Brighton & Hove City Council

Health & Wellbeing Board

Title:	**Health & Wellbeing Board**
Date:	**27 November 2013**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
	Board Members
Councillors:	Jarrett (Chair), K Norman (Opposition Spokesperson), Meadows (Opposition Spokesperson), Bennett, Bowden, Pissaridou and Shanks
BHCC: CCG Youth Council HealthWatch	Pinaki Ghoshal, Statutory Director of Children's Services Denise D'Souza, Statutory Director of Adult Social Care Dr. Tom Scanlon, Statutory Director of Public Health Dr. Xavier Nalletamby, Clinical Lead Geraldine Hoban, Non-clinical member Hayyan Asif Frances McCabe
Contact:	**Caroline De Marco** Democratic Services Officer 01273 291063 caroline.demarco@brighton-hove.gcsx.gov.uk

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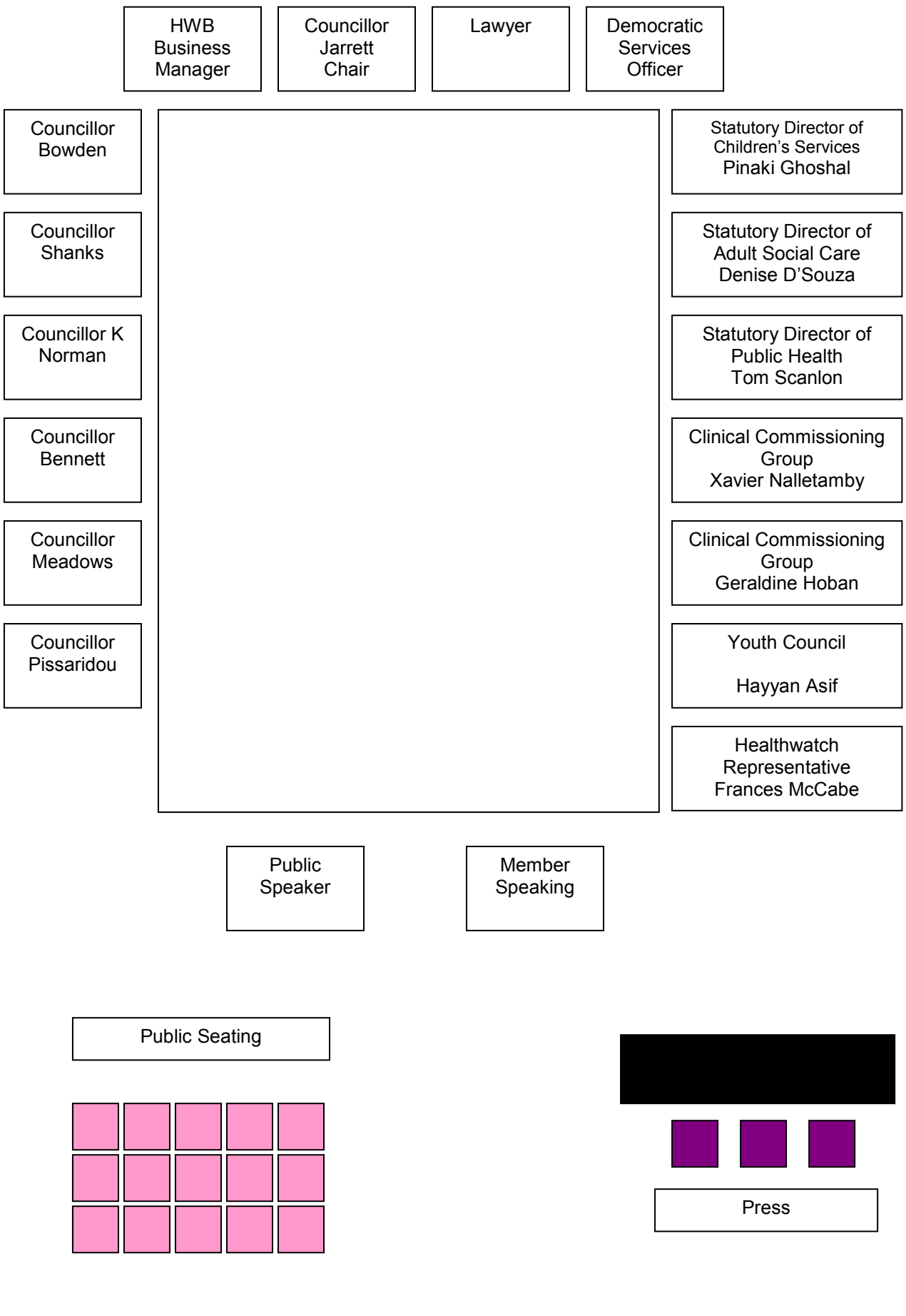
Health & Wellbeing Board



AGENDA

PART ONE **Page**

25. 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 – Statements by all Members present of any personal interests in matters on the agenda, outlining the nature of any interest and whether the Members regard the interest as prejudicial under the terms of the Code of Conduct.

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

NOTE: *Any item appearing in Part 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.

26. MINUTES **1 - 18**

Minutes of the meeting held on 11 September 2013 (copy attached).

27. CHAIR'S COMMUNICATIONS

28. PUBLIC INVOLVEMENT **19 - 20**

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 20 November 2013 (copy attached).
(c) **Deputations** – to receive any deputations submitted by the due date of 12 noon on the 20 November 2013.

29. ISSUES RAISED BY COUNCILLORS AND MEMBERS OF THE BOARD

To consider the following matters raised by councillors and Members of

the Board:

- **(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

30. INTEGRATED TRANSFORMATION FUND

Presentation by the Chief Operating Officer, CCG and Executive Director, Adult Services.
Ward Affected: All Wards

31. BRIGHTON & HOVE CCG - COMMISSIONING INTENTIONS OF BRIGHTON 2014-16 **21 - 50**

Report of Chief Operating Officer (copy attached).

Contact Officer: Geraldine Hoban Tel: 01273 574863
Ward Affected: All Wards

32. AUTISM STRATEGY: SELF ASSESSMENT **51 - 74**

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

Contact Officer: Mark Hendriks Tel: 01273 293071
Ward Affected: All Wards

33. WINTERBOURNE VIEW IMPROVEMENT PROGRAMME -STOCKTAKE **75 - 92**

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

Contact Officer: Mark Hendriks Tel: 01273 293071
Ward Affected: All Wards

34. PUBLIC HEALTH SCHOOLS' PROGRAMME **93 - 98**

Report of Director of Public Health (copy attached).

Contact Officer: Lydie Lawrence Tel: 01273 295281
Ward Affected: All Wards

35. WINTER SERVICE PRESSURES **99 - 134**

Report of Director of Public Health (copy attached).

Contact Officer: Max Kammerling Tel: 01273 574861
Ward Affected: All Wards

36. DECLARATION ON TOBACCO CONTROL **135 - 138**

Report of Director of Public Health (copy attached).

Contact Officer: Tom Scanlon Tel: 29-1480

HEALTH & WELLBEING BOARD

Ward Affected: *All Wards*

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

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Date of Publication - Tuesday, 19 November 2013

HEALTH & WELLBEING BOARD	Agenda Item 26 Brighton & Hove City Council

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING BOARD

4.00pm 11 SEPTEMBER 2013

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Jarrett (Chair) Councillors K Norman (Opposition Spokesperson), Meadows (Opposition Spokesperson), Bowden, Pissaridou and Shanks.

Other Members present: Pinaki Ghoshal,Statutory Director of Children's Services, Denise D'Souza, Statutory Director of Adult Social Care, Dr. Tom Scanlon, Statutory Director of Public Health, Dr. Xavier Nalletamby, Geraldine Hoban, Clinical Commissioning Group Hayyan Asif ,Youth Council.

PART ONE

13. PROCEDURAL BUSINESS

13A Declarations of Substitute Members

13.1 There were none.

13B Declarations of Interests

13.2 There were none.

13C Exclusion of the Press and Public

13.3 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.

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

14. MINUTES

14.1 **RESOLVED -** That the minutes of the meeting held on the 12 June 2013 be approved as a correct record of the proceedings and signed by the Chair.

15. CHAIR'S COMMUNICATIONS

Pinaki Ghoshal

15.1 The Chair welcomed Pinaki Ghoshal, Statutory Director of Children's Services to his first meeting of the Board.

Sarah Creamer

15.2 The Chair welcomed Susan Creamer, Director of Commissioning at NHS England, Surrey & Sussex Area Team.

Robert Brown

15.3 The Chair reported that Robert Brown had sent his apologies. He was unable to attend the meeting as the LINk Transitional Board disbanded in July. Robert wished to inform the Board that Healthwatch were currently recruiting staff. It was hoped that a Healthwatch representative could be in place for the next Board meeting. Robert thanked all members of the Shadow Board and the present Board for their help and friendship in setting up the Health and Wellbeing Board.

15.4 **RESOLVED** – That a vote of thanks to Robert be recorded for all the time he has spent involved in health matters.

16. PUBLIC INVOLVEMENT

(a) Petitions

Improving Mental Health and Mindfulness

16.1 John Kapp presented the following e-Petition which was signed by 27 people.

"We the undersigned call on the Health and Wellbeing Board to empower the Clinical Commissioning Group (CCG) to outsource provision of the Mindfulness Based Cognitive Therapy (MBCT) course to the third sector, so that GPs could prescribe it on a voucher scheme to reduce the waiting time from 20 years to a few weeks."

16.2 The Chair responded as follows.

"I recognise both that MCBT is a valuable treatment option and that 3rd sector providers have a role to play in providing this and other services. The CCG recently re-commissioned a range of services in this area, seeking to improve quality and reduce waiting times. This re-commissioning has been widely welcomed – specifically by HWOSC – and providers now include non-NHS not for profit providers of MCBT. Given

these actions I am content that the CCG is acting properly in this regard and do not intend to ask them to make further changes."

16.3 **RESOLVED-** That the petition be noted.

(b) Written Questions

16.4 Mr Terence Rixon had asked the following questions:

- It has just been reported by Hansard that yesterday (11th June) Jeremy Hunt, the Secretary of State for Health, when asked about "What steps he is taking to increase accountability in the NHS" ….
- That he replied "We have transformed accountability in the health system by setting up Healthwatch and introducing stronger local democratic accountability through Health and Wellbeing boards".

- My question is ...
- Can the Health & Wellbeing Board apply pressure to the Community Voluntary Sector Forum (the CVSF) to accept the recommendations (and comments) of Robert Francis QC in respect of how they are developing the Brighton & Hove Healthwatch?

- The Francis Report identified many serious shortcomings of the Staffordshire Link, and made firm recommendations to be carried forward into the new Health & Social Care Watchdog to be known as Healthwatch.

- These are detailed in a separate paper, which is too long to read out now.

- My own experiences of our local LINk and the CVSF show many parallels with Mr Francis's findings, and I am concerned that the CVSF are now developing our Brighton & Hove Healthwatch without any regard to the Francis Report recommendations.

- We are now over two months into the contract for the new HealthWatch, and there has been no Public Engagement yet. The CVSF seem to be going their own "closed shop" way, and showing no "transparent process", despite questions being asked of their Chief Executive Officer.

- I shall conclude by quoting just two examples:
    - Paragraph i.174 (of the Francis Report) states that those with a responsibility for HealthWatch should seek the involvement of the public (as set out in the full table of recommendations).
    - Page 481 of the Francis Report is flagrantly being disregarded in which concerns are expressed about "recruiting from a small unrepresentative pool of the usual suspects". The CVSF are not inviting "fresh blood" to join them in the set-up of HealthWatch.

- So my question is:

Can the Health & Wellbeing Board apply pressure to the CVSF to accept the recommendations (and comments) of Robert Francis QC in respect of how they are developing the Brighton & Hove Healthwatch?

16.5 Mr Rixon had been given the following response:

"The Health & Social Care Act (2012) required all upper-tier local authorities to establish a local Healthwatch organisation to replace Local Involvement Networks (LINks) in enabling public and patient involvement in the commissioning and provision of health and social care services.

In Brighton & Hove we opted to go out to tender for a Healthwatch provider. The ensuing procurement process was managed by the council's Communities & Equalities team, which also performance manages the Healthwatch provider going forward.

A steering group was established to oversee the procurement process. This included representatives from the Council's Policy, Scrutiny, Finance, HR, Legal and Procurement teams. It also included representation from the Clinical Commissioning Group and the LINk steering group volunteers. (The actual procurement was undertaken by a core group with no possible commercial interest in the awarding of the funding agreement.)

Subsequent to the Brighton & Hove Community & Voluntary Sector Forum (CVSF) being awarded the Healthwatch contract, the steering group was re-constituted as a virtual implementation group overseeing the implementation and performance management of the agreement.

One of the major issues in managing the transition from LINk to Healthwatch that was identified, was the loss of organisational memory and working capacity during the period of transition and the early months of Healthwatch operation. Local and national experience of managing the transition from Patient & Public Involvement Forums (PPIF) to LINks in 2008 underpinned these concerns. Many LINks took a year or more to actually begin investigative work following the transition from PPIFs, and few local areas had measures in place to ameliorate this problem. As the Francis report makes clear, this was the situation pertaining in Staffordshire at the time of the crisis in Mid Staffs hospital.

Having identified this major risk in terms of the LINk/Healthwatch transition, the approved provider - CVSF sought to mitigate the risk by appointing a group of former LINK members as a transitional group to continue investigative and representative work while Healthwatch was established. This action has the support of the implementation group as it offers continuity between LINK and Healthwatch, ensures that there is some retention of organisational memory, and avoids a situation where there is a 'gap' between one organisation and its successor (as was the case in Mid-Staffs).

An additional risk consists of the current limited public understanding of Healthwatch. It was felt that an exercise to recruit Healthwatch volunteers at an early stage would be unlikely to succeed in attracting the broad cross-section of the local public necessary to ensure that Healthwatch does not only appeal to the "usual suspects". To reach a broad section of the local public, a process of public awareness of what Healthwatch is needs

to be ongoing: hence there are significant advantages in having a considered approach to the involvement of the public.

There is absolutely no intention of limiting the recruitment of volunteers to Healthwatch to "a small representative pool of the usual suspects". It is CVSF's intention and that of the implementation group to encourage as wide a group as possible of local residents to become involved in Healthwatch. However, it has been agreed that the most sensible and least risky approach in the early months of Healthwatch is to retain a transition group of experienced LINK members whilst establishing Healthwatch organisational structures and planning how best to recruit and support volunteers to Healthwatch in the longer term. There is no intention to retain the transitional group for longer than is strictly necessary or to favour its members in terms of the development of volunteer roles within Healthwatch.

In terms of the question then, I'm sure it is the case that HWB and HWOSC members would agree that Healthwatch Brighton and Hove should "seek the involvement of the public" and should avoid "recruiting from a small unrepresentative pool of the usual suspects."

However, at this time we are confident that the measures being taken by CVSF accord with both of these aims (and with the need to ensure there is continuing volunteer capacity to undertake investigative/representative work during the early days of Healthwatch), so we will not be seeking to apply additional 'pressure'.

We are actively monitoring the establishment of Healthwatch and the HWB plans to have an item on Healthwatch development at its September committee meeting."

16.6 Mr Rixon asked the following supplementary question in respect of contract compliance:

'Given the growing groundswell of public concern about the lack of broad democratic public involvement of our Local Healthwatch, as evident from the content of the paper to be discussed at Agenda Item 22, page 135, when can we expect a report to be brought to this committee which has been prepared by the council's Contract Monitoring Section as to levels of performance and compliance concurrently being achieved under the contract?

Finally one of the 'Tag Lines' or 'Mission Statements' of Healthwatch is 'For the People by the People'.'

16.7 The Chair informed Mr Rixon that he would receive a written response to his supplementary question. He gave a commitment that he would get in touch with Healthwatch to find out when they would be fully operational. He was concerned as Mr Rixon that Healthwatch should be the face of the public.

16.8 **RESOLVED-** That the written questions be noted and a written response be prepared for Mr Rixon' supplementary question.

(c) Deputations

16.9 The Chair noted that the following deputation had been referred from full Council held on 18 July 2013.

16.10 Mr Kapp presented the following deputation:

"I am a complementary therapist, and a facilitator of the Mindfulness Based Cognitive Therapy (MBCT) 8 week course (1) which is NICE-recommended (2) to improve mental health by teaching people self-help tools by which to better manage their emotions, so they don't need to go to A&E. There are more than 20 facilitators in the third sector of the city (3) providing this course for clients who pay the going rate (£150-370). This course is provided free on the NHS, but the waiting time is 20 years unless you are suicidal. (4) causing health inequalities as the poor can't afford it.

3 years ago, to reduce the waiting time, I created the Social Enterprise Complementary Therapy Company (SECTCo) (5) whose slogan is: 'medication to meditation', and whose mission statement is: 'Give a man a pill, and you mask his symptoms for a day. Teach him mindfulness, and he can heal his life'. To get public sector contracts I sent hundreds of e mails, documents, phone calls, to commissioners. These were not answered, because there was no-one at home who could make a decision, even to say: 'no'. The NHS did turn 65 last week, and decision paralysis is a symptom of dementia. Even Jeremy Hunt says it is sick. My experience proves that it has dementia. For the sake of both doctors and patients, we need to cure it. I am the Julia Bailey of Brighton, and pleading for your help now,

The government has done its part by filling the democratic deficit in health. You are now responsible for public health, and for directing the strategy of the new Clinical Commissioning Group, (CCG). I am therefore calling on you councillors to play doctor to the CCG and cure its demented paralysis by banging heads together. Please set up a 'chemist shop' voucher system by which GPs can prescribe the MBCT course as easily as Prozac. This would boost their morale by restoring their original function as teachers, (6) Then patients could access the course free within a few weeks from the third sector, so wouldn't need to go to A&E. This will fill the disconnect (7) between drugs and talking therapies, and restore patients' trust.

Please do not dismiss this proposal automatically as 'privatisation by the back door'. It is just a way of reducing waiting times for effective treatment, which has had all-party support nationally for more than 7 years. (8). Opening up the market to local complementary therapists would create local jobs and keep the money in the local economy, benefitting our citizens, rather than swelling the profits of drug companies. It will also improve health, reduce inequalities (9) and save taxpayers' money.

First recommendation. The Council authorises the CCG to engage with SECTCo to do 2 pilot trials of the MBCT course for £5,000 (10) and to engage a researcher to evaluate them, and report back to Council in November.
Trial 1. Up to 12 patients referred from a GP surgery in Hove.
Trial 2. Up to 12 sick council staff.

Second recommendation. The Council instructs the CCG to consider this proposal to set up a voucher system for the MBCT course in the city, and report back to the Health and Wellbeing Board (HWB) at its next meeting on 11.9.13."

16.11 The Chair had given the following response at full Council:

"Thank you for your enquiry.

Improving mental health and wellbeing has been a priority for the city council and Clinical Commissioning Group and there is considerable joint work in pursuing this aim. The 2012 Mental Health Commissioning Prospectus was as you know a joint initiative between the CCG and the city council the commissioning and the management of mental health budgets are undertaken jointly.

You will also know that there is now a Brighton and Hove Wellbeing Service which aims to improve access to psychological and support services for people with common mental health conditions such as anxiety and depression. This contract was awarded following a competitive tendering process and includes as part of the specification a range of evidence-based treatments including Mindfulness CBT. General practitioners across the city are referring patients to this new service.

The city council and Clinical Commissioning Group will be retendering mental health promotion contracts next summer (2014) following approval of the Public Health Commissioning paper at P&R committee on 11th July 2013. The defined outcomes will reflect the mental wellbeing strategy that is being developed through the Health and Wellbeing Board and is likely to 'Five Ways' (Connect, Be Active, Take Notice, Keep Learning, Give) and the Public Health /NHS/ Adult Social Care outcomes frameworks.

Many other locally commissioned programmes across the city council and CCG deliver on 'Five Ways'. These include joint work of Public Health with the Sports Development Team (Be Active), considerable city council and CCG community development and equalities work (Connect), Adult Learning Schools (Keep Learning), Volunteer training and coordination (Give) and a large arts and culture programme (Take Notice) including a proposal for specific arts and culture work for World Mental Health day this year.

Mindfulness courses are also delivered independently by several local voluntary organisations such as Mind and MindOut, and you will be aware that there are several local independent practitioners of mindfulness.

The city council and CCG will continue to work together on the mental health and wellbeing agenda, and promote mindfulness where there is evidence for its effectiveness. Mental wellbeing will remain a priority on the current Health and Wellbeing Strategy."

16.12 **RESOLVED** - That the deputation be noted.

Deputation on Sexual Health Services to Brighton and Hove Health and Wellbeing Board meeting on 11 September 2013

16.13 Mr D A Baker and Mr Ken Kirk presented the following deputation:

'We apologise for the short notice of this deputation. We have only recently been alerted to the issue and have therefore submitted this deputation for your consideration at short notice. We thank the board and the Chair of the board for their indulgence in receiving this deputation. Because of the short notice we have only been able to put two names and addresses to this deputation. However many people were involved in discussions about this issue and we could send a full list to the chair after the meeting if he requests it.

We the undersigned (and others) are concerned about the possible competitive tendering and hence privatisation of Brighton and Hove sexual health services. As lay people we may not fully understand the current position. We will layout our understanding of the position in point 2 below.

