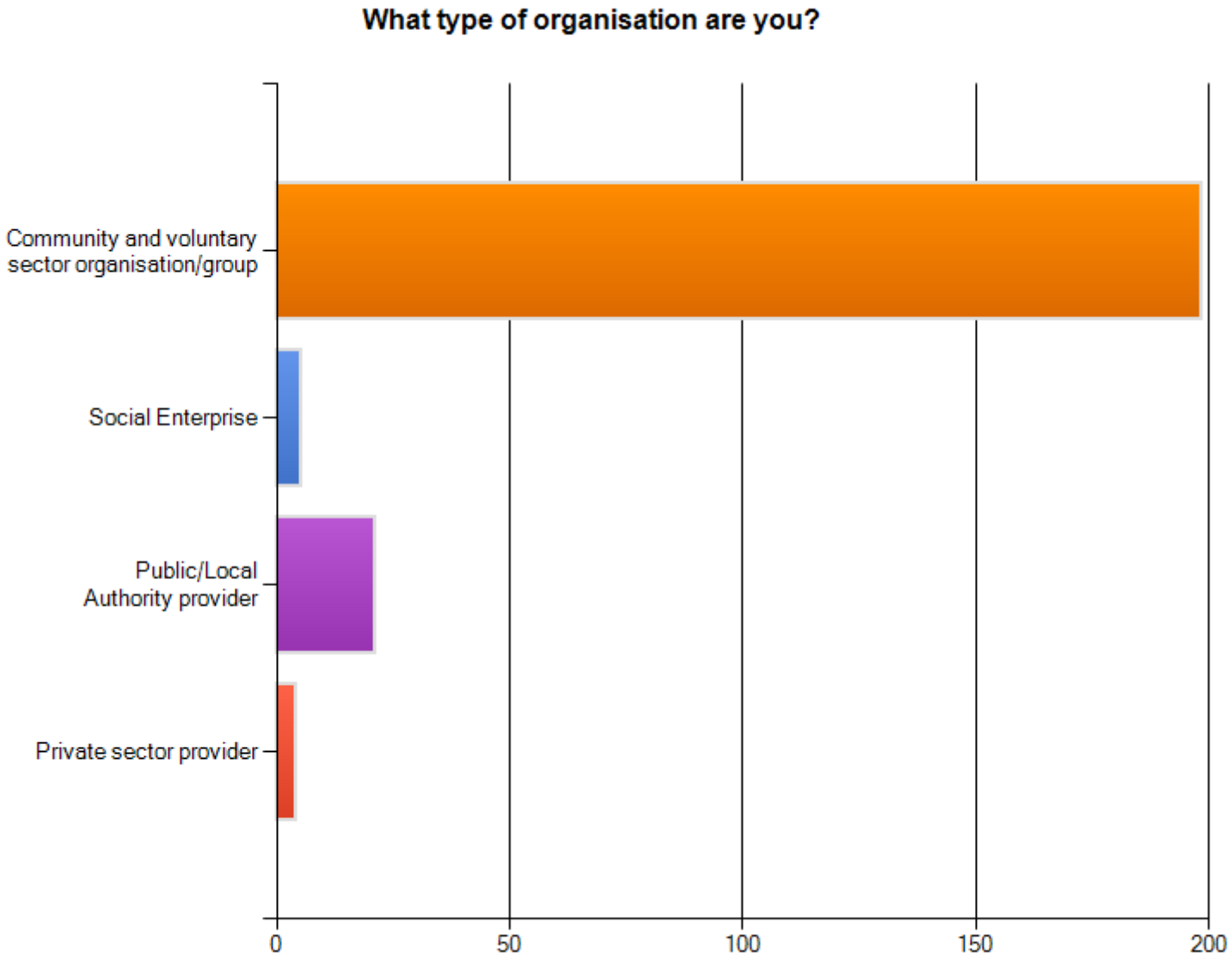
What have we been up to?

- The Project has gathered information from 250 groups, clubs and social activities on offer in neighbourhood areas in Brighton & Hove
- We developed a website, searchable by postcode, which will show you what's going on in your area
- There are one thousand low cost or free activities taking place across the City
- We are working with partners to help people "to and from" activities

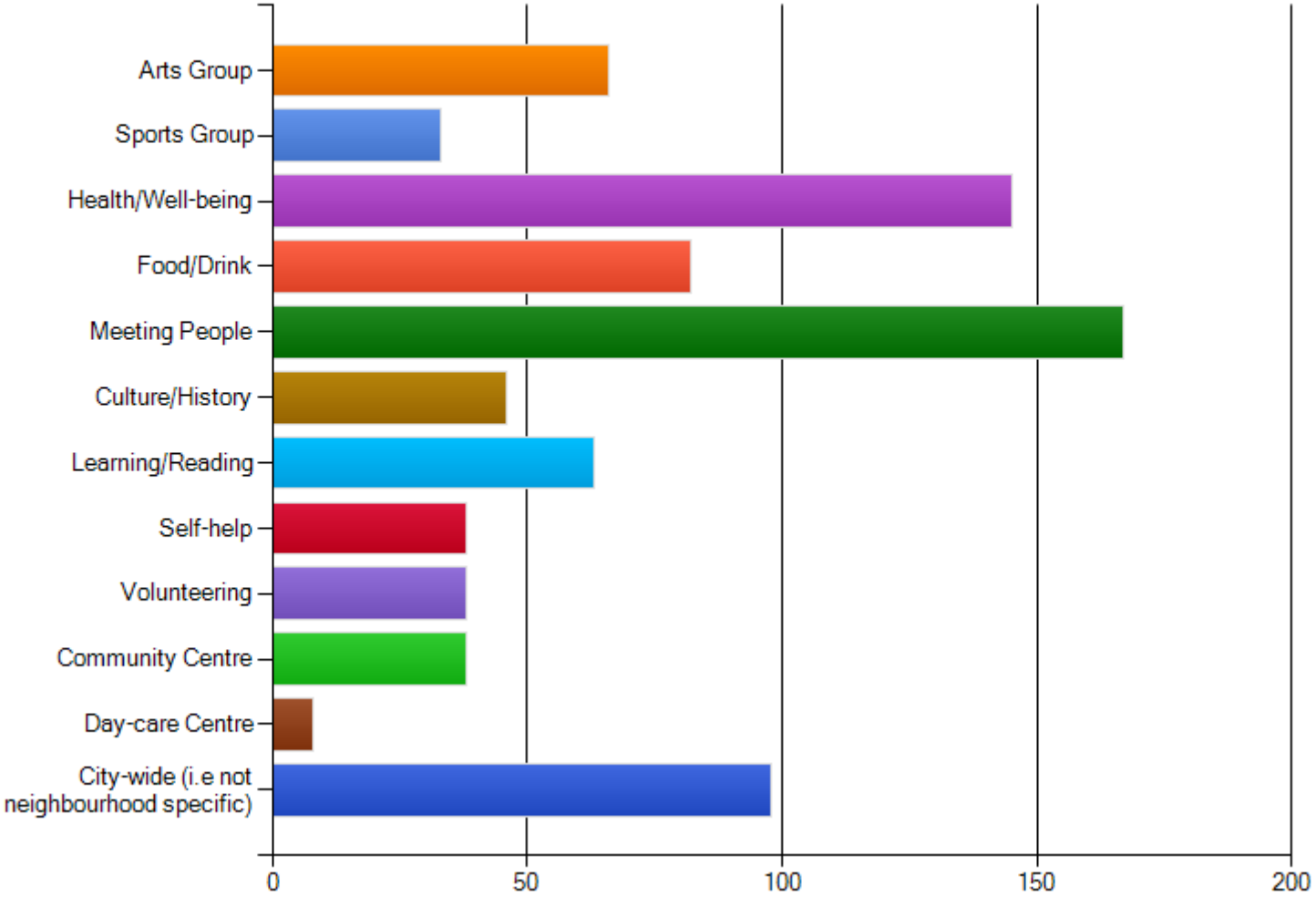
Mapping Neighbourhoods

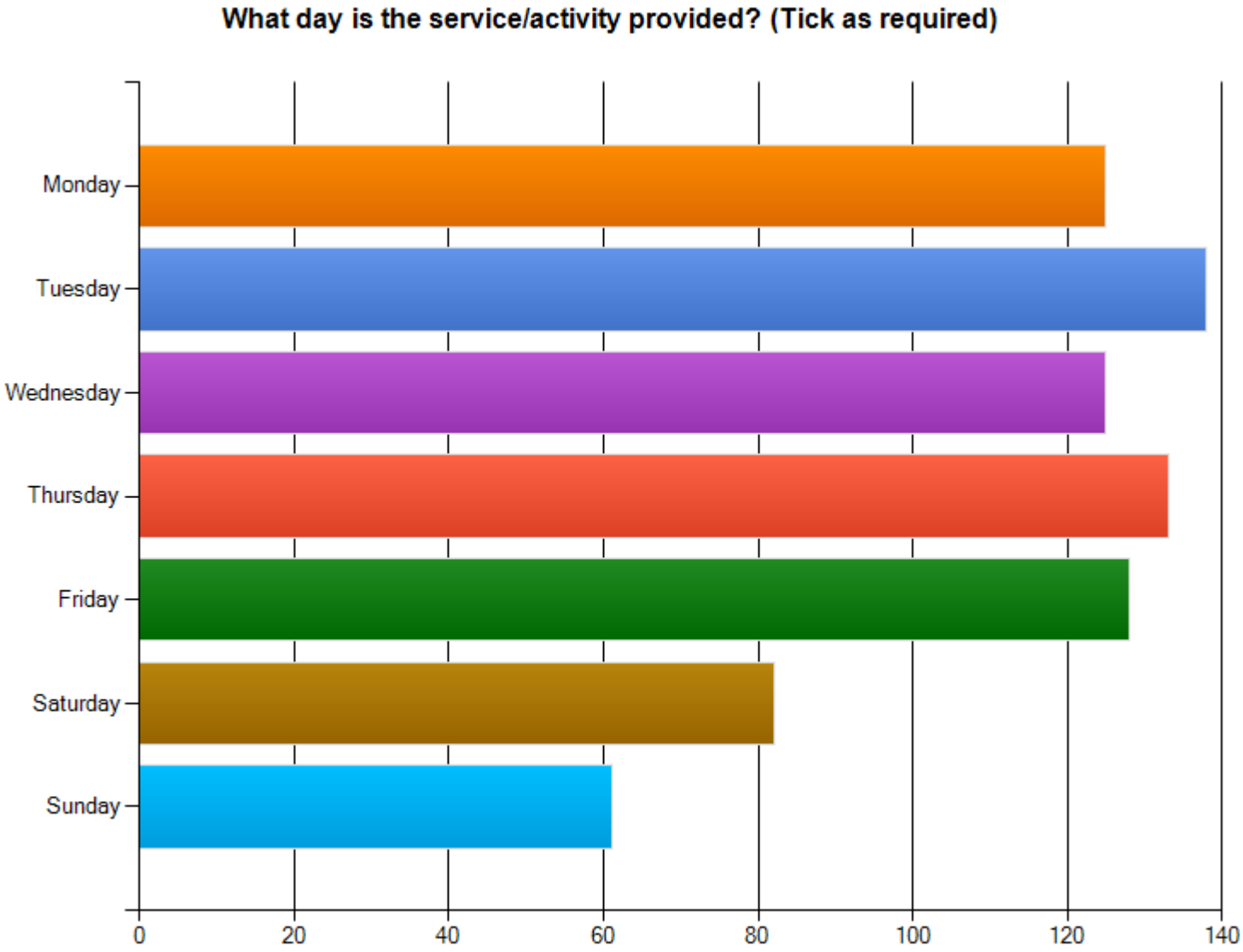
- A few things that we have found …

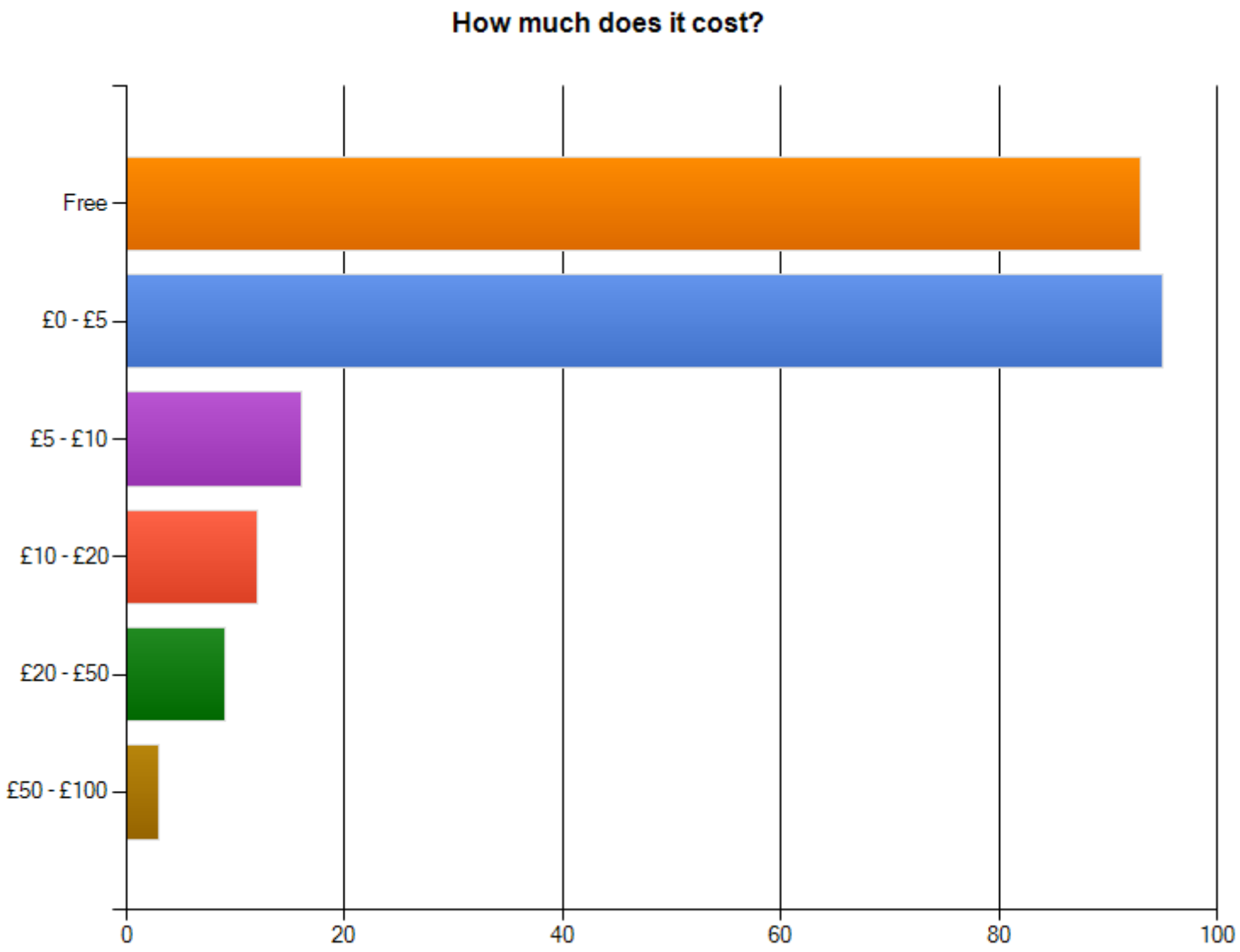
The following slides give a taster of some of the information we have gathered



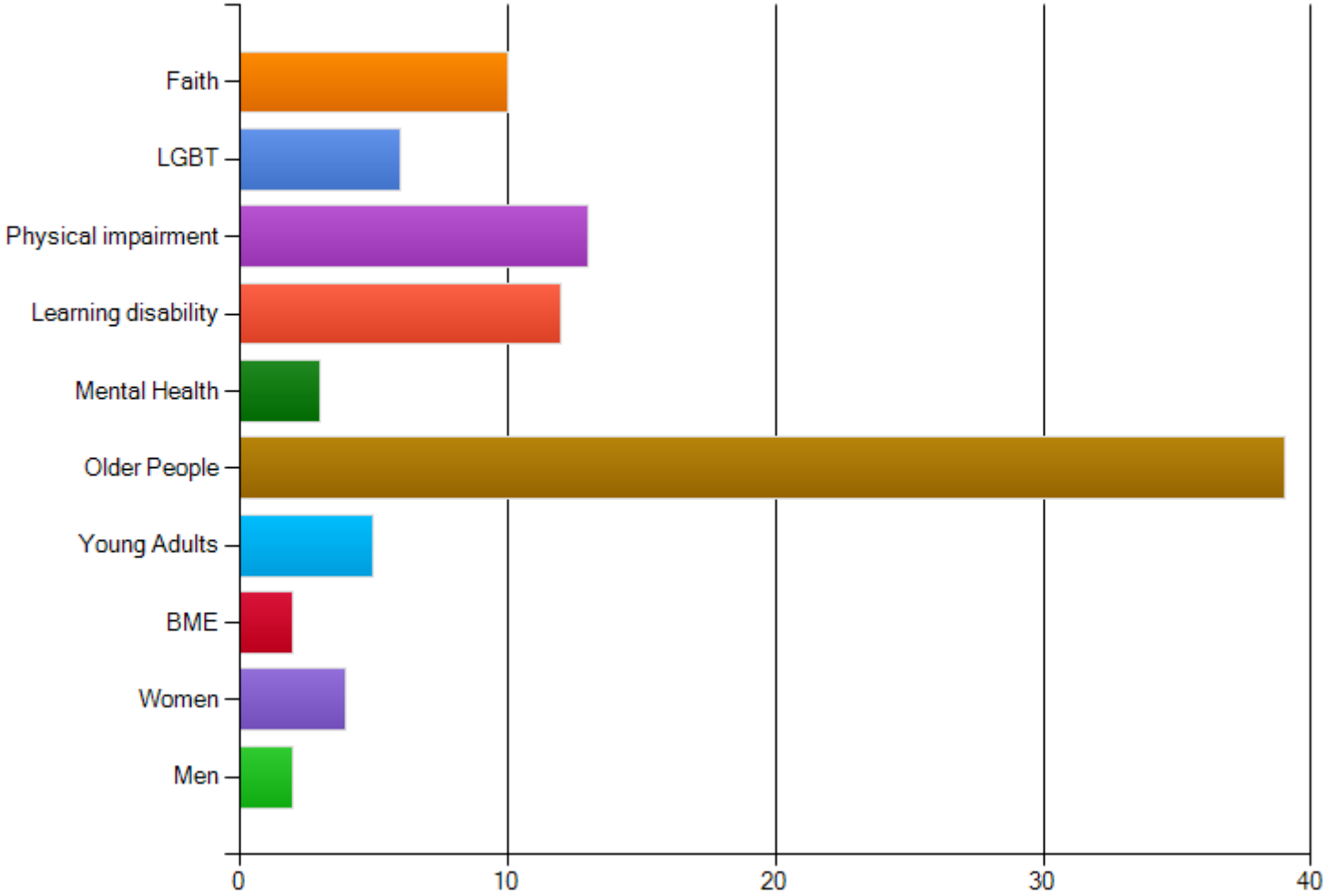
Please tick below which best describes your group's/club's activity. You may tick more than one!






How much does it cost?
Free
£0 - £5
£5 - £10
£10 - £20
£20 - £50
£50 - £100
0
20
40
60
80
100

Please specify if your service/activity for a specific faith/cultural or equality group? (Tick as required)



Details of activities by ward and specialist groups in Brighton & Hove

The analysis

- Drawn from the original survey
- The information is provided by groups
- The information held on the site is not a definitive list of all services/activities provided by community groups in the City
- The data reflects the fact that some community groups have selected more than one category to describe their activity
- Sports activities are fully reflected in the Active For Life directory
- BME groups are not adequately reflected: limited success in engaging through the current networks and infra- structure

All activity/services by ward

Ward	Number Of Listings
St Peter's & North Laine	53
East Brighton	43
Queens' Park	38
Central Hove	33
Hangleton & Knoll	30
South Portslade	27
Hollingdean & Stanmer	25
Moulsecoomb & Bevendean	24
Regency	24
Rottingdean Coastal	23
Brunswick & Adelaide	22
Patcham	20
Withdean	18
Woodingdean	17
North Portslade	17
Preston Park	17
Hove Park	16
Westbourne	15
Wish	14
Hanover & Elm Grove	14

Activity/service profile: East Brighton

Type of Service/Activity	Number Of Listings
Meeting People	33
Health/Well-Being	30
Food/Drink	17
Self-help	13
Volunteering	9
Arts/Music	8
Culture/History	6
Learning/Reading	6
Community Centres	5
Sports	5
Games	4
Day Centre	3
Gardening	3
Computer/Internet	2

This information is available in this format for all wards in Brighton & Hove

Specialist Groups providing activities/services for Communities of Interest

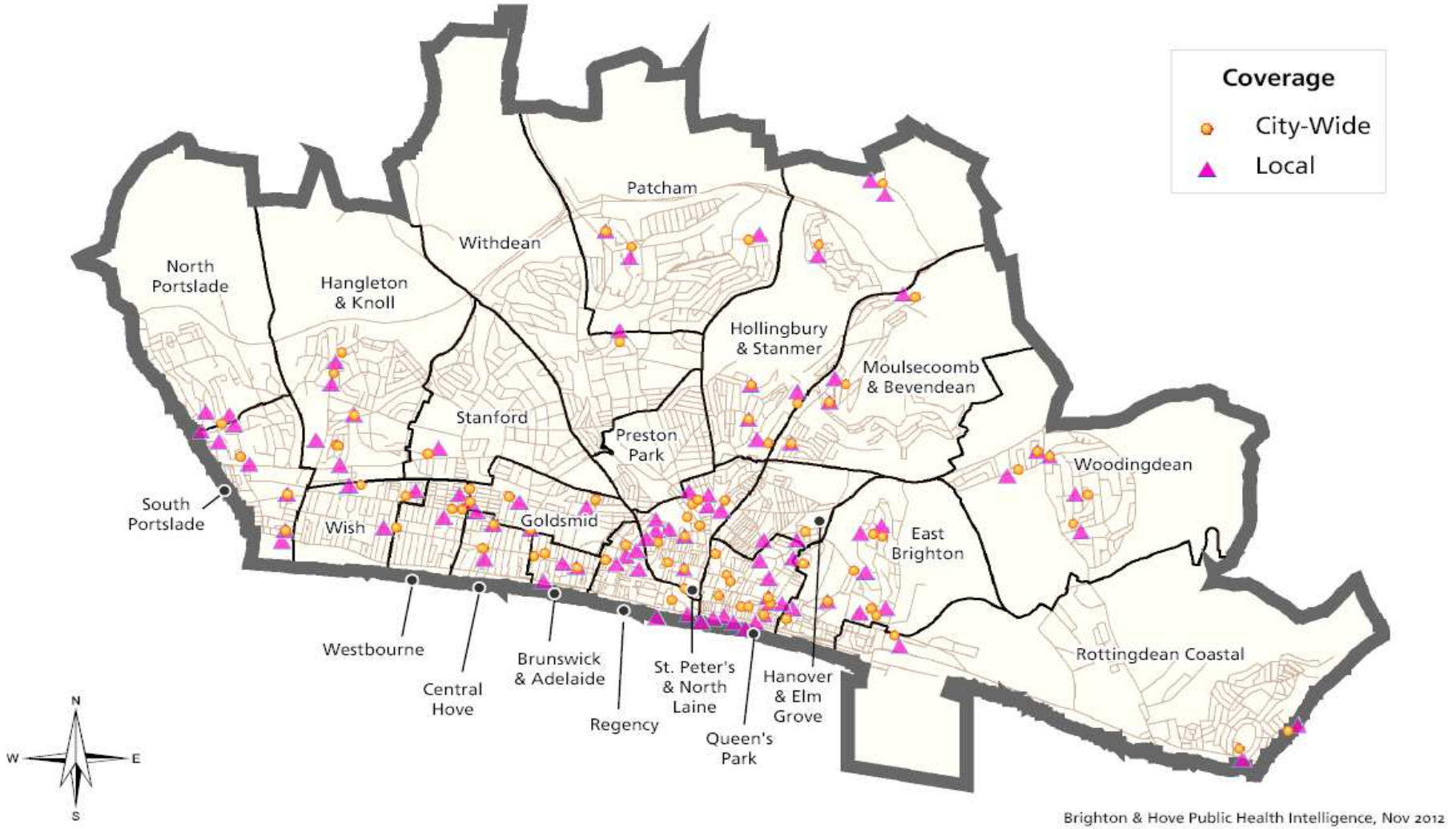
Group	Number Of Listings
Older People	50
Physical Impairment	18
Learning Disability	18
Young Adults	11
Faith	11
Mental Health	7
LGBT	6
Men	5
Women	4
BME	2
Other	2

Types of activities/services provided for Older People

Type of Service/Activity	Number Of Listings
Meeting People	43
Health/Well-Being	38
Food/Drink	27
Arts/Music	18
Learning/Reading	16
Games	12
Community Centre	11
Culture/History	10
Computer/Internet	9
Sports	9
Volunteering	3
Self-help	3
Day Centre	2
Gardening	1

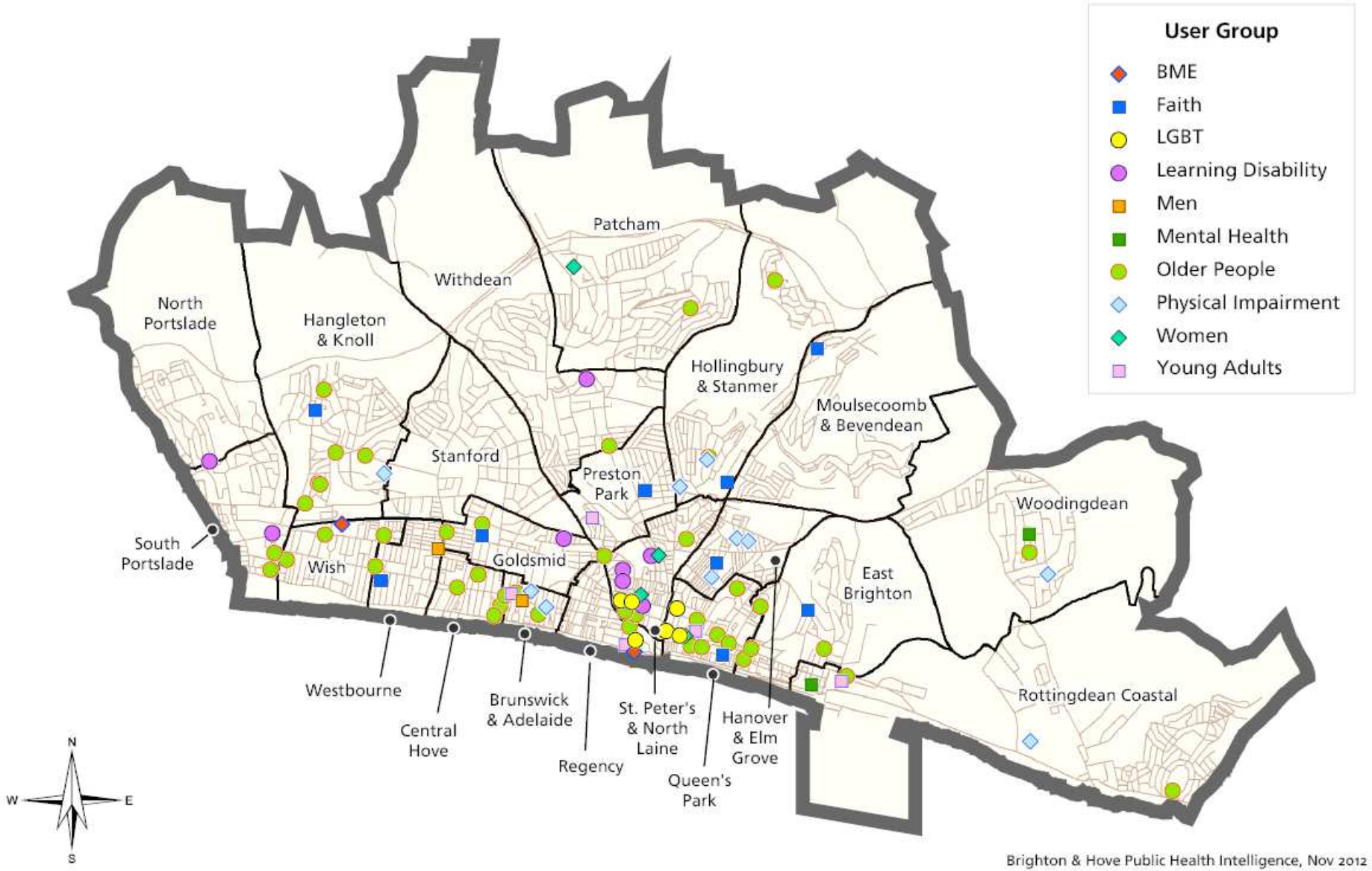
This information in available in this format for young adults, mental health service users, people with physical impairments, people with learning disabilities, faith groups , BME and cultural groups, LGBT groups and activities specifically for men or women.

Community Based Activities in Brighton and Hove - Food & Drink



Brighton & Hove Public Health Intelligence, Nov 2012

Community Based Activities in Brighton and Hove - User Groups



Brighton & Hove Public Health Intelligence, Nov 2012

Full report

You will be able to download a full copy of the report from -

http://www.thefedonline.org.uk/embrace-information-project

Embrace going forward

- Promoting "It's Local Actually"
- Enabling people to have their needs met within and by the community
- Addressing social isolation
- Providing support for carers
- Maximize volunteering and effective partnership working
- Capitalising on the networking opportunities within communities and neighbourhoods

Thank you for listening

We are happy to take any questions you may have?

Geraldine Desmoulins
Keith Beadle

ADULT CARE & HEALTH COMMITTEE	Agenda Item 11 Brighton & Hove City Council

Subject:		**Finance Report**
Date of Meeting:		**17 June 2013**
Report of:		**Executive Director of Finance & Resources**
Contact Officer:	**Name:**	**Anne Silley** **Tel: 29-5065**
	Email:	**Anne.silley@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report sets out the provisional outturn position for the 2012/13 financial year for Adult Services and NHS Trust Managed S75 Budgets as reported to Policy & Resources on 13 June 2013.

1.2 The report also provides further detail on the agreed 2013/14 budget for Adult Services, NHS Trust Managed S75 Budgets and Public Health

2. RECOMMENDATIONS:

2.1 That the Committee notes the provisional outturn position for Adult Services and NHS Trust Managed S75 Budgets.

2.2 That the Committee notes budget information for Adult Services and NHS Trust Managed S75 Budgets, and Public Health for the 2013/14 financial year.

2.3 That the Committee agrees the proposed reporting timetable and to receive a S75 performance report as indicated to avoid duplication.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

Adult Services Performance (Appendix 1)

3.1 The Targeted Budget Management Reporting Framework focuses on identifying and managing financial risks on a regular basis throughout the year. The table below shows the provisional outturn for Council controlled Adult Services revenue budgets as £1.789 million underspend (2.8%), an increase over month 9 as reported to Policy & Resources Committee on 13 June 2013. The overall Council budget position is shown for information. A more detailed explanation of the variances can be found in Appendix 1.

Forecast Variance Month 9 £'000	Unit	2012/13 Budget Month 12 £'000	Provisional Outturn Month 12 £'000	Provisional Variance Month 12 £'000	Provisional Variance Month 12 %
(114)	Commissioner - People	1,088	1,039	(49)	-4.5%
(1,801)	Delivery Unit - Adults Assessment	47,610	45,452	(2,158)	-4.5%
529	Delivery Unit - Adults Provider	14,496	14,914	418	2.9%
(1,386)	Total Adult Services	63,194	61,405	(1,789)	-2.8%

3.2 The Community Care budget, included within the total Adult Social Care budget above, is classed as a Corporate Critical budget as it carries potentially higher financial risks and therefore could have a material impact on the council's overall financial position. Community Care has underspent by £2.055 million (4.7%) in 2012/13.

Forecast Variance Month 9 £'000	Corporate Critical	2012/13 Budget Month 12 £'000	Provisional Outturn Month 12 £'000	Provisional Variance Month 12 £'000	Provisional Variance Month 12 %
(2,055)	Community Care	43,286	41,231	(2,055)	-4.7%

NHS Controlled S75 Partnership Performance (Appendix 1)

3.3 The NHS Trust-managed Section 75 Services represent those services for which local NHS Trusts act as the Host Provider under Section 75 Agreements. Services are managed by Sussex Partnership Foundation Trust (SPFT) and Sussex Community NHS Trust (SCT) and include health and social care services for Mental Health, Substance Misuse, AIDS/HIV, Intermediate Care and Community Equipment.

3.4 These partnerships are subject to separate annual risk-sharing arrangements and the monitoring of financial performance is the responsibility of the respective host NHS Trust provider. The forecast outturn (after risk share) is an underspend of £0.409 million (2.9%). More detailed explanation of the variances can be found in Appendix 1.

Forecast Variance Month 9 £'000	S75 Partnership	2012/13 Budget Month 12 £'000	Provisional Outturn Month 12 £'000	Provisional Variance Month 12 £'000	Provisional Variance Month 12 %
(601)	Sussex Partnership Foundation NHS Trust (SPFT)	11,485	11,169	(316)	-2.8%
(126)	Sussex Community NHS Trust (SCT)	2,436	2,343	(93)	-3.8%
(727)	Total Revenue - S75	13,921	13,512	(409)	-2.9%

Budget 2013/14 (Appendix 2 & 3)

3.5 The General Fund budget for 2013/14 was agreed at Budget Council on 28 February setting the budget allocation for Adult Social Care (including S75) at £74.807 million after savings of £5.574 million and investment of £1.000 million for service pressures. The breakdown of the budget is set out in the budget book (available on the website in the council finance section)-an extract from the budget book covering Adult Services (which includes NHS Trust managed Section 75 services) is included within Appendix 2.

3.6 The Public Health budget for 2013/14 was agreed at Budget Council on 28 February and is based on the ring fenced grant of £18.2 million awarded by the Department of Health. An extract from the statutory Revenue Account return to the DCLG which shows the budget for 2013/14 against main service areas is attached as Appendix 3.

3.7 The proposed timetable for TBM reports to include contextual information is set out at Appendix 4.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

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

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The financial implications are covered in the main body of the report.

Finance Officer Consulted: Anne Silley Date: 14/05/13

Legal Implications:

5.2 Under the terms of the Council's constitution the annual Budget is set by Full Council. Policy and Resources Committee has overall responsibility for the financial and other resources of the Council. Quarterly reports are provided to Policy and Resources for the purpose of identifying and managing financial risks. This Report, which is for noting only, provides Committee with financial and budget information contained in the most recent quarterly report to Policy and Resources Committee pertaining to Adult Social Care in addition to further information on Adult Social Care budget. This information provides Committee with a context on the overall budget to inform and assist in discharging its functions and decision making on specific recommendations concerning commissioning and delivery of Adult Social Care.
There are no other specific legal or Human Rights Act 1998 implications arising from this Report.

Lawyer Consulted: Sandra O'Brien Date: 20/05/2013

Equalities Implications:

5.3 The process for assessing the equalities implications of the budget changes for 2013/14 and an assessment of the cumulative impact was presented as part of the report to Budget Council.

Sustainability Implications:

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

Crime & Disorder Implications:

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

Risk and Opportunity Management Implications:

5.6 The council maintains general and earmarked reserves and contingencies to cover specific project or contractual risks and commitments.

Public Health Implications:

5.7 Other than in reference to the budget as set out in paragraph 3.5, there are no public health implications arising from this report

Corporate / Citywide Implications:

5.8 The Council's financial position impacts on levels of Council Tax and service levels and therefore has citywide implications.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Not applicable.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The Committee requested detailed financial information on performance.

SUPPORTING DOCUMENTATION

Appendices:

1. Revenue Budget Performance- Adult Social Care and NHS Trust Managed S75 Budgets.

2. Budget Book extract- Adult Social Care

3. Revenue Account extract- Public Health

Documents in Members' Rooms

1. None

2.

Background Documents

1. Targeted Budget Management 2012/13 (outturn) report to Policy & Resources Committee 13 June 2013.

2. General Fund Revenue Budget & Council Tax 2013/14 report to Budget Council 28 February 2013.

People - Revenue Budget Summary

Forecast Variance Month 9 £'000	Unit	2012/13 Budget Month 12 £'000	Provisional Outturn Month 12 £'000	Provisional Variance Month 12 £'000	Provisional Variance Month 12 %
(114)	Commissioner - People	1,088	1,039	(49)	-4.5%
(1,801)	Delivery Unit - Adults Assessment	47,610	45,452	(2,158)	-4.5%
529	Delivery Unit - Adults Provider	14,496	14,914	418	2.9%
(1,386)	Total Adult Services	63,194	61,405	(1,789)	-2.8%

Explanation of Key Variances

Key Variances £'000	Service	Description (Note: FTE/WTE = Full/Whole Time Equivalent)	Mitigation Strategy (Overspends only)
Commissioner – People			
(49)	Commissioner - People	There is an underspend from savings against contracts.	
Delivery Unit – Adults Assessment			
see below	Assessment Services	Assessment Services are reporting an underspend of £2.158m at outturn (representing 4.4% of the net budget), an improvement of £0.357m from Month 09. The underspend is split against client groups as follows:	
(442)	Corporate Critical - Community Care Budget (Older People)	Older People services are reporting an underspend of £0.442m, which is a continuation of the financial trends seen during 2011/12 and builds upon the success of reablement and other initiatives in delivering ongoing efficiencies. The underspend has reduced by £0.763m from Month 09, largely reflecting two one-off adjustments; a contribution to the Adult Social Care long term capacity reserve of £0.348m which is earmarked for proposed conversion works at Craven Vale and a contribution to capital of £0.250m to fund ASC vehicles, thereby saving on unsupported borrowing costs. There was also an increase in actual homecare costs at year-end due to recording of variations in packages of care which will be reviewed	

Key Variances £'000	Service	Description (Note: FTE/WTE = Full/Whole Time Equivalent)	Mitigation Strategy (Overspends only)
		for forecasting purposes in 2013-14.	
(1,647)	Corporate Critical - Community Care Budget (Learning Disabilities)	Learning Disabilities are reporting an underspend of £1.647m due mainly to the full year effect of management decisions taken during 2011/12 and the successful re-negotiation of contracts and the improved identification of appropriate funding streams. The improvement of £0.611m from Month 09 is largely a result of changes in need of 5 placements where funding has transferred to health, which were previously assumed to be a cost against the community care budget (approx. £0.300m) and reductions in expected commitments & growth that has not materialised..	
34	Corporate Critical - Comm. Care Under 65's	Under 65's are showing an overspend of £0.034m, which is an improvement of £0.152m from Month 09 reflecting a reduction in expected demand and further savings made against the financial recovery plan.	
(103)	Support & Intervention Teams	The underspend is largely from vacancy management savings achieved across the service.	
Delivery Unit – Adults Provider			
418	Provider Services	Provider Services are showing an overspend of £0.418m (representing 2.9% of the net budget) which is an improvement of £0.158m from Month 09. The overspend is mainly from the shortfall in delivery of budget strategy savings on Learning Disabilities Accommodation (£0.311m) as a result of the deferment of a decision at the June meeting of Adult Care & Health Committee, with a further proposal accepted at the September meeting of the Committee and and a delay in developing proposals on day activities. The improvement over Month 09 relates to an improved level of non residential client contributions which has helped mitigate the shortfall in delivery of budget strategy savings.	