1 We seek the following from the board:

1.1 a clarification of the current position (see our understand in point 2 below)

1.2 an undertaking that putting sexual health services out to competitive tender will only be undertaken if there is clear evidence that such a process will lead to an improvement in sexual health services for the people of Brighton and Hove and that this evidence will be made available publically.

1.3 a reassurance that if there is evidence that sexual health services will be improved by putting them out to competitive tender then to ensure the best possible service the CCG or other commission body will insist that the current NHS providers in the field of sexual health will be expected to submit a tender.

1.4 an explicit reassurance that any potential restructuring of sexual health services resulting from competitive tendering will not result in any adverse sexual health services for the people of Brighton and Hove.

1.5 an undertaking that any potential restructuring of the sexual health services due to competitive tendering will not result in adverse employment conditions for current staff in the area of sexual health in Brighton and Hove.

2 Our understanding of the current position.

Since April 2013 the NHS Commissioning Board is responsible for commissioning HIV treatment, while local authorities remain responsible for the commission of sexual health and genito-urinary medicine (GUM) services, and HIV prevention and testing. At the moment many of the facilities in sexual health are shared. Plans to put sexual health services out to competitive tender could result in a clear cut separation of such services. This separation may mean that if a part of the sexual health service goes to an outside provider then the BSUH trust may find that continued independent HIV treatment and care is unviable. This may have huge implications for HIV patients. They might either lose a vital service or have these services transferred to a different or new provider.'

16.14 The Chair responded as follows.

"I recognise concerns about the future of sexual health services and would not want to see any reduction in quality of these services. However, it is important that services for local people are as good as they can be and offer the best possible value for money. This does mean that the council will put services out to tender when there is a compelling case to do so. A written response will be provided on what the current obligations are and what commissioning will take place."

16.15 **RESOLVED-** That the deputation be noted.

17. ISSUES RAISED BY COUNCILLORS AND MEMBERS OF THE BOARD

17.1 The Chair noted that there were no petitions, written questions, letters or Notices of Motion from Councillors or members of the Board.

18. NEW ECONOMICS FOUNDATION: A PRESENTATION ON WELLBEING

18.1 The Board considered a presentation with slides from Juliet Michaelson from the Centre for Wellbeing nef (the New Economics Foundation). The presentation showed a map of the UK highlighting levels of wellbeing after controlling for deprivation. Another map of the UK showed local wellbeing inequality. The presentation set out nef's research on well-being and local government and explained the understanding of wellbeing at a local level. The dynamic model of wellbeing was explained.

18.2 The research recommended looking at means of linking disparate areas of local authority work and re-imagining the role of local government from provider of services to facilitator of good lives. The research showed that factors promoting wellbeing were not evenly distributed, so to improve wellbeing inequalities and deprivation should be tackled. There was also a need for balance between support for the vulnerable & the whole population focus.

18.3 The areas for action were strategic leadership, services & commissioning, strengthening communities, using LAs' own organisation levers and measuring wellbeing outcomes.

18.4 Councillor Meadows asked if nef was an independent think tank. She stated that she did not find anything new being proposed and stressed that the council had been discussing these issues for many years. Councillor Meadows considered that the council were already engaged in this work and already knew what it wanted to achieve. Ms Michaelson replied that nef were funded through its research work. She was sorry she had not brought anything new to the table. She was hopeful that there would be the opportunity to work more closely in future.

18.5 The Chair informed members that the council had not contracted nef to carry out this work. He further explained that he had seen a presentation that Juliet had given to the Local Government Association and had invited her to give the presentation to the HWB.

18.6 Tom Scanlon found the research very interesting and thought that there might be an opportunity to work together. He was keen to bring wellbeing into the sexual health service. There was a need to re-commission with a broader mind set.

18.7 Geraldine Hoban stressed the need to commission social capital. It was necessary to promote health and wellbeing in the city more generally. Any help in how officers commissioned would be valuable.

18.8 Ms Michaelson reported that an area of research was co-production. This was working in partnership. For example, time banks were a mechanism for people to help in any way they could and a means of building up relationships.

18.9 Councillor Pissaridou considered that the council should look at its own resources. The LA could be equipped to deliver this service. Ms Michaelson stressed that although nef did work with local bodies, she was not attending the Board to make a direct pitch to provide a service.

18.10 The Chair stated that there could be further discussions as to whether the council needed a further service as a result of considering this research. He thanked Ms Michaelson for her presentation.

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

19. SARAH CREAMER, DIRECTOR OF COMMISSIONING AT NHS ENGLAND, SURREY & SUSSEX AREA TEAM TO ADDRESS THE BOARD

19.1 The Board considered a presentation with slides from Susan Creamer, Director of Commissioning at NHS England, Surrey & Sussex Area Team. The presentation was an introduction to the Surrey and Sussex Team of NHS England. It explained the role, ways of working and responsibilities of NHS England. The presentation further explained the NHS England structure along with the structure of the Surrey and Sussex CCGs and hospital sites. The Surrey and Sussex Areas Team structure was set out with details of work carried out by the area team.

19.2 Ms Creamer explained that NHS England would welcome a seat on the Health and Wellbeing Board.

19.3 Councillor Pissaridou asked to whom were the area team responsible and how did they commissioned GPs. Ms Creamer explained that the area team was responsible to the board of NHS England. GPs were commissioned in a variety of ways. For example there were general medical contracts, lifelong contracts and other contractible vehicles and personal medical services.

19.4 Councillor Meadows thanked Ms Creamer and stated that she hoped NHS England did get a seat on the HWB. Councillor Meadows referred to the commissioning of primary care. She pointed out that private businesses such as dentists and opticians were involved and asked how this could be monitored. Ms Creamer explained that the CCG provided oversight for commissioning. There were a variety of vehicles for monitoring quality.

19.5 Xavier Nalletamby noted that the area team was not huge and stressed the importance of working together. Ms Creamer would commission what was required in partnership with GPs.

19.6 Councillor Meadows asked if GPs commissioned services to dentists and pharmacists. Geraldine Hoban explained that the situation was complex. The CCGs did not commission GPs. Basic contracts were agreed through the Area Team. GPs were CCG members and the CCG was trying to engage its members regarding quality issues. The CCG influenced better quality services rather than holding people to account over a contract. There was a need to work closely with the Area Teams.

19.7 Denise D'Souza asked where safeguarding would be placed. Sarah Creamer replied that there had been conversations to decide on where safeguarding should sit. A variety of models existed. She offered to take the question back for a definitive answer.

19.8 Councillor Bowden stated that this was the fourth reorganisation of the NHS that he had observed. He considered it a complicated hierarchical arrangement. He asked how much it would cost and what it would mean to the general public. He asked where sexual health would be placed. He further asked whether there would be further reorganisation if there was a general election and a new government.

19.9 Sarah Creamer referred to the NHS England, "Call to Action" agenda which was encouraging a debate to help the NHS meet future demand and tackle funding gaps. She stressed that if services continued to be delivered in the same way as now it could result in a funding gap which could grow to £30bn by the end of the decade. A dialogue was beginning with stakeholders to see how health services could be affordable.

19.10 Councillor Pissaridou asked about the position of preventative medicine in the new NHS structure. Tom Scanlon explained that this was part of the public health agenda and included work in housing, the environment, transport and education.

19.11 The Chair thanked Ms Creamer for her presentation and informed her that there would be discussions about her presence on the HWB.

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

20. JOINT HEALTH & WELLBEING STRATEGY SEPTEMBER 2013

20.1 The Board considered a report of the Director of Public Health which stated that the Health & Social Care Act 2012 required each local Health & Wellbeing Board to publish a Joint Health & Wellbeing Strategy. Brighton & Hove Shadow HWB agreed a draft JHWS in September 2012. However, HWB's did not become statutory bodies until April 2013, meaning that the JHWS must also be agreed by the statutory board.

20.2 The Health and Wellbeing Board Business Manager introduced the report. Members were informed that the strategy that members were being asked to consider was substantially the same document that was agreed at the September 2012 meeting. However, the opportunity had been taken to:
a) update the strategy where relevant (e.g. with a new section on the Joint Strategic Needs Assessment);
b) reflect consultation and engagement with a range of stakeholders - principally facilitated by the Brighton & Hove Community & Voluntary Sector Forum (CVSF);
c) undertake equalities impact assessment work (an EIA for the JHWS was attached as Appendix 2 to the report).

20.3 The revised JHWS was included as Appendix 1 to the report. The five priorities were listed in paragraph 3.3 of the report. (Cancer & Cancer Screening, smoking, emotional health and wellbeing (including mental health), dementia and healthy weight and nutrition.)

20.4 Geraldine Hoban reported that one of the areas that the CCGs were concerned about was the health of homeless people. It was considered that the delivery of this service needed better integration. She asked if it was time to consider whether the health of homeless people should be a priority.

20.5 The Deputy Director of Public Health replied that the five key priority issues in the strategy have been identified through a prioritisation process. There are several health and wellbeing priorities for the city, such as alcohol, which are not included in the strategy. In the first instance the plan is for a programme board to be established to consider issues related to homelessness.

20.6 The Chair stated that the HWB could think about additional items that don't fall into the normal identification process, when choosing priorities in the next cycle.

20.7 The Health & Wellbeing Board Business Manager stressed that the strategy was intended to add value to what was already happening in the city. He asked if the Board wanted to carry out this work through the strategy or through other measures. There was a need for a carefully managed strategy.

20.8 The Director of Public Health agreed that the paper on homelessness would be considered by the programme board.

20.9 Hayyan Asif asked about the process for deciding priorities for the next session. He asked how organisations would be contacted. The Health and Wellbeing Board Business Manager explained that there would be engagement with a number of organisations, particularly the CVSF.

20.10 Councillor Meadows asked how long it had taken to finish the consultation. The HWB Business Manager replied that the CVSF response was received in late spring 2013.

20.11 The Chair stated that it would be logical to think about priorities for the next year in the next few months.

20.12 Councillor Bowden stated that he considered smoking as a target to be an unwinnable battle. Many smokers were students who moved into the area. The Director of Public Health stated that prevalence was decreasing. A great deal of work was being carried out in East Brighton, although he acknowledged that new smokers were being imported.

20.13 Councillor Shanks asked if there was joint working with the universities. The Director of Public Health replied that Public Health did work with the universities with regard to smoking, alcohol etc. It was important to engage universities.

20.14 Councillor Norman stated that it was a good strategy which allowed for flexibility. He looked forward to seeing continued good work in the future.

20.15 Councillor Bowden praised the strategy's impact on licensing applications.

20.16 **RESOLVED** – (1) That the Joint Health & Wellbeing Strategy set out at Appendix 1, be approved and that its publication be authorised.

21. JOINT STRATEGIC NEEDS ASSESSMENT UPDATE SEPTEMBER 2013

21.1 The Board considered a report of the Director of Public Health which explained that from April 2013, local authorities and clinical commissioning groups had equal and explicit obligations to prepare a Joint Strategic Needs Assessment (JSNA). This duty was to be discharged by the Health and Wellbeing Board. The Board were therefore asked to note the publication of the JSNA summary for 2013. The plan for the 2013 summary update was approved by the shadow Board in March 2013. The Head of Public Health Intelligence informed members that the JSNA 2013 had been updated in line with this plan.

21.2 Members were informed that as part of the consultation process, there had been a call for evidence to the community and voluntary sector. There were 14 submissions from 12 organisations as set out in paragraph 4.5 of the report. The Head of Public Health Intelligence thanked the Community and Voluntary Sector Forum for its involvement in this process, and in promoting it to the sector.

21.3 Hayyan Asif asked about whether information from the schools surveys feed into the JSNA. The Head of Public Health Intelligence confirmed that evidence from the surveys is used widely in the JSNA.

21.4 Hayyan Asif asked about public engagement. The Head of Health Intelligence noted that the board had agreed in March that there would be no specific engagement with the public for the 2013 update. With Healthwatch now in place, Jane Viner, Healthwatch Manager, attended the September City Needs Assessment Steering Group to discuss and plan for how Healthwatch will be involved in providing further public voice into the JSNA. This is part of the action plan of the City Needs Assessment Steering Group.

21.5 Tom Scanlon stressed that the JSNA was a fantastic piece of work which provided a great wealth of information.

21.6 The Chair asked if additional information was expected from the 2011 census which could feed into the JSNA. The Head of Public Health Intelligence explained that more detailed data will be released up until February 2014.

21.7 The Chair thanked the Head of Public Health Intelligence, and all those involved, for their work on the JSNA.

21.8 **RESOLVED –** That the 2013 JSNA summary be noted for publication on BHLIS: www.bhlis.org/jsna2013

22. HEALTHWATCH: PROGRESS UPDATE - PRESENTATION

22.1 The Board received a presentation from Jane Viner, Healthwatch Manager, along with a Healthwatch Update paper.

22.2 Ms Viner explained that Healthwatch was an independent organisation which worked with patients to provide a quality service. The three main roles of Healthwatch were i) Influencing services, ii) Signposting through a helpline which was open from 10.00 am to 12.00 noon every day and iii) Advising. People could be referred to the complaints process.

22.3 Ms Viner explained the Healthwatch development process. The transition process Phase 1 - took place from April to July 2013. Phase 2 – Mobilisation was taking place between August to October 2013. Phase 3 – Implementation would take place from November to March 2014. Phase 4 – full independence would be in place from April 2014 onwards. By then the Healthwatch contract would be transferred from the CVSF to the new Independent Governing Body.

22.4 Councillor Shanks referred to the Shadowing Governing Body which was being set up. She asked how Healthwatch was ensuring diversity in the open recruitment process. Ms Viner explained that part of the selection and recruitment process was to interview people who had skills. Healthwatch wanted to ensure that the process was representative and were keen to engage young people.

22.5 Councillor Pissaridou asked who funded Healthwatch and how many workers were paid employees. She asked if Healthwatch was already a statutory body. Ms Viner replied that funding was received from the government, via the local authority. There was a tendering process and Healthwatch was centrally managed by Michelle Pooley, Community Engagement Co-ordinator at the council. There were four members of staff and an independent Chair who were all paid. 80 volunteers were signed up. The Volunteer Co-ordinator was a paid post.

22.6 Councillor Bowden asked if the helpline could be extended to 24 hours. Ms Viner explained that the helpline was transferred from the PCT. It was currently 10-12.00 noon, five days a week. Healthwatch wanted to extend this service and this might be carried out via outreach drop-ins or surgeries.

22.7 Councillor Bowden observed that most surveys of NHS users showed satisfaction. He asked how people were evaluated when they phoned and how complaints were validated. Ms Viner replied that Healthwatch worked with individuals and if someone wanted to make a complaint they would be referred to an independent advocacy process. Healthwatch empowered individuals to make choices for themselves.

22.8 Geraldine Hoban noted that Healthwatch would be accountable to the council over the next year. She asked to whom Healthwatch would be accountable post 2014. Ms Viner explained that Healthwatch would be independent but would still be funded and monitored by the council. Healthwatch would also be required to send an annual report to the Department of Health.

22.9 The Chair stated that he was keen to have a Heathwatch representative on the Health & Wellbeing Board. Ms Viner explained that a Healthwatch representative could be appointed when the Shadow Governing Body was in place. This would happen before the next meeting of the Health & Wellbeing Board.

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

23. INTEGRATED HEALTH, SOCIAL CARE & HOUSING SUPPORT FOR "HOMELESS" PEOPLE

23.1 The Board considered a report from the Chief Operating Officer, CCG which informed members that the Department of Health had informed the CCG that the proposal for the delivery of integrated health, social care and housing advice to “homeless people” through a co-located multi-disciplinary team had not been successful. Whilst feedback on the bid was very positive, they did not feel that the pilot would have the broader population impact required of the national pioneer sites.

23.2 There was however, from earlier discussions with partner agencies, a real willingness to implement a local integrated service along the lines of the model proposed. It was therefore recommended that despite not achieving national pioneer status the City proceed with a programme to deliver an integrated service and set up the necessary governance arrangements to oversee implementation.

23.3 Geraldine Hoban informed the Board that there had been a significant increase in street homelessness and that the life expectancy for the street homeless was low. There was increasing evidence that if resources were used wisely it led to better outcomes. Great improvements could be made by changing ways of working. The proposal was to provide a model of care for the homeless in the city which was primary care led.

23.4 Councillor Meadows expressed disappointment that the Government had not supported the bid. She supported the recommendation to implement the integrated model. Councillor Meadows considered that the probation service and the police should be involved in the project. She asked where the pump priming would come from and how much money was required.

23.5 Geraldine Hoban explained that a small amount of start up money might be required to fund nursing teams. She agreed that the suggestion to involve probation services and the police was a good idea.

23.6 Councillor Pissaridou also supported the recommendation. She mentioned that she was having a meeting with the Head of Housing and the Executive Director of Adult Services regarding the current lack of integration. There was currently no formal link between Adult Care & Health and Housing.

23.7 Councillor Bowden thought the approach was excellent. He asked if there were plans to work with ex service charities. Geraldine Hoban confirmed that working with ex service charities had been expressly focused on in the bid.

23.8 Hayyan Asif asked how the model would be assessed. Geraldine Hoban replied that there had been a national call for a pioneer bid and an opportunity to test integrated

working. There was a recommendation for a strong integrated team model. This was about creating a culture to innovate and test the service. Ms Hoban explained that she would like to develop links with the University of Brighton in order for them to carry out an evaluation of the model.

23.9 Pinaki Ghoshal stated that he supported the model and noted that there were many actions. He stressed the need to look at what was already happening in the City to avoid duplication and explore what would be the right options. Mr Ghoshal drew attention to the needs of young people who were homeless.

23.10 Geraldine Hoban agreed that there should not be duplication and reported that there would be multi disciplinary teams. She would make sure Mr Ghoshal's comments regarding young people were considered.

23.11 The Chair agreed with Councillor Meadows that the probation service and the police should be involved in the project.

23.12 **RESOLVED** – (1) That the detailed expression of interest in becoming a national pioneer site for integrating health, social care and housing support and the Department of Health's response, be noted.

(2) That the intention of partner agencies to implement the integrated model described in Appendix 1, be endorsed.

(3) That the setting up of a multi-agency Programme Board to oversee implementation of the integrated care model, be approved.

(4) That an oversight of the Programme Board be provided on an ongoing basis.

24. FUNDING TRANSFER FROM NHS ENGLAND TO SOCIAL CARE

24.1 The Board considered a report of the Chief Operating Officer, CCG and the Executive Director, Adult Social Services, BHCC which sought approval from the Board for the proposed plans developed jointly for the use of funding streams to support health and social care joint working.

24.2 In previous years this allocation had been passed by Primary Care Trusts to local authorities. In 2013/14 it was announced that the funding transfer to local authorities would be carried out by the NHS Commissioning Board and that the sign off of local proposals should be by Health and Wellbeing Boards.

24.3 The allocation for 2013/14 in Brighton and Hove is £4,397,579. It is a condition of the transfer that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. The funding must be used to support adult social care services in each local authority, which also has a health benefit.

24.4 Members were informed that this was the first opportunity for the Board to formally approve the Section 256 agreement. The Executive Director of Adult Social Services explained that plans were already in train and that some of the funding had already been committed in projects.

24.5 **RESOLVED** – (1) That the proposed use of the allocation as set out in section 3.5 be agreed and that the Section 256 agreement between the local authority and NHS England appended to this report be signed.

(2) That the Health and Wellbeing Board is provided with regular updates on how the funding is being used locally against the overall programme of adult social care expenditure and the overall outcomes against the plan, in order to assure itself that the conditions for the funding transfer are being met.

The meeting concluded at 6.36pm

Signed Chair

Dated this day of

HEALTH & WELLBEING BOARD	Agenda Item 28B 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 members of the public who either live or work in the area of the authority.

The following written question has been received from a member of the public.

(a) Dave Baker

"The response dated 7 Nov. 2013 to our deputation to the Health and Wellbeing Board on Sexual Health Provision in Brighton and Hove on 11 September 2013 is inadequate. In one item we sought an undertaking that competitive tendering would only be undertaken if there was clear evidence that it would improve service for patients. Your response only listed official and governmental guidance. Those documents supported competitive tendering on policy grounds and were not evidence based. Our question remains: what empirical evidence exists that shows that competitive tendering provides an improved service for patients? There is a strong possibility, if not mounting evidence, that competitive tendering may endanger patients' health and that you and the CCG will be responsible for it by taking non-empirically based decisions."

HEALTH & WELLBEING BOARD	Agenda Item 31 Brighton & Hove City Council

Subject:		**Brighton and Hove CCG - Commissioning Intentions of Brighton 2014-16**		
Date of Meeting:		**27th November 2013**		
Report of:		**Geraldine Hoban, Chief Operating Officer, Brighton and Hove Clinical Commissioning Group**		
Contact Officer:	**Name:**	**Geraldine Hoban**	**Tel:**	**574671**
	Email:	**Geraldine.Hoban@nhs.net**		
Ward(s) affected:		**All**		

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The CCG has a requirement to share its commissioning intentions with stakeholders, partners, patients and the public and provider organisations.

1.2 The attached document sets out the emerging commissioning intentions of the CCG for the two year period 2014/15 and 2015/16.

2. RECOMMENDATIONS:

2.1 That the Health and Wellbeing Board note the commissioning intentions of the CCG for the period 2014-2016.

2.2 That the Health and Wellbeing Board gives its opinion on whether the draft commissioning intentions 2014-1016 take proper account of the published Joint Health and Wellbeing Strategy.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The CCG has a Strategic Commissioning Plan outlining its priorities and commissioning programmes over the next five years.