NHS Trust Managed S75 Budgets - Revenue Budget Summary

Forecast Variance Month 9 £'000	S75 Partnership	2012/13 Budget Month 12 £'000	Provisional Outturn Month 12 £'000	Provisional Variance Month 12 £'000	Provisional Variance Month 12 %
(601)	Sussex Partnership Foundation NHS Trust (SPFT)	11,485	11,169	(316)	-2.8%
(126)	Sussex Community NHS Trust (SCT)	2,436	2,343	(93)	-3.8%
(727)	Total Revenue - S75	13,921	13,512	(409)	-2.9%

Explanation of Key Variances

Key Variances £'000	Service	Description (Note WTE = Whole Time Equivalent)	Mitigation Strategy (Overspends only)
Sussex Partnership Foundation NHS Trust			
(316)	SPFT	Sussex Partnership Foundation NHS Trust (SPFT) finished the year with an underspend of £0.632m, which was a slight improvement from Month 9. The budget strategy savings target of £0.326m was fully achieved. On top of this, savings of £0.308m were achieved against the mainstream budget from robust vacancy management and tight budgetary control and a further £0.329m from the community care budget as a result of increased funding through the assessment process and robust review of all placements. There continues to be pressures against the Adult Mental Health Community Care budget from a lack of suitable accommodation, which has been highlighted as part of the budget process for 2013/14. In line with the agreed risk-share arrangements for 2012/13 the underspend has been shared 50/50 between SPFT and BHCC.	
Sussex Community NHS Trust			
(93)	SCT	Sussex Community NHS Trust (SCT) are showing an overspend of £0.146m against two services-ICES (£0.070m) from increased demand for equipment and Intermediate Care services (£0.076m) from staffing pressures. This is offset by the underspend against the HIV budget of £0.239m is a continuation of the position from 2011-12 for services now managed by Assessment services.	

Adult Services

Adult Social Care Commissioners

- The Adult Social Care Commissioners and commissioning support team cover (including allocation of resources to or major procurement of) over 90% of adult social care services which are delivered by the private and voluntary sector in the city. The commissioners work jointly with corporate and NHS colleagues to ensure a consistent and joined up approach to services. The Commissioning Support Team deal with the social care performance, quality and service development areas as well as supporting the commissioners.

Adult Assessment

- Access, Assessment and Review Services - These services provide the statutory assessment and review functions for Adult Social Care. As a result of the assessment, the service has a duty to meet assessed needs within Fair Access to Care (FACS) criteria. The service also undertakes the Council's lead responsibility for Safeguarding Adults at Risk.
- Community Care - Statutory services arranged through the independent sector to around 3,000 vulnerable people with frailty, mental ill health, disability and those with drug and alcohol misuse issues. The authority has a duty under the NHS and Community Care Act (1990) to assess needs and provide services to meet those assessed needs.

Adult Provider

- Care and support services for older people, older people with mental health needs and people with a learning disability which enable people to continue to live independently in their own home or within our specialist accommodation.
- Services include Residential and Supported living, Day Services and Day Options, Carelink Plus community alarms and tele-care services, respite and short term breaks to support carers, support to improve independence following illness or crisis within our short term beds services, Community Support, support for families providing homes for disabled people (Shared Lives), Independence at Home - short term homecare services to promote independence and support for people leaving hospital to return home, and provision of care within extra care housing facilities.
- Support for disabled people to gain work experience, training and volunteering experience, and to obtain and maintain employment. Supported Business (able and willing) which directly employs disabled people in printing and embroidery production.

Adult Services - Revenue Budget Summary

2012/13		2013/14 Budget				
Net Expenditure / (Income) £'000	Service Area	Expenditure £'000	Income £'000	Budget Allocation £'000	Capital Charges & Recharges £'000	Net Expenditure / (Income) £'000
1,082	Adult Social Care Commissioners	5,547	(4,850)	697	(1,088)	(391)
66,696	Adult Assessment	81,628	(21,224)	60,404	2,721	63,125
15,734	Adult Provider	19,506	(5,800)	13,706	2,810	16,516
83,512	**Total**	**106,680**	**(31,873)**	**74,807**	**4,443**	**79,250**

Adult Services - Capital

Capital Scheme	Budget 2013/14 £'000
Adult Social Care Commissioners	
Adult Social Care IT Infrastructure Grant	75
Social Care Reform Grant	62
Adult Social Care Commissioners Total	**137**
Adult Provider	
Craven Vale Development	1,442
Learning Disability Accommodation	354
Telecare - Adults Provider	50
Adult Provider Total	**1,846**
ADULT SERVICES TOTAL	**1,983**

Adult Services – Service Pressures Funded

Service	Service Pressure Investment Area	Amount £'000
Adult Assessment	Adult social care - particularly in relation to demographic pressures on learning disability transitions and mental health services.	942
Adult Provider	Adult social care - particularly in relation to demographic pressures on learning disability transitions and mental health services.	58
ADULT SERVICES TOTAL		**1,000**

Adult Services – Savings Included in 2013/14 Budget

Service	Description of Saving Opportunity	Savings identified 2013/14 £'000
Adult Social Care Commissioners		
Service Strategy	Review of support services to include commissioning, performance and development and contract management.	50
Across all Adults Commissioning areas	Review of all contracts for services as part of commissioning plans and where appropriate re-specify contracts to meet changing needs. Focus on prevention/early intervention.	150
Support & Intervention Teams (Over 65)	Review and re-specify Community Meals in the context of personalisation and the range of options that are currently available. The design process has included the Adult Social Care & Health Overview & Scrutiny Committee which held a workshop in January 2012.	50
Adult Social Care Commissioners Total		**250**

Adult Services – Savings Included in 2013/14 Budget Continued

Service	Description of Saving Opportunity	Savings identified 2013/14 £'000
Adult Assessment		
Support & Intervention Teams (Over 65)	Jointly commissioned with housing to deliver extra care capacity to meet the need identified in the city. Plan to reduce the number of people placed in residential care - options to include the use of Sheltered Accommodation / Extra Care Housing, 'Shared Lives' and other accommodation.	1,640
Learning Disabilities	Develop proposals to implement the Learning Disabilities accommodation and support strategy and consult on the options. Look to utilise the capacity in the city and operate a robust and appropriate service. Key areas: - Supporting move on to greater independence by increasing low level supported living options and modernising 'shared lives'. - Remodel services to provide short term crisis support and for those with the most complex needs to reduce out of area respite and emergency placements.	150
Across all client groups	Community Care. Scope potential to increase move on by: - Further focus on reablement activities - Short term interventions - Prevention activities - Better use of Telecare - Better use of in-house residential services - Improved short term services - Continue to maximise sources of funding/income A stretch target of £500k has been included over what was originally planned.	2,284
Across the whole of the service	Look at options for re-modelling staffing arrangements in Assessment Services.	340
Across all client groups	Home Care recommissioned to a new specification and contract let from 1 June 2012. Ongoing impact following introduction of the Electronic Care Monitoring System.	170
Adult Assessment Total		**4,584**

Adult Services – Savings Included in 2013/14 Budget Continued

Service	Description of Saving Opportunity	Savings identified 2013/14 £'000
Adult Provider		
Learning Disabilities	Develop proposals for the in house service to implement the Learning Disabilities accommodation and support strategy and consult on the options. In house service to refocus on short term crisis intervention and those with the most complex needs. Potential capital receipts for the Council when properties become vacant which may need to be reinvested in alternative service provision. - Reduce unit costs - In-house service to focus on those with the most complex needs.	465
Learning Disabilities and Support & Intervention Teams (Over 65)	Day Activities. Option appraisal is in development with focus on in-house building based day activities and contract for services provided in the independent sector. Proposal to be developed for consultation.	150
Learning Disabilities and Support & Intervention Teams (Over 65)	Explore future models for delivery of services that deliver statutory services in the most cost effective way, and explore models of provision for non statutory services for vulnerable people. The savings associated with this could be across both the provider and assessment service.	125
Adult Provider Total		**740**
ADULT SERVICES TOTAL		**5,574**

Adult Services – Breakdown of Service Budget

Service Description	Employee Expenditure	Other Expenditure	Total Expenditure	Income From Customers & Clients	Income From Other External Bodies	Government Grants	Total Income	Total Budget Allocation	Capital Charges & Recharges	Total Revised Budget
	£	£	£	£	£	£	£	£	£	£
Adult Social Care Commissioners										
Adult Mental Health	0	570,390	570,390	(11,090)	0	0	(11,090)	559,300	33,240	592,540
AIDS	0	245,210	245,210	0	0	0	0	245,210	6,020	251,230
Learning Disabilities	0	130,810	130,810	0	0	0	0	130,810	6,490	137,300
Older People Mental Health	0	0	0	0	0	0	0	0	250	250
Service Strategy	1,488,530	1,736,770	3,225,300	(2,650)	(4,835,840)	0	(4,838,490)	(1,613,190)	(1,202,280)	(2,815,470)
Substance Misuse	0	0	0	0	0	0	0	0	530	530
Support & Intervention Teams (Over 65)	250	1,304,620	1,304,870	0	0	0	0	1,304,870	66,000	1,370,870
Support & Intervention Teams (Under 65)	0	70,000	70,000	0	0	0	0	70,000	2,200	72,200
Adult Social Care Commissioners Total	**1,488,780**	**4,057,800**	**5,546,580**	**(13,740)**	**(4,835,840)**	**0**	**(4,849,580)**	**697,000**	**(1,087,550)**	**(390,550)**
Adult Assessment										
Adult Mental Health	1,431,953	5,785,074	7,217,027	(1,338,440)	(232,180)	0	(1,570,620)	5,646,407	386,890	6,033,297
AIDS	40,547	135,900	176,447	(9,460)	0	0	(9,460)	166,987	8,580	175,567
Integrated Community Equipment Store	167,703	487,951	655,654	0	0	0	0	655,654	33,820	689,474
Intermediate Care	962,382	269,547	1,231,929	0	(792,743)	0	(792,743)	439,186	72,690	511,876
Learning Disabilities	792,626	24,442,611	25,235,237	(1,743,190)	(88,780)	0	(1,831,970)	23,403,267	919,490	24,322,757
Older People Mental Health	901,377	11,291,194	12,192,571	(3,836,900)	(2,753,743)	0	(6,590,643)	5,601,928	490,160	6,092,088
Service Strategy	1,170,539	(321,226)	849,313	(23,500)	(46,990)	0	(70,490)	778,823	(1,037,910)	(259,087)
Substance Misuse	214,618	133,510	348,128	(35,140)	(126,218)	0	(161,358)	186,770	11,970	198,740
Support & Intervention Teams (Over 65)	4,632,937	20,614,171	25,247,108	(8,308,300)	(612,830)	0	(8,921,130)	16,325,978	58,380	16,384,358
Support & Intervention Teams (Under 65)	0	8,474,300	8,474,300	(1,275,300)	0	0	(1,275,300)	7,199,000	1,777,320	8,976,320
Adult Assessment Total	**10,314,682**	**71,313,032**	**81,627,714**	**(16,570,230)**	**(4,653,484)**	**0**	**(21,223,714)**	**60,404,000**	**2,721,390**	**63,125,390**
Adult Provider										
Learning Disabilities	7,865,570	145,711	8,011,281	(1,130,700)	(880,110)	0	(2,010,810)	6,000,471	1,697,720	7,698,191
Service Strategy	601,420	(266,390)	335,030	0	0	0	0	335,030	(490,890)	(155,860)
Support & Intervention Teams (Over 65)	9,189,250	974,929	10,164,179	(1,756,530)	(1,824,510)	0	(3,581,040)	6,583,139	1,493,840	8,076,979
Supported Employment	802,940	192,320	995,260	(207,900)	0	0	(207,900)	787,360	108,960	896,320
Adults Provider Total	**18,459,180**	**1,046,570**	**19,505,750**	**(3,095,130)**	**(2,704,620)**	**0**	**(5,799,750)**	**13,706,000**	**2,809,630**	**16,515,630**
ADULT SERVICES TOTAL	**30,262,642**	**76,417,402**	**106,680,044**	**(19,679,100)**	**(12,193,944)**	**0**	**(31,873,044)**	**74,807,000**	**4,443,470**	**79,250,470**

Revenue Account Return - Public Health Budget 2013/14

		EXPENDITURE		
		Net current expenditure	Capital charges	Net total cost excluding specific grants
		£ 000	£ 000	£ 000
		(1)	(2)	(3) = (1) + (2)
PUBLIC HEALTH				
361	**Sexual health services** - STI testing and treatment (prescribed functions)	3,328	0	**3,328**
362	**Sexual health services** - Contraception (prescribed functions)	456	0	**456**
363	**Sexual health services -** Advice, prevention and promotion (non-prescribed functions)	1,491	0	**1,491**
365	**NHS health check programme** (prescribed functions)	436	0	**436**
366	**Health protection -** Local authority role in health protection (prescribed functions)	76	0	**76**
368	**National child measurement programme** (prescribed functions)	101	0	**101**
370	**Public health advice** (prescribed functions)	426	0	**426**
371	**Obesity** - adults	567	0	**567**
372	**Obesity** - children	116	0	**116**
373	**Physical activity** - adults	188	0	**188**
374	**Physical activity** - children	243	0	**243**
376	**Substance misuse** - Drug misuse - adults	4,478	0	**4,478**
377	**Substance misuse** - Alcohol misuse - adults	978	0	**978**
378	**Substance misuse -** (drugs and alcohol) - youth services	108	0	**108**
380	**Smoking and tobacco** - Stop smoking services and interventions	733	0	**733**
381	**Smoking and tobacco** - Wider tobacco control	69	0	**69**
383	**Children 5–19 public health programmes**	1,737	0	**1,737**
385	**Miscellaneous public health services**	2,654	0	**2,654**
390	**TOTAL PUBLIC HEALTH (total of lines 361 to 385)**	**18,185**	**0**	**18,185**
NOTE	**Public Health Grant**	18,185		18,185

Timetable for Finance Reports

ACH meeting date	TBM Month	JCB	ACH
17 June 2013	TBM Outturn	Included	Yes
23 September 2013	TBM 3	Yes	No
25 November 2013	TBM 5	Combined	Combined
20 January 2014	TBM 7	Combined	Combined
17 March 2014	TBM 9	Combined	Combined

Note: Timetable will be updated for reporting budget information for 2014/15

ADULT CARE & HEALTH COMMITTEE	Agenda Item 12 Brighton & Hove City Council

Subject:		**Day Activities Review Progress Report**
Date of Meeting:		**17th June 2013**
Report of:		**Executive Director of Adult Services**
Contact Officer:	**Name:**	**Anne Richardson-Locke Tel: 29-0379**
	Email:	**Anne.Richardson-Locke@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE/ EXEMPTIONS

1. SUMMARY AND POLICY CONTEXT:

1.1 This report sets out the progress that has been made in the Day Activity Review since the last Committee report in March 2013 and concentrates on developments in the Council day services for people with a learning disability

1.2 At the March committee, members noted:

- The increase in demand for different community based day opportunities.
- That more flexibility in existing day services was required to promote independence and to support carers.
- The need for individuals to have a personalised day service.

1.3 This report provides an update on how developments have affected the Council provided learning disability Day Options service and in particular the Buckingham Road day centre. An update on the Connaught day centre is provided in a separate report to Committee.

2. RECOMMENDATIONS:

2.1 That Committee note the progress of the Day Activities Review and the proposals for the changes to the Council provided services.

2.2 That Committee agree to the proposal to return with a further progress report in November 2013.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The Day Activities Commissioning Plan was presented to Adult Care & Health Committee in November 2012 and the Joint Commissioning Board in January 2013 and a new Vision for day activities was agreed by Members. A progress report was presented to Adult Care & Health Committee and the Joint Commissioning Board in March 2013 and it was agreed that a further progress report would be presented in June.

3.2 The Vision for day activities is of a modern, flexible day options model that provides personalised care and support and makes the best use of localised community activities. Whilst the majority of users of day centres are satisfied with their service there is still a limited choice of activities and a lack of personalised day options. Day service providers are exploring how they can offer more flexible opening times, wrap around services, employment and voluntary opportunities and make the best use of community resources as well as their own buildings.

3.3 This report focuses on the changes taking place to Council provided day services for people with a learning disability. The report also gives information on the social care assessments that are currently taking place for individuals to ensure that they have personalised day options. This report's focus is due to the concentration of activity in these two areas since the last report to Committee in March and is particularly in light of the proposed changes to the Buckingham Road and Connaught day centres.

4. COUNCIL PROVIDED DAY OPTIONS SERVICE

4.1 The Vision for Day Activities sets out the need for Council provided services to focus on supporting the people with the most complex needs. The Day Options service currently supports approximately 132 people with learning disabilities across four bases and is currently running to capacity.

4.2 The November committee report highlighted the importance of making the best use of council resources (including staff skills and buildings). Members agreed with the recommendations that the Day Options service will refocus its provision to concentrate on people with a learning disability and complex physical health and / or challenging needs.

4.3 The service will make the best use of the buildings and staff expertise and support those people with the most complex needs and create pathways to enable people to move on, where possible. Life skills and work skills programmes are in great demand, particularly with younger people coming through transitions. Capacity is needed as it is predicted that there will be 12% increase in the number of people with severe or moderate learning disabilities by 2030.

4.4 Resources within the Day Options service will be focused in the following areas :

- **Profound and multiple learning disabilities (PMLD)** - to enable people with PMLD to learn, achieve and be actively involved in their community.
- **Challenging needs** – to enable people with challenging needs to learn, achieve and be actively involved in their community and to provide an assessment function for people who may require support before moving on to new opportunities.
- **Work skills** – to provide a work environment that promotes skill development and work ethics.
- **Life skills** – to enable people to learn the skills they need to live the life they choose.

4.5 A new programme of activities will be introduced in September 2013 which will incorporate the four areas detailed above. In addition to this, there will also be a leisure activity offered each day. It is recognised that leisure activities are important to people and that they provide opportunities for social and communication skills to develop and for friendship groups to form. The leisure activities that will continue are those that already have links with the community, for example 'In the gym' which takes place in the community, yoga which is facilitated by an external trainer, a singing group and 'knit and natter'.

4.6 Day Options will also develop a support co-ordination service that will enable people, either individually or in groups, to use community based activities. A co-ordinator will work closely with service users and the assessment team and providers to identify what services and activities are needed to bring groups of people together over the City or to link individuals into community activities, within assessed resources.

4.7 Day Options staff and commissioners will work together with colleagues in Sports Development and the independent sector to look at which leisure activities currently being provided by Day Options might be accessed differently elsewhere, for example swimming, as well as exploring any that might become self-sustainable. People with learning disabilities have expressed concern about the accessibility of community activities (see section 7.3 for more detail) and there is work ongoing with the independent sector to look at access to mainstream activities as well as exploring the use of volunteers in linking, introducing or accompanying people to activities.

4.8 A Care Manager is in post and two social workers are being recruited to carry out assessments of people whose needs are not currently being met in their day service, of those people affected by any other changes to day services and of those service users whose needs could be met in a more person- centred way.

4.9 To date there have been 16 assessments completed and the care manager has worked closely with the service users, their carers, advocates, the day service staff and staff where they live if they are in residential care to ensure that an alternative service meets their needs. Service users' needs were not being met for a variety of reasons that include, for instance, incompatibility with other day service users, too long a day for service users who are getting older, ability level for activities too high or too low.

4.10 Two examples of how changes have improved the outcomes for people's day activities are detailed below (names are changed to protect peoples' privacy):

Reason for reassessment and current provision	**New provision**
John lives in supported living and attends a day service for four days a week. Although he needs support due to a physical disability he is currently at a day service where there are people with much higher support needs. John is keen to do voluntary or	John will no longer attend the day centre for three days a week and instead will receive an additional 10 hours of support a week from his supported living provider to support him to access voluntary work and community based activities. He

paid work.	particularly wants to assess the accessibility of services for people with disabilities and will be supported to do this. John will retain one of his current activities whilst the transition happens and it involves giving information to other people with learning disabilities which links with his work ambitions.
Sally lives in supported living and attends a day service for four days a week. Sally wants to link more with other young women in a similar situation to herself, do some voluntary work and work skills and wants to eventually work in catering. She also wants to access sports and leisure activities in the community.	Sally will no longer attend the day centre but will access cookery sessions and a work skills course for two half days elsewhere. Sally's supported living provider will provide 1:1 support within the current support package. This will be to help Sally access health related activities such as health walks and swimming. Sally will also be supported to run a monthly coffee morning for other people with similar conditions to help her meet new people.

4.11 The assessment team will ensure that activities are grouped together wherever possible to enable friendship groups to continue or new friendships to flourish. Residential care providers have been keen to provide some activities themselves or open their doors to personal assistants or day activity providers who can provide activities on or off site for groups or individuals.

4.12 A self-directed support working group has been established in order to review systems and access to direct payments and personal budgets. A reference group has also been set-up to review the supporting information to ensure that it is accessible.

5 BUCKINGHAM ROAD AND CONNAUGHT DAY CENTRES

5.1 **Buckingham Road day centre** is currently the site for three popular work-based activities; Feast, Our Art Collective and the recycling project Can It. The building has been earmarked for disposal under Phase 3 of the Workstyles Programme and therefore staff have been working closely with service users and carers to identify alternative sites for these activities. The following locations have been successfully identified:

5.1.1 'Can It!' is a recycling project that washes and crushes cans and sorts and recycles various products. It is proposed that the bulk of the service will move to Wellington House. The bottle top element of the recycling project is moving to the Whitehawk Green Centre on one day a week which would mean a positive increase in community presence for those service users. In addition to linking with the community more, the recycling that takes place at the centre will have a cost benefit for local charities.

5.1.2 'Our Art Collective' is an art project that provides opportunities for people to produce and exhibit their own art. This activity needs a large space as the mediums include printmaking and pottery and artists need room to store and produce their work. It is proposed that Our Art will move to Belgrave day centre.

5.1.3 'Feast' is a popular catering project where people can be supported to complete food safety training, plan menus, shop, prepare and cook lunches for day centre attendees and also occasionally cater for other events. It is proposed that Feast will move to Wellington House day centre.

5.2 The decision to dispose of Buckingham Road day centre will be taken at the Policy and Resources Committee in July. Feedback from the current service users (which is set out in more detail in section 6 of this report) will be incorporated into that report to inform that decision.

5.3 The proposed change to the delivery of the learning disability day options service does mean that some capital expenditure will be required in the short term. Day Options staff are working closely with Property and Design Services to confirm the cost of any capital works needed at Wellington House and Belgrave day centre. In addition ICT are looking at any costs of equipment and installation. Estimates for work to be undertaken are being sought at present and will be detailed in the November Committee report.

5.4 **Connaught day centre** building is required by Education from January 2014 to provide additional school places for children at the West Hove Infants School (Connaught Annex). Patcham House School has been proposed as an alternative site for the day service and service users and carers that use the Connaught day centre are currently being consulted about the alternative site. There are more details in the Connaught report also being presented at the June Committee.

6. COMMUNITY ENGAGEMENT AND CONSULTATION

6.1 Speak Out, an independent advocacy organisation held three meetings with 44 people with learning disabilities in March and April. 27 of these people attend the Council's Day Options service and 17 access activities in the independent sector. The meetings focused on changes to the use of day centre buildings, barriers to accessing universal and mainstream services and ideas of what activities people would like to do.

6.2 Changes to the Day Options service**:** Concerns were expressed by users of Buckingham Road around changes to friendship groups, travel to alternative locations and sadness about leaving the building. People expressed the need for regular updates and accessible information and wanted reassurance the activities would continue at another site. With regard to wider changes people were worried that there would not be enough money in a personal budget to do the things that they want to do and that there might be less space on supported and voluntary employment schemes. On the positive side, some people are keen to meet new people, want to do more in the community and like the variety of attending different locations.

6.3 Barriers to using universal and mainstream services: People with mild learning disabilities expressed some concern about using mainstream community activities due to safety, fear of going on their own, concern that workers there would not understand their needs, lack of knowledge of what is available and how to get there. People tend to favour specialist community projects as they described them as user friendly, collective and welcoming.

6.4 Activities people want to do:

- More leisure activities e.g. cinema, football, bowling, walking, power lifting.
- Meet friends at day centres or out in the community.
- Getting involved in services or local organisations e.g. self-advocacy, being involved in meetings, projects and interviewing staff.
- Learning and life skills.
- Evening and weekend activities.
- Arts and Crafts.
- Work and employment.

6.5 Staff at Buckingham Road day centre have been working closely with service users to identify alternative locations for the activities that currently take place there. Service users have been able to identify what is important to them in alternative locations and visit potential sites and contribute to risk assessments.

Examples include:

- Can It groups have visited Wellington House to discuss what they will need and have been able to visit the Green Centre in Whitehawk.
- People who attend computer groups at Belgrave have produced photos of rooms for the Our Art users so that they can visualise the space and artists also have a large scale floor plan of Belgrave in the studio to help plan where the activities will go.
- Each day centre has posters detailing the changes to promote discussion.
- 'Chatterbox' is a newsletter produced by people with learning disabilities which will be used to present the views of Day Options service users.
- 'DOUG' (Day Options User Group) are planning to gain feedback from everyone by putting boxes out around day centres and asking what people think about the changes.

6.6 Feedback from Speak Out is that the Buckingham Road service users have a good level of awareness of what the future plans for the service are.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 The current 2013/14 gross budget for Day Services is £4.8 million, of which £2.9 million is allocated to in-house services and £1.9 million to independent sector provision. The highest spend area is Learning Disabilities with a gross budget of £3.4 million across both in-house and external providers, representing 72% of the budget.

This progress report concentrates mainly on the provision of day services for Learning Disability clients. Funding has been identified for the care manager and social worker posts referred to in paragraph 4.8 of this report. The 16 assessments completed to date are part of the plans that are still being developed to identify future needs and the detailed financial implications of revenue and capital costs will be provided in the next committee report.

Financial implications regarding proposals for the Connaught day centre are included in the separate report also included on this agenda.

Finance Officer Consulted: Neil Smith Date: 04/06/13

Legal Implications:

7.2 This report provides an update to Committee and is for noting only. As described in the body of the report the decision regarding disposal of Buckingham Road is be made by Policy and Resources Committee in July. The views of potentially affected users of Buckingham Road and Equalities implications as a result of the proposed closure must inform that decision.

There are no other specific legal or Human Rights Act implications arising from this report.

Lawyer Consulted: Sandra O'Brien Date:05.06.2013

Equalities Implications:

7.3 The Day Activities Review is expected to have a positive equalities impact by promoting access to activities that are relevant and appropriate to meet an individual's support needs as identified in a full social care assessment.

7.4 An Equalities Impact Assessment on the Day Options service is in progress and is regularly updated as the remodelling of the service progresses. The current Equalities Impact Assessment is available for Members to view on request.

Sustainability Implications:

7.5 The Vision highlights better use of resources including buildings and transport and advocates for the co-production of any future services with service users, carers and providers resulting in a more sustainable model of provision.

Crime & Disorder Implications:

7.6 The Vision and changes to day services will promote social inclusion for people from all client groups through supporting increased access to mainstream services and participation as equal citizens in the community.

Risk and Opportunity Management Implications:

7.7 The Day Activities Commissioning Board is overseeing the risk management of the Day Activities Review to ensure that risks are carefully considered.

Public Health Implications:

7.8 Adult Social Care has clear interconnection with the wider public health agenda and the proposed Vision reinforces the aim to support equality, health and well-being in the city.

Corporate / Citywide Implications:

7.9 The Vision will increase access to mainstream and universal services available locally and so enable people to participate more fully in the city.

8. EVALUATION OF ANY ALTERNATIVE OPTION(S):

8.1 The alternative option is for Council provided day services to remain as they are. The impact of this would be that Day Options would not be able to support the increased numbers of people with learning disabilities and complex needs and service users and carers would not benefit from more flexible, personalised provision.

9. REASONS FOR REPORT RECOMMENDATIONS

9.1 This report follows the agreed recommendations noted in the November 2012 report to Adult Care & Health Committee with regard to the Day Activity Review. This report is for noting progress made on those recommendations.

SUPPORTING DOCUMENTATION

Appendices: None

ADULT CARE & HEALTH COMMITTEE	Agenda Item 13 Brighton & Hove City Council

Subject:		**Connaught Day Service**	
Date of Meeting:		**17th June 2013**	
Report of:		**Executive Director Adult Services**	
Contact Officer:	**Name:**	**Naomi Cox**	**Tel: 29-6400**
	Email:	**naomi.cox@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE/ EXEMPTIONS

1. SUMMARY AND POLICY CONTEXT:

1.1 In October 2012 the Childrens and Young Persons Committee received a report which recommended the expansion of West Hove Infants School to enable to the council to provide the increased number of primary school places required in the Hove area.

1.2 To facilitate this expansion the relocation of the Connaught Day Service for adults with learning disabilities would be required.

2. RECOMMENDATIONS:

2.1 That Committee Note the Decision to consult users of the Connaught Day Service on the proposed new site at Patcham House School made by the Executive Director of Adult Services in consultation with the Committee Chair Cllr Jarrett.

2.2 That Committee Approve the proposal of the Executive Director of Adult Services to use her Constitutional Delegated Powers to make a decision concerning the proposed move of the Day Service from the Connaught Building to Patcham House School informed by the consultation process, EIA and related Decision of the extraordinary meeting of the Children and Young People's Committee proposed for 9 September 2013.

2.3 Where recommendation 2 is not approved, approve the convening of an extraordinary meeting of Adult Care and Health Committee to take place shortly after the proposed extraordinary meeting of Children and Young People's Committee on 9 September to consider recommendations and make a decision regarding the proposed move of the Day Service from Connaught Building to Patcham House School.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Connaught Learning Disability Day Options Service currently provides a service for 20 people with a range of complex needs including challenging behaviours.

3.2 In the light of the councils requirement for an increase in primary school places in the Hove area Officers from Adult Social Care Provider Services and Education Services and have worked closely together to identify potential options for a relocation of the Connaught Day Options Service.

3.3 The proposal is that the education provision for the younger cohort of pupils at Patcham House School is relocated to Downs Park School from September/ October 2013. This will enable some remodelling of the Patcham House site to facilitate continued provision for young people in key stage 4 at Patcham House and will release part of the building for the relocation of Connaught Day Options Service.

3.4 The current proposed timescale for these changes is that Connaught Day Options would move to the Patcham House site in January 2014. This fits with the requirement that the expanded West Hove Primary School is ready by September 2014.

3.5 On 16 May 2013 the Interim Executive Director for Children's Services in consultation with the Chair of the Children and Young People Committee made the decision under Delegated Authority to agree to the consultation of pupils, parents, carers and staff regarding the proposed move of Patcham House Key Stage 3 pupils to the Downs Park school site. It is understood the timing of this decision was to enable proposed building alterations and pupil moves in the context of timescales imposed by education legislation.

3.6 In the interests of fairness, to ensure that we were able to match the Children and Young Peoples Services consultation launch and ensure Connaught Service Users and Carers properly learned of the proposed changes from officers in Adult Social Care, in consultation with the Chair of Adult Care and Health Committee Cllr Rob Jarrett, the Executive Director of Adult Services using her constitutional Delegated Authority approved the decision to consult regarding the proposed move on the same day. The duly approved Delegated Authority form is shown as **Appendix 1.**

3.7 A letter was sent out to service users and carers on 17th May 2013. The letter outlines the reason for the proposed relocation, provides some information about Patcham House and the locality including a photograph and a map. The letter includes a feedback form for service users and carers to give their views and ask any questions they might have. Service Users and carers have also been invited to an Open Day at Patcham House so they can view the site and the space that will be available for use by adult care day options service users. A copy of that letter can be found at **Appendix 2.**

3.8 Officers from Adult Social Care are working closely with colleagues in Education and Property and Design to ensure that the space available at the Patcham House site will meet the needs of day service users and the Key Stage 4 pupils. Each will have their own clearly defined and separate spaces to ensure both services can be provided safely on the site. Adaptations will be required to facilitate this.

3.9 The proposed Patcham House site is situated in Patcham Village with local shops, post office, pub, library and recreation ground. The area is served by a frequent bus service to London Road and onwards into the centre of the city. Depending on where service users live some would be nearer to the Patcham House site whilst for others this would entail a longer journey.

3.10 Subject to appropriate Committee approvals staff will work with service users and carers to develop individual transitions plans for service users to ensure successful transitions to the new site.

3.11 All Connaught service users will be offered a reassessment of their needs. Family carers will be fully involved in the reassessment process as will staff who know the service users well.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 All current Connaught Day Options service users and their carers were sent a letter explaining the proposal; inviting them to an open day on 29th June 2013 at Patcham House and seeking their views regarding the proposed relocation.

4.2 Service Users and Carer views will be collated at the end of the consultation period which is due to end on 28th August 2013.

4.3 Officers will answer queries and questions raised by service users and carers as part of the consultation process and will ensure regular communication via a news letter with the opportunity to meet with officers to discuss any specific concerns.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The current 2013/14 gross revenue budget for the In-House Learning Disabilities Day Options is £1.9 million, which includes Connaught Day Centre and the 3 other Learning Disabilities Day Centres

Detailed financial implications for the capital costs and funding for the remodelling of the Patcham House site will be available once the proposals are further developed and will be reported to Policy & Resources Committee for approval, if appropriate, in due course

The financial implications on the revenue budgets are also still being quantified and will be included in the Day Activities Review which is currently being carried out. A progress report for this Review is included elsewhere on this agenda

Finance Officer Consulted: Name Neil Smith Date: 04/06/13

Legal Implications:

5.2 Paragraph 7 (2)(a) Part A, Part 6.2 of the Council's Constitution contains the following power: *After consultation with the Chair (or in his / her absence, a Deputy Chair) of the relevant Committee or Sub-Committee, to exercise any of the functions within the service area of the officer in cases of urgency where it is not reasonably practicable to obtain prior approval of a Committee or Sub-Committee.*
7(2)(b) provides for the action to be reported, as appropriate, to the Committee or Sub-Committee.
As described in the body of this report the timing of the decision within Children's Services to consult was a reflection of the legislative requirements for consultation on Educational matters in the context of the proposals to move pupils and undertake adaptations in time for the expanded school admission deadline.
The direct link between the proposals of Children's Services and Adult Services resulted in it being essential to ensure the different consultation processes took place in parallel. In circumstances where the recommendation to consult was brought to Committee the resulting time lapse between one element of the potentially affected community being consulted and the other not would have been just, fair or transparent. Therefore once information was received regarding the Children's Services decision immediate action was taken to avoid this by application of the urgency powers described above.
Committee is provided with a Record of the Decision in compliance with paragraph 7 (2) (b).
Committee is further asked to approve the Executive Director making a decision regarding the proposed move of Connaught Day Service following the completion and consideration of the consultation exercise and the related decision by Children and Young People Committee at the proposed extraordinary meeting in September 2013. If Committee does not approve this proposal then to ensure adherence to timing an extraordinary meeting will be required after the Children and Young People Committee meeting in September.
In preparing, undertaking and considering the Consultation exercise, EIA and proposals for a new location for the Connaught Day Service Human Rights Act 1998 implications for the affected individuals must be taken into account.

Lawyer Consulted: *Name Sandra O'Brien* *Date: 04/06/2013*

Equalities Implications:

5.3 An Equalities Impact Assessment has been carried out as part of the Review of Day Activities.

Sustainability Implications:

5.4 There will be energy efficiencies from the co-location.

Crime & Disorder Implications:

5.5 There are no specific implications in relation to the Councils duty to prevent Crime and Disorder.

Risk and Opportunity Management Implications:

5.6 The Day Activities Commissioning Board is overseeing the risk management of the Day Activities Review to ensure that risks are carefully considered.

Public Health Implications:

5.7 Adult Social Care has clear interconnection with the wider public health agenda and the proposed Vision reinforces the aim to support equality, health and well-being in the city.

Corporate / Citywide Implications:

5.8 The relocation of Connaught Day Options Service supports the city priority to increase primary school places in the Hove area. Relocating to the Patcham House site enables Adult Care to continue to provide a day service for people with learning disabilities and complex needs.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 The Connaught Day Service could not be relocated into the remaining Day Services buildings due to lack of space for this specialist service. There were initial proposals that Downs Park School be considered as a potential relocation option. Patcham House however offers a better site with the premises all being on one level.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 To inform Committee of the Decision taken by the Executive Director of Adult Care in compliance with the Constitution and to seek a decision on the process for determining the outcome of the consultation and related Children's Services decision.

SUPPORTING DOCUMENTATION

Appendices:

1. Record of Decision taken by Executive Director Adult Services 16.5.13

2. Letter to Connaught Service Users and Carers dated 17.5.13

Background Documents

1. Day Activities Review Progress Committee Reports March 2013 & June 2013.

Decision No.01: Adult Services

Executive Director of Adult Services
Denise D'Souza

Date: 16 May 2013

This record relates to decisions taken by officers under Delegated Authority

RECORD OF DECISION TAKEN BY THE EXECUTIVE DIRECTOR OF ADULT SERVICES

DATE OF DECISION: **16/05/13**

DECISION-MAKER: Denise D'Souza

SUBJECT: **MOVE OF CONNAUGHT DAY OPTIONS SERVICE AT THE CONNAUGHT CENTRE [WEST HOVE INFANT SCHOOL CONNAUGHT ANNEX] TO PATCHAM HOUSE SCHOOL SITE**

CONTACT OFFICER: Naomi Cox

THE DECISION

1. To consult on the proposed move of Connaught Day Options Service from the Connaught Centre [West Hove Infant School Connaught Annex] to Patcham House School Site.

REASONS FOR THE CONSULTATION

In order to be able to meet the Local Authority's statutory duty to provide school places for children within the City, the LA needs to relocate the Adult Social Care Day Options Services for adults with a learning disability currently based to the rear of West Hove Infants School (Connaught Annexe) to allow for expansion of primary places on that site. This has to be achieved within the context of a very limited range of options for accommodation across the City.

Children's Services are consulting on the proposal to move some of the pupils from Patcham House School site to Downs park thus providing a new potential location for the Day Options Services for Adult Care.

The consultation exercise in relation to Patcham House and Downs view has to be undertaken by Children's Services in compliance with statutory

requirements. In order to meet those statutory requirements and timescales agreement has been given to commence that process from today. To ensure fairness and transparency for all those affected by the potential connected decisions to be taken concerning the movement of services from the Connaught location and pupils from Patcham House to Downs View, the [separate] consultation processes need to commence at the same time.

DETAILS OF ANY ALTERNATIVE OPTIONS

Patcham House is considered suitable, with refurbishment, to accommodate the Day Options Services currently provided at the Connaught Centre whilst facilitating joint working between children's services and adult social care services, particularly in relation to transition to adulthood in line with new SEN 0-25 years legislative changes. It could also allow space for the accommodation of related learning disability professional support services.

OTHER RELEVANT MATTERS CONCERNING THE DECISION

A report will be made to the Committee on the outcome of the consultation process in due course.

CONFIRMED AS A TRUE RECORD:

We certify that the decision this document records was made in accordance with the Local Authorities (Executive Arrangements) (Access to Information) (England) Regulations 2000 and is a true and accurate record of that decision

Date:	**Decision Maker:**
16 May 2013	Denise D'Souza Executive Director for Adult Services
	Signed:
	In Consultation with the Chair of Adult Care and Health Committee:
	Councillor Jarrett
16 May 2013	**Signed:**
Report Attached:	*A Copy of the report considered by the Director is attached.*

Move of Patcham House School to Downs Park School Site/Move of Adult Social Care Day Centre at Connaught Road to Patcham House School

Proposal

The Governors of the CDP Federation and Brighton and Hove LA are putting forward a proposal to re-locate Patcham House Special School onto the site of Downs Park Special School in Portslade.

The key reason behind this proposal is the need to move the Connaught Day Centre to accommodate expansion of primary provision in the City. Potential re-location is to Downs Park Special School or onto the Patcham House site. However Patcham House School does not have the space to accommodate the Centre at present, Co-locating the two special schools thus seems a more sensible option as there are potential educational advantages and economies of scale. Additionally the LA sees potential in co-locating the two special schools, which are in an existing federation, while retaining some space for transitional services with adult social care at Patcham House. This would further key priorities in the SEN Partnership Strategy notably:

- improved transition arrangements post 16
- post 16 education for pupils with complex needs
- provision of more holistic integrated services for children and young adults with complex needs with linked autistic spectrum condition (ASC) strategies in Children's and Adult Services

Background

The Brighton and Hove Cedar Downs Park Patcham (CDP) Federation consists of three special schools catering for pupils with complex special needs on three separate sites:

- Cedar Centre (primary/ secondary school for pupils with complex SEN and associated learning difficulties in central Brighton)
- Downs Park School (primary/ secondary school for pupils with complex needs and associated learning difficulties in Portslade)
- Patcham House School (secondary school for more able pupils with complex needs. who can access a full mainstream secondary curriculum with support)

The Federation of schools have a single governing body and an executive headteacher overseeing the work of the heads of the three schools. As part of this proposal, the Governing Body and the LA are also considering expanding the remit of the Federation to offer Post-16 education to its students.