3.2 The attached document outlines how, over the coming two years, the CCG, within the funds available, will deliver its strategic goals.

3.3 In addition to delivering the strategic direction for the CCG these commissioning intentions must also take into account national planning guidance as it emerges. Detailed planning guidance and financial allocations will be confirmed in November.

3.4 Our finalised Operating Plan for 2014-16 will be published in early 2014 and will come back to a future meeting of the Health and Wellbeing Board for final sign off.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Commissioning Intentions set out the financial context for planning over the next two years. Key issues to note are:

4.1.1 We will be required to make an additional efficiency saving of £6m approximately in 2014/15 – rising to £7m in 2015/16. We are confident that we will be able to deliver this through reduced demand for urgent care services and a number of re-procurements.

4.1.2 We will make full use of our 2% non-recurrent reserve to pump prime developments in primary and community services with a view to radically transforming the patient pathway and service model for elderly frail people in particular. This we will do in partnership with the Council through the Integrated Transformation Fund.

4.2 We will continue to deliver our programmes of service improvement with a focus on:

4.2.1 promoting integration across primary, community and secondary care;

4.2.2 redesigning high quality urgent care services that are responsive to patient needs and are delivered in the most appropriate setting;

4.2.3 aligning our commissioning to the health needs of our population and addressing health inequality across the City;

4.2.4 integrating mental and physical health services in order to improve outcomes and the health and wellbeing of all our population;

4.2.5 plan services that deliver greater integration between health, social care and housing and promote the use of pooled budgets;

4.2.6 deliver a sustainable health system by ensuring our clinical care models, commissioning and procurement processes and internal business practices reflect the broader sustainability agenda and deliver on our duties under the Public Sector (Social Value) Act 2012.

4.3 The Commissioning Intentions describe in detail commissioning plans for a range of service areas including: primary care development, community services, mental health, urgent care, planned care, maternity, children and young people's services, medicines management and continuing health care.

4.4 The document sets out the implications for the City of the Integrated Transformation Fund – £18.8m budget for integrating health and social care and transforming health outcomes and use of services for our most frail and vulnerable communities.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 Commissioning Intentions are pulled together following an extensive year round engagement process with member practices, patients and the public, partner organisations and co-commissioners. See pages 4-5 in the attached document for further details.

6. CONCLUSION

6.1 The CCG are obliged to publish commissioning intentions describing how funding will be applied on an annual basis to deliver our local strategic priorities and implement national planning guidance.

6.2 The attached document describes in detail the commissioning intentions for each of the key service areas over the coming 2 year period.

7. FINANCIAL & OTHER IMPLICATIONS:

7.1 Commissioning Intentions are required to include broad financial assumptions for the CCG only. These are included in section 3. The amount of funding required of the CCG in relation to the Integrated Transformation Fund (2015/16) is outlined in Section 7.

7.2 Any financial impact on the Council of the Commissioning intentions will be reflected in the budget strategy for 2014/15 and the Medium Term Financial Strategy.

Finance Officer Consulted: Anne Silley *Date: 18/10/13*

Legal Implications:

7.3 The National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) requires Clinical Commissioning Groups to consult the Health and Wellbeing Board on its draft commissioning plan and seek the Board's opinion as to whether the draft takes proper account of the joint health and wellbeing strategy. The Health and Wellbeing Board must also be consulted on further revisions or drafts.

Lawyer Consulted Elizabeth Culbert *Date: 29th October 2013*

Equalities Implications:

7.4 Equality Impact Assessments will be conducted on specific commissioning plans.

Sustainability Implications:

7.5 Section 9 in the attached document deals with sustainability.

Any Other Significant Implications:

7.6 Public Health has been involved in the identification of commissioning priority areas and production of the Commissioning Intentions document.

SUPPORTING DOCUMENTATION

Appendices:

1. Brighton and Hove Clinical Commissioning Group - Commissioning Intentions 2014-16.

Brighton and Hove Commissioning Intentions 2014-2016

Contents

1. Introduction

This document sets out the commissioning intentions for Brighton and Hove Clinical Commissioning Group (CCG) for the years 2014/15 and 2015/16.

These commissioning intentions reflect the direction of travel outlined in our 5-year Strategic Commissioning Plan namely to:

- increase capacity and capability in primary and community services so that we focus on preventative and proactive care – particularly for the most frail and disadvantaged communities;
- Design high quality urgent care services that are responsive to patient needs and delivered in the most appropriate setting;
- Align our commissioning to the health needs of our population and ensure we are addressing health inequalities across the City;
- Integrate physical and mental health services to improve outcomes and the health and wellbeing of all our population;
- Plan services that deliver greater integration between health, social care and housing and promote the use of pooled budgets;
- Deliver a sustainable health system by ensuring our clinical care models, commissioning and procurement processes and internal business practices reflect the broader sustainability agenda and deliver on our duties under the Social Value Act.

2014/15 will be a year in which we expect to see the full year effect of QIPP savings released from our urgent care programmes as people are supported to be maintained in the community through improved pathways of care and increased community capacity. In re-commissioning a number of integrated pathways for elective care we expect to deliver a better quality of service but also provide greater value for money. We are therefore confident that our QIPP challenge of £4-£6m will be delivered in 2014/15.

We recognise that in order to make the paradigm shift required to meet the growing demand for healthcare in future years we will need to radically transform the way in which health services are configured. 2014/15 will therefore be a year in which we fully utilise our 2% non-recurrent reserve. We will invest in enablers such as IM&T to facilitate greater integration between services. In addition we will be making significant investments in preventative care and community services in order to keep people well and rebalance the health system. Our intention is to maintain people at home and in the community wherever possible, ensuring any stay in hospital is kept to a minimum and facilitated by effective early discharge. We will do this in collaboration with providers of services and our commissioning colleagues to ensure alignment of

our commissioning plans and delivery of essential improvements such as the 3Ts capital development of the Royal Sussex County Hospital.

2. Developing our plans

Our Commissioning Intentions have been pulled together following an extensive year-round engagement process with:

i. our member practices:

- we have identified primary care based clinical leads for each of our key commissioning areas whose role it is to link back to member practices;
- bi-monthly discussions with each of our three Localities on commissioning plans including urgent care, diabetes, dermatology, substance misuse etc;
- on-line surveys on specific re-commissioning issues;

ii. patients and the public:

- quarterly public events discussing key themes such as use of urgent care services, the constitution – rights an obligations etc.
- regular meetings with third sector organisations contracted to provide feedback from traditionally excluded groups such as LGBT, gypsies and travellers, disabled people etc;
- quarterly meetings with Healthwatch to triangulate feedback on services;
- Feedback from PPG members via newly elected Patient Reps on Locality Management Groups, newly established PPG network etc;
- A summary document on our draft commissioning intentions will be send to all members of Patient Participation Groups across the City and a public event is planned for November where PPG members and Third Sector Organisations will be invited.

iii. The City Council,

- We have a regular Joint Officers Group where our draft commissioning intentions have been discussed at the earliest stage and co-designed. The Council are represented on our CCG Governing Body where commissioning plans are regularly discussed;
- Our Plans align with the Health and Wellbeing Strategy for the City and will go to the Health and Well-being Board's November meeting for information;
- Plans for the Integrated Transformation Fund are being discussed with the Health and Wellbeing Board and our governance structures around strategic planning and operational delivery of integrated plans are being strengthened.

iv. neighbouring CCGs and co-commissioners from NHS England:

- We have a memorandum of understanding with neighbouring CCGs to act as a co-ordinating commissioner for Brighton and Sussex University Hospitals. As such we have lead the process on developing commissioning intentions for the Trust on behalf of our neighbouring CCGs and ensuring these align with NHS England and longer term strategic aims around the 3Ts Development. There are robust governance mechanisms in place to ensure collaboration between commissioners and with the Trust.

3. Financial and planning context

In the absence of any national guidance, initial planning assumptions as reported in table 3.1 below have been discussed and agreed for local use, by Chief Finance Officers.

Table 3.1: Initial Planning Assumptions

	2014-2015	2015-2016
Growth on CCG Opening Allocations	2.00%	2.00%
Tariff (Mandatory)	-1.10%	-1.10%
Non Mandatory (Non-PbR, Tariff)	-1.30%	-1.30%
Activity Growth	2.35%	2.35%
CQUIN	2.50%	2.50%
Prescribing Inflation (before new drugs)	5.00%	5.00%
Contingency	0.50%	0.50%
Integrated Transformation Fund (est)	0.30%	3.00%
Non Recurrent Expenditure Reserve	2.00%	2.00%
Planned Surplus (1)	3.50%	1.50%

The CCG intends to increase its surplus in 2013/14, which will enable it to plan for a greater surplus in 2014/15 and be available to fund the major service transformation needed in future years.

Currently we are planning for a 3.5% surplus (£11.6m) in 2014/15, which would require us to make savings in the region of £6m.The intention to protect our surplus at 3.5%, needs to be balanced against the need to ensure that we also set a realistic and achievable level of saving, so we can ensure that we remain focused on the longer term transformational change and efficiencies and savings in future years.

Table 3.2:

	2014-2015 £'000's	2015-2016 £'000's
Growth	6,636	6,769
Return on prior year surplus	5,269	11,613
Additional surplus	6,969	
QIPP & Efficiency Savings-FYE	968	
QIPP & Efficiency Savings-New	5,383	7,781
Total Funding Available	**25,225**	**26,164**
Cost Pressures	2,000	2,000
Growth/Inflation/Tariff/CQUIN	6,790	7,109
Re-Establish Non-Rec Support	2,500	
Contingency	1,659	1,692
ITF	995	10,153
Top Up Non-Rec Expenditure Reserve	(333)	133
Planned Surplus	11,613	5,077
Total Funds Utilised	**25,224**	**26,164**
Non-Rec Expenditure Reserve	**6,636**	**6,769**

4. Service Specific Commissioning Intentions

4.1.Community Services

Providing responsive pro-active care in the community is a key priority for Brighton and Hove CCG. The population is ageing and many are living with more than one long term condition. We know from feedback from patients and their carers that they want services to be more holistic and more personalised. They want services to be supportive of them to achieve self-care and to be able to plan their future care (care planning); services which involve them in decisions about their care (shared decision making) and services which support them in their own homes without having to go to hospital if there are alternatives (care closer to home).

In Brighton and Hove we have recently redesigned a number of care pathways as part of this strategic approach including:

- Development of more community based dementia services in line with the National Dementia Strategy;
- Redesign of the End of Life Model of Care to support more people dying at home;
- Redesign of the Falls Care Pathway that prevents unnecessary attendance at hospital;
- Development of Integrated Primary Care Teams that provide pro-active care in the community using a case-finding approach;

- Redesign of the Community Short Term Services Model of Care into a single integrated provider model that provides more support to people in their own homes and less in bed based services.

In 2014-15 the CCG will focus on monitoring the redesigned care pathways; embedding changes and developing the models of care to ensure they deliver the anticipated outcomes and they are responsive, for example to patient and carer feedback and changing patterns of demand.

The CCG in collaboration with Brighton and Hove City Council and other local partners intend to develop an Integrated Frailty Care model as part of the CCGs longer term for a more radical integration of health and social care at a whole system level. The CCG has outlined a two year programme for this major transformational change programme which will have an impact on the current contractual arrangements for all local providers of care. We will work collaboratively with all local providers and other stakeholders over the next year to design the model. The preferred contractual route to secure the model of care will be developed as part of the business case process and we plan implementation from 2015-16.

Prior to the new model of care being introduced the CCG will continue to strengthen community services during 2014-16. Pathways that are in the process of being redesigned and will be re-commissioned are summarised in table 4.1.1 below.

Table 4.1.1:. Community Services Work Streams

Work stream	Description
Integrated frailty care	The CCG intend to develop an outcome based commissioning model for the delivery of integrated frailty care. We will fundamentally redesign the frailty model ensuring care is integrated and based in the community wherever possible.
Diabetes	We will develop an integrated community based model of care based on a multi-disciplinary team approach. We anticipate the new model of care being in place from April 2015.
Integrated Community Equipment Service	We are exploring the possibility of jointly procuring the community equipment service with Brighton and Hove City Council &West Sussex County Council.
Anti-coagulation Service	We will review the service model in light of changes to guidance and new drugs and tender a contract for an updated model of care which will start from April 2015.

4.2.Mental Health

Improving mental health and wellbeing is a key priority for the CCG and we are striving to ensure that mental health has equal status to physical health. The City has high levels of mental health need both in terms of numbers and degree of complexity and major transformational change has taken place within mental health services over the last few years with the aim of providing preventative care and support as early as possible. This strategic approach aims to prevent problems escalating and make the best use of our available resource. Recent Improvements that have been made to mental health services include:

- More services are available in community settings and there is greater accessibility for example a self-referral option to the Wellbeing Service;
- Increased provision by the community and voluntary sector, for example day services; psycho-social and employment support;
- Strengthened working arrangements between GP practices and providers of mental health services, for example the Wellbeing Service and Seriously Mentally Ill Enhanced Service;
- Enhanced crisis support service;
- Increased capacity in terms of supported accommodation, helping to prevent unnecessarily long stays in hospital.

In 2014-15 the CCG will focus on monitoring the changes that have been made; to ensure they deliver the anticipated outcomes and make any further adjustments where necessary, for example in response to patient and carer feedback and changing patterns of demand. We will also deliver a final tranche of service improvements including:

Table 4.2.1: Mental Health Work Streams:

Work stream	Description
Mental Health and Substance Misuse	We will develop an integrated model of care for people with a dual diagnosis of mental and substance misuse issues for people with more serious mental illness. This will form part of the Substance Misuse procurement process being led by Brighton and Hove City Council. The new model of care will be in place form April 2015.
Eating Disorder Pathway	We will commission a local comprehensive eating disorders service covering the spectrum of mild to severe disorders; improving physical health care as well as maintaining the health of those with more severe disorders . The new service will be in place from April 2014.
Psychological Support for Survivors of childhood sexual abuse	We will review pathways for psychological support for survivors of childhood sexual abuse with a view to developing improved streamlined care pathways.
Money Advice	We will review the current arrangements for provision of Money advice and ensure that we commission a comprehensive service across inpatient and community settings.

Work stream	Description
Pro-Active Crisis Prevention Pathway for Adults with Learning Disability	We will explore the development of an intensive response service for adults with learning disability with complex needs, for example with behavioural challenges and/or mental health conditions. The aim is to provide more preventative support in the community, preventing unnecessary use of out of area hospital placements.

The national Payment by Results programme for mental health is continuing to develop and we will use opportunities it presents to further advance transformational change through joint work with other CCG commissioners in Sussex, provider organisations and service users and carers.

Whilst the CCG will continue to focus on ensuring our mental health services deliver the best possible outcomes; moving forwards the strategic approach will broaden in line with the national strategy *No Health Without Mental Health.*During 2013 the CCG has been working with Brighton and Hove Council to develop a whole system Mental Wellbeing Strategy that will be implemented from 2014-15 onwards. The strategy aims to take promote wellbeing and build resilience and will provide a framework for further improvement to mental health services. It will also address the wider determinants of mental health and wellbeing including housing, education, leisure and employment. This broader approach aims to support the mainstreaming of mental health and wellbeing into all parts of the CCG's and BHCC's business as well as the community. By making the promotion of mental wellbeing part of everyone's business we anticipate it will help reduce some of the stigma associated with mental health.

4.2.1 Integration of Physical and Mental Health

A key strategic priority for the CCG is to develop pathways which improve integration of physical and mental health services. The CCG will continue to ensure that all pathways that are redesigned are done so in a holistic way that improves the integration of physical and mental health.

4.3.Urgent Care

Urgent and emergency care has been the subject of much focus at a national level. It is suggested that the current system is unaffordable and unsustainable and national figures highlight overall levels of activity and spend increasing year on year despite significant investment in alternatives. We have seen a loss of public confidence in GP out of hour's services and a shaky start to the implementation of the NHS 111 services.

In response to this NHS England has established a national review of emergency and urgent care services and has published four emerging principles:

- Provides **consistently** high **quality** and **safe** care, across all seven days of the week;
- Is **simple** and guides good choices by patients and clinicians;

- Provides the **right care** in the **right place**, by those with the **right skills,** the **first time;**
- Is **efficient** in the delivery of care and services.

At a local level, we know that despite the positive changes we have made in the system:

- Patients and the public still find it complicated and difficult to navigate;
- Patients are calling 999 and being taken to hospital when they could be supported on alternative community pathways;
- Our local acute hospital has struggled to achieve the 4 hour A&E standard and ambulance handover delays are a frequent occurrence;
- Despite year on year decreases in emergency admission, some patients are still being admitted to hospital for conditions that could be managed at home.

Our focus over the next two years will be to:

- Support patients and the public to make the right choices in accessing urgent care services;
- Streamline and integrate urgent care services so that patients get the right treatment first time however they choose to access care;
- Build capacity in primary care to manage urgent care demand;
- Work alongside the local acute hospital to achieve sustainable improvement in the A&E 4 hour standard and ambulance handover delays;
- Maximise the opportunities provided by technology to improve information sharing between professionals about patients in urgent care settings;
- Deliver a further reduction in avoidable ambulance conveyances;
- Develop and implement an integrated 24/7 urgent care model.

The proposed work streams to support this focus are summarised in Table 4.3.1 on the following page.

Table 4.3.1:Urgent Care Work Stream

Work stream	Description
GP Out of Hours	We will work with other CCGs to implement the new specification for GP out of hours from April 2014. This service will continue to be delivered from the Royal Sussex County site and be closely linked with A&E minors. We will continue to commission redirection pathways to OOHs from adult and paediatric A&E and weekend review clinics.
Supporting patients and the public to access care	We will continue to develop and implement our local communications strategy building on the work already started via the We could be heroes campaign.
NHS 111	We will work with our commissioning partners to ensure full delivery of the service specification for NHS 111 and the Professional Support Line (PSL) including achievement of key performance and quality indicators.

Work stream	Description
Building capacity in primary care	See Primary Care
Non admitted pathway	Following an audit of emergency admissions with a 0 length of stay, we will seek to develop a non-admitted care pathway for those patients whose care cannot be completed with the 4 hour A&E standard but who do not need to be admitted to a hospital bed.
Delivering the 4 hour A&E standard	We will continue to work in collaboration with our local acute hospital to achieve sustainable improvement in the 4 hour A&E standard and in ambulance handover delays.
Rapid Access Clinic for Older People (RACOP)	We expect to see the full implementation of the revised service specification for the Rapid Access Clinic for Older People (RACOP) including re-emphasising the urgent nature of the service and increasing same day appointments and direct referrals from A&E. We also intend to move to a locally agreed tariff from April.
Reducing ambulance conveyance	We will build on the findings of the supported conveyance pilot to secure a significant reduction in the number avoidable conveyances to hospital aiming for a maximum of 50% of patients being conveyed to A&E. We will work with other CCGs to develop a local approach to contracting and commissioning of ambulance services that is much more responsive to local need and priorities.
Using technology to support patient care	We will maximise the opportunities that technology offers to support information sharing between professionals in urgent care settings e.g. A&E access to SCR and anticipatory care plans.
Integrated Urgent Care model	We will commence a two year change programme to develop an integrated primary care led service as the entry point to urgent care in the city. We will be aiming for implementation 2015/16 and it is likely we will contract on an outcome based prime provider model which will include walk in centre, GP out of hours and A&E minor injury and illness. During 2014/15, following the piloting of the primary care navigator and GP in A&E roles, we will be seeking to implement a primary care stream in A&E minors.

4.4.Planned Care

We will continue to build on existing work to ensure that planned care services are high quality, accessible, timely and value for money. In particular we will ensure services:

- Provide support and education to primary care;
- Are based on evidence based clinical pathways and referral guidelines;
- Provide seamless and integrated care and so that the patient sees the right person the first time;
- Are convenient for the patient offering one stop facilities wherever appropriate;
- Enable patients to make informed choices about treatment options;
- Have sufficient focus on supported self-care and shared care wherever appropriate;
- Take account of the psychological as well as physical wellbeing of the patient;

- Are efficient and value for money and avoid duplication.

The work streams intended to facilitate these aims are summarised in table 4.4.1 on the following page. Also included in this table are examples of our work with the Clinical Network and Sussex Collaborative Delivery Team.