Rationale for proposed accommodation move

In order to be able to meet the LA's statutory duty to provide school places for children within the City, the LA needs to relocate an Adult Social Care day for adults with a learning disability currently based to the rear of West Hove Infants School (Connaught Annex) to allow for expansion of primary places on that site. This has to be achieved within the context of a very limited range of options for accommodation across the City.

The site that initially appeared to meet the majority of requirements for Adult Social Care was Downs Park but this would mean having two unrelated services on one site and would involve considerable alterations to the building to meet the different needs of the two groups.

Accommodation at Patcham House School has a number of limitations in relation to offering a full secondary curriculum and the building requires refurbishment in some areas to meet the increasingly complex needs of its pupils. The Downs Park site is generally felt to be superior to that at Patcham House and to offer more space and amenities than Patcham House.

Logistically it therefore seems a more sensible and cost-effective solution to move the Patcham House pupils onto the Downs Park site. This would allow for efficient sharing of space including the sharing of expensive specialist accommodation such as the science lab and home economics room.

It is proposed that the areas of the building not used for KS4 pupils at Patcham House will be used by adults with a learning disability currently attending the Connaught Day Centre. This would facilitate joint working between children's services and adult social care services, particularly in relation to transition to adulthood in line with new SEN 0-25 years legislative changes. It could also allow space for the accommodation of related learning disability professional support services.

From September, Downs Park and Patcham House would remain two distinct schools, each retaining their own Head of School, their own roll, admission arrangements and staffing structure. However, opportunities for sharing will be immense with a wider range of opportunities potentially available for staff and pupils.

Brighton & Hove City Council

Day Options
For adults with a learning disability

Connaught Day Options
Connaught Road
Hove
BN3 3WB

Date: 17th May 2013
Ref::
Phone: (01273) 295570
Fax: (01273) 295956
e-mail: Naomi.cox@brighton-hove.gov.uk

Dear Parents, Carers and Service Users

I am writing to update you on news about a new base for our Connaught Day Options Service.

The Council has to make sure there are enough primary school places for children in the city. As you know we have been working with Education to identify any possible options for us as our building at Connaught is needed by West Hove Infants school.

Education are consulting about a proposal to provide some of their school places currently at Patcham House School on the Downs Park site. It is proposed that pupils aged 14-16 will remain in place at Patcham House at least until current pupils have left the school in order not to disrupt their examination courses and so that the current joint curriculum offer with Patcham High can continue. This would enable Adult Social Care to use part of the Patcham House site for our Connaught Day Options Base. This has to be achieved within the context of a very limited range of options for accommodation across the City. The proposed date for this change is January 2014.

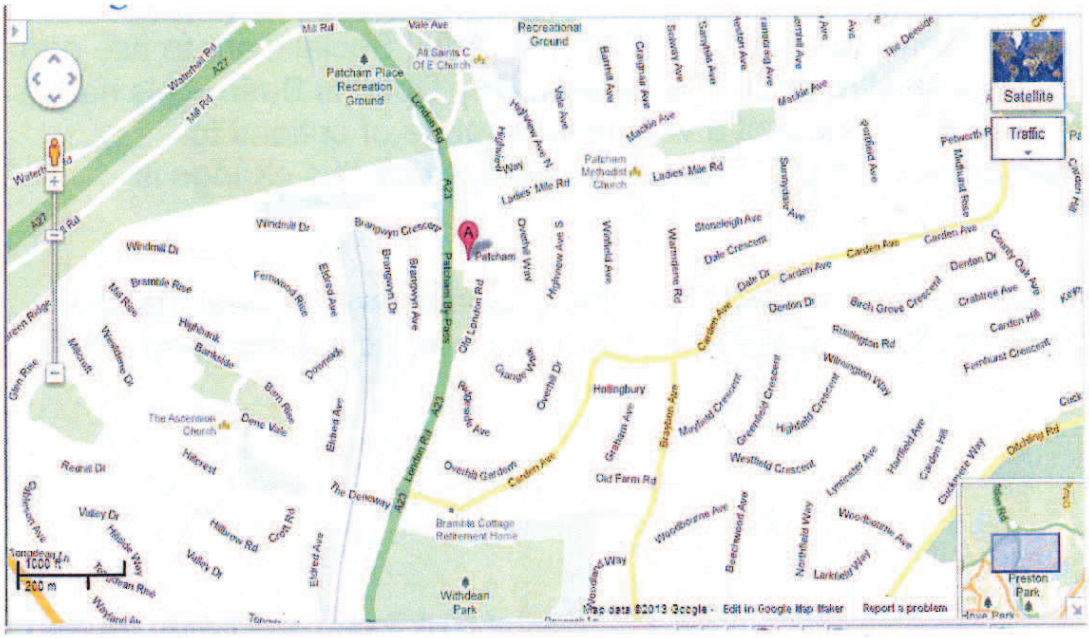
We have now been to look at Patcham House School and we feel that the needs of current and future Day Options service users could be met on this site.

Patcham House School, 7 Old London Road, Brighton BN1 8XR

Patcham House is a school for young people on the autistic spectrum.

Getting there:
Bus Route – 5a Bus.
Parking – On road
Day Options vehicle can be parked on site

Local Facilities include: Shops, Post Office, Pub, Recreation ground



Opportunities for you to get involved – we will work with the school to decide how we will use the space. The building is all on one level which is good and there is a lot of outside space including a garden. There will be some space just for us and some just for the school – there will also be some space we may want to share.

We will be having an Open day on:

Saturday 29th June 2013 from 11am – 2pm

At: Patcham House School, 7 Old London Road, Brighton BN1 8XR

If you would like transport to the Open Day please contact Stuart Vincent on Tel 01273 29 5137.

Please come along and get involved in planning how we will use the space for our service. We want your views on this proposal as part of a consultation process which will end on 28th August 2013.

We will ensure you receive regular updates and your views will be taken into account. We will let you know when a final decision will be made as soon as this is confirmed.

If you have any questions or concerns please contact: Naomi Cox on Tel 01273 296400 or email naomi.cox@brighton-hove.gov.uk or fill in the form attached to this letter and return to me at Community Learning Disability Services, 86 Denmark Villas, Hove, BN3 3TY.

We look forward to seeing you on 29th June.

Best wishes

Naomi Cox
General Manager – Learning Disability Services Adult Social Care

Connaught Day Service Move – Feedback Form

Please give us your views on the proposed move:

Your Name	
Your Address	
Your Tel No	

Your Comments:

Your questions:

Return to: Naomi Cox, Community Learning Disability Services, 86 Denmark Villas, Hove, BN3 3TY. Before 28.8.13.

ADULT CARE & HEALTH COMMITTEE	Agenda Item 14 Brighton & Hove City Council

Subject:		**Extra Care Housing Update**
Date of Meeting:		21 March 2013 – Policy & Resources 6 March 2013 – Housing Committee **17 June 2013 – Adult Care & Health Committee**
Report of:		**Strategic Director Place / Director Adult Social Services**
Contact Officer:	**Name:**	**Martin Reid** **Tel: 29-3321**
	Email:	**martin.reid@brighton-hove.gov.uk**
Ward(s) affected:		**Queens Park**

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report updates Committee on progress to secure increased supply of extra care housing in the City in relation to our recent bid to the Homes & Communities Agency (HCA) for funding under the Care and Support Specialist Housing Fund. This funding is made available by the Department of Health to support the development of specialist housing for older people and adults with disabilities. Over 5 years from 2013/14, £160m funding will be made available by the Department of Health to be delivered through the HCA. The prospectus is clear that:

'Priority will be given to schemes which have already achieved, or are well advanced in the process of achieving planning consent and in particular those which can start on site in the first year of the Fund (2013/14)'.

1.2 Although the City has a relatively young population, growth over the next 20 years is likely to be strongest in those people aged over 60. In particular, there is an anticipated 30% increase of people aged 85 and over living in the City.

1.3 In light of this demographic change, delivery of more extra care housing in the City remains a Corporate Plan, Housing Strategy, Older Peoples Strategy and City Plan priority. Extra care housing, not only for older people but for vulnerable adults who need to live in a supported environment, enables people to maintain their independence whilst delivering economies of scale that drive down unit costs. As a high user of expensive residential care, it is also a Budget priority to identify and promote cost effective alternatives including the development of more extra care housing.

2. RECOMMENDATIONS:

2.1a That it be noted that the recommendations set out in paragraphs 2.1 to 2.3 below were approved by the Housing Committee held on 6 March 2013 and the Policy & Resources Committee held on 21 March 2013.

2.1 That Committee note the proposed Brooke Mead Extra Care scheme which will be funded through affordable rents, a contribution from Adult Social Care

revenue budgets, shared ownership and subsidy funding incorporated within the recent bid to the Homes & Communities Agency (HCA).

2.2 That Committee note proposals to proceed with a Planning application for the approval of extra care housing on the Brooke Mead Extra Care scheme, the current timetable for the proposed development and the pursuit of other funding options as detailed in the report.

2.3 That the Committee recommend that the Policy and Resources Committee agree that the vacant Housing Revenue Account ('HRA') block of Brooke Mead, Albion Street, Brighton as shown on the annexed plan be demolished in order to be redeveloped, subject to Planning consent.

3. HOUSING NEED/STRATEGY:

3.1 Brighton and Hove has a growing population facing a significant increase in the number of older people, in particular those over eighty with a support need. The City is currently a high user of residential care and is committed to providing alternative accommodation options, in particular developing extra care housing for adults and older people as a Corporate and Budget priority.

3.2 The Council has a strong track record in securing investment for new extra care housing in the City, working in partnership with Department of Health, Housing Corporation and Registered Providers in delivery of New Larchwood, Patching Lodge and Vernon Gardens extra care schemes.

3.3 Following the development of the City's first extra care scheme at New Larchwood in Coldean, both Housing Committee and Adult Social Care Committee agreed to adopt the extra care strategy on 3 November 2005 and 12 December 2005 respectively as a basis for the further development of extra care to meet the long term care needs of older people in the City.

3.4 In 2009 a joint report was taken by Adult Social Care and Housing which recommended that Extra Care Housing was allocated through Choice Based Lettings. This was agreed and by both Housing and ASC Committees and has been the adopted policy ever since.

3.5 This is reflected and will be developed under the following Council Corporate Plan priorities aligned to Tackling Inequality:

Vulnerable adults supported to live healthy, independent lives

3.6 Provide more extra care housing and supported accommodation to meet the growing demand of those people with complex needs to remain in the community.

Decent, affordable, healthy housing

3.7 Work with the Homes & Communities Agency, neighbouring authorities, housing associations and other organisations to provide new and improved affordable and energy efficient homes including the regeneration of Council owned housing estates and the development of other housing land.

3.8 The Brighton & Hove Local Housing Investment Plan supports the City's Housing Strategy: 'healthy homes, healthy lives, healthy city' which recognises housing as a key Determinant of Health and forms an integral part of the City's Sustainable Community Strategy.

3.9 Through our Housing Strategy we are committed to:

- Improving housing supply, including the provision of extra care housing
- Making best use of the housing stock
- Increasing the supply of affordable rented housing
- Identifying opportunities to improve and develop deprived neighbourhoods

3.10 This extra care investment priority has been identified with our partners via the Housing Summit, Strategic Housing Partnership and through our regular meetings with Homes and Communities Agency as well as Registered Providers via our Affordable Housing Delivery Partnership.

Affordable Housing Development Programme 2011-15

3.11 We are reviewing the current Affordable Housing Development Programme and discussing with providers the options for the modelling around the 60% portion which was planned for the open market as this may provide a solution if the units meet the specification for extra care. We are discussing with providers what the cost of this would be, e.g. to enable those units to be rented at Local Housing Allowance rates and identifying any capital shortfall that may impact on viability.

City Plan

3.12 Our proposed City Plan has identified a significant shortfall in affordable homes by 2030, including extra care housing. New affordable homes, including extra care, are expected to deliver the following benefits to:

- Households: support needs are met; stability for households; improved health outcomes
- Communities**:** attract & maintain employment opportunities; quality neighbourhoods
- The City**:** benefits the economy; supports One Planet Living; supports a strong labour force; helps meet our statutory duties

Housing Needs and Older People

3.13 The extra care strategy agreed by the City Council in 2005 was based on the premise that extra care housing should be developed to meet the long term care needs of older people. By providing the necessary levels of personal care in decent and affordable housing, extra care provides a dignified and cost-effective alternative to both residential care and high cost home care packages.

3.14 Population projections1 for Brighton & Hove show that an additional 2,000 people aged 85 or over will be living in the City by 2030 (30% increase). While there may be improvements in people's health and well-being during this time, overall it

[1] ONS population projections DH POPPI website

is reasonable to expect that such an increase will lead to additional demand for long term care services.

3.15 Specifically, it is estimated that by 2030:

- more than 2,000 people aged 85 or over will have some form of dementia (an increase of 27% over current numbers;
- 26% of people aged 85 or over will be on low incomes (in receipt of pension credit);
- there will be over 11,000 people aged 75 or over living alone.

3.16 For people in these 'risk' categories, there is likely to be a significant impact on their ability to remain living independently in their own homes.

3.17 Without the development of additional extra care facilities, this impact will require a significant increase in the provision of residential care and home care, with a corresponding increase in the community care budget. By 2030, it is estimated that there will be an additional 390 people in residential care supported by the City Council, a potential 25% increase on current spend levels.

3.18 The 30% increase in the number of people aged 85 or over also suggests an upward pressure on the provision of intensive home care services and there could be an additional 343 older people requiring this service by the year 2030. Overall, therefore, there appears to be a need to provide additional long term care resources for over 700 people by 2030.

3.19 Meeting this need through the provision of extra care housing provides an alternative to the current dilemma where there is sometimes an invidious choice between 'best value' and 'independence and dignity'. Enabling someone to remain living independently at home may become unaffordable; placing someone in a care home may result in institutionalisation and the consequent loss of independence and dignity.

3.20 Extra care provides a 'halfway house' where independence and dignity can be protected by enabling people to live in what is in effect their own home in a supported environment. At the same time, it achieves financial efficiency: at Patching Lodge the current weekly unit cost of £201 per resident compares favourably with high cost home care packages, and residential care rates of between £341 and £460 per week.

3.21 As well as providing a modern and dignified form of long term care that better responds to the changing life experiences and expectations of the next generation of older people, the development of extra care resources across the City offers significant benefits for housing:

- the ability to free up family housing;
- the provision of higher density housing, using relatively small urban sites;
- the ability for some people to retain their housing equity;
- the creation of schemes heavily advocated by their users.

3.22 Brighton & Hove places comparatively large numbers of people in care homes. However the City is committed to moving away from care settings which do not meet the expectations and requirements of older people and which places a

significant financial burden on the authority, NHS and the third sector. The increased numbers of people with dementia places additional pressure on City. We are therefore developing extra care housing for adults/older people and are committed to provide additional options in the City other than residential care. As a consequence the Council budget strategy includes the need to focus on developing more extra care housing to meet demand.

4. BROOKE MEAD DEVELOPMENT

4.1 Brooke Mead as an extra care option initially arose from a review of Housing Revenue Account (HRA) assets. Brooke Mead is a HRA asset and was originally a sheltered housing scheme of 9 non self contained units mostly bedsits with warden accommodation and shared facilities. The scheme became unattractive and hard to let due to aging and poorly served accommodation i.e. no lift etc. For the past 20 years the building was used as temporary accommodation for people we have a duty to accommodate under the homelessness legislation but was decanted and identified for redevelopment on the discovery of asbestos in the roof. The building is currently empty.

4.2 Brooke Mead would provide an extra care housing scheme for older people and those living with dementia. It will serve as a quality extra care scheme in the heart of the City centre in an area with substantial numbers of older people, many from low income households in poor neighbourhoods. Many of the older people appear to be living on the periphery of this central location and are often excluded and marginalised from the wider community. Proposed investment of an extra care housing scheme in this location will make a major contribution to the quality of life for those who hitherto have been unable to access affordable supported high quality accommodation and provide an alternative form of housing for those who can no longer live at home and who previously would have to move to a care home. An extra care scheme offers older people a dignified environment which enhances their quality of life.

4.3 The proposal is to develop an extra care housing scheme of 45 self contained flats in a 5 storey development. The scheme is based on 39, 1 bed units for rent and 6, 2 bed units for low cost home ownership, with all flats developed to life time home standards. Generous space standard have been allowed for, enabling sufficient room for entertaining, relaxing and enjoying personal pursuits, with minimum net internal space standards of 52 m2 for 1 bed and 75 m2 for 2 beds depending on orientation. 10% of all developments have been identified for fully adapted wheel chair use. Capital costs for the entire building are appraised at BREEAM standard ‘Good’. Each apartment is designed for independent living with a separate kitchen / living area to the bedroom and a shower room designed to be fully accessible. The rooms will be well lit, with a terrace / balcony for each resident. Terraces could be used for flower pots or easily accessible window boxes. The development has been imaginatively designed with communal space at its heart. It is envisaged that the development of community based resources at Brooke Mead will be modelled on the City’s successful work at Patching Lodge where through the work of the LifeLines project, a thriving community hub has been established.

4.4 Individual flats are developed around the central court yard with double aspect views to and from the flats, one view looking out to the street scene, the other

looking down into the communal space below. The design which is safe for people who may become lost creates a sense of community, removing a feeling of isolation prevalent of residential settings. The development has been designed as a hub for the community particularly for those with dementia complementing existing community provision. The wrap around designs has particular relevance to those experiencing dementia are well as creating a sense of space and openness.

4.5 The community and communal space can be utilised at all times particularly early evenings where much of the surrounding existing community activity closes down. The central garden space made with glass curtain walling enables night and day light to penetrate at all times lending itself to a comfortable, modern exciting space in which community activity can coalesce. Office, staff and facility space is included in the design as well as outside space with the use of balconies and a walled roof garden.

4.6 The Scheme design developed by Fielden Clegg & Bradley Studios is appended to this report.

4.7 Deliverability, as well as value for money, innovation and quality are key criteria. In light of this we propose to proceed with a Planning application for the approval of extra care housing on the Brooke Mead Extra Care scheme.

4.8 The table below sets out the indicative timescales for the various stages of the planning application. This timetable assumes a three month process with a start date from 11 February 2013 and the submitting of the planning application by the end of April. The process assumes regular client contact and progress meetings (one every two weeks).

Project start	w/c 11th February 2013
Commission surveys	w/c 11th February 2013
Pre-application and design process	w/c 11th February 2013 to 15th April 2013
Consultation	Early March 2013
Review of scheme following consultation	Early April 2013
Collation of planning application documents	From 15th April 2013
Submission	**w/c 23 rd April 2013**
Determination	13 weeks from validation

5. PROPOSED FUNDING OPTION – SUBSIDY FROM HCA

5.1 Lambert Smith Hampton consultants were appointed to develop the extra care housing bid for submission to the HCA. The proposed scheme currently includes a mix of 39 Affordable Rented and 6 shared ownership homes. In line with HCA bid requirements, homes for Affordable Rent are to be made available at a rent level of up to 80% of gross market including service charges. However our current modelling limits the rent to the Local Housing Allowance on the basis that this equates to c 65% of market rent.

5.2 Therefore, this model assumes the HRA land as subsidy (which is consistent with recent practice for redevelopments in the City), that rents would be set at affordable rent levels up to the Local Housing Allowance levels and the six 2 bed homes would be low cost shared ownership. In addition to rental income, the development includes ongoing revenue contribution for the scheme from the general fund (Adult Social Care) of £0.102 million per annum. On this basis the development requires a net capital subsidy/grant of £2.686 million from the HCA towards the total scheme capital cost of £8.925 million.

5.3 Shared ownership is an Affordable Home Ownership product that is designed to help people who are in housing need. There are two products one for those who cannot otherwise afford to purchase without assistance .Through shared ownership the purchaser buys a share of the property on a leasehold basis and pays low rent on the unsold share with the option to increase ownership over time. The other is to enable older people to buy a home with support on a shared ownership basis usually using the equity released from the sale of their existing home.

5.4 This model assumes that the development will remain within the HRA which would need to make capital payments of up to £8.925 million during the build programme with reimbursement of the HCA grant payments, currently proposed to be made in agreed instalments, through the development programme and capital receipts from the shared ownership at the end of the project. This is likely to result in short term cashflow deficits which will be managed within the HRA capital programme and by possibly utilising the debt set aside. However, this will also result in a longer term borrowing in the region of £5.159 million fully financed by the net rental income streams from the new units.

5.5 The HRA currently has headroom for additional borrowing of around £31m, subject to affordability. This scheme would therefore reduce the future borrowing capacity to £26m for other regeneration projects and new developments. There is provision of £1m in the 2013/14 HRA budget and £2m in each of the years 2014/15 and 2015/16 to pay off existing debt which could, if necessary, be used to subsidise new schemes or in this case be used to support short term funding requirements due to development cashflows.

5.6 Indicative revenue savings to the General Fund, Adult Social Care budget arising from the delivery of this project are in the region of £0.300 million per annum. This is based on the average current cost of care provided at existing extra care schemes compared to current Residential Care costs and is after taking into account the £0.102 million per annum, contribution required to make the project viable. It is difficult to accurately quantify the level of savings as these will be dependant on the individual clients that are accommodated in the scheme.

5.7 The outcome of the HCA bid will be known in May which will determine which, if any of the other options need to be considered further. At this stage a report will be submitted to Policy & Resources Committee seeking approval for the recommended capital scheme.

6. ALTERNATIVE FUNDING OPTIONS

6.1 There are alternative options of delivery available, which can be considered alongside the preferred HCA option outlined in section 5 above. These include:

I. Retain within the HRA without HCA funding
II. Transfer to the General Fund
III. Transfer to an Registered Provider
IV. Private sector funded options

6.2 As highlighted in the Housing Summit the housing funding landscape has changed. Development surpluses generated from homes built for sale and used to cross subsidise, via planning obligations, the provision of affordable housing are squeezed. This reflects a major shrinkage in the mortgage market as bank lending has reduced and buyers are generally required to invest more significant amounts of their own equity.

6.3 To instigate the supply of more affordable housing, including extra care housing, means the council exploring alternative / innovative funding options. Over the last year the council has been working with a number of agencies, including dedicated support from the HCA, to develop the opportunities.

6.4 At this stage it is recommended that all funding options are kept under consideration with future consideration and reports back to Committee reflecting potential arrangements for improving availability of funding including financial implications and risk assessments.

i) HRA Self Financing Option without HCA funding

6.5 Initial modelling has been undertaken using the same outline cost and income assumptions as for the HCA bid but modelled within the HRA financial scheme model. The base position is that the HRA manages and retains all homes except for those leased for shared ownership. This modelling using affordable rents and an ongoing contribution of £0.102 million per annum for 30 years from the General Fund results in a HRA subsidy of £2.686 million which would need to be funded from either general HRA reserves or revenue surpluses within the HRA funding additional borrowing. This scheme would then deliver the same general fund savings as the preferred option.

6.6 In order for the HRA to develop this scheme it is likely that the HRA would need to borrow up to c£7.8 million, subject to utilising any available reserves (such as debt set aside of which £3 million would be available by 2014/15). This would reduce the HRA headroom for additional borrowing to around £23 - £26 million.

ii) Transfer to the General Fund

6.7 There is also the option to transfer the land to the general fund and redevelop using prudential borrowing with or without HCA grant/subsidy funding. This option would reduce the level of savings available to the general fund as in addition to the £0.102 million annual contribution required in option 1), the general fund would lose the economies of scale of administering this scheme compared to the housing service and would also need to fund the additional borrowing costs on £2.686 million if the HCA funding was not awarded. This development is new housing for a specific client group and will support housing priorities and also Adult social care priorities through extra care needs and therefore the sharing of the subsidy as outlined in option i) would be more appropriate.

iii) Transfer to a Registered Provider (RP) Funding Option

6.8 Government Social Housing Grant is no longer available and Registered Providers are expected to combine available funding with any balance sheet surpluses to provide affordable housing for rent at no less than 80% of the market level capped at LHA rates. In addition to Social Housing Grant and Registered Provider funding, previous extra care schemes in the City also received significant support from Department of Health funding which is also no longer available.

6.9 As outlined above we are already reviewing the current Affordable Housing Development Programme and discussing with providers the options for the modelling around the 60% portion which was planned for the open market as this may provide a solution if the units meet the specification for extra care.

6.10 The option of a Registered Provider partner supporting bidding on the Council's behalf for HCA Care & Support funding was explored but no RP willing to bid / fund was forthcoming within the tight bid timescale. We propose to continue to keep RP options open and subject to review.

6.11 In general terms, RPs in the City have indicated that they would be willing to work in close partnership with the Council where appropriate and supported. Whilst some may be willing and capable of acting solely in a development capacity, the funding option likely to be attractive is where they take ownership of the new homes financed and/or built by them.

6.12 Depending on specific site development viability, this may produce a capital receipt for the Council on a sale or leasehold arrangement. RPs in particular are likely to be better structured, experienced and staffed to manage development risk than the local authority. It may also be possible to expand the funding capacity of the development programme and thus the volume of new homes supplied. Such an arrangement, however, may involve ownership, rents, service charges, management and maintenance being held and primarily determined by the Provider. That said some Providers may be open to negotiating the principle and detail of this including Council led nomination to new tenancies. Financial implications would need to be developed alongside any firm proposals brought forward in the future.

iv) Private Sector Funded Options

6.13 A range of private sector funding options are emerging and the council is already utilising private bank funding from Santander in the establishment of Brighton & Hove Seaside & Community Homes (BHSCH).

6.14 Perhaps the most significant change has been the interest of Institutional investors, including pension companies and finance houses in providing development finance in return for guaranteed (i.e. the council underwrites) and inflation indexed (i.e. Retail Price Index) loans at market interest rates. The market interest rate will reflect that banks and institutional investors are seeking to invest relatively large sums in safe places against the backdrop of stock market and business uncertainty and council guaranteed borrowing is regarded by them as low risk.

6.15 Some emerging models, subject to full financial appraisal, do not require council underwriting income, rather are based on assurance of a long term nominations guarantee.

6.16 Additionally some major development companies are seeking to create tailored packages of finance and development delivery with local authorities. These may include price negotiated permutations related to housing ownership, leaseback deals, management, maintenance, rent levels and nomination rights.

6.17 Private sector funded options usually have higher transactions costs and are therefore more viable for larger scale developments. In addition they usually still require some form of council guarantee or subsidy. Financial implications would need to be developed alongside any firm proposals brought forward in the future.

7. COMMUNITY ENGAGEMENT AND CONSULTATION

7.1 Consultation with the local community will be an important part of developing the proposal for the Brooke Mead Extra Care scheme. The site is located within a residential area and the proposals have an element of community use and facilities which it is hoped will be used by the wider community in the area and not just the future residents of Brooke Mead. It will also be necessary to satisfy the local authority's requirements to undertake public consultation.

7.2 Brighton and Hove City Council's adopted Statement of Community Involvement (SCI) details the various forms of engagement that are expected of both

developers and the Council when considering proposals for planning applications. For a scheme such as this and based on the information set out in the Council's (SCI) it is envisaged that the following consultation will be undertaken:

- A leaflet drop to local residents and other stakeholders informing them of the proposals and inviting them to a public exhibition;
- Preparation of a leaflet about the scheme and register of attendees for exhibition;
- An exhibition outlining the proposals with members of the professional team on hand to answer questions (assume and late afternoon to evening 3-8pm) and an opportunity for the public to leave their comments on the scheme;
- Meetings with any key identified groups (e.g. Local residents associations and amenity groups).

7.3 An exhibition on the early proposals for the Brooke Mead site is considered to be the most effective way to involve the community and explain the proposals and the need for Extra Care facilities in Brighton and Hove. Following the consultation, the comments and feedback received from both meetings with residents and amenity groups, and the exhibition will be collated and a statement of consultation included with the submission of the planning application to demonstrate compliance with the SCI and summaries the consultation process and results.

7.4 In parallel to the external consultation with relevant groups and the community the proposals will also be subject to discussions with other departments within Brighton and Hove City Council, where officers will be able to give feedback and comment on the proposals.

7.5 Ward Member consultation is due to take place following 6 March Housing Committee meeting. Our consultants (LSH) will present the scheme to Members, power point presentation detailing the designs. A letter drop to the surrounding residents and community groups will also be undertaken. Consultation drop in sessions are due to take place week commencing 11th March. Large boards showing designs plus an inexpensive model that residents can touch/see. We can also have a presentations session being shown on a loop as a backdrop or specific timed presentations.

8. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

8.1 The financial implications of the preferred option are set out in section 5 which assumes that this scheme will remain within the HRA. The HCA bid provides grant funding to enable the capital scheme to be fully funded without any HRA subsidy.

8.2 This scheme would deliver £0.300 million contribution towards the general fund Adult Social Care savings target as included in the council's Budget Strategy.

8.3 The bid for grant funding will be subject to negotiation with the HCA and any future successful bid will be reported to Policy & Resources Committee for capital scheme approval.

8.4 Section 6 of the report sets out alternative options that have been initially considered and rejected in favour of the preferred option for the reasons highlighted in the report, mainly due to the additional grant funding from the HCA. Following the outcome of the HCA bid, the alternative options maybe reconsidered. Financial implications for those options will be assessed as required and reported to future Committees.

Finance Officer Consulted: Michelle Herrington/ Sue Chapman Date: 21/03/13

Legal Implications:

8.5 The Strategic Director of Place has delegated powers to manage properties within the HRA. The council's constitution provides that the power to manage includes the power to make the necessary planning applications. The proposal to seek planning consent for the development outlined in this report therefore does not need Committee approval. Should the preferred approach for the Brooke Mead site, that is remaining within the HRA, not come to pass, the legal implications for the alternative options will need to be assessed and reported to a future meeting.It is not considered that the recommendations in the report adversely affect any individual's human rights.

Lawyer Consulted: Liz Woodley Date: 22/02/13

Equalities Implications:

8.6 Extra care housing supports Tackling Inequality, priority one of the Corporate Plan.

The statistical evidence demonstrates that a significant increase of older people, particularly those experiencing dementia, will be living in the City in coming years. This increase is set against a backdrop of a limited number of suitable homes able to meet demand. The development of housing catering to a segment of people in the City who hitherto have experienced a lack of suitable accommodation with the availability of care packages that support increasing health and social care needs provides access to a much needed and new avenue of independent living ,within good quality accommodation which also offers care and support for older people within the City.

An increase in the supply of extra care housing will increase housing choice for older people with housing, health and social care needs and enable the City to better manage demand for specialist housing with support. In addition, the Brooke Meade proposal has been designed to ensure that 10% of the dwellings will be fully wheelchair adapted.

Sustainability Implications:

8.7 Newly built homes will be built to Affordable Housing Brief standards in terms of size, Code for Sustainable Homes, amenity space, Lifetime Homes Standard. Development to the BREEAM standard level 'Good' ensures that new homes are designed sustainably to minimise carbon emissions and use sustainable materials in their construction. New homes will support One Planet Living principles.

Crime & Disorder Implications:

8.8 Good architectural and urban design can contribute to safer homes and neighbourhoods. The proposed development includes Secure by Design principles and IT enabled technology supporting older people particularly those experiencing dementia.

Risk and Opportunity Management Implications:

8.9 HCA funding is not guaranteed. The HCA prospectus is clear that priority will be given to schemes which have already achieved, or are well advanced in the process of achieving planning consent and in particular those which can start on site in the first year of the Fund (2013/14). The HCA fund may be over-subscribed. The HCA will also go through a scheme appraisal and review process that may impact on the Development Appraisal submitted in support of the bid. Should HCA funding not be achieved or less subsidy be available than envisaged the development appraisal and scheme modelling will be subject to review.

Improving the supply of extra care housing is a Corporate and Adult Social Care Budget priority. Failure to deliver additional extra care housing will have an adverse budget impact.

Further development risks and opportunities will continue to be assessed and amended throughout the life of the project and adjusted in line with internal and external factors which emerge including those arising from consultation.

Public Health Implications:

8.10 Secure affordable extra care housing is key to supporting households to maintain a healthy life and sustain their independence.

Corporate / Citywide Implications:

8.11 Extra care housing aligns to the following Corporate Plan commitments under Priority One: Tackling Inequality:

- Develop 50 new extra care housing and supported accommodation units each year for the next three years to help people with complex needs to remain in the community
- Work with partners including the Homes & Communities Agency, neighbouring authorities and housing associations to provide 250 new and improved affordable and energy efficient homes.

In addition, the City will benefit from additional specialist housing provision and assist in meeting the targets for new housing as identified in the Housing Strategy and the City Plan.

9. EVALUATION OF ANY ALTERNATIVE OPTION(S):

9.1 The report outlines the opportunity to support the requirement for new supply of extra care housing that has arisen with the Brooke Mead site aligned to the opportunity to bid for HCA funding under the Care and Support Specialist Housing Fund.

9.2 Alternative options for the supply of additional extra care housing in the City will be subject to future reports to Committee.

10. REASONS FOR REPORT RECOMMENDATIONS

10.1 Reasons for report recommendations are included in the body of the report.

SUPPORTING DOCUMENTATION

Appendices:

1. Brooke Mead Plan & Scheme Design.

Documents in Members' Rooms

1. None

2.

Background Documents

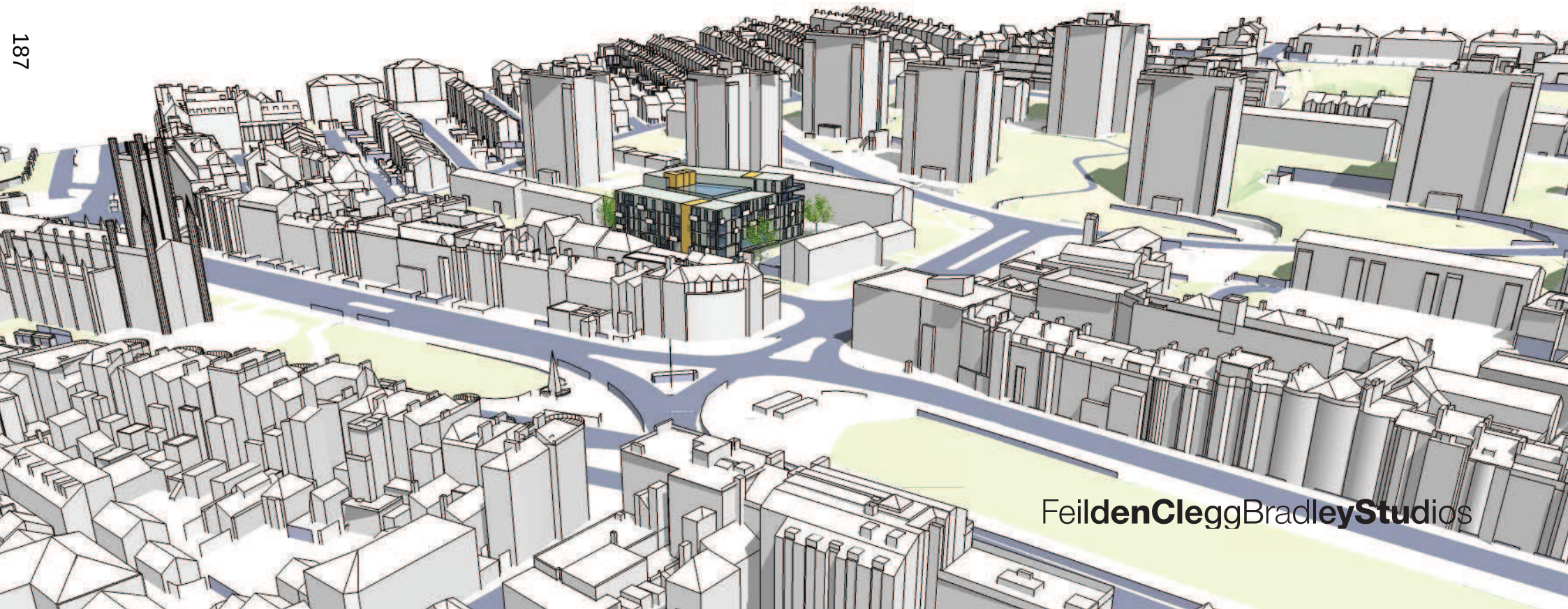
1. None

2.

Design Submittal | revised 8th March 2013

Brooke Mead
Extra Care Housing

Feasibility Study



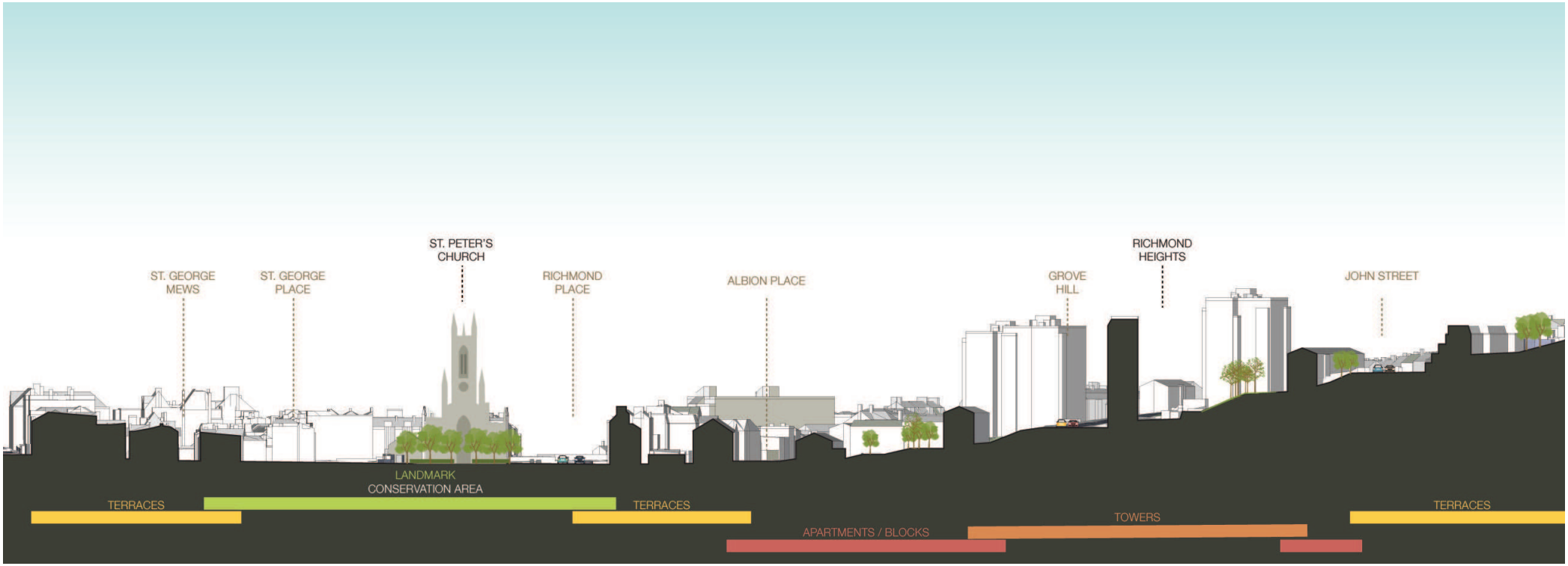
FeildenCleggBradleyStudios

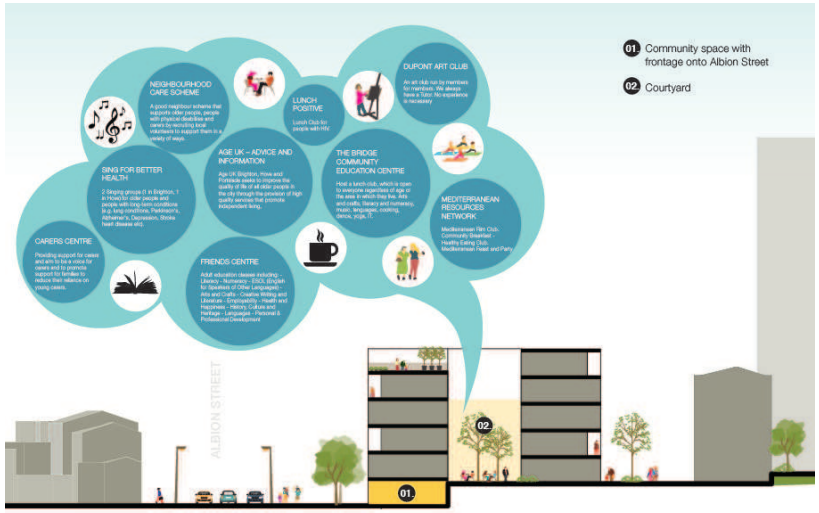
Brooke Mead
Extra Care Housing

Site Analysis
Scheme Summary
Area Schedule
Description of Proposed Scheme

The Brooke Mead Extra Care Housing proposal is an exemplar scheme for 45 residential units, communal space and space for community use.