Table 4.4.1: Planned Care Work Streams

Workstream	Description
Peer review and education	We will develop and implement in conjunction with the Primary Care team, a structured approach to mentoring, supporting and feeding back to practices about referrals supported by clear referral criteria and evidence-based guidelines.
Advice and Guidance	Subject to the outputs of an evaluation, we will be seeking to commission the Advice and Guidance service on a recurrent basis at the non-face to face outpatient tariff.
MSK	Brighton and Hove, along with other CCGS, will conclude the procurement of a new integrated musculoskeletal service. This service will be contracted on a prime provider basis with the financial envelope including all MSK activities including secondary care spend. The CCGs will be looking to implement the new service from October 2014.
Dermatology	Following completion of the procurement process, we will be commencing the implementation of an Integrated Dermatology Service in July 2014. This service will include all dermatology activity currently provided via the integrated dermatology service plus outpatient paediatric dermatology. This service will be contracted on a prime provider model.
Nurse Follow ups	We would like to all review nurse led outpatient activity with a view to implementing a local tariff.
Consultant to consultant referrals	We are currently reviewing consultant to consultant referrals and this may lead to changes in process.
Cancer	We will link with the SEC Strategic Clinical Networks and Senate, Public Health England and the Department of Health regarding national campaigns and consider the impact of these on contractual arrangements with providers for 2014/2015. We will use our NAEDI money to roll out a programme of work with our newly appointed Cancer Clinical Leads (GP and nurse) work with practices around early detection of key cancers.
Armed Forces	Continue to work, though the Sussex Collaborative, to deliver our obligations under the Armed Forces Covenant, ie ensure appropriate and timely treatment of the health needs of armed forces personnel and their families. This will include programmes relating to homeliness, mental health and prosthetics.
Endo Bronchial Ultra Sound	We will, through the Sussex Collaborative, complete the procurement of EBUS to take full effect from 01-04-2014

4.5.Children and Young People

In the light of national changes in commissioning structures the Section 75 Agreement was amended in April 2013. The agreement now outlines how the City Council will deliver service improvements acting as Lead Commissioner for a range of community based services for children with disabilities and children and young people with mental health problems. The strategic aim is to ensure good integration with other services provided by the Council and across the City. The CCG will undertake a further review of this arrangement in 2014/15.

Children and Young Peoples Services are provided in the City via a number of commissioning arrangements summarised in table 4.5.1 below.

Table 4.5.1: Children and Young People Commissioning Arrangements

Lead Commissioner	Service Area
NHS England - Public Health	Health visiting, family nurse partnership and screening programmes
Public Health Team in the Council	School nursing, sexual Health, teenage Pregnancies, substance and alcohol misuse and local health promotion programmes
Brighton and Hove Clinical Commissioning Group	Acute health care including planned and urgent care, maternity and routine new-born services
Brighton and Hove City Council Section 75 Agreement with the CCG	Community health servicesincluding community pediatrics, the Integrated Disabilities Team, therapies and child and adolescent mental health services

Strong collaborative working on shared agendas is essential to ensure children and families receive joined up care. There are a number of key work streams in table 4.5.2 below which illustrate this.

Table4.5.2: Children and Young People's Workstreams (CCG and the City Council)

Workstream	Description
Child and adolescent mental health services	We will undertake a multi-agency review of young people's mental and wider health issues. This will focus on early intervention, prevention and resilience building. Key to these developments will be effective working between children's and adult's services and improved and smoother transitions processes. We will continue to support initiatives such as online counselling and seek to engage further with digital and social media. We will undertake further work with adult services to develop the available support for children and young people who have experienced sexual abuse, recognising the long term impact of such abuse and the importance of early intervention.
Children's disability	Continued multi-agency partnership work to develop greater use of personal budgets across education, health and social care. As part of the achievement of Best Practice Tariff in children's epilepsy outpatient care the Children's Hospital have recruited an epilepsy nurse specialist. A parallel development in the community

Workstream	Description
	for children with disabilities will allow for greater collaboration between acute and community. We will work collaboratively with all partners to ensure appropriate access to therapies, equipment for daily living and wheelchairs to ensure children are enabled to access education and remain healthy.
Psychological support for unwell children	A limited additional psychological resource from CAMHs has been provided to work within the children's hospital to support the wellbeing of unwell children and those with long term conditions. Joint work with the children's diabetes team has led to the development of a screening tool to help identify those children that require psychological input. An evaluation intended to take place in 2014 will inform the further roll out of a model for integrating physical and mental health, particularly for children with long term conditions.
Transition (adolescent services)	We will undertake a review with key stakeholders to map transition from children's diabetes to adults. Engagement work with families and patients will be a key part of this. Joint work to define the transition pathway from community paediatrics to adult hospital/GP services will be undertaken. We are working with the Children's hospital to review their adolescent services with the local voluntary group for young people - Right Here.
Children's Community Team (Hospital at Home)	A joint review of this team based at the children's hospital will enable a specification with key performance indicators to be developed for this service and help to understand the gaps and how to improve integrated pathways with the community.

4.6.Maternity

Maternity services in Brighton and Hove are provided by Brighton and Sussex University Hospitals Trust; there is an Obstetric Led Unit at the Royal Sussex County Hospital site or women can choose to have a home birth which accounts for about 5% of local births. Brighton does not provide full choice of birth place as it does not have a midwifery-led unit. Following initial delays there are now plans being developed for such a service that will provide for increased capacity, a co-located birth centre and a women's health centre for both ante natal and gynaecology outpatients. The current timescale for the completion of all this work is 2015.

Performance at Brighton has improved steadily in the last 2 years against the key performance indicators. Recentadditional investment in midwifery posts has seen an improvement in the midwife: birth ratio, bringing it down to 1:30 from 1:34;it will also impact on the homebirth rate

as a 24/7 Home Birth Service has been implemented. C- section rates, however, provide a very variable picture from month to month despite work to promote a culture of normalising birth. An audit of the Birthing Choices Clinic is proposed in 2014 to understand in more detail the choices women make with regard to child birth.
Brighton and Hove CCG will continue to monitor all maternity key performance indicators for our local population and work with our parent – led Maternity Services Liaison Committee to ensure that local women continue to have a positive and safe experience of maternity services.

4.7.Medicines Management

We will continue to build on the excellent work the team has achieved with partners across Sussex and in our local health community to promote medicines optimisation.
The Medicines Management Team will continue to provide expert input to the commissioning of services and will also deliver a Medicines Optimisation Projects which will outline the key work plans for 2014-15 aligned to the following priorities:

- Promoting efficient medicines use by focusing on GP practice and clinical variation;
- Medicines optimisation in care pathway redesign, and further integrating the medicines management team with the commissioning teams;
- Local decision making and managing innovation;
- Quality and safety improvement;
- Continue to build on the work on blueteq with partners to manage the Payment by Results Excluded Drugs;
- Collaboration with partners through the Brighton Area Prescribing Committee.

Table 4.7.1; Medicines Management Work streams 2014-2016

Workstream	Description
Continue to develop and implement the Joint Formulary, and create a paediatric joint formulary	We will continue to review and implement the joint formulary. We aim to develop a paediatric formulary in 14/15. We will continue to monitor adherence to the joint formulary using the eclipse system. We will feedback variance to adherence to all GP practices and other users.
High Cost Medicines Management	We will continue to develop and monitor Blueteq. We will work with providers to develop a CQUIN around high cost drugs. We will also audit the use of high cost drugs in selected specialities. We will develop closer links with finance teams and contracts within CSU to enable more timely challenges to be made on invoices for high cost items
Wound Care Project	We will roll out the ONPOS system and work with the community trust and DNs to tighten up the formulary choices. We will monitor the use of dressings and work collaboratively with our partners in the local health economy to optimise the use of dressings. We will monitor the effectiveness of ONPOs. This will help reduce wastage and improve adherence to the dressings element of the formulary.
Continence, stoma and Catheter supplies	We will embark on a project to optimise the use of these items and collaboratively develop guidance on appropriate choices and

Workstream	Description
	quantities. We will explore different procurement and ordering options and scope the options available. We will then implement the most efficient system throughout the CCG .
Care and Nursing Homes Medicines Management Support	We will continue to commission IRx to deliver the medicines management reviews to our care and nursing homes. We will build on this year's work and look to address systems issues highlighted in last year's and this year's work. We will continue to deliver QIPP savings without compromising on high quality care for the residents. The wound care project and continence project will help underpin the work in the homes.
Area Prescribing Committee	We will work with our two neighbouring CGGs and the provider trusts to ensure a robust work plan is in place. We will also ensure that all decisions are effectively communicated to stakeholders inc patients.
Primary Care Prescribing Project	The CCG will continue to provide support to GP practices (including dedicated practice-based technicians) across the city to ensure optimisation of efficiencies in standard prescribing through the use of script switch etc.

4.8.Continuing Health Care

We are committed to meeting our obligations under the National Framework for Continuing Health Care - in particular to provide assessments within the 28 day standard and to conduct regular reviews. The team has struggled, however, to meet the standards defined within the Framework given the increasing numbers of referrals and growing caseload as a result of *the retrospective requests for assessments of eligibility for cases* during the period 2004-12.

We have invested in additional nurse assessment capacity to address the backlog of patients during 2014/15 and to ensure we meet standards on an ongoing basis.

From April 2014 we will be offering the choice of personal health budgets to all adults and children eligible for CHC.

4.9.Vulnerable Communities and Traditionally Excluded Groups

Need to complete this section on Martin's return

5. Reducing Inequalities

Life expectancy in the Brighton and Hove City is higher than it has ever been. Women in the City can expect to live on average to 82.6 years and men 78.5 years. This is lower than the national

average by 2.5 months and almost three months respectively for women and men. Additionally, within the City we see a significant difference in life expectancy between wards. Women living in the most deprived parts of the city have a life expectancy of 80 years compared to 84.4 years for women living in the least deprived area. For men there is a gap of 10 years with men in the most deprived and least deprived areas expecting to live to 71.7 years and 81.7 years respectively.

In order to address the gap in life expectancy and improve mortality and morbidity in the City overall, the CCG plans to commission a range of high impact, evidence based interventions to improve health outcomesin 2014/15.

The type of evidence based interventions being considered is summarised in the table 5.1 below. These will be prioritised for investment following the outcome of the local Preventing Premature Mortality Audit.

Table5.1: Evidenced based interventions to improve health outcomes

Indicator	Action
Cardiovascular disease: Secondary prevention	Four treatments (beta blocker, aspirin, ACE inhibitor, statin) for all patients with a previous CVD event (currently untreated and partially treated)
Additional treatment for hypertensives with no previous CVD event	Additional hypertensive therapy Statin treatment for hypertensives with high CVD risk.
Treatment for heart attack	Primary angioplasty (PCI) for heart attack.
Anticoagulant therapy (Warfarin) for all patients over 65 with atrial fibrillation	
Diabetes	Reducing blood sugars (HbA1c) over 7.5 by one unit
Chronic obstructive pulmonary disease (COPD	Statins to address CVD risk among COPD patients
Reducing smoking in pregnancy	Eliminating smoking in pregnancy (infant deaths averted)
Harmful alcohol consumption	Brief intervention for 10% of harmful drinkers
Lung cancer	Increasing rates of early presentation
Smoking cessation clinics (setting a quit date)	Increasing rates of early presentation

Delivering successful interventions of the type described above will depend on building capacity within primary care. Drawing on examples of successful models elsewhere and building on our

primary care development strategy we will work with member practices on potential models for delivery which will also address:

- Greater consistency of achievement for QOF clinical indicators associated with premature mortality within and between General Practices;
- Higher achievement of QOF clinical outcomes moving closer to ONS peer comparators and England average;
- Reducing the prevalence gap between those with risk for conditions not yet identified in the community and those on Practice registers;
- Promoting peer challenge and learning based on benchmarking of achievement and identification of good and effective practice in General Practice;
- Identification of the clinical indicators within General Practice most strongly associated with premature mortality;
- Agreement of acceptable thresholds for exception reporting for clinical indicators most strongly associated with premature mortality;
- Enhancing the reach of primary care to identify those with risk – improve access and reach;
- Increasing capacity within General Practice to assess risk, register, treat and review new patients for major killers: COPD, CHD, stroke, diabetes;
- Incentivising higher achievement for clinical indicators associated with reducing premature mortality;
- Incentivising reducing exceptions for agreed indicators;
- Enhancing CQUINS in acute settings: e.g.
- smoking cessation;
- completion of stage 4 cardiac rehabilitation.

6. Primary Care Development

Primary care is considered to be the bedrock of NHS care provision, offering direct entry into the health care system and accounting for 9 out of every 10 patient contacts. Demands on general practice have never been greater with primary care professionals seeing more patients than ever with complex co-morbidities. In addition to an ageing population, rising patient expectations and persistent health inequalities illustrate the challenges facing primary care. In the UK the number of people with multiple long term conditions is set to rise from 1.9 to 2.9 million from 2008 to 2018.

There are also significant challenges within the primary care workforce. In Kent, Surrey & Sussex, 22% of GPs are over the age of 55, 20 % of Practice Nurses are over 55 with a high proportion of single-handed practices and part time workers. A shift to the management of long-term conditions in primary care has resulted in the need to facilitate longer patient consultation in general practice, and a subsequent impact on capacity.

In order to develop primary care we will focus our support and resources on three interlinked priority areas; **primary care infrastructure, workforce and organisational development.**

Delivering the highest standards of quality primary care for patients is paramount, alongside developing a quality workforce in our member practices that is sustainable, and can meet the challenges that lie ahead in general practice.

During 2013 we have established a Primary Care Development Team, including three Locality Member Group (LMGs) each with a General Practitioner (GP) Chair supported by three Practice Nurses, four Practice managers and more recently six locality patient representatives. We will continue to engage with members of the public through our public events to ensure that we are driving changes in care that are patient centred at all times. The LMG teams will be working with our member practices and also engaging with the public, to develop primary care across Brighton & Hove CCG.

Our focus over the next two years will be to:

- Develop an infrastructure to maximise the IT systems across general practice to enable a sharing of data and benchmarking for quality improvement;
- Collaborate with charity partners such as Macmillan Cancer Support & Prostate Cancer UK to pilot initiatives including the National Early Detection & Awareness Initiatives (NAEDI)and pilot a Prostate Cancer Charity Primary Care Nurse to offer support and information for men considering having a screening test for prostate cancer calledProstate Specific Antigen (PSA) testing in the community;
- Develop local and national outcome based quality indicators, to gain an evidence base of quality improvements in general practice. Exploring the commissioning of a best practice scheme across the practices;
- Systematically start to quantify those patients with unmet needs and those in the community whose risk has not yet been detected;
- Undertake a pilot of primary care workforce development-Community Education Providers Network (CEPN) to build a future workforce across primary care;
- Support our member practices to explore amongst themselves new models of collaborative working to develop as organisations and providers of primary care;
- Ensure that appropriate resources follow the patient when services move to primary care settings;
- Build and support capacity in primary care to meet increasing urgent care demands;
- Continue to develop a primary care strategy across Brighton & Hove CCG.

Table6.1: Primary Care Commissioning Intentions

Workstream	Description
IT systems	We aim to develop IT systems across General Practice to enable a sharing of data and benchmarking – including GP Data Extractions and continue with Quest Browser, developing requirements for CCG and Practice GP performance dashboards. We will also support the Preventing Premature Mortality Audit to create an evidence base of those patients not on disease registers

Workstream	Description
Building capacity for the future	We will work with the LMG to identify those areas that require existing and new premises developments led by the Area team. Alongside those practices which could maximise space and capacity in innovative way with new partners.
Working with our Local Member Groups	We will continue to develop and support our LMGs and our patient representatives to be fully involved in clinical commissioning and primary care development ensuring robust two way communication and feedback which reaches each member of the primary care workforce and including the patient population of the practices
Workforce Development	We are committed to taking part in a Kent Surrey Sussex (KSS) Health Education England (HEE) Pilot a city-wide Community of Education Providers Network (CEPN) . This will develop a multi-professional ethos of education in primary care In phase 1 nurse tutors will be identified and trained across Brighton & Hove CCG to develop a new primary care workforce We will facilitate clinically led peer review process and shared learning, based on benchmarking of achievement and identification of best practice in General Practice. This will enable our member practices to share best practice and drive quality improvements
Organisational development	The LMG will lead a 6 month Pilot of the Innovations Forum to develop new ways of working together for our member practices We will support our member practices to have discussions about models and functions of collaborative working to support the sustainable future of General Practice
Reducing health inequalities and supporting outcomes	We will develop and work with charity partners such as Macmillan Cancer Support & Prostate Cancer UK to pilot initiatives with National Early Detection & Awareness Initiatives (NAEDI) and pilot a Prostate Charity Development Nurse to sign post men for PSA testing in the community. We will utilise the data from the Primary Care Audit Tool & indicators and develop locally agreed outcome indicators to look at best practice. We will explore differing models of commissioning and supporting best practice in quality improvements in primary care. We will develop a systematic way to quantify those patients with unmet needs and those in the community whose risk has not yet been detected
Impact on primary care from service redesign	We will work with our patients, members of the public member practices and commissioning teams in the CCG to identify those services that could be provided more closer to home

Workstream	Description
	We will then ensure that consideration is given to ensuring that appropriate resources (including workforce) follows the patient when services move to primary care settings
Supporting Urgent Care	In conjunction with the unscheduled care team we will implement a range of initiatives to build capacity in primary care including: Developing the primary care workforce to support urgent care in primary care, including trial of 'pop up clinics' and development of Practice Nurse skills & competencies Peer review and education to reduce variation in clinical practice Supporting the utilisation of the urgent care dashboard to support decision making Pilot Dr First within the LMG Supporting & embedding the urgent care standards Collate data from indicator practices on activity in primary care to understand the pressures within the whole system and how to action plan accordingly

7. Integrated Transformation Fund

The Integrated Transformation Fund (ITF), announced as part of the Spending Round in June 2013 makes £3.8bn available (in 2015/16) for local deployment through pooled budget arrangements on integrating health and social care. The aim is to transform outcomes (and use of services) in the most vulnerable and frail in our community and address criteria such as 7 day working. Whilst £1.9bn is already in system i.e. in budgets for carers breaks, re-ablement funding etc, an additional £1.9bn NHS funding will be made available. The financial implications for Brighton and Hove are estimated below.

Table 7.1: Financial Implications of Integrated Transformation Fund for Brighton and Hove

Elements of the Integrated Transformation Fund	£mill
Social Care Grant	4.3
Additional Funds 14/15	1.0
DoH – Capital Grants	1.7
Reablement Funding	1.4
Carers Breaks Funding	0.6
Additional Funds 15/16	9.1
Total	**18.1**
Existing	8.0
New	10.0

Further guidance on the use of the fund is expected in November as part of 2014/15 planning round but the CCG in collaboration with the Council are developing plans for extending integrated commissioning and delivery into the frailty pathway and homeless service which are detailed below.

7.1.Integrated Frailty Pathway

The re-design of the frailty pathway is being led by the Urgent Care Clinical Forum. A two-year programme of work to fully scope and implement the integrated pathway is being initiated and funding for a Programme Manager, working across the CCG and Council has been agreed. A key early element of the programme will be to quantify the pump-priming and double running costs required of the 2% non-recurrent reserve and fully describe and quantify patient outcomes and impact elsewhere in the system. Discussions with stakeholders and providers will be initiated to understand and plan for the most effective delivery model for this new community based service.

7.2.Integrated Homeless Service:

The model for a Primary Care Lead, co-located in a multidisciplinary team for homeless people in the City – incorporating housing support and third sector provision -was signed off by the Health and Wellbeing Board at its September meeting. Dedicated managerial support has now been secured to scope the integration process, quantify required elements of pump priming and define outcomes and impact in the system.

Both of the above represent significant programmes of work which are key elements of our commissioning intentions and Operating Plans for 2014/15.Proposals for these and the governance surrounding the Integration Programme will go the November 2013 meeting of the City's Health and Wellbeing Board.

8. Quality and Safety

Quality and safety in the delivery of health services, is the fundamental core to the roles and responsibilities of every commissioning and provider organisation. Within Brighton & Hove Clinical Commissioning Group (CCG), quality is defined as clinical effectiveness, patient experience and patient safety. We are committed to ensuring patient focussed outcomes arising from the standards should be embedded in service redesign, planning and commissioning and that all contracts are robustly monitored , in order to provide assurance that the quality standards and outcomes are being met.

We take full regard of the recommendations from the Francis Report (Department of Health 2013), and will seek assurance from providers that;

- fundamental standards and measures of compliance are always met
- they demonstrate openness and candour
- they promote and provide compassionate, caring and committed clinical staff
- they promote strong healthcare leadership
- they provide information and data that is transparent to service users and the public

We formally monitor the quality and patient safety of our three main NHS providers by meeting with them monthly. For Brighton and Sussex University Hospital NHS Trust we are the lead commissioner and fulfil this role for our partner CCGs and NHS England. Sussex Partnership NHS Foundation Trust (SPFT) and Sussex Community Trust (SCT) lead commissioners are Costal West Sussex CCG and Horsham & Mid Sussex CCG respectively. We have a robust framework assuring information sharing and joint decision making regarding quality and safety issues with both these partner CCGs. B&H CCG also have monthly quality monitoring meetings with the B&H locality clinical management teams.

We are committed to building relationships with other smaller providers and a work program to monitor quality and patient safety relative to the scope and risk of the contracts is being developed.

Our focus over the next two years will be to:

Table 8.1; Quality and Safety Work Streams

Workstream	Description
Patient Safety	We will be hosting the Patient Safety Team for all the Sussex CCGs, building on the benefits of the pan Sussex approach to managing Serious Incident and Never Event reporting and learning. In April 2013 NICE were established in primary legislation, becoming a Non Departmental Public Body (NDPB) and placing them on a statutory footing as set out in the Health and Social Care Act 2012. NICE's role is to improve outcomes for people using the NHS and other public health and social care services . We will monitor the providers compliance with implementing NICE guidance. B&H CCG is committed to ensuring the use of NICE Guidance in its decision making and has committed to work with the local NICE Field Agent to support the development of NICE guidance.
Patient Safety Champions in Primary Care	Working with the NHS England Area Team and the Local Member Group practice nurse representatives and practice nurse forum we will be supporting the development of primary care patient safety champions. Developing a culture and capacity in the workforce to support the ethos of patient safety throughout the pathway of care, building confidence in the system and sharing good practice.
Infection Prevention and Control resources	We will host the jointly commissioned Infection Control Practitioner with Costal West Sussex CCG. This post will lead on infection control and prevention, survey, review and analyse healthcare associated infections (HCAIs) and support cross agency working to facilitate standardised approach to infection prevention and control. Clostridium Difficile (C-Diff): We will be working with provider organisations and across the pathway of care alongside our medicines management team to ensure the reduction in avoidable C-Diff cases. Methicillin Resistant Staphylococcus Aureus (MRSA): There is a zero tolerance to avoidable MRSA. We will continue to work with providers and monitor the outcome of the investigation of any cases.
Decontamination Advice	We will jointly commission, with Costal West Sussex, a decontamination expert in order that B&H CCG has access to technical advice and guidance.