Revised 8th March 2013





Location

The residential and community scheme is located at the heart of Brighton.

The brownfield site is just one road away from the Steine, the historic central green space to the city with a network of public transport links and local amenities in buildings on Albion Street and the adjoining Richmond Parade.

The proximity to the life of the city enables residents to be involved with city centre community groups and activities and continue to contribute to and enjoy the vibrancy of city life around them.

Site in context

Conservation and archeaology

Entrances and community

Building heights in context

Site

The site is also located in part of a local residential quarter of the city which could provide continuity for residents who have lived in the area at other times in their life.

The site slopes up steeply from Albion Street to the housing on Albion Hill behind.

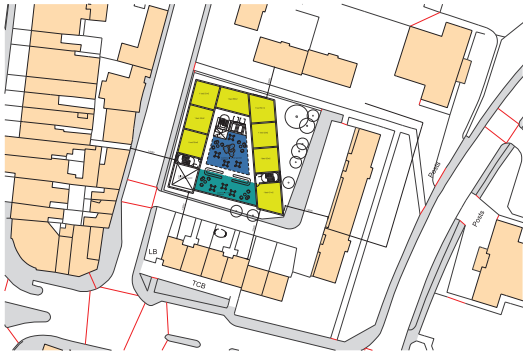
The difference in level up the site appears to be approximately 2.7m.

The site is currently occupied by a residential building of approximately 450 m2 which is not in use. To the rear of the site there is a sloping garden with a mix of apparently mature trees, shrubby growth.

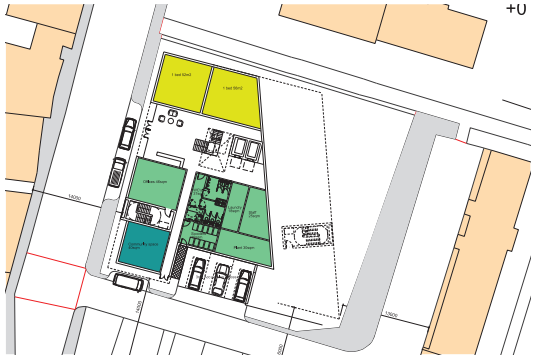
Brooke Mead I Extra Care Proposal
Summary sheet of Scheme

East-West section

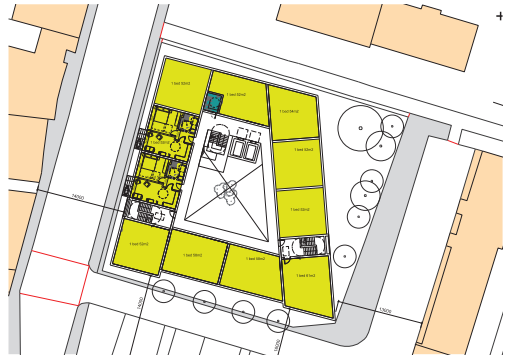
3D view from above ground level



Typical plan in context



Ground floor onto Albion Street



First floor

Number, size and tenure mix of the properties

The proposal will provide a mix of 1 bed and 2 bed apartments, approximately 75 % are 1 bedroom apartments and the remaining 25 % are 2 bedroom apartments. In accordance with Brighton and Hove City Council guidance 10 % of the units are fully wheelchair accessible. All the units have been designed to Lifetime home standards.

AREA SCHEDULE, 5 STOREY SCHEME

REVISED COURTYARD OPTION (1) - 15/01/13 REV C

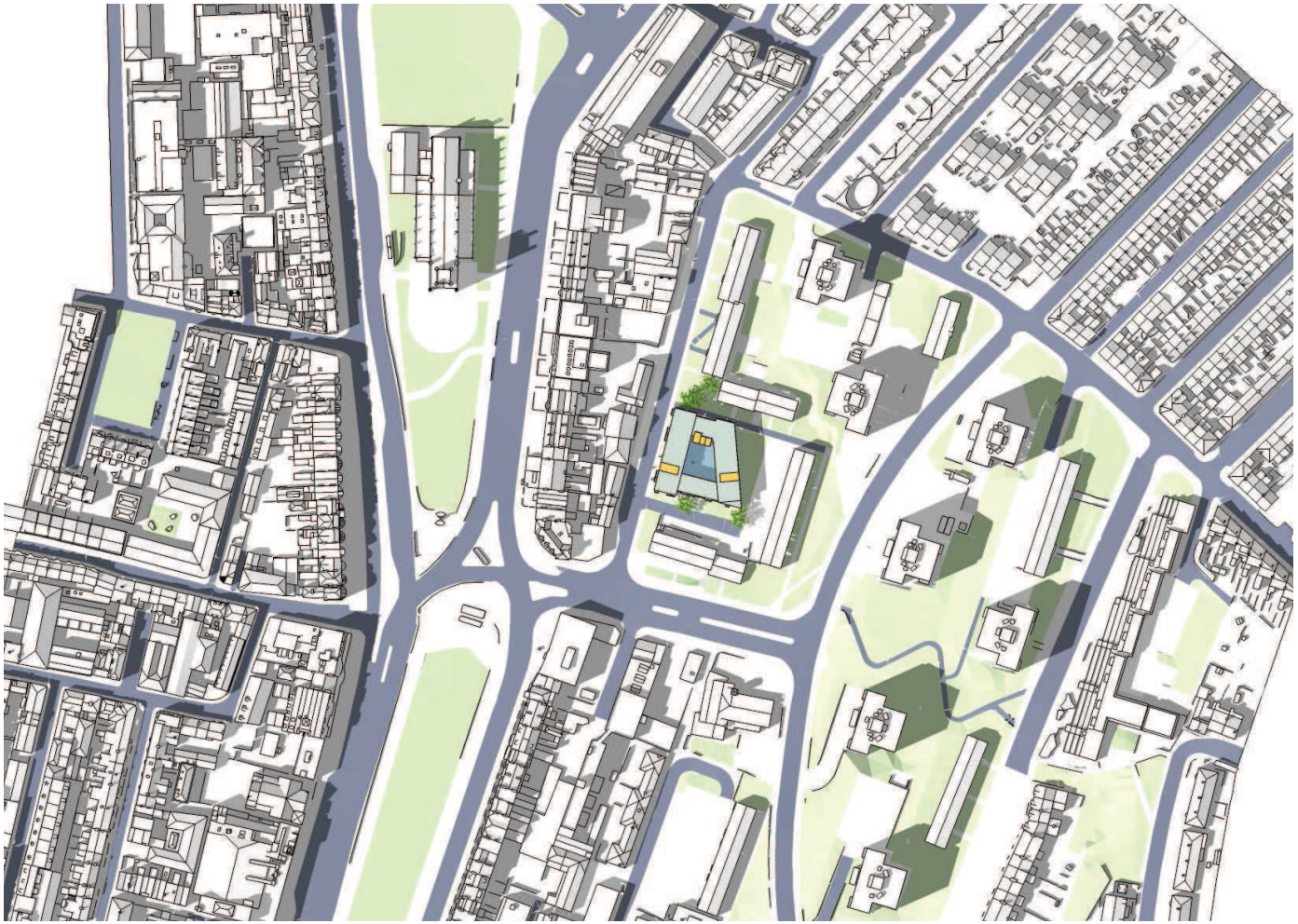
Floor	Office	Bback of house	Community	Communal	no. 1 bed flats	no. 2 bed flats	GEA
G	46	129	40		2		573
1st			116	118	8		915
2nd					11		848
3rd					11		848
4th					7	3	848
5th						3	376
TOTALS	46	129	156	118	39	6	4408

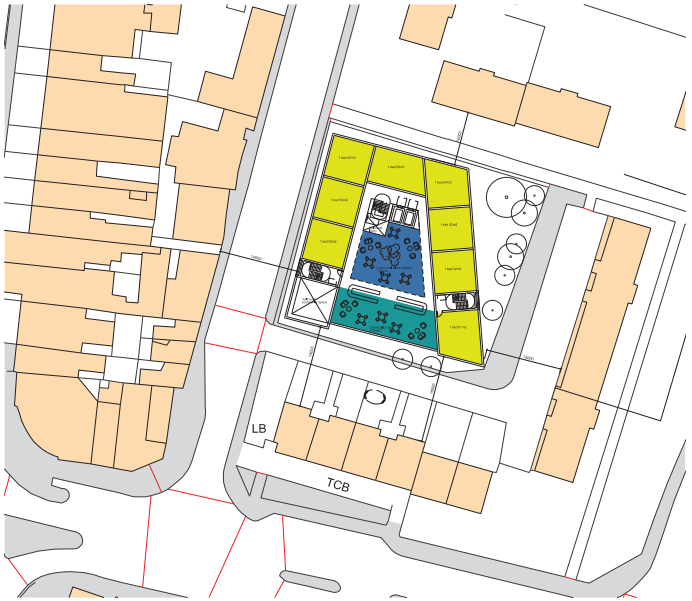
NIA = Includes internal flat partitions, measured face to face of flat party walls and external walls
GIA - Includes all internal spaces, including circulation, measured to internal face of external walls, excludes voids and lifts
GEA = Total internal area, including external walls, excluding atria and lifts

Note : the average size of a 1 bed apartment is 52 m2 gross internal and a 2 bed 75 m2 gross internal

Because the geometry of the building varies there is sometimes additional area in the corner units.

Building Mass and Organisation





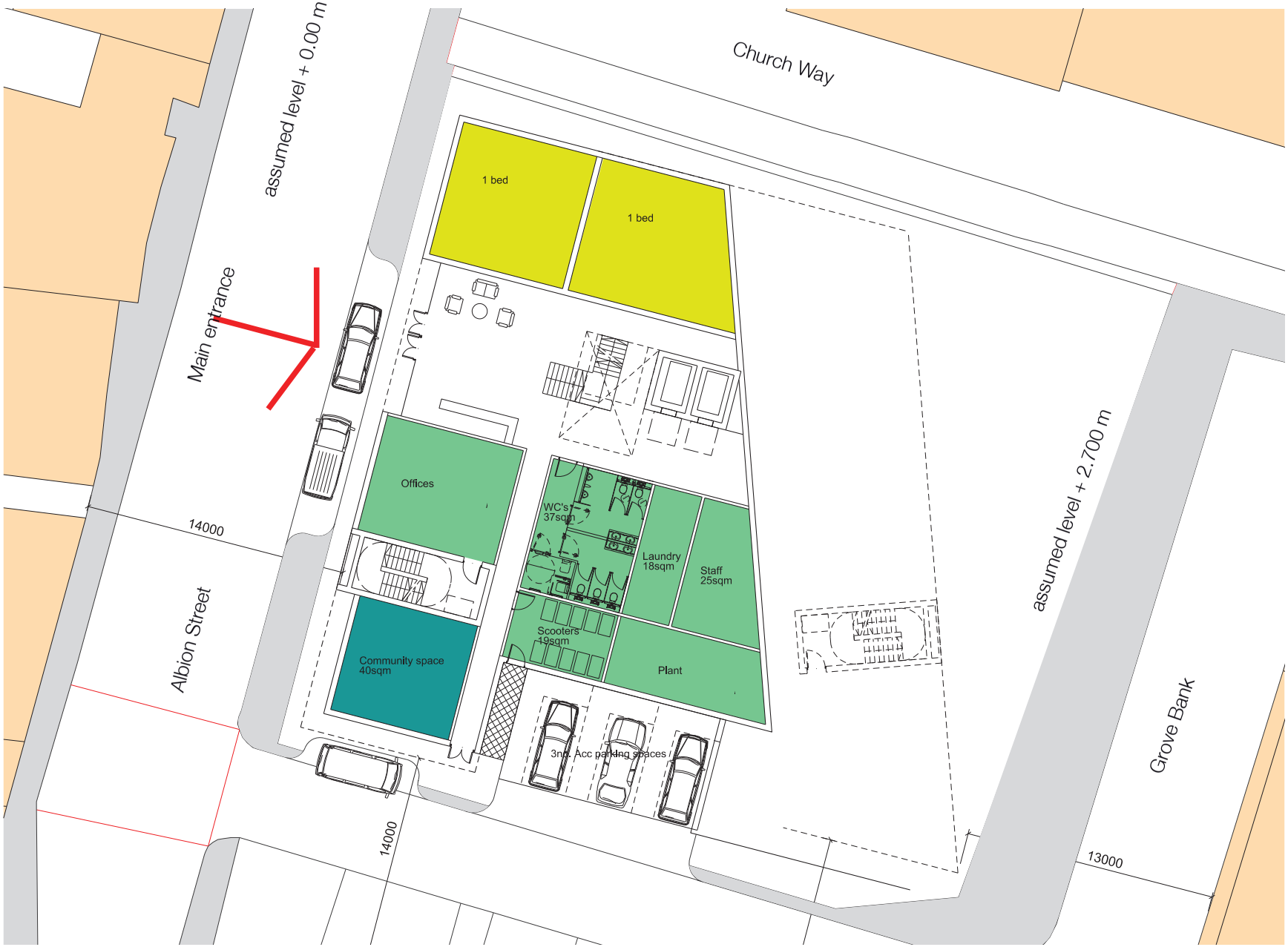
Typical floor plan in context

Building form and organisation

The building form is a stepped courtyard building of 5 storeys. The enclosed courtyard is at the heart of the scheme, and provides a space for the residents and the community to use and share.

The courtyard lets light into the centre of the building, and provides a view out at ground floor, to the South, with a Southerly aspect. The building line is re-instated along Albion Street giving the street a width of 13-14 m, wider than Victorian terraced streets.

Ground floor on Albion Street



Ground floor onto Albion Street

Ground Floor - entrance

The main entrance, for residents, visitors and the community is on Albion Street.

The entrance level contains the offices for those managing the building, services space for those who work there, the laundry and 2 x 1 bed units.

It also contains the lower level of community use which looks out over the street and is visible from the main approach to the site. The community use continues at ground floor, and there are visual connections between the two spaces across the double-height space.

The lifts and stairs to the residential accommodation at higher levels is immediately accessible from the front door.

There are 3 stair cores in the building. The central staircase and lifts look across and into the enclosed central garden room and provide generous circulation space to the front door of every flat.

First floor on Albion Street

First Floor plan - shared space with 1 bed flats around it.

First Floor - shared spaces

The local community are invited to come into the heart of the building and use the space to the South of the building which looks into the enclosed courtyard or garden room. This space has a Southerly outlook.

In the centre of the plan is the communal space. This is imagined to be a garden room, with fragrant internal planting to provide a canopy, a lounge space for shared activities and a place to invite visitors.

Between the spaces for community use and communal activities there is space to provide 'pop-up' catering facilities for particular occasions or at the request of the residents.

Second foor plan

Second Floor Plan - 1 bed units, with a loop of circulation

Typical Floor Plan Layout

The flats wrap around the central garden room. Adjoining the vertical circulation is a generous circulation space for people to stop and chat, or rest.

All the flats enjoy good views into the central shared communal space, but also outlook across the street, into the garden. Each flat has a terrace or balcony.

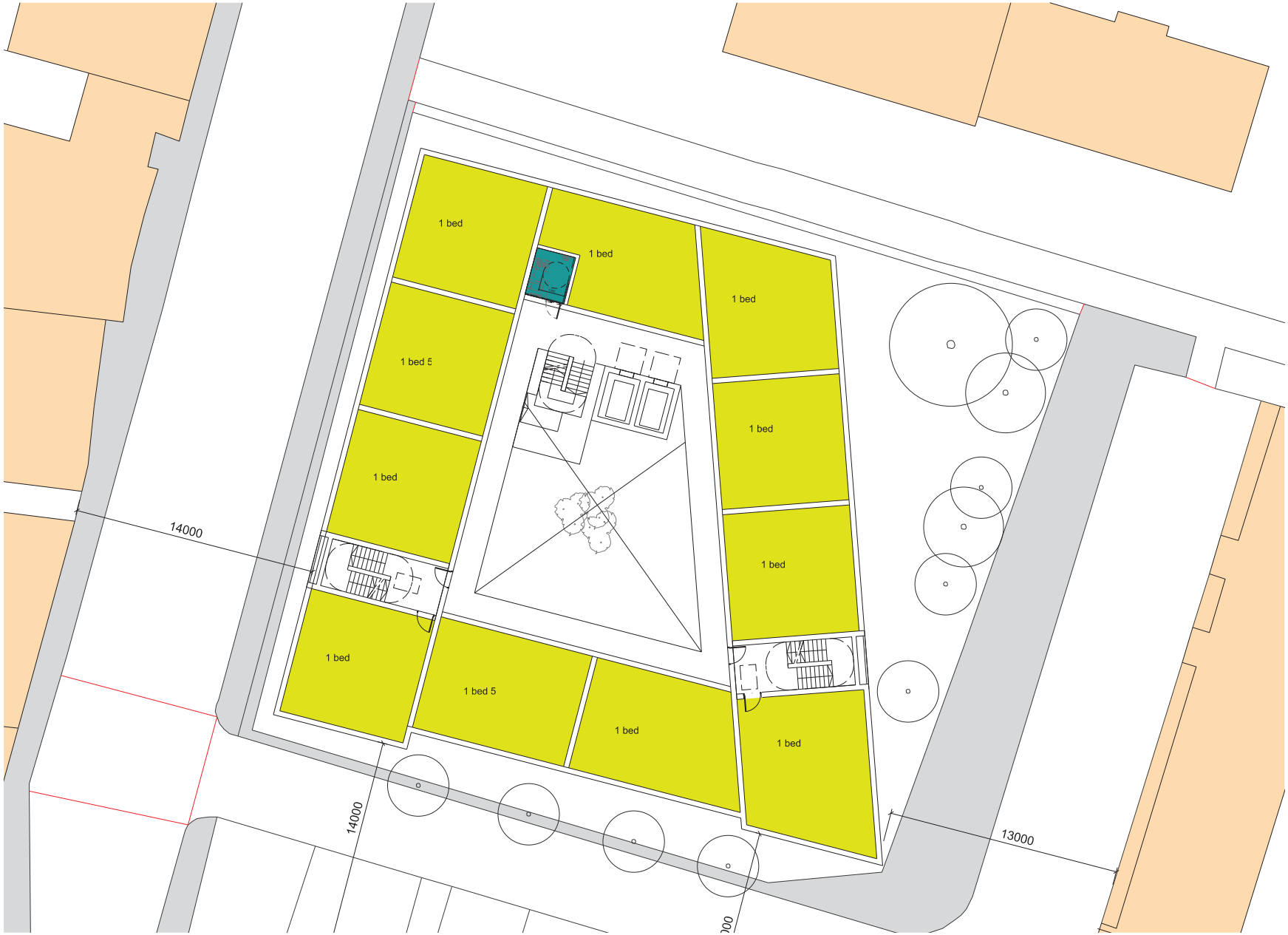
Each entrance is easily visible and recognisable, through the use of light, and colour in the internal decorations. Despite being an internal door, the front door to every flat will be detailed as if to an external front door.

There will be views from the kitchen out into the circulation. There will be the opportunity to personalise the area immediately adjoining the front door. An integrated seat, light to make it easy to put the key in the lock, and a small window so residents can see who has arrived.

Outlook between the circulation and the internal life of the flats is important to encourage interaction and neighbourliness, as might be generated in a street of terraced houses.

The circulation loops around the central, top lit space so it is easy to navigate for those suffering from dementia. The central space acts as a key point of orientation.