Workstream	Description
	This will support the CCG to manage the safety of patients in current and newly commissioned services.
Quality monitoring	The Quality and Patient Safety team will work alongside the commissioning team and CSU commissioning managers as clinical quality and patient safety advisors. There will continue to be a program of formal quality and patient safety monitoring and challenge through quality review meetings with the 3 large NHS providers. There is a program of meetings with local Care Quality Commission and Health-watch representatives to share intelligence. Local General Practitioners are also responsible for feeding patient experience and issues in to the system via a dedicated email address.
Safer staffing and Workforce Development	We will ensure that individual providers maintain a process of assurance that service redesign and development has Chief Nurse and Medical Director agreement that patient safety will not be compromised. B&H CCG will engage through membership of the Lead Nurse network with the National review of safe staffing underway at present.
Patient Experience	We commit to assure that patient feedback drives the development and improvement of services. The Friends and Family Test is mandatory in acute settings and maternity settings and will form a part of the quality review information. Patient experience feedback will also inform the quality monitoring though CCG held public events, national patient surveys, GP practice patient forum and Local member group patient representative feedback
Safeguarding	Protecting vulnerable adults and children is a multi-agency responsibility and depends of excellent communication and information sharing. Adults: Our Lead Nurse and Director of Clinical Quality & Primary Care is the Executive Lead for Safeguarding. All Quality and Patient Safety managers will also have level 3 adult safeguarding training and are able to undertake Health Investigations. It is anticipated that during the year 2014-15, Adult Safeguarding will become a statutory requirement and will require additional resource both in the form of named doctor (part time) and a financial contribution to theAdult Safeguarding Board running cost. Children: Our Lead Nurse and Director of Clinical Quality & Primary Care is the Executive Lead for Safeguarding and sits on the B&H Local Safeguarding Children's Board (LSCB) We have a WTE Designated Safeguarding Children's Nurse We commission .2 sessions of Designated Doctor sessions per week to support the CCGs strategic responsibilities and planning, and we have a .2 Named GP to support primary Care.
Winterbourne View Concordat	B&H CCG has been working in partnership with the City Council through a section 75 agreement to deliver improvements in the care for individuals with learning disabilities and are in a placement out of the area. Repatriation is the aim where possible. All individuals have a dedicated case manager to support this aim.
Clinical pathway redesign	All Clinical Quality and Patient safety managers employed in the quality governance team will be working with commissioning managers, and

Workstream	Description
	primary care clinical leads to support the development of care pathways and service redesign, assuring a focus on the quality and safety of services
Facilitating partnership working across the system	We will continue to support and facilitate the Nursing Home forum. Bring together clinicians and mangers from the private sector, the acute, community, mental health and primary care providers in order to develop an shared understanding of the challenges and pressures, facilitate the sharing of good practice, and to support the development of partnership working in order to ensure the best outcomes for in particular but not exclusively older people and those who are vulnerable.
CQUINS	We will fully utilise CQUINS as a lever to drive real improvements in quality and patient experience.

9. Sustainability

The CCG, as part of its authorisation process committed to developing a Sustainable Commissioning Plan. We have begun the process of pulling our plan together under the following three areas:

9.1.Commissioning for Sustainability:

- Ensuring our clinical pathway designs address prevention, quality, innovation productivity and integration.
- Delivering our duties under the Social Value Act of 2012 and embedding social value and community assets in our procurement practice.
- Fully utilising contractual levers to ensure sustainable practice within commissioned services.

9.2.Being Sustainable as an Organisation

- Ensuring we have energy efficient business processes;
- Paying our staff the City's living wage;
- Providing a workplace which facilitates health and wellbeing.

9.3.Leading our Member Practices

- Supporting general practice with energy audits and top 10 high impact actions;
- Addressing areas such as medicines wastage;
- Facilitating enablers such as the roll out of electronic prescriptions;
- Agreeing a programme of work with member practices and developing a "sustainability pledge" for members.

A detailed Sustainability Plan will go to the Governing Body for sign off in January 2014 and will inform our commissioning and business processes in 2014/15 and beyond.

HEALTH & WELLBEING BOARD	Agenda Item 32 Brighton & Hove City Council

Subject:		**Autism Strategy: Self Assessment**
Date of Meeting:		**27th November 2013**
Report of:		**Executive Director of Adult Services**
Contact Officer:	**Name:**	**Mark Hendriks** **Tel: 29-3071**
	Email:	**Mark.hendriks@brighton-hove.gcsx.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The Department of Health required all areas to report on the progress of local Autism Strategies through a national self-evaluation exercise, the Autism Self-Assessment Framework 2013. The Minister of State for Care & Support, in a letter to Directors of Adult Social Services (2nd August 2013, Appendix 1) required that local Autism Self-Assessments are *"discussed by the local Health and Well Being Board by the end of January 2014 as evidence for local planning and health needs assessment strategy development and supporting local implementation work."*

1.2 The Department of Health intend to use the information gathered from all areas to inform a refresh of the Adults Autism Strategy in 2014.

2. RECOMMENDATIONS:

2.1 That the Health & Well-Being Board notes the content of the Brighton & Hove Autism Self-Evaluation report (Appendix 2)

2.2 That the Health & Well-Being Board notes the progress made to date through the Autism Strategy and the plans for further development and improvement of local services and outcomes for people with Autism Spectrum Conditions (ASC).

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The local response to meeting the needs of adults with autism is driven by a range of national and local activities:

- The recommendations of the Autism Act (2009),
- 'Fulfilling and Rewarding Lives', the strategy for adults with autism in England (2010), which has accompanying statutory guidance for implementation.
- Local recommendations through extensive consultation

- The Scrutiny Panel on Services for Adults with Autistic Spectrum Conditions (March 2011)
- The Joint Strategic Needs Assessment (JSNA) for Adults with Autism

3.2 Local priorities and actions are defined in the Brighton & Hove Joint Commissioning Strategy for Adults with Autistic Spectrum Conditions 2012-2015. The strategy is led by the Adult Social Care Commissioning team.

3.3 This local strategy *"sets out the longer-term direction and scope of how health and social care services and their partners can achieve better outcomes for adults with autism, their families and carers"* (p3)

3.4 The strategy sets out 25 strategic objectives, each with relevant strategic actions and outcomes. The governance of the strategy sits with the Adult Autism Strategy Stakeholder Group which includes representation for people with autism, carers, community groups and professionals from across the public sector and meets throughout the year to monitor and drive activities to achieve the strategy's objectives.

3.5 The strategy is currently in the early stages of year 2 of its 3 year life:
Year 1 has focussed on improving the diagnostic and care pathway for adults with autism and improving the training and awareness of ASC in the workforce.
Years 2 and 3 will increase focus on the transition for people with autism as they move from being children to adults and local planning and commissioning of services. This will involve actions to improve services across sectors in health, housing, social care, employment, education & leisure.

3.6 The agenda for improving the lives of adults with autism is wide-ranging and complex, as it implicates services across the city at every level. Consistent and continuous efforts are needed from a range of partners in order to make comprehensive progress.

3.7 In this context significant progress has been made and there is an ongoing commitment to improving local services for adults with autism. The comprehensive strategy and partnership working arrangements will support ongoing and long-term progress.

3.8 All local areas were required to complete and submit an Autism Strategy Self-Assessment.

3.9 The local Autism Strategy Self-Assessment highlights the following key areas of good performance

- We have a local lead for Autism and a thorough local Joint Strategic Needs Assessment which informs our local strategy
- We are engaged with our local CCG on the Autism Strategy and work jointly with CCG colleagues, as well as colleagues in the Criminal Justice System.
- We have re-commissioned a comprehensive new programme of training for Adult Social Care staff, including training Autism 'Champions' in mainstream services
- Our Autism Strategy has been developed with wide consultation and we have a Autism Stakeholder group that includes multi-agency representation from

the statutory, independent and voluntary sectors as well as engagement from family carers

- Although our diagnostic services have historically not kept pace with demand, we have commissioned an additional service that is dramatically reducing waiting times for diagnosis and full performance figures will be available by January 2014.
- We do have a range of community and voluntary sector services that support people with ASC and their family carers.
- Autism Sussex have been awarded lottery funding to enrich Autism services within Brighton and Hove, particularly where there are gaps in provision, or in cases where referrals do not meet eligibility criteria for social care. There are now three new projects in Brighton & Hove that are in the initial stages of development
- We have good local Supported Employment services that can be accessed by people with ASC.
- We are working with commissioners in children's services and education to ensure our strategy complements the changes and developments in services for children as they reach adulthood.

3.10 The Autism Self-Evaluation highlights the following key areas where significant improvement is needed to meet Department of Health best practice expectations.

- Although we have some data collection in social care, health and housing services, these are not collated on a single database and therefore our data collection is limited and segmented. Information about older people with ASC is extremely limited. We will aim to improve systems and data collection by 2015 (the end of current Adult Autism Strategy)
- The majority of services fulfil their duties for reasonable adjustments under the Equality Act 2010, without specifically referencing ASC. We have only a few examples of services which have made reasonable adjustments specifically for people with Autism, This includes services provided in the statutory, independent and voluntary sectors. We want more local organisations to make adjustments to enable people with autism to access services. We need to do further work develop a clear council policy and develop key services to make specific reasonable adjustments for people with ASC
- We need to review the range and level of community and voluntary sector services available to people with ASC who need ongoing support but are not eligible for statutory services, and highlight gaps in services to inform commissioning priorities. This will be completed in 2014.
- We need to improve the information available to people with ASC at their point of contact with Adult Social Care services and develop a clearer pathway to assessment and support. This will be completed in 2014.
- We need to improve the uptake of training delivered to key services: assessment, advocacy, primary care. This is being reviewed and will be completed by Spring 2015.

3.10 The Adult Autism Strategy half-way through its 3 year life (April 2012-March 2015). In that context we would expect there to be a number of areas that are not completed, but all of the areas for improvement highlighted in the self-evaluation exercise are addressed through objectives in our local strategy.

3.11 Brighton & Hove's self-assessment for improving local services and outcomes for people with ASC is expected to be broadly in line with progress across England, although there will of course be variations between regions. With a comprehensive local strategy and a multi-agency Stakeholder Group overseeing its progress, there are reasons to be confident that further significant progress will be made in the next 18 months and areas needing improvement will be addressed.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 The Autism Strategy Self-Assessment response was developed in full consultation with the Adult Autism Stakeholder Group.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There is no specific funding attached to the autism strategy, the plans for further development will need to be met through the Adults Services budget and resources identified by partners.

Finance Officer Consulted: *Anne Silley* *Date: 01/11/13*

Legal Implications:

5.2 There are no legal implications arising from the recommendation in this report

Lawyer Consulted: *Elizabeth Culbert* *Date: 01/11/13*

Equalities Implications:

5.3 An Equality Impact Assessment has not been completed specifically in connection with the completion of the Autism Strategy Self-Assessment, but a full EIA was completed in the development of the Autism Strategy.

Sustainability Implications:

5.4 The Autism Strategy Self-Assessment itself has no specific Sustainability implications, but progress of the strategy implies more sustainable solutions to meeting the needs of local people with ASC.

Crime & Disorder Implications:

5.5 The Autism Strategy Self-Assessment itself has no specific Crime & Disorder implications, but specific areas of the strategy address the need to engage with the Criminal Justice System to ensure that training and awareness of ASC creates a an awareness of the specific needs of people with ASC who may come into contact with CJS services. The wider aims of the strategy to meet the needs of people with ASC will reduce the risks to people with ASC being victims of or engaging in risky or criminal behaviour.

Risk and Opportunity Management Implications:

5.6 The Autism Strategy Self-Assessment itself has no specific Risk Management Plan. The risks, opportunities and barriers to progress are managed through the strategy itself which is managed and monitored through the Adult Autism Stakeholder Group.

Public Health Implications:

5.7 The Autism Strategy Self-Assessment itself has no specific Public Health implications, but progress of the strategy implies positive Public Health impacts in terms of better planning for children and young people, greater capacity for self-determination for individuals with complex needs, better access to work and meaningful activity, better health outcomes through enhanced diagnostic services and greater awareness and training for health staff, and more sustainable communities and places through improved training, awareness and reasonable adjustments.

Corporate / Citywide Implications:

5.8 The Autism Strategy Self-Assessment itself has no specific Corporate / Citywide implications, but progress of the strategy is in line with council and citywide priorities (through partnership working) to reduce inequalities, improve value for money, develop capacity in local services, improve health and well-being outcomes and ensure the city meets the needs of the most vulnerable.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Not to complete the Autism Strategy Self-Assessment, however it is a national requirement that all Local Authorities complete and submit by 10th October 2013.

6.2 Not to share the Autism Strategy Self-Assessment with the Board, but this is also a national requirement.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 As a requirement of the Minister of State for Care & Support.

SUPPORTING DOCUMENTATION

Appendices:

1. Letter from Minister of State for Care & Support, Norman Lamb MP, 2nd August 2013

2. Brighton & Hove Autism Self-Evaluation, 2013, Final version

Documents in Members' Rooms

1. None

Background Documents

1. The Autism Act (2009)
2. 'Fulfilling and Rewarding Lives', the strategy for adults with autism in England (2010)
3. The Scrutiny Panel on Services for Adults with Autistic Spectrum Conditions (March 2011)
4. The Joint Strategic Needs Assessment (JSNA) for Adults with Autism (2011)
5. Brighton & Hove Joint Commissioning Strategy for Adults with Autistic Spectrum Conditions 2012-2015

From Norman Lamb MP
Minister of State for Care and Support

To: **Directors of Adult Social Services**

Copied to: **Directors of Public Health**
Directors of Children's Services
Clinical Commissioning Group Leads and Accountable Officers
Chairs of Health and Wellbeing Boards

Richmond House
79 Whitehall
London
SW1A 2NS

Telephone: 020 7210 3000

2 August 2013

Dear Colleague

The 2010 Adult Autism Strategy *Fulfilling and Rewarding Lives:* Evaluating Progress – the second national exercise.

This letter is to obtain your assistance in taking forward the second self-assessment exercise for the implementation of the Adult Autism Strategy. Local Authorities play a key role in implementing the recommendations of the Strategy and the statutory guidance that supports it.

The purpose of the self assessment is to:

- assist Local Authorities and their partners in assessing progress in implementing the 2010 Adult Autism Strategy;
- see how much progress has been made since the baseline survey, as at February 2012;
- provide evidence of examples of good progress made that can be shared and of remaining challenges.

An on-line return to Public Health England via the Improving health and lives website is required **by Monday 30 September 2013**.

I am sorry that this exercise is to a broadly similar timescale as the one on Learning Disabilities. We had tried to avoid this but with the information

that is submitted being a vital part of the Review of the Adult Autism Strategy and the unavoidable timetable for the Learning Disabilities self assessment, this has not proved possible.

The Adult Autism Strategy

The Adult Autism Strategy *Fulfilling and Rewarding Lives* was published in 2010. It is an essential step towards realising the Government's long term vision for transforming the lives of and outcomes for adults with autism. The Department of Health is the lead policy department for the Strategy but with delivery shared across a range of government departments and agencies, and local health and social service providers.

The Autism Strategy has five areas for action aimed at improving the lives of adults with autism:

- increasing awareness and understanding of autism;
- developing a clear, consistent pathway for diagnosis of autism;
- improving access for adults with autism to services and support;
- helping adults with autism into work; and
- enabling local partners to develop relevant services.

The Strategy is not just about putting in place autism services but about enabling equal access to mainstream services, support and opportunities through reasonable adjustments, training and awareness raising.

Review of the Strategy

The Department of Health is currently leading a formal review of progress against the Strategy. This is an opportunity for Government to assess whether the objectives of the Strategy remain fundamentally the right ones, to be assured of the progress that is being achieved by Local Authorities and the NHS, and consider what should happen to continue to make progress and what barriers could be resolved. The investigative stage of the Review will last until the end of October and the Strategy will be revised as necessary by March 2014.

The self-assessment exercise

This exercise builds on the first self assessment exercise which looked at what progress had been made since February 2012. This was based around the self-assessment framework which the Department of Health

launched in April 2011 to support localities with the delivery of the Adult Autism Strategy and the statutory guidance for health and social care which was issued in December 2010. The individual returns received and related reports from February 2012 can be found at www.improvinghealthandlives.org.uk/projects/autsaf2011.

We hope to get a national overview of local area implementation of the strategy, identify the good progress made with examples of the impact for people with autism where possible and for this to assist the review in developing next steps for the strategy. We are also keen to understand the challenges which may be impacting on progress and local solutions.

The list of questions is more focused than last time but will still enable a comparison with results from the 2012 exercise. For some questions there is a RAG rating system with scoring criteria for that question. If a question is scored Red or Amber, respondents will be asked to say what is stopping progress and for Green scores there will be the opportunity to say what actions have enabled progress. Examples of good practice and where actions have made a positive impact on individuals are also being sought.

It is important to come to a multi-agency perspective, including liaison with Clinical Commissioning Groups, to reflect the requirements of the implementation of the strategy, although the Local Authority is tasked with the consolidation of the return as the lead body locally. The returns will be analysed by the Public Health England learning disabilities observatory. The on-line questionnaire can be accessed at www.improvinghealthandlives.org.uk/projects/autism2013. Respondents should be aware that all local responses will be published in full online.

Action needed

I would be grateful if you could draw attention to and discuss this letter with the person who is responsible for adult autism within your authority, so that they lead the co-ordination of the return in your area. The timescale for completion of this part of the exercise is **Monday 30 September 2013**.

The response for your Local Authority area should be agreed by the Autism Partnership Board or equivalent group, and the ratings validated by people who have autism. I am also asking that you are aware of the content of the return when it is submitted and that it is discussed by the local Health and Well Being Board by the end of January 2014 as

evidence for local planning and health needs assessment strategy development and supporting local implementation work.

Technical detail on how the returns are to be made can be found on the improving health and lives website.

Queries on:

- The Autism Strategy Review itself can be sent to autism@dh.gsi.gov.uk
- Questions on the self assessment exercise can be sent via the ADASS Network e-mail address Team@ADASS.org.uk for the attention of Zandrea Stewart, the ADASS National Autism Lead.

The letter has been prepared with the support of Zandrea Stewart and Sam Cramond (Head of Partnerships, NHS England). A briefing for all Directors of Social Care on the Review will also be sent via the ADASS network. The letter will be circulated to CCGs via the NHS England CCG bulletin on 8 August.

NORMAN LAMB

Autism Self Evaluation

Local authority area

1. How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area?

1

Comment

2. Are you working with other local authorities to implement part or all of the priorities of the strategy?

⊗ *Yes*
○ *No*

If yes, how are you doing this?

We have developed the workforce development framework for social care staff jointly with East and West Sussex County Councils (see training section for detail)

Planning

3. Do you have a named joint commissioner/senior manager of responsible for services for adults with autism?

⊗ *Yes*
○ *No*

If yes, what are their responsibilities and who do they report to? Please provide their name and contact details.

Anne Hagan
Lead Commissioner
Adult Social Care
Brighton & Hove City Council
Room G23, Kings House
Grand Avenue
Hove
BN3 2LS
anne.hagan@brighton-hove.gov.uk
Tel 01273 296112

Anne Hagan has allocated responsibility for leading the commissioning of community of community care services for adults with autism. Anne Hagan reports to the Director of Adult Social Services, local councillors and the Health & Well-Being Board.

4. Is Autism included in the local JSNA?

- ◯ Red
- ◯ Amber
- ⊗ Green

Comment

We have a specific "Adults with autistic spectrum conditions needs assessment", published May 2011, which informs our strategy. A summary was updated in June 2013. These are available here: http://www.bhlis.org/

5. Have you started to collect data on people with a diagnosis of autism?

- ⊗ Red
- ◯ Amber
- ◯ Green

Comment

Data collection exists, but further work is ensure appropriate links are made between data sources.
Our social care, health and housing databases collect information, but this has only been in place in recent years and the data is not cross-referenced. We have commissioned an enhanced diagnostic service which will improve data collection for newly diagnosed people. We are also aiming to extract data from GP practices in late 2013 as part of a data extraction exercise for the Learning Disability SAF.

6. Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any)?

- ⊗ Yes
- ◯ No

If yes, what is

the total number of people?

14

the number who are also identified as having a learning disability?

4

the number who are identified as also having mental health problems?

0

Comment

Data collection for Adults with Autism receiving social care is new, therefore this data will be an incomplete picture of actual numbers. The data is based on:

The number of new people being assessed each year and what the outcome of the assessment was broken down by client category- for our RAP return. The outcomes are as follows:

-Some or all (new) services intended or already started (incl. those started and finished)

-(New) Service(s) offered but declined

-Other sequel to assessment

-No(new) services offered or intended to be provided

7. Does your commissioning plan reflect local data and needs of people with autism?

- [x] Yes
- [ ] No

If yes, how is this demonstrated?

Yes - our Adult Autism strategy is underpinned with data from our Adult Autism needs assessment

8. What data collection sources do you use?

- [ ] Red
- [ ] Red/Amber
- [x] Amber
- [ ] Amber/Green
- [ ] Green

Comment

We have made a start in data collection, as described in question 5, across social care, health and housing. We will explore how to cross-reference this data and this is an action in our strategy as follows: "Develop a locally coordinated & comprehensive data system to inform planning"

9. Is your local Clinical Commissioning Group or Clinical Commissioning Groups (including the Support Service) engaged in the planning and implementation of the strategy in your local area?

- [ ] Red
- [ ] Amber
- [x] Green

Comment

We have the clinical lead GP fully engaged and part of our Stakeholder Group; she leads the autism agenda strategically at the CCG and we jointly commission specialist services such as the diagnostic service.

10. How have you and your partners engaged people with autism and their carers in planning?

- [ ] Red
- [x] Amber
- [ ] Green

Please give an example to demonstrate your score.

We have people with ASC and carers represented in our Stakeholder Group, which also includes all our local specialist community and voluntary sector agencies. As part of our work to develop a network of 'Autism Champions' we are surveying people with ASC to gather their views on local services.

11. Have reasonable adjustments been made to everyday services to improve access and support for people with autism?

- [x] Red
- [ ] Amber
- [ ] Green

Please give an example.

Council policy would include our duties under the Equality Act, but do not specifically reference Autism. There are some anecdotal examples of reasonable adjustments in local services.

12. Do you have a Transition process in place from Children's social services to Adult social services?

- [x] Yes
- [ ] No

If yes, please give brief details of whether this is automatic or requires a parental request, the mechanism and any restrictions on who it applies to.

Yes - there is a specific process governing transition from our Children's Disability Service to our Community Learning Disability Team. There is a transitions team for people with learning disabilities. There is also a transitions process for young people with mental health needs.

13. Does your planning consider the particular needs of older people with Autism?

- [x] Red
- [ ] Amber
- [ ] Green

Comment

We do not have data on the numbers or needs of older people with ASC. Our needs assessment states that "many older people will be undiagnosed because the autistic spectrum condition only became formally recognised as a range of conditions in the late 1960s." http://www.bhlis.org/disability/ p2. Autism training is available to staff in older people services, but uptake is low. We will target this area for the Autism Champions network to improve awareness, but we do not have any further specific plans around this group.

Training

14. Have you got a multi-agency autism training plan?

- [ ] Yes
- [x] No

15. Is autism awareness training being/been made available to all staff working in health and social care?

- [ ] Red
- [x] Amber
- [ ] Green

Comment: Specify whether Self-Advocates with autism are included in the design of training and/or whether they have a role as trainers. If the latter specify whether face-to-face or on video/other recorded media.

We have newly commissioned training program in place for social care staff which is designed and delivered by a self-advocate. From September 2013 the Workforce Development Team will be offering a range of courses and qualifications on autism. The revised courses follow consultation with Brighton & Hove's Autism Stakeholder Group and partnership working with colleagues in East and West Sussex. The revised framework integrates the autism knowledge and skills framework developed by Skills for Care and Skills for Health as well as referencing national occupational standards. There is a clear development pathway and a link between courses and qualifications.

The new approach builds on the statutory guidance Implementing Fulfilling and Rewarding Lives and introduces autism champions.

Training records and workforce data are available.

16. Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?

- [x] Red
- [ ] Amber
- [ ] Green

Comments

We do offer training to social care staff in accessible information, Autism, sensory interaction and related, but work is required to increase uptake as it is currently below 50%.

17. Have Clinical Commissioning Group(s) been involved in the development of workforce planning and are general practitioners and primary care practitioners engaged included in the training agenda?

- ⊗ *Yes*
- ○ *No*

Please comment further on any developments and challenges.

Yes - We have the clinical lead GP fully engaged and part of our Stakeholder Group; she leads the autism agenda strategically at the CCG. We are at the early stages of workforce planning for GPs and primary care but we have a strategic objective around this area: "Autism awareness included in Primary Care workforce development", which has a number of actions attached to it. Our themed Stakeholder Group meeting will focus on workforce development and we have representatives joining us from the CCG who have specific responsibilities for primary care commissioning.

18. Have local Criminal Justice services engaged in the training agenda?

- ⊗ *Yes*
- ○ *No*

Please comment further on any developments and challenges.

Our local probation service have independently commissioned a local Autism agency to deliver training to their staff.

Sussex Police are part of our stakeholder group and are reviewing their training requirements.

Diagnosis led by the local NHS Commissioner

19. Have you got an established local diagnostic pathway?

- ○ *Red*
- ⊗ *Amber*
- ○ *Green*

Please provide further comment.

There is a pathway to a Neuro-Behavioural diagnostic clinic and it has been recognised that the clinic cannot meet the level of demand and the waiting times have exceeded 6 months. However, this year the CCG have invested in an additional resource to address this which will bring down the waiting list and allow an improved pathway to be implemented. The new service went operational in Sept 2013 and it is expected that by Jan 2014 a new pathway and reduced waiting times will be fully established.

20. If you have got an established local diagnostic pathway, when was the pathway put in place?

Month (Numerical, e.g. January 01)

1

Year (Four figures, e.g. 2013)

2014

Comment

Please see comment above - pathway in development.

The Neurobehavioural Clinic was first established in May 2007.

21. How long is the average wait for referral to diagnostic services?

Please report the total number of weeks

52

Comment

The newly commissioned service will bring the waiting times down to within 6 months. By early 2014 we would expect to be 'Green' as GPs will be fully aware of the referral route, the wait for referral will be lower and the new service specification has used NICE guidelines to develop the service design.

22. How many people have completed the pathway in the last year?

31

Comment

31 people from Brighton and Hove have been assessed for an ASC at the Neurobehavioural Clinic in the last year, 14 are on the waiting list to be seen for an assessment. These people will be a priority for the new service.

23. Has the local Clinical Commissioning Group(s)/support services taken the lead in developing the pathway?

- [x] Yes
- [ ] No

Comment

Yes, we have a clinical lead from the CCG who attends the Autism Stakeholder Group and has led on the development of the pathway and the new diagnostic service.

24. How would you describe the local diagnostic pathway, ie Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?

- [ ] a. Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis
- [x] b. Specialist autism specific service

Please comment further

The pathway is for people with high-functioning Autism or Asperger's and the referral route is through their GP.

25. In your local diagnostic path does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?

- [ ] Yes
- [x] No

Please comment, i.e. if not who receives notification from diagnosticians when someone has received a diagnosis?

Not automatically for all people diagnosed, but it is part of the pathway where people are in need of a Community Care Assessment.

26. What post-diagnostic support (in a wider personalisation perspective, not just assuming statutory services), is available to people diagnosed?

The diagnostic service will;

** Link patients into services such as social skills training and other structured and predictable training programmes based on behavioural principles that are commissioned and run locally by third sector organisations and also connecting individuals to existing education, employment and leisure programmes.*

** Work with mental health, learning disability and adult social care services post diagnosis to implement patient recommendations into their treatment plans. The service will also providing consultation and assist with complex case reviews for patients of these services.*

** Provide a rolling group therapy programme including a Psyocheducation group for people with ASC helping them understand and manage their diagnosis*

Care and support

27. Of those adults who were assessed as being eligible for adult social care services and are in receipt of a personal care budget, how many people have a diagnosis of Autism both with a co-occurring learning disability and without?

a. Number of adults assessed as being eligible for adult social care services and in receipt of a personal budget

2444

b. Number of those reported in 27a. who have a diagnosis of Autism but not learning disability

8

c. Number of those reported in 27a. who have both a diagnosis of Autism AND Learning Disability

48

Comment

Table with more detail:

Self Directed Support (Personal Budget) cohort 2012-13:

Adult with Autistic Spectrum Condition: 4
Frailty with Autistic Spectrum Condition: 1
Mental Health with Autistic Spectrum Condition: 1
Physical Disability with Autistic Spectrum Condition: 2

Learning Disb with Autistic Spectrum Condition
48

28. Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?

○ *Yes*
⊗ *No*

If yes, please give details

No - currently information about services is available in more than one place. We are in discussions with the social care Access Point service to ensure they can operate as a single signposting service to all other relevant services.

29. Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?

- ◯ *Yes*
- ⊗ *No*

If yes, please give details

Discussions have been held with Managers across Assessment services, to seek improvements to the current arrangements - people with Autism who need a community care assessment should contact our Access Point and they will be directed to the appropriate team according to their needs.

30. Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?

- ⊗ *Red*
- ◯ *Amber*
- ◯ *Green*

Comment

Advocacy services are being commissioned with the expectation that all services can work with the population defined as "adults using or seeking to use adult social care and health services", but training for autism is not specifically required.

31. Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

Yes, advocacy services are available to people with autism and we would expect reasonable adjustments are made to meet their needs.

32. Can people with autism access support if they are non Fair Access Criteria eligible or not eligible for statutory services?

- ⊗ *Yes*
- ◯ *No*

Provide an example of the type of support that is available in your area.

We have local agencies specifically working with adults with Autism:

Assert provides the following services for people with AS and HFA:
One to one support
Benefits advice and support
Monthly drop in for people with AS/HFA
Monthly mutual support group for parents, partners and carers of people with AS/HFA
One to one support for parents, partners and carers of people with AS/HFA
Social events and social inclusion activities for people with AS/HFA
Resource Library
Liaison with statutory services on behalf of individuals.
Support for people with AS/HFA in accessing volunteering opportunities with other charities and community groups
Free Life Skills courses
A monthly walking group
Other services of Assert
Assert can also provide information and advice to services and organisations that work with people with AS and HFA.
Assert can provide training to other professionals wanting to increase their knowledge of working with people with AS and HFA.
Assert can support other non profit organisations wanting to recruit new volunteers by using our matching service and placing our members with your group as a volunteer.
Assert promotes, encourages and supports good practice in working with people with AS and HFA.
Assert also participates in campaigning and lobbying for autism rights.

http://www.assertbh.org.uk/

ASpire supports adults with Asperger syndrome, High Functioning Autism and similar social issues through mentoring and group activities.

http://www.bh-impetus.org/aspire/

Autism Sussex operates a range of services across the county:

http://www.autismsussex.org.uk/

33. How would you assess the level of information about local support in your area being accessible to people with autism?

◯ *Red*
⊗ *Amber*
◯ *Green*

Comment

There is no central database of information, but there are some local support services. The range of services available will be reviewed in the coming year to identify gaps.

Housing & Accommodation

34. Does your local housing strategy specifically identify Autism?

◯ *Red*
⊗ *Amber*
◯ *Green*

Comment

Universal housing strategy details needs of people with disabilities, autism not specifically referenced. Minimal current and historic data availability on individual housing needs and usage of different housing services.

Employment

35. How have you promoted in your area the employment of people on the Autistic Spectrum?

◯ Red
◯ Amber
⊗ Green

Comment

Promoting the Employment of People on the Autistic Spectrum:

The council's Adult Social Care Supported Employment Team support people to find and maintain employment. 13.5% of the team's clients are on the Autism Spectrum. www.brighton-hove.gov.uk/supportedemployment

This council is one of the few in the country to offer specialised employment support. The support offered by the Supported Employment Team is more intense and more personalised than support offered by the government work programmes and job centre plus. In fact the Brighton & Hove job centres often refer people with autism to the council's Supported Employment Team.

The Supported Employment Team also works in partnership with and accepts referrals from the Mental Health Wellbeing Service's Work & Learning advisor and the council's Community Learning Disability Service. These are two services to which people with autism are often referred initially. The Adult Social Care team also network regularly with the Mental Health Services supported employment team.

The Supported Employment Team engages with employers in the city to encourage reasonable adjustments in recruitment and employment processes. The team maintain a database of engaged employers that allows them to keep track of employers engaged with, especially details such as names of contact people and details of any work placement opportunities identified.

The council's supported business, Able & Willing, works with the government Work Choice programme to provide paid work and training opportunities for job seekers with disabilities. 18% of the Able & Willing staff have autism listed as their primary barrier to employment. www.ableandwilling.org.uk

The Supported Employment Team has a partnership with the council's HR department to enable disabled people to fill carved job roles within the council. These carved job roles are especially valuable to people with autism who may have the skills for only specific aspects of a job.

In February of 2013 the council sponsored training provided by the National Autistic Society. The training was titled "Supporting People with ASD into Sustainable Employment". The training was made available to organisations within the city which support people in employment. 6 organisations attended including City College, Youth Employability and both the Adult Social Care and the Mental Health Services supported employment teams.

36. Do transition processes to adult services have an employment focus?

◯ Red
◯ Amber
⊗ Green

Comment

The Supported Employment Team is part of the same service as the LD transition team and accepts referrals from the transition team. The two teams often work in partnership regarding specific service users and employment support workers will often be invited to reviews.

The Supported Employment Team is represented in the SEN Partnership Strategy working group for transitions

All transitions plans refer to employment/activity opportunities. There are dedicated employment advisors contracted to support people with mental health needs.

Criminal Justice System (CJS)

37. Are the CJS engaging with you as a key partner in your planning for adults with autism?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

Discussions with the CJS are underway, including training of the police and wider CJS and inclusive of the use of alert cards. Representative from CJS sits on autism partnership board or alternative.

Optional Self-advocate stories

Self-advocate stories.

Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.

Self-advocate story one

Question number

35

Comment

Rita is a young lady with Autism, who the Supported Employment Team started working with in October 2012. She was referred by the Community Learning Disability Team, as she didn't meet eligibility criteria for their services, yet she was clearly in need of support as she was isolated and unoccupied at home and on her own all week. The council's Supported Employment team supported Rita to do voluntary work in a charity shop, and worked closely with the manager to ensure that Rita could develop her skills. Rita did a range of tasks including pricing, sorting stock, and her favourite task was working on the till. This demonstrated that Rita had the skills to work in retail, and it greatly increased her confidence. Rita worked in the charity shop for 5 months, and then did an unpaid work experience at a major high street retailer 2 days per week for 3 months. Rita did very well in her work experience, so well in fact that she was offered paid employment by the manager in July 2013. Rita was successful at getting this paid job by showing the employer what a good worker she is, something she would have struggled to do in an interview situation due to her Autism. Rita continues to receive support from the Supported Employment Team even now that she is settled in her job. This is mainly to deal with her anxiety and to support her with any changes or issues that arise at work. With this on-going support she continues to succeed at her job and is a valued employee who has achieved her goal of working in the retail industry.

Self-advocate story two

Question number

192129

Comment

1. Although I have had poor health all my life, I was close to 50 before a clinical psychologist suggested I might have an autism spectrum problem. Later (in 2008) I asked my GP to refer me to the Neurobehavioural clinic at Brighton General Hospital. Although I eventually received a diagnosis of high functioning autism in 2009, the process took well over a year. I first had to see a psychologist at Hove Polyclinic before being referred on to the Neurobehavioural clinic with a long waiting list.

2. At present I live with my mother, who is very old and disabled. I have been promised help from Social Services to move into extra care accommodation after she dies. Naturally, there some uncertainty about funding and organisation of this at an unknown time in the future.

3. Basically, I have had to leave employment services behind after some earlier attempts, because my combination of health difficulties and intellectual ability (I have an M. A., and Ph.D) has meant my only option was to write.

I hope that will be helpful, and maybe even point up a few problems in the way things operate where services are concerned.

Self-advocate story three

Question number

Comment

Self-advocate story four

Question number

Comment

Self-advocate story five

Question number

Comment

This marks the end of principal data collection.

Can you confirm that the two requirements for the process to be complete have been met?

a. Have you inspected the pdf output to ensure that the answers recorded on the system match what you intended to enter?

☒ *Yes*

b. Has the response for your Local Authority area been agreed by the Autism Partnership Board or equivalent group, and the ratings validated by people who have autism, as requested in the ministerial letter of 5th August 2013?

☒ *Yes*

The data set used for report-writing purposes will be taken from the system on 30th September 2013.

The data fill will remain open after that for two reasons:

1. to allow entry of the dates on which Health and Well Being Boards discuss the submission and
2. to allow modifications arising from this discussion to be made to RAG rated or yes/no questions.

Please note modifications to comment text or additional stories entered after this point will not be used in the final report.

What was the date of the meeting of the Health and Well Being Board that this was discussed?

Please enter in the following format: 01/01/2014 for the 1st January 2014.

Day

27

Month

11

Year

2013

HEALTH & WELLBEING BOARD	Agenda Item 33 Brighton & Hove City Council

Subject:		**Winterbourne View Improvement Programme - Stocktake**
Date of Meeting:		**27th November, 2013**
Report of:		**Executive Director of Adult Services**
Contact Officer:	**Name:**	**Mark Hendriks** **Tel: 29-3071**
	Email:	**mark.hendriks@brighton-hove.gcsx.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 In May 2011 a Panorama programme screened an undercover investigation into abuse at Winterbourne View a specialist hospital for people with learning disabilities and mental health problems. This resulted in convictions of a number of staff and a serious case review commissioned by South Gloucestershire Council.

1.2 The Department of Health produced final report, Transforming Care, in December 2012, and this alongside a partnership-wide Concordat set out the requirements and developments needed in all local areas.

1.3 A national Winterbourne View Joint Improvement Programme was also announced to ensure all local authorities take action to minimise and remove risks to service users with Learning Disabilities and Autism in specialist hospitals and work towards providing appropriate accommodation more locally and in community settings.

1.4 A “stocktake” on progress was required to be submitted by 5th July 2013. The purpose of the stocktake is to enable local areas to assess their progress against commitments in the Concordat and to allow for good practice and progress from local areas to be shared nationally.

1.5 The Winterbourne View Joint Improvement Programme asked local authorities to lead this process given their leadership role through Health and Well Being Boards and required that responses were developed with local partners, including CCGs, and shared with Health and Wellbeing Boards.

1.6 The purpose of this report is to inform the Board how the requirements are being delivered in Brighton & Hove and to update the board on local progress.

1.7 The Brighton & Hove stocktake submission is attached as Appendix One.

2. RECOMMENDATIONS:

2.1 That the Board note the content of the Winterbourne View Joint Improvement Programme – Brighton & Hove Response: Initial Stocktake of Progress against key Winterbourne View Concordat Commitment submission, attached to this report. (Appendix One)

2.2 That the Board note the progress made in Brighton & Hove regarding the future commissioning arrangements for people requiring treatment and assessment placements.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The abuse that was exposed by Panorama was deeply shocking and indicated not only local but systemic failures in the care and treatment of "people with learning disabilities *or* autism who also have mental health conditions or behaviours viewed as challenging".

3.3 In Brighton & Hove there are no specialist hospitals; however placements are made out of area for such services. Although there were no allegations of abuse in any of these services, all clients were reviewed in 2011 to ensure the quality, safety and appropriateness of the placements. The CCG now fund the Community Learning Disability Team for a specialist ongoing resource to ensure that people who require placement within specialist hospitals receive effective assessment, review and discharge planning to ensure people have good quality hospital services and remain in them no longer than is absolutely essential.

3.4 All local areas were asked to carry out a stock check on actions required. The stocktake covered 11 key areas:

- Models of partnership
- Understanding the money
- Case management for individuals
- Current review programme
- Safeguarding
- Commissioning arrangements
- Developing local teams and services
- Prevention and crisis response capacity
- Understanding the population who may need/receive services
- Children and adults transition planning
- Current and future market requirements and capacity

3.5 The Brighton & Hove Stocktake is attached (Appendix One) which outlines the local situation against the following headings:

3.6 Overall the stocktake indicates that good progress has been made in Brighton & Hove. There are good partnerships and good joint working with health partners and providers and we have the resources in place to ensure every individual receives high quality care planning, including discharge planning. We are developing local community services for people who may be ready for discharge, and/or those who are at risk of admission. We plan with children's services to

identify, assess and plan for young people at risk as they become adults. We have had a local improvement plan in place since the publication of Transforming Care and the Concordat to ensure we are working towards all the requirements.

3.7 Our next steps are to develop a strategic plan for this population group, including all at risk adults and children, by April 2014 in line with DH requirements. A strategic steering group is in place and draft strategic objectives are proposed as:

1. Ensure all hospital placements are good quality, appropriate and reviewed regularly with a focus on effective intervention & timely discharge

2. Review & improve processes for the commissioning of hospital placements

3. Review & enhance the local resources in place for crisis intervention and prevention of admission

4. Ensure all local services provide good quality, safe services for people in the defined group

5. Review and improve how children and young people considered to be in the at risk group are identified, assessed and planned for.

3.8 Our main focus for development will be ensuring that we develop strong commissioning arrangements with specialist providers, ensuring we develop the necessary local services to enable discharge/prevent admission of the most complex clients, including ensuring that at risk complex children are identified and planned for.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 Local progress toward the post-Winterbourne agenda has been reported to the Learning Disability Partnership Board, Learning Disability Provider Forum, Safeguarding Adults Board and the CCG Quality Assurance Committee in the last 12 months.

4.2 The local stocktake was developed in partnership with the CCG and signed by the CCG, Local Authority and chair of the Health & Well-Being Board.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are no direct financial implications associated with this report

Finance Officer Consulted: *Anne Silley* *Date: 01/11/13*

Legal Implications:

5.2 There are no legal implications arising from this report

Lawyer Consulted: *Elizabeth Culbert* *Date: 01/11/13*

Equalities Implications:

5.3 An Equality Impact Assessment has not been completed specifically in connection with the completion of the stocktake. Consideration will be given within the review and provision of individual placements to address gender, age, race, sexuality, religion and cultural background.

Sustainability Implications:

5.4 The stocktake itself has no specific Sustainability implications, but progress toward local community placements rather than high cost out of city hospital placements implies more sustainable solutions to meeting the needs of local people with complex needs.

Crime & Disorder Implications:

5.5 The stocktake itself has no specific Crime & Disorder implications, but progress toward local community placements for people who may have high-risk behaviours will need to incorporate measures to protect individuals returning to the community, the people that support them and the public. This will be addressed on an individual basis including engaging with relevant public sector partners as required.

Risk and Opportunity Management Implications:

5.6 The stocktake itself has no specific Risk Management Plan. The risks, opportunities and barriers to progress are referenced within the stocktake document. Risks to the individual are considered and steps taken to minimise risks are included in the individual assessment and planning for care and support.

Public Health Implications:

5.7 The stocktake itself has no specific Public Health implications, but progress toward local community placements rather than high cost out of city hospital placements implies positive Public Health impacts in terms of; better outcomes for people with complex needs, better care planning for children and young people, greater capacity for self-determination for individuals with complex needs, better access to work and meaningful activity in community settings, better health outcomes through enhanced review and bespoke commissioning, and more sustainable communities through enhanced local specialist services.

Corporate / Citywide Implications:

5.8 The stocktake itself has no specific Corporate / Citywide implications, but progress toward local community placements rather than high cost out of city hospital placements is in line with council and citywide priorities (through partnership working) to reduce inequalities, improve value for money, develop capacity in local services, improve health and well-being outcomes and ensure the city meets the needs of the most vulnerable.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Not to complete the stocktake, however it is a national requirement that all Local Authorities complete and submit by 5th July 2013.

6.2 Not to share the stocktake with the Board, but this is also a national requirement.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The Local Government Association, NHS England and the Minister of State for Care & Support has required local areas to ensure Health & Well-Being Boards are aware of and engaged with the Winterbourne View Joint Improvement Programme and this stocktake specifically.

SUPPORTING DOCUMENTATION

Appendices:

1. Winterbourne View Joint Improvement Programme – **Brighton & Hove Response**: Initial Stocktake of Progress against key Winterbourne View Concordat Commitment

Documents in Members' Rooms

1. None

Background Documents

1. Documents relating to the Winterbourne Joint Improvement Programme are included in the Local Government Association Website and can be found by following this link: http://www.local.gov.uk/web/guest/adult-social-care/-/journal_content/56/10180/3912043/ARTICLE

2. Transforming care: A national response to Winterbourne View Hospital *Department of Health Review: Final Report* (December 2012) and associated documents are available here: https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

Winterbourne View Joint Improvement Programme – BRIGHTON & HOVE RESPONSE

Initial Stocktake of Progress against key Winterbourne View Concordat Commitment

The Winterbourne View Joint Improvement Programme is asking local areas to complete a stocktake of progress against the commitments made nationally that should lead to all individuals receiving personalised care and support in appropriate community settings no later than 1 June 2014.

The purpose of the stocktake is to enable local areas to assess their progress and for that to be shared nationally. The stocktake is also intended to enable local areas to identify what help and assistance they require from the Joint Improvement Programme and to help identify where resources can best be targeted.

The sharing of good practice is also an expected outcome. Please mark on your return if you have good practice examples and attach further details.

This document follows the recent letter from Norman Lamb, Minister of State regarding the role of HWBB and the stocktake will provide a local assurance tool for your HWBB.

While this stocktake is specific to Winterbourne View, it will feed directly into the CCG Assurance requirements and the soon to be published joint Strategic Assessment Framework (SAF). Information compiled here will support that process.

This stocktake can only successfully be delivered through local partnerships. The programme is asking local authorities to lead this process given their leadership role through Health and Well Being Boards but responses need to be developed with local partners, including CCGs, and shared with Health and Wellbeing Boards.

The deadline for this completed stocktake is Friday 5 July. Any queries or final responses should be sent to Sarah.Brown@local.gov.uk

An easy read version is available on the LGA website

May 2013

Winterbourne View Local Stocktake June 2013 – BRIGHTON & HOVE RESPONSE			
1. Models of partnership	**Assessment of current position evidence of work and issues arising**	**Good practice example (please tick and attach)**	**Support required**
1.1 Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s).	We are working jointly with commissioners from LA & CCG meeting regularly to oversee our local action plan and monitor progress for individuals Joint plan attached	Local Action Plan attached	
1.2 Are other key partners working with you to support this; if so, who. (Please comment on housing, specialist commissioning & providers).	We have a Framework of providers for complex needs who we will use for clients approaching discharge and needing community services. Commissioner's work in partnership with the Community Learning Disability Team regarding reviews and discharge plans – our CLDT is a fully integrated team with Sussex Partnership NHS Foundation Trust.		
1.3 Have you established a planning function that will support the development of the kind of services needed for those people that have been reviewed and for other people with complex needs.	Please see above – we have a Framework for complex needs – specification attached. We also have a Positive Behaviour Support Network consisting of framework providers, clinicians and practitioners & commissioners, to support the development of best practice – TOR attached.	Framework spec attached PBSN TOR attached	
1.4 Is the Learning Disability Partnership Board (or alternate arrangement) monitoring and reporting on progress.	We reported our draft action plan to our LDPB and will update them.		
1.5 Is the Health and Wellbeing Board engaged with local arrangements for delivery and receiving reports on progress.	Draft action plan and other details have been sent to the chair of the H&WB Board & there are plans to formally report to the Board.		
1.6 Does the partnership have arrangements in place to resolve differences should they arise.	The local CCG and LA commissioners meet regularly to discuss progress against the action plan and resolve any barriers or differences.		

1.7 Are accountabilities to local, regional and national bodies clear and understood across the partnership – e.g. HWB Board, NHSE Local Area Teams / CCG fora, clinical partnerships & Safeguarding Boards.	See above re: HWB. We have also reported local progress to our Safeguarding Board and will update them. We have reported progress to the CCG Quality Assurance Committee (a sub-committee of the CCG Governing Body)		
1.8 Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with this.	There are no OR issues that relate specifically to specialist hospital placements, but more broadly OR is a significant problem in Brighton & Hove which is an attractive destination for London and South-East area people, plus we have a vibrant Supported Living market which is regularly used by other authorities.		
1.9 Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan.	Consideration is being given to resources that could be reconfigured to support the preventative and crisis response elements to this area of service. For examples, we are planning to discuss the provision of an outreach service with the local health trust who provide our nearest assessment and treatment unit.		
2. Understanding the money			
2.1 Are the costs of current services understood across the partnership.	We are aware of the costs of all specialist placements		
2.2 Is there clarity about source(s) of funds to meet current costs, including funding from specialist commissioning bodies, continuing Health Care and NHS and Social Care.	CCG fund all of the inpatient placements, a very small number (2) have been identified where responsibility will be transferred to specialist commissioning as appropriate.		
2.3 Do you currently use S75 arrangements that are sufficient & robust.	We do not have S75 agreements for learning disabilities, but there are close joint commissioning arrangements.		
2.4 Is there a pooled budget and / or clear arrangements to share financial risk.	We do not have pooled budgets, the local CCG hold the budget for these placements and the financial risks of potential discharges will be discussed through our joint working arrangements.		
2.5 Have you agreed individual contributions to any pool.	No		
2.6 Does it include potential costs of young people in transition and of children's services.	No		
2.7 Between the partners is there an emerging financial strategy in the medium term that is built on current cost, future investment and potential for savings.	Initial discussions are being held around how we use resources differently to support and sustain placements in the community.		
3. Case management for individuals			

3.1 Do you have a joint, integrated community team.	Yes		
3.2 Is there clarity about the role and function of the local community team.	Generally, yes, though the service specification needs updating		
3.3 Does it have capacity to deliver the review and re-provision programme.	Yes a full-time specialist post has been newly commissioned by the CCG and is working well with the integrated Community LD Team		
3.4 Is there clarity about overall professional leadership of the review programme.	Yes – LA has strategic lead, working jointly with CCG.		
3.5 Are the interests of people who are being reviewed, and of family carers, supported by named workers and / or advocates.	Yes – dedicated reviewing officer for all placements, and that officer is ensuring adequate representation is in place		
4. Current Review Programme			
4.1 Is there agreement about the numbers of people who will be affected by the programme and are arrangements being put in place to support them and their families through the process.	Yes – we have a client list shared by LA & CCG and updated by dedicated reviewing officer to take account of admissions & discharges		
4.2 Are arrangements for review of people funded through specialist commissioning clear.	Discussions are being held with specialist commissioning to agree this, but our assumption is that existing arrangements will continue until alternative arrangements are made		
4.3 Are the necessary joint arrangements (including people with learning disability, carers, advocacy organisations, Local Healthwatch) agreed and in place.	Our dedicated reviewing officer has developed a comprehensive schedule of areas to be covered through the review process. This includes ensuring there is adequate representation through advocacy and the involvement of family. Locally we are sharing the action plan with the Learning Disability Partnership Board. Safeguarding Board, CCG governance boards and the Health & well-Being Board to ensure adequate oversight from all partners.		
4.4 Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used.	We have a Behaviour Support Team in our CLDT who have an active caseload of clients who need specialist support due to challenging behaviour. We have a client register of people in specialist inpatient services		
4.5 Is there clarity about ownership, maintenance and monitoring of local registers following transition to CCG, including identifying who should be the first point of contact for each individual	Please see 4.1 & our register includes all relevant contact details		

4.6 Is advocacy routinely available to people (and family) to support assessment, care planning and review processes	Please see 3.5		
4.7 How do you know about the quality of the reviews and how good practice in this area is being developed.	There are quarterly meetings in place with: • Specialist Placements Reviewing Officer • Operations Manager, CLDT • LA Commissioning Manager, LD • CCG Commissioning Manager, MH At these meetings review process and content was agreed and review outcomes for each client are discussed		
4.8 Do completed reviews give a good understanding of behaviour support being offered in individual situations.	Yes, acknowledging that reviewing is an ongoing process and new information is produced and processed over time. We are confident that so far reviews are thorough.		
4.9 Have all the required reviews been completed. Are you satisfied that there are clear plans for any outstanding reviews to be completed.	All reviews have been completed and commissioners have received comprehensive verbal feedback on each client		
5. Safeguarding			
5.1 Where people are placed out of your area, are you engaged with local safeguarding arrangements – e.g. in line with the ADASS protocol.	Yes – links are made with local Safeguarding teams as appropriate		
5.2 How are you working with care providers (including housing) to ensure sharing of information & develop risk assessments.	Care providers are given full information when discharge plans are developed and referrals are made.		
5.3 Have you been fully briefed on whether inspection of units in your locality have taken place, and if so are issues that may have been identified being worked on.	We have no units in our locality		
5.4 Are you satisfied that your Children and Adults Safeguarding Boards are in touch with your Winterbourne View review and development programme.	We have reported to our adults Safeguarding Board and are communicating through the children's commissioner to ensure they are aware and involved in the programme.		
5.5 Have they agreed a clear role to ensure that all current placements take account of existing concerns/alerts, the requirements of DoLS and the monitoring of restraint.	We do not have any local specialist hospitals/ATU, but we link with the local safeguarding teams where we have clients placed.		
5.6 Are there agreed multi-agency programmes that support staff in all settings to share information and good practice regarding people with learning disability and behaviour that challenges who are currently placed in hospital settings.	We have a multi-agency Positive Behaviour Support Network as a forum for sharing and improving practice, and we have a local Positive Behaviour Support policy.		

5.7 Is your Community Safety Partnership considering any of the issues that might impact on people with learning disability living in less restrictive environments.	We have not yet discussed this with the CSP, but plan to do so.		
5.8 Has your Safeguarding Board got working links between CQC, contracts management, safeguarding staff and care/case managers to maintain alertness to concerns.	Yes		
6. Commissioning arrangements			
6.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	We have received initial summaries of reviews of clients and outlined next stages – for those that may be suitable for discharge in the near future this involves the completion of paperwork/referral information. Once this is done we will be setting up MDT meetings around individual's care planning to review the information and make commissioning plans		
6.2 Are these being jointly reviewed, developed and delivered.	Please see 6.1 – where bespoke commissioning is required we will be doing this through a multi-disciplinary approach.		
6.3 Is there a shared understanding of how many people are placed out of area and of the proportion of this to total numbers of people fully funded by NHS CHC and those jointly supported by health and care services.	Yes we hold this information, and systems will be developed to ensure this can be held in a way that ensures full shared understanding across commissioning bodies.		
6.4 Do commissioning intentions reflect both the need deliver a re-provision programme for existing people and the need to substantially reduce future hospital placements for new people.	Yes – we are looking at existing populations and seeing who can be supported in the community & when. We are also developing community capacity to prevent future population e.g. PBS Network and setting up of 2 new specialist services for people with behaviour that challenges. We need to do more work in planning for high-risk people coming through transition		
6.5 Have joint reviewing and (de)commissioning arrangements been agreed with specialist commissioning teams.	No, but discussions are underway.		
6.6 Have the potential costs and source(s) of funds of future commissioning arrangements been assessed.	No, but discussions will be held as part of the planning for individuals.		
6.7 Are local arrangements for the commissioning of advocacy support sufficient, if not, are changes being developed.	Advocacy services are currently being re-commissioned and consideration will be given to the needs of people being discharged from specialist hospitals.		
6.8 Is your local delivery plan in the process of being developed, resourced and agreed.	Local action plan is a working draft and is in the process		

	of formal sign-off.		
6.9 Are you confident that the 1 June 2014 target will be achieved (the commitment is for all people currently in in-patient settings to be placed nearer home and in a less restrictive environment).	For some people this will be an appropriate timescale, but this may not be enough time for all people: in our experience planning services for people of this level of complexity can take up to 2 years, once their needs are fully assessed and how to support them safely is well understood.		
6.10 If no, what are the obstacles, to delivery (e.g. organisational, financial, legal).	• Thorough assessment is an ongoing process and may in itself generate the need for further assessment and interventions • Initial feedback from our reviewing officer is that some individuals are extremely institutionalised and therefore discharge planning may be lengthy • Identifying the appropriate providers may take some time and may involve engaging with providers we do not currently work with, depending on the needs of some clients • Providers need time – to recruit, train and develop staff with the right skills, attitude and experience • Housing solutions may take time to source • The need to involve multiple agencies and disciplines may take more time • Legal frameworks for supporting someone in the community need to be explored in different settings and the application of the MH Act may slow the process down • Funding sources will need to be agreed/identified • There may be procurement procedures that have prescribed timescales.		
7. Developing local teams and services			
7.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	Yes, see 6.1		

7.2 Do you have ways of knowing about the quality and effectiveness of advocacy arrangements.	Yes, our local advocacy agencies are actively reviewed and contract managed		
7.3 Do you have plans to ensure that there is capacity to ensure that Best Interests assessors are involved in care planning.	This will be addressed as part of the discharge planning process outlined in 6.1		
8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies			
8.1 Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally.	We are aware that more could be achieved to prevent crisis and the requirement for crisis management. We will therefore be developing a strengthened preventative model of care and community response, for inclusion in our 2014- 2015 planning cycle. This will include exploring opportunities for outreach specialist support to local community providers to assist them in supporting and managing people in more independent living. This will help to prevent a number of crises and the need for crisis management and/or hospital admission.		Would like support here
8.2 Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA.)	See above		Would like support here
8.3 Do commissioning intentions include a workforce and skills assessment development.	This will form part of the commissioning intentions above.		Would like support here
9. Understanding the population who need/receive services			
9.1 Do your local planning functions and market assessments support the development of support for all people with complex needs, including people with behaviour that challenges.	Generally yes; we have good information sharing with children's services and processes for JSNA and are developing a Market Position Statement. We are aware that we can of course sometimes make improvements in the way we plan for individuals. To ensure we do this we are actively reflecting and learning from experience to focus on better planning and preventative interventions.		

9.2 From the current people who need to be reviewed, are you taking account of ethnicity, age profile and gender issues in planning and understanding future care services.	This will be taken into account in the review process		

10. Children and adults – transition planning 10.1Do commissioning arrangements take account of the needs of children and young people in transition as well as of adults.	Yes – we commission strategically with that in mind and commission services for named individuals as they approach adulthood. We have planned further joint work to improve our arrangements.		
10.2 Have you developed ways of understanding future demand in terms of numbers of people and likely services.	Yes, to some extent, but this could be improved – for example working more closely with children's and education commissioners. We are scheduling strategic planning meetings to improve our processes in this area.		
11. Current and future market requirements and capacity 11.1 Is an assessment of local market capacity in progress? 11.2 Does this include an updated gap analysis? 11.3 Are there local examples of innovative practice that can be shared more widely, e.g. the development of local fora to share/learn and develop best practice.	Starting work on Market Position Statement which will include this area Yes, it will Please see attachments • Complex Needs Framework specification • Positive Behaviour Support Network ToR		

Please send questions, queries or completed stocktake to Sarah.brown@local.gov.uk by 5th July 2013

This document has been completed by

Name: Mark Hendriks

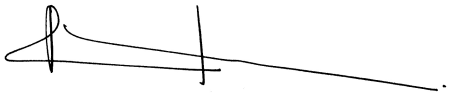
Organisation: Brighton & Hove City Council

Contact: mark.hendriks@brighton-hove.gov.uk or 01273 293071

Signed by:

Chair HWB: **Councillor Rob Jarrett, Chair of Brighton & Hove Health & Well-Being Board**

LA Chief Executive: **Penny Thompson, Chief Executive, Brighton & Hove City Council**



CCG rep: **Dr Christa Beesley, Accountable Officer, Brighton & Hove Clinical Commissioning Group**

HEALTH & WELLBEING BOARD	Agenda Item 34 Brighton & Hove City Council

Subject:		**Public Health Schools' Programme**
Date of Meeting:		**27th November 2013**
Report of:		**Dr Tom Scanlon, Director of Public Health**
Contact Officer:	**Name:**	**Lydie Lawrence, Public Health Programme Manager** **Tel: 295281**
	Email:	**Lydie.lawrence@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The purpose of this report is to bring the Public Health Schools' Programme to the attention of the Health and Wellbeing Board Members.

1.2 The proposed Public Health Schools' Programme takes into account recent policy changes, the opportunity afforded by the arrival of Public Health in local authorities, the need to build on the good work of the Healthy Schools/Settings programme as well as the concerns of schools themselves. The programme reflects evidence based practice. The programme will be offered to all state schools including academies and free schools. It is anticipated that in due course the programme will be rolled out to colleges.

2. RECOMMENDATION:

2.1 That the Health and Wellbeing Board note and comment on the report and agree to refer it the Children and Young People's Committee for endorsement.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 As of 1st April 2013, Public Health within local authorities is responsible for commissioning the Healthy Child Programme 5-19, which includes school nursing. In April 2015, the commissioning of the Healthy Child Programme 0-5 will also pass to Public Health in Local Authorities. The 0-5 programme is currently commissioned by the area team (Surrey and Sussex) of the NHS Commissioning Board although this is in partnership with local public health teams.

3.2 The Department of Health Call to Action for school nursing (2011) recommends a revitalisation of school nursing services for the delivery of a core programme of evidence based preventative health care for all children and young people, with additional support and care for those who needs it. School nursing is now within the remit of Public Health in local authorities.

3.3 A national Public Health Outcomes Framework has been developed to assess progress in improving Public Health. Several of the indicators in this framework support a Public Health approach to school health.

3.4 In recent years the local approach to health in schools has been through the national Healthy Schools Programme, alongside a number of other public health programmes. In 2010 there were changes to the national programme with resultant local funding reductions. Two council employees, one funded by public health now oversee a streamlined Healthy Settings Programme for schools, nurseries and colleges with a reduced number of criteria and school self-validation of progress. In addition to this programme, a number of health promotion and prevention activities are commissioned by the Public Health team. For example:

- BIKE IT: a project to encourage and support children to cycle as part of their school journeys;
- Community Youth Champions: an after school peer mentoring project where pupils aged 11-15 years are trained as advocates for physical activity;
- Smoking prevention and cessation: education about tobacco and associated development of smoking policies and stop smoking sessions;
- Sun safety campaigns;
- National Child Measurement Programme for children aged 4-5 and 10-11 years.

3.5 There can be capacity challenges in the effective implementation of these interventions including when they require school nursing support at universal level.

3.6 There are also a number of national programmes delivered through schools through the NHS Commissioning Board in partnership with Public Health England and local authority Public Health; for example the management of communicable disease outbreaks and national vaccination programmes.

3.7 The Annual Report of the Chief Medical Officer, Our Children Deserve Better: Prevention Pays (2012) recommends that local authorities support schools to engage in the health agenda to create school connectedness, build resilience, support health and wellbeing and encourage physical activity. The National Institute of Health and Clinical Excellence (2007; 2010) recommends that a range of public health interventions should be school-based including to prevent smoking and alcohol consumption.

3.8 Following the formal move of Public Health in the City Council, The Director of Public Health met with primary, secondary, special needs schools and with schools Governors to discuss the public health priorities for children and young people and the possibility of developing a broad Public Health Schools' Programme.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The Public Health Schools' Programme takes a comprehensive approach to health and wellbeing. The programme will provide a whole school community approach to health improvement for pupils, staff and parents. This will

contribute to pupils' attainment and achievement and support the implementation of the Early Help Strategy.

4.2 Schools will be provided with Annual School Health Profiles with information about their pupils' demographics as well as health and lifestyles issues and inequalities:

* Immunisation profile - MMR (5yr olds), HPV (secondary schools)
* Healthy weight prevalence - primary school entry and leaving
* Lifestyle profile- smoking, alcohol /drug use, physical activity
* Mental health - self-reported mental wellbeing, self harm; domestic abuse, emotional wellbeing
* Sexual health - sexual activity, teenage pregnancy

Note: In the event of some school-level datasets being too small and risking identification of individuals, relevant data will not be shown.

4.3 Schools will identify a number of issues that they wish to focus on based in part on the issues identified in their School Health Profile. Schools will be offered support in the development of relevant school policies such as drug and alcohol, healthy weight (school meals, vending machines), tobacco control and other health and wellbeing related policies. Schools will also be offered support in the development of school resilience and emergency management plans. There will be opportunities for schools to sign up to parental contracts for parents not to provide alcohol to their children.

4.4. Health and wellbeing for pupils and students. Based on the issues identified in the School Health Profile, the work will incorporate the current healthy settings work and the public health initiatives already in place, for example healthy diet and nutrition, physical activity, substance misuse, smoking cessation, sexual health, emotional health and wellbeing - including mindfulness and suicide prevention, injuries and accident prevention and targeted work aimed at reducing inequalities in health. The proposed initiatives will enhance the Personal Social, Health and Economics (PSHE) education programme. There will also be scope for support to improve vaccine uptake in this programme

4.5 Staff and parent initiatives. A number of public health programmes will be offered to staff and parents: smoking cessation, drug and alcohol awareness, mental health and wellbeing promotion, Change4Life and Smart Restart (a national programme offered at the start of the new school year to establish healthy habits), and parenting initiatives.

4.6 Reducing inequalities. Some schools may be offered additional support including, though leisure and tourism and public health departments, easier access to out of school activities in culture and leisure.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 The Director of Public Health engaged with head-teachers from primary, secondary and special needs schools to discuss the public health priorities for children and young people and to discuss what a wider Public Health Schools' Programme might include. These discussions informed the development and the content of the Public Health Schools' Programme which the Director of

Public Health recently presented to head-teachers and to a meeting of the Governors, Strategy and Partnership group.

5.2 The head-teachers from two secondary schools attended meetings and training on parental contracts.

5.3 As part of the School Nursing development work engagement with school nurses, schools and other stakeholders is taking place.

5.4 The Public Health Programme Manager consulted wit the Youth Council and engagement is on-going.

6. CONCLUSION

6.1 The Public Health Schools' Programme will provide a whole school community approach to health and wellbeing. It will contribute to pupils' attainment and achievement.

6.2 The programme will support the delivery of Brighton & Hove City Council children services strategic priorities including the implementation of the Early Help Strategy.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 The programme will pool current financial resources funded by the Public Health grant spread across the Healthy Settings programme, public health schools' initiatives, school nursing programme and other programmes where resources can be redirected. Schools may also contribute.

7.2 There are no anticipated additional costs associated with this programme and it is expected to deliver improved value for money.

Finance Officer Consulted: Anne Silley *Date: 31/10/13*

Legal Implications:

7.3 There are no legal implications arising from the report

Lawyer Consulted: Elizabeth Culbert *Date: 31/10/13*

Equalities Implications:

7.4 An Equality Impact Assessment will be conducted.

Sustainability Implications:

7.5 The Public Health Schools' Programme will support the sustainability priority of Local and Sustainable Food by encouraging schools to promote healthier diets using locally sourced food where possible. The programme will support the priority of Health and Happiness through the promotion of healthy lifestyles and wellbeing.

Any Other Significant Implications:

7.6 None.

Supporting documentation

Appendices

1. Public Health Outcomes Framework.

Public Health Outcomes Framework

A national Public Health Outcomes Framework has been developed to assess progress in improving Public Health. Several of the indicators in this framework support a Public Health approach to school health:

- Improved readiness for school:
- Increased population vaccination cover;
- Reduced tooth decay in children aged 5;
- Reduced excess weight in 4-5 and 10-11 year olds;
- Reduced smoking prevalence in 15 year olds;
- Increased Chlamydia diagnoses 15-24 year olds;
- Reduced under 18 conception rates;
- Improved emotional wellbeing of looked after children;
- Reduced hospital admissions due to unintentional or deliberate injuries;
- Reduced alcohol and drug misuse;
- Reduced school absences.

Documents listed in Members' Rooms
None.

Background documents
None.

HEALTH & WELLBEING BOARD	Agenda Item 35 Brighton & Hove City Council

Subject:		**Winter Service Pressures**	
Date of Meeting:		**27th November 2013**	
Report of:		**Director of Public Health**	
Contact Officer:	**Name:**	**Max Kammerling**	**Tel: 01273 574861**
	Email:	**Max.kammerling@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The report identifies the range of activity in hand to manage winter pressures in a coordinated and integrated fashion.

2. RECOMMENDATIONS:

2.1 That the Health and Wellbeing Board notes the range of activities and delegates the Director of Public Health to develop further mechanisms to ensure coordinated and integrated working.

3. CONTEXT/ BACKGROUND INFORMATION

The requirement for effective winter planning crosses different organisations and a wide range of services, such as highways, emergency planning, housing, adult social care, schools, primary and secondary health care services. Some organisations produce their own detailed operational winter plans. This paper summary paper describes the preparations and connectivity in winter planning across the local authority and clinical commissioning group in Brighton & Hove.

Current Planning and recent reviews

Current Planning

3.1. BHCC has a Winter Service Plan, which describes how the Council meets its legal obligations under the Highways Act. The Council has a duty as a highway authority to ensure, ***as far as is reasonably practicable,*** that safe passage along a highway is not endangered by snow or ice. This means that although some form of service is mandatory, it is recognised that it is impossible to ensure that all or part of the network is always completely clear of snow or ice.

3.2. The Council has other winter-related plans related to specific service provision, such as Social Care procedures for service delivery during severe weather, and other initiatives to tackle fuel poverty, and excess winter deaths.

Some joint agency winter arrangements involving BHCC exist, for example, the MOU around the winter transport hub.

3.3. The Council has a well - established and documented process to escalate the response to incidents and a regularly exercised process for warning departments of periods of severe weather. Individual services use these warning as the trigger to activate their own response. This includes enhancing the Communications and Media messages. Where necessary communications are escalated to an Executive Director to give a strategic lead. A Major Incident Support Team meets on a regular basis and discusses the winter service arrangements so that operational managers are reminded of the actions required during winter

3.4. The local health economy has a Surge Plan, covering winter issues, and an agreed local escalation plan, jointly produced by a range of health agencies, and the Adult Social Services team within the Council. An Urgent Care Programme Board oversees the development of the plan and the high level strategic approach, and a local Urgent Care Task Force meets weekly over the winter to coordinate local responses in relation to the heath economy around the Royal Sussex hospitals.

3.5. However, there is no cross-directorate, multi-agency overarching 'winter plan' that brings together diverse areas such as health, social care, transport, health protection, gritting, schools etc. While links are reflected in the various plans, beyond health and social care, plans are still developed separately. This means that opportunities for enhancing and/or simplifying service delivery in severe weather through operational synergies may be missed.

3.6. The legal obligations on the Council changed with the passing of the Health and Social Care Act 2012 ("the Act"), which gave the Council new duties to:

- Improve the health of the people in its area, and
- Take steps to ensure that plan are in place to protect the health of the population.

It also transferred a significant public health resource to support this role.

3.7. This change gives the opportunity for a revised approach to planning for winter in a more holistic fashion.

3.8. As well as the usual process for winter planning, a number of other initiatives have been established to ensure a coordinated, effective and efficient response across multiple agencies, and these are described below.

Findings from recent reviews

3.9. The Winter Service Plan Review Scrutiny panel in 2010 identified a range of improvements needed, including the need for greater coordination within BHCC and with partners, more streamlined chains of command, better linkages with schools & better communication. A debriefing of staff involved in

winter planning in 2012/13 identified improvements in local resilience over recent years, but also noted the need for improved strategic direction and oversight of such issues. In particular, the more integrated planning approach in the NHS is perceived to have had significant benefits in ensuring business continuity.

Managing winter pressures

National Cold Weather Plan

3.10. A National Cold Weather Plan has been released annually since 2011, and this year's plan was released in late October. The plan encourages multi-agency cooperation to reduce excess winter deaths and promote health and wellbeing during winter & severe weather, and suggests this should be coordinated by Public Health.

3.11. Last year's national plan encouraged areas to apply for 'warm homes' healthy people funding. BHCC successfully applied for this funding, and incorporated the associated actions into the winter planning process. However, this funding will not continue into 2013/14. Instead, this year's plan states that what is required is "strong local leadership and partnership working at all levels across sectors to tackle the range of causes and reduce the number of "excess" deaths observed each winter".

3.12. This year's plan emphasises the commissioner and local authority role, requiring holistic planning linking in housing, schools and transport as well as 'health', to identify vulnerable people, and prevent morbidity and mortality, and highlights that the greatest total health burden occurs at relatively moderate cold temperatures.

Flu Vaccination

3.13. Flu continues to be a potentially serious illness in older, vulnerable people, and younger adults with coexisting chronic conditions. Although commissioning seasonal flu vaccination services is now carried out by NHS England, the Council has a role in assuring itself that this is being carried out robustly, and in supporting and encouraging the take up of the vaccine in the target groups. Locally, uptake amongst the over 65s is much lower than elsewhere in England. A social marketing survey trying to identify the barriers to immunisation in this age group has been commissioned for this year, funded by the former SHA.

3.14. The CCG is agreeing specific measures with the NHS Area Team to improve vaccination rates, including additional payments to practices that achieve higher rates, and additional financial support to increase immunisation rates among the housebound (including people in nursing homes).

3.15. When flu is common in the community, it increases the workload required to support patients/clients. However, flu also has an impact on the health of the

workforce, and can result in significant loss of staff time due to staff contracting flu. Hence, encouraging flu vaccination amongst care staff both helps tackle business continuity issues, but also meets the duty of care to employees, who are likely to have more exposure to people with flu than the normal population.

3.16. This year's target for staff vaccination rates in agencies with frontline healthcare staff is 75%. Some extra funding made available to acute trusts (including BSUHT) is in-part dependant on reaching targets. Frontline Council staff, particularly those in social care, are being strongly encouraged to take up the offer of vaccination by Occupational Health Teams. Work continues in partnership with the CCG to increase support for other non-statutory providers, especially the care home sector.

3.17. In addition, a seasonal flu vaccination programme for children has started; initially targeting children aged 2-3 years. One of the major aims of this programme is to reduce the circulation of flu virus in the community, and increase the protection for vulnerable adults and the elderly. Over time, this programme will be rolled-out to all ages of children, possibly through an annual schools based programme.

Pandemic Flu

3.18. Although there is no new specific risk of the start of a flu pandemic, it remains a high nationally identified risk. Further national guidance is due shortly, and local flu plans will be revisited in the light of its recommendations. Much work will take place across the wider community, within the Local Health Resilience Partnership, and the Strategic Resilience Forum, but local planning will still be needed, for example, to confirm collection points for anti-viral medication, and there may also be a local 'coordinating role'.

Winter health system escalation

3.19. In Brighton & Hove, the Winter Services Plan for highways is based on treating all main roads and all bus routes. The road network is treated throughout winter in advance of ice, frost and snow. In total, 192 miles or nearly 50% of the road network is treated.

3.20. Work has been progressed on revising the arrangements for the Transport Hub this winter, should it need to be activated. Activation will only occur if major road problems are severe and/or prolonged (for example, lasting for more than one week).

3.21. The CCG is coordinating local winter surge escalation arrangements for the health economy. Adult social care is an active partner in the planning process

3.22. The Acute Trust, social care and other providers have been offered £2.3m extra cash to ensure that winter performance is maintained, particularly in relation to the 4 hour A&E wait.

3.23. A Local Health Economy Surge plan is attached as a supporting document. It was developed by the Urgent Care Programme Board – a multi-agency CEO level group that includes representatives from BHCC Adult Social Care.

3.24. Its key components are:

- Robust single agency plans for business continuity
- Good communications and shared governance arrangements during a winter surge, including a local Urgent Care Task Force, meeting weekly at peak times
- Joint LHE plan for the management of outbreaks of infectious diarrhoea across acute, primary and community settings
- Flu immunisation, including frontline staff
- Targeted interventions for at risk groups
- Creating capacity in primary care to manage urgent care demand
- Reducing avoidable ambulance admissions

3.25. Two unresolved issues were identified in the Plan, and one remains outstanding. It is not clear who will take responsibility for sharing information on cold weather issues with local pharmacies, now that the NHS Area Team is the commissioner of pharmacy services. There are also a range of risks around managing the winter pressures successfully, which hare outlined in section 9 of the Surge Plan

Integrated working

3.26. Staff from NHS England's Area Team, and the Council delivered a Sussex Health CEO-level exercise on Fri 25th Oct. This has resulted in a draft protocol for surge escalation for the local health economy. This includes the following elements:

- Operational meetings across the Local Health Economy
- Prioritising referrals and assessment activity across the system
- Open extra hospital capacity and review staffing of services
- Authorisation of social care placements above normal funding levels, including spot purchasing of additional capacity
- Engagement and escalation processes with the overall social care market
- Supporting a co-ordinated approach across all agencies in relation to visits to vulnerable people

3.27. Within social care services, a number of work streams are in place to ensure robust business continuity

3.27.1. In- house service provision

- Each service has an up-to-date business continuity plan and information has been collated on the availability of all staff members, flexibility to work in alternate bases and alternate times of day as well as the skill base to complete alternative tasks.

- 'Independence at Home' has plans in place for 4X4 vehicle support, reviewed orders for winter grit, salt and shovels, and have purchased shoe socks for the county car and additional shoe grippers for individual staff.
- A vulnerability scale matrix continues to be used by Independence at Home, Independent Home Care Providers and District Nurses to allow a quick response to the most dependant service users/ patients in the community.

3.27.2. Contracted services provision

- Linking with service providers to remind them of their contractual requirements in relation to business continuity plans and business continuity within the monthly audit programme
- Ensuring providers receive key information, such as severe weather alerts and the flu vaccination programme
- Supporting home care providers to work collectively when severe weather conditions significantly impact on service delivery, such as heavy snow on the ground

3.28. Schools make their own decisions regarding closure due to weather conditions. However, during periods of severe weather, the Council issues advice to schools about risks, issues and the likely impact, to inform the local decisions about school closure. The Council is informed by schools immediately a decision to close its taken, and the Council website is updated very rapidly thereafter, to assure as much up to date information as possible is widely available.

3.29. A shared programme of work between Public Health & Housing is in place for this winter, providing a range of support, including:

- training for front line staff on warmer homes,
- training for older people and volunteers to cascade warmer homes information to peers and colleagues
- advice on managing energy bills and saving energy in the home
- targeted financial inclusion checks
- warm packs for rough sleepers and vulnerable residents, and
- a small emergency grant scheme.

3.30. To maximise the success of integrated planning across the community, Council, staff from Public health, Social care and the Civil Contingencies Team, NHS providers, CCG, 3rd Sector, GP out of hours services and the NHS Area team are meeting to assure themselves that the winter plans are as robust and joined up as possible, and to see if they are messages in the national Cold Weather Plan that need to be taken on board.

Vulnerable People

3.31. There are plans to contact vulnerable people during an incident - and this relates not just to winter planning, but also in a heat-wave or other major incidents.

3.32. Current local arrangements are based upon identifying who, in which agency, would hold that agency's list of vulnerable people. There remain concerns about whether this arrangement is sufficiently developed to support shared working and prioritisation across multiple agencies, in the event of a very severe or long-term incident.

3.33. The Strategic Resilience Forum has recently updated its Vulnerable People Plan and this is being used as a starting point for work to develop a more robust local system. A development group has been established.

3.34. There will be a specific local exercise in the New Year to test any new arrangements in one specific area, involving the operational staff who would need to make it work in a real emergency.

Winter pressures and the revised local authority health protection function

3.35. Nationally produced advice to local authorities on their new health protection responsibilities has recommended the establishment of a health protection group, possibly reporting the Health and Wellbeing Board.

3.36. Local reviews have also noted the potential benefits of a defined council strategic lead for Health Protection.

3.37. The joint winter planning approach could be seen as a test bed for a new style of working on health protection issues.

3.38. As well as ensuring stronger integration for all the Council/health service run elements, the joint working group will explore whether there are ways of encouraging increased resilience through closer link with schools, other educational establishments, the third sector and other relevant bodies.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Continuation of the current system of planning in separate directorates. Whilst this will deliver the core responsibilities for all parts of the Council, it is likely that some potential befits of more integrated working will be missed.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 As this relates to internal Council functions, no specific community consultation has taken place. However, third sector partners such as age concern play an important role in supporting vulnerable people and assisting local authorities in delivering relevant programmes.

6. CONCLUSION

6.1 The new duties of the local authority to take steps to ensure that plan are in place to protect the health of the population, offer opportunities to develop a more holistic approach to winter planning, as well as other similar planning tasks.

6.2 Each agency has produced its own business continuity plans, and cooperated in agreeing a multi-agency surge plan and escalation protocol for the local health economy.

6.3 Joint work has been initiated this winter to tackle specific multi-agency issues, such as the transport hub, or ensuring the safety of vulnerable people. An overarching group is also reviewing the National Cold Weather Plan to consider what improvements which could be made to local plans, and to ensure that we can maximise the synergies between plans. The success or otherwise of this group will be used to inform discussions on further ways of enhancing cooperation and integration between agencies.

7. FINANCIAL & OTHER IMPLICATIONS:

There is provision for Winter Planning within the budget and in reserves. Adult Social Care receives approximately £500k per annum of winter pressure funding (£570k in 2012/13) which is funded through health, joint commissioning plans are agreed with health on how such funding is applied. Transport has a revenue budget of £297k for winter maintenance in 2013-14. There is also a winter maintenance reserve which is used to supplement the transport budget if conditions are severe.

Housing management does not have a specific budget for winter planning. The estates services team would be on alert to clear snow and ice from council tenants' walkways and housing give money advice, especially over the winter months where tenants are struggling to pay their fuel bills. Housing management's capital programme for 2013/14 includes £8.2 million for works to communal boilers, Solar PV's and over-cladding work specifically targeted at reducing fuel poverty.

Finance Officer Consulted: Anne Silley *Date:11/11/13*

Legal Implications:

7.1 The proposed approach of increased integration in relation to winter planning is in line with the Council's legal responsibilities, in particular in relation to public health. The role of promoting integration and joint working in health and social care services across the City is delegated to the Health and Wellbeing Board.

Lawyer Consulted:: Elizabeth Culbert *Date: 13/11/13*

Equalities Implications:

7.2 Equalities implications will need to be considered for any plans emerging form the revised planning arrangements

Sustainability Implications:

7.3 None identified

Any Other Significant Implications:

7.4 None identified

Supporting Documentation

1. Surge Plan 13/14: Brighton and Hove LHE

Surge Plan 13/14

Brighton and Hove LHE

V4

Contributing Organisations:

Brighton and Hove Clinical Commissioning Group (BHCCG)

Brighton and Sussex University Hospitals NHS Trust (BSUH)

Sussex Community Trust (SCT)

Brighton and Hove City Council (BHCC)

Sussex Partnership Foundation NHS Trust (SPFT)

South East Coast Ambulance Service NHS Foundation Trust (SECAmb)

Integrated Care 24 (IC24)

Contents

1 Introduction

This surge plan sets out the expectations and contingency arrangements, agreed across the Brighton and Hove Local Health Economy (LHE), to ensure appropriate management of anticipated and unplanned peaks in demand. This includes the winter period.

Drawing on experience from previous years and work already underway via our improvement work programme, this plan includes a summary of:

- operational readiness across the LHE to meet demand;
- our key system priorities and actions including preventive strategies ;
- additional contingency arrangements identified after a review of lessons learnt from last year
- actions being taken against the 8 priority areas highlighted in the winter planning toolkit for 13/14.

2 Planning Context

All providers are expected to be able to demonstrate that they have:

- detailed projections of likely demand informed by historic patterns of activity, seasonal fluctuations and other factors such as the impact of significant service changes and prolonged holiday periods;
- robust plans in place to meet the expected levels of demand and to continue to meet all agreed contractual requirements, targets and service standards.

3 Operational Readiness

3.1 Leads

Across the LHE, each organisation has identified senior personnel who are the named surge planning lead (see Appendix 1). Due to the nature of the patient catchment area for Brighton and Sussex University Hospitals NHS Trust (BSUH), this includes the surge planning leads for the Crawley, Horsham and Mid Sussex and High Weald Lewes Havens Clinical Commissioning Groups. The surge plan for Crawley, Horsham and Mid Sussex CCGs is attached at Appendix 2.

3.2 Local networks for surge planning

The BSUH LHE Urgent Care Programme Board provides strategic leadership