Third Floor on Albion Street

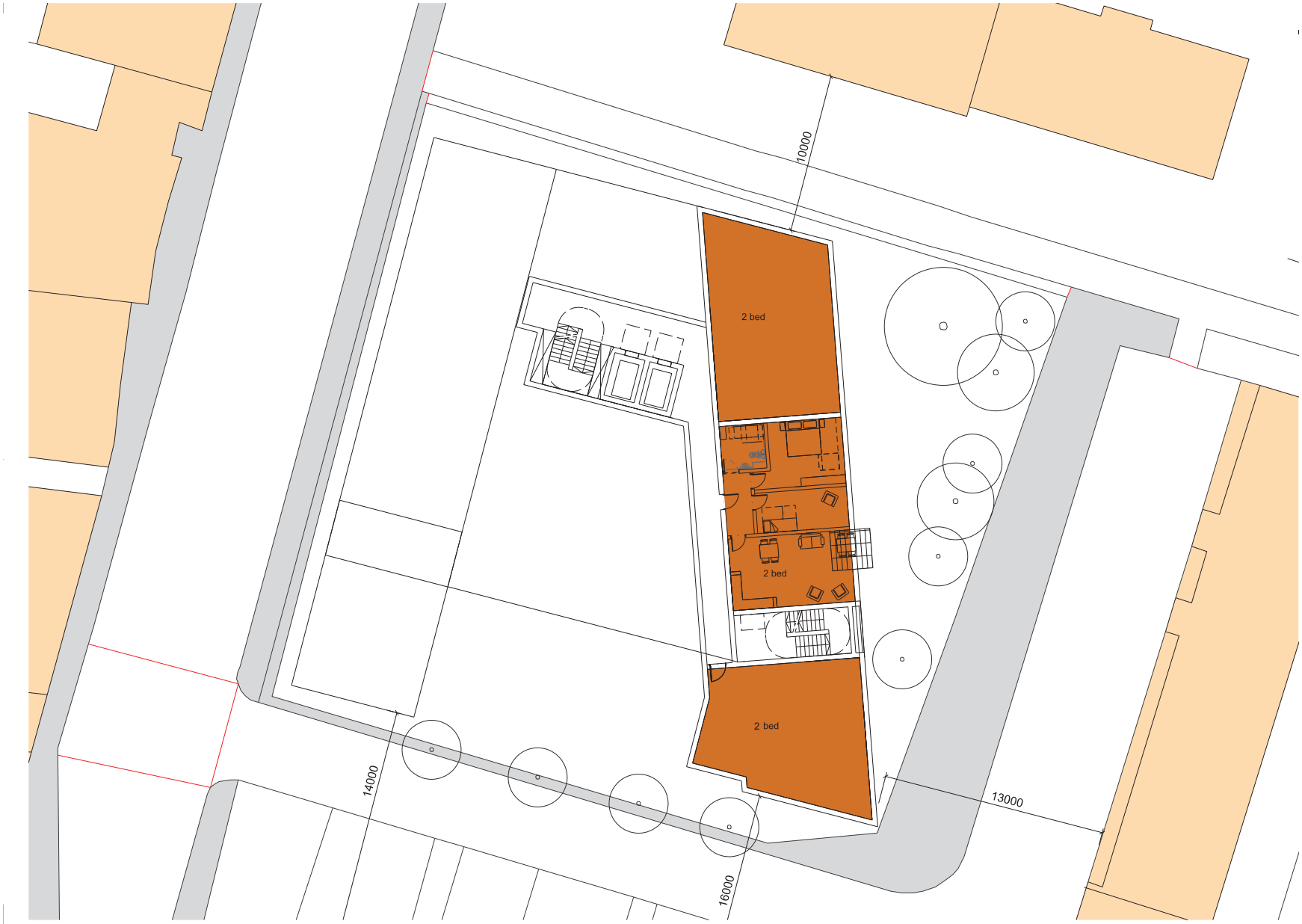


Third Floor (as second floor) - 1 bed units, with a loop of circulation

Fourth Floor on Albion Street

Fourth Floor - a mix of 1 bed and 2 bed units

Fifth Floor on Albion Street



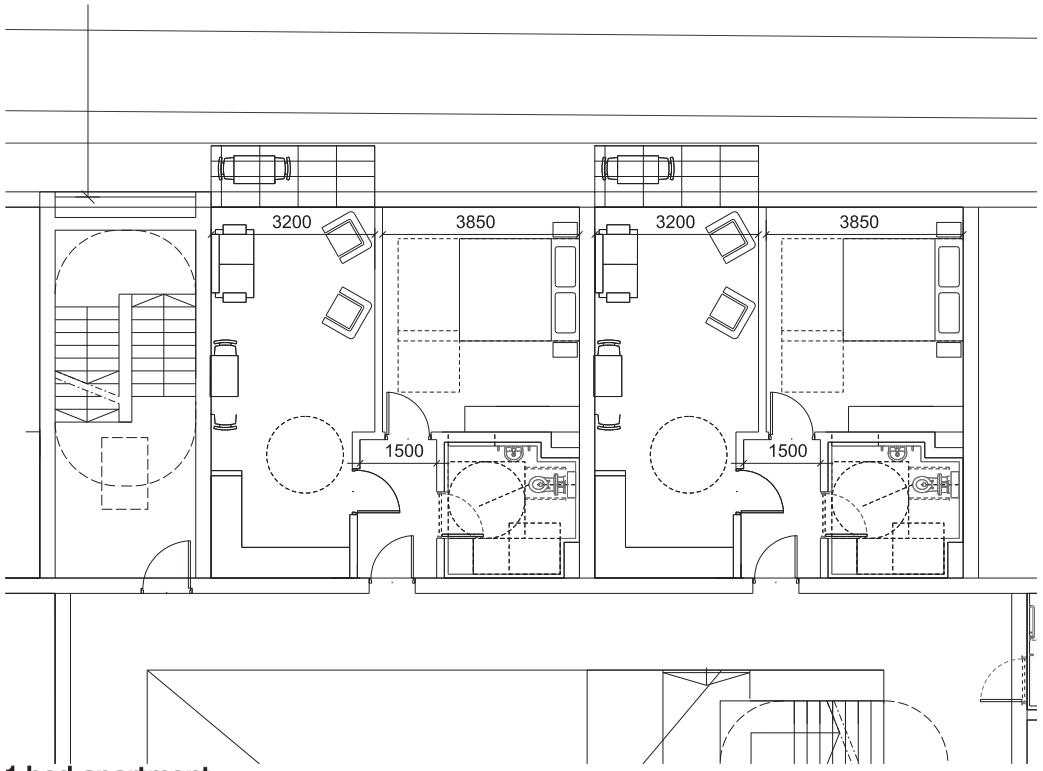
Fifth Floor - 2 bed units

Higher level floor Plans

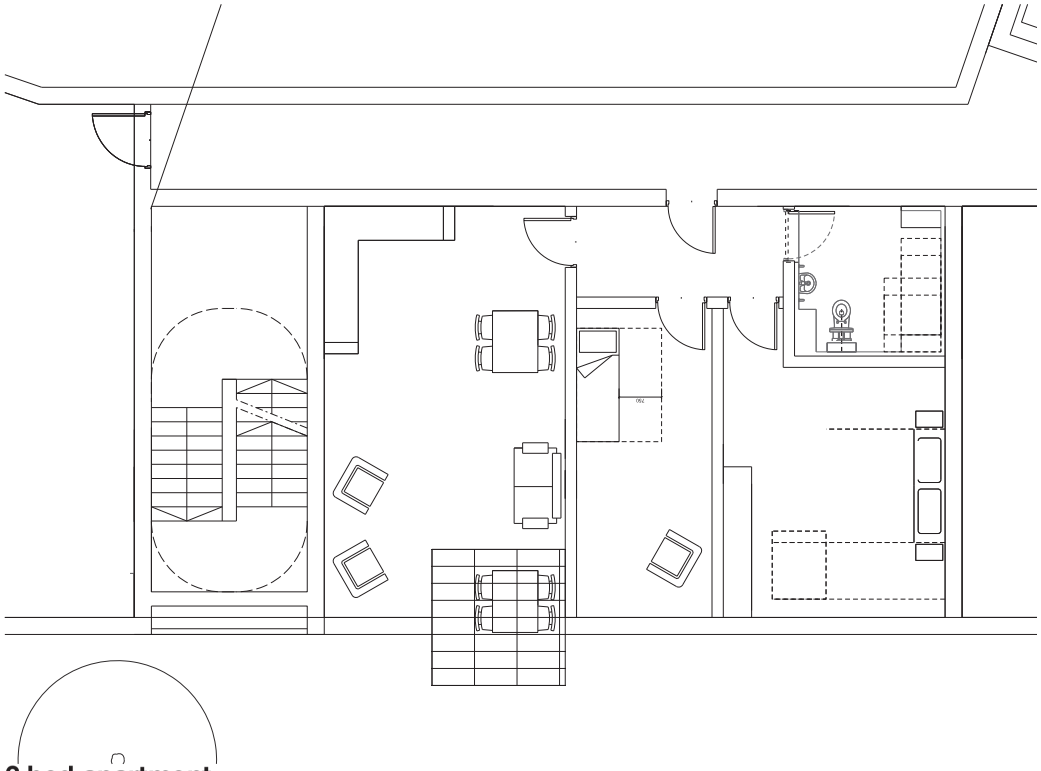
The 2 bedroom apartments are grouped together at higher level.

At the highest floor level they have easy access to the roof garden which could be protected, like a walled garden, and provide a further venue for shared activities such as a gardening club.

1 bed and 2 bed apartments



1 bed apartment
52 m2 GIA



2 bed apartment
75 m2 GIA

200

Typical Flat Plan

Each apartment is designed for independent living. It has a separate kitchen / living area to the bedroom and a shower room designed to be fully accessible. The living area is generous enough to have friends for a meal as well as being close to the television.

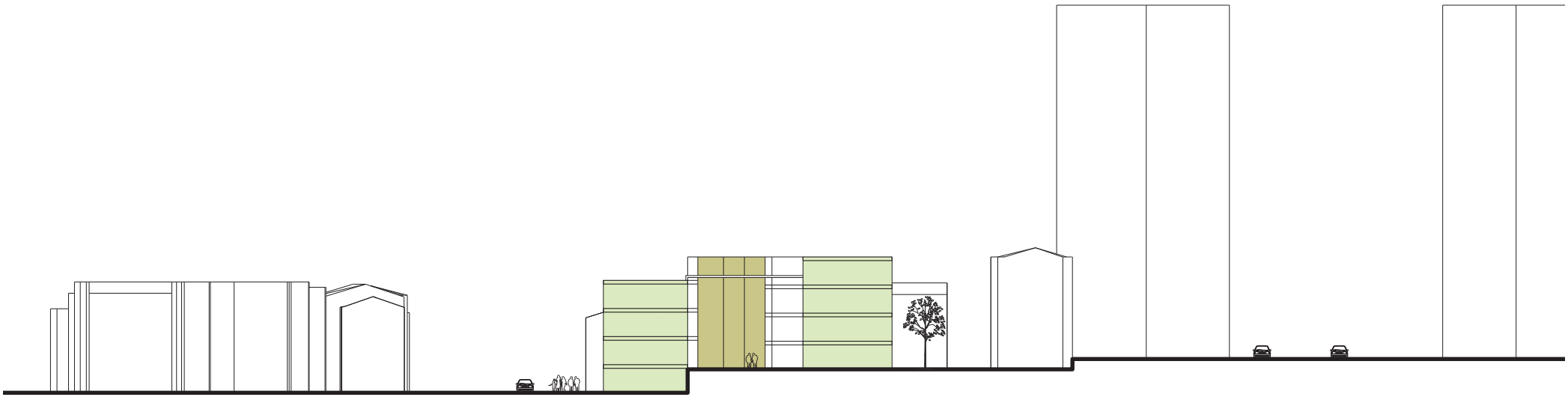
These are well lit rooms, with a terrace / balcony for each resident. Terraces could be used for flower pots or easily accessible window boxes. The shallow floor plan enables cross ventilated spaces into the shared, central enclosed space.

The average size of a 1 bed apartment is 52 m2 gross internal and a 2 bed 75 m2 gross internal. Because the geometry of the building varies there is sometimes additional area in the corner units.

Street Views

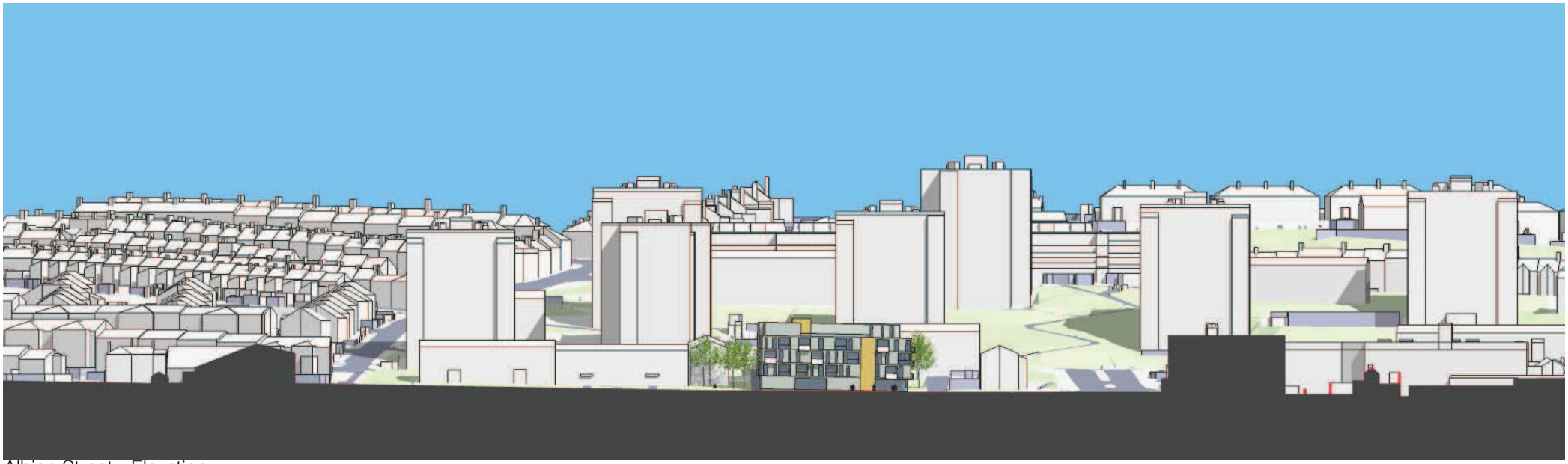
View along Albion Street from Richmond Parade

Looking South down Albion Street



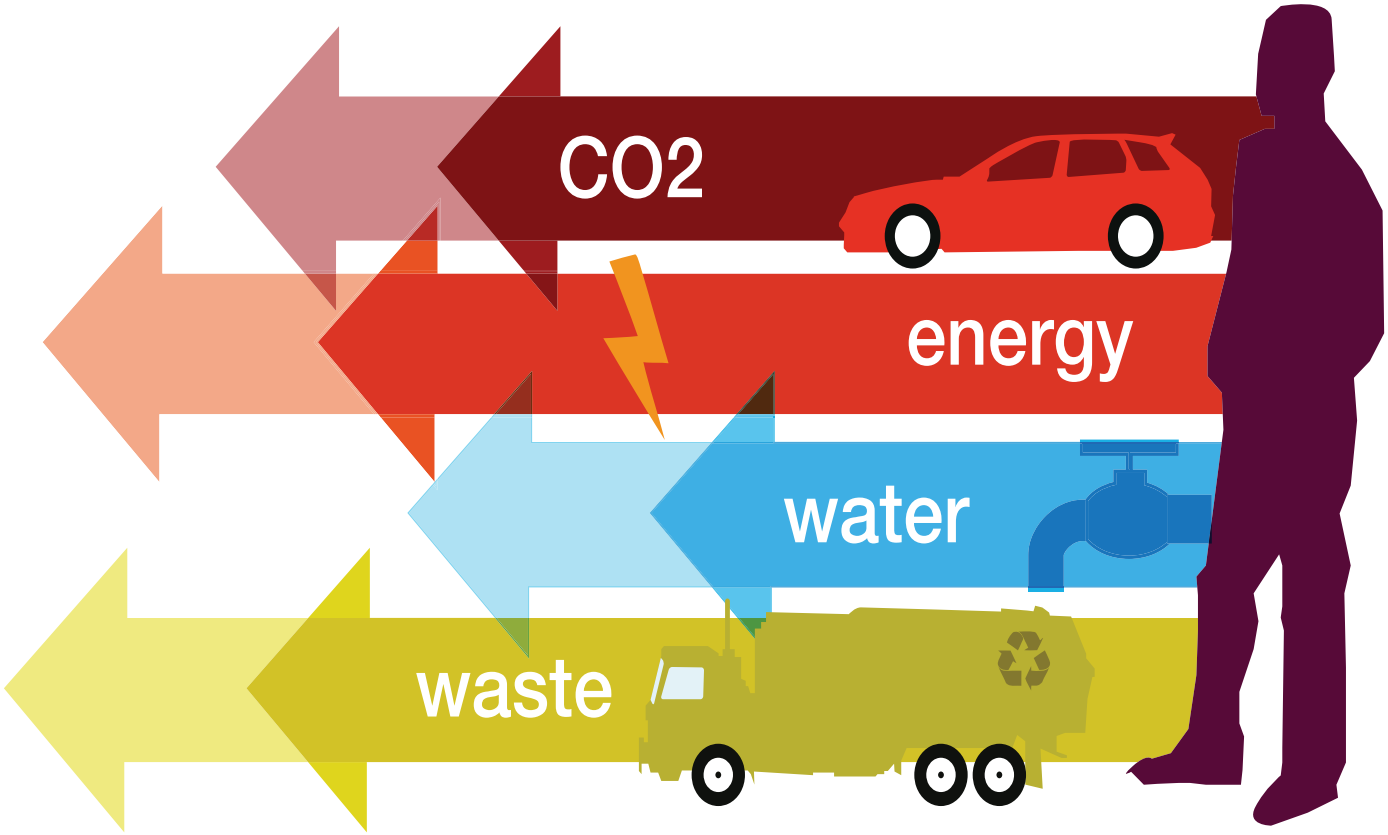
cross section

Albion Street



Albion Street - Elevation

Illustrative section



Sustainability – flexible and adaptable

The building design has been developed to be adaptable in the long term and flexible in the short term to respond to the evolving needs of the residents. The housing has been designed on a repeating module which fits with 1 and 2 bed apartments which means that in the long term bedroom, bathroom, kitchen and living spaces can be introduced into the structural grid during future re-fits.

The flats have been designed such that they can be adapted as the needs of the resident changes.
At ground floor the office space could easily be converted into residential use, or, with the higher floor to ceiling height could be a small retail outlet, joining the rank of public services on Albion Street and Richmond Parade.

The scheme achives BREEAM level 3.

HAPPI principles in the design

Brook Mead HAPPI Principles at feasibility stage

1. Number of habitable rooms relates back to the brief. The 1 bed and 2 bed units are designed on a structural bay so the type of units can be adjusted over the life of the building.

2. Apartments face look out of the building to enjoy good ventilation, sunlight, views but also have kitchen windows and front doors within the building to relate to circulation and the shared life of the community.

3. All corridors are 'single sided' with views out or into the building on one side and apartments on the other side. Many of the apartments have balconies. There is a terrace at roof level which could have furniture and plants.

4. 'Care ready' specification to be developed as design progreses beyond feasibility stage.

5. Floor plans allow for a loop of circulation, around a central double height communal space. Good views to the wider context. Paired etnrances to flats coudl be developed to promote interdependence.

6. Central Multi-purpose space is at the heart of the scheme and can be used for communal activities and care. The Community can use this central space also.

7. The main entrance is off Albion Street, with drop off for visitors and residents. It has a clear view up into the shared communal space and to the circulation. The building re-instates the line of the street in this urban district of Brighton.

8. When the design progresses into Strategic and detailed design the design will achieve Code Level 4, it will be well insulated, with good U values, deep or shaded balconies. The central double-height space allows cross vent through the depth of the plan.

9. Storage will be included outside the flars for mobility scooters, and cycles with minimal parking. There is also fitted storage within the typical apartment plans.

10. The building engages with an existing street pattern.

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1 to 45
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Grove Bank
1 to 12
Brooke Mead
Church Way
1 to 6
7 to 12
Ebenezer Apartments
1 to 49
Ivory Place
Sussex Place
Elim Church Centre
Surgery
Richmond Hotel (PH)
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1 to 19
Albion Street
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Richmond Place
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PCs
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Shelter
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PH
13.4m
13.0m
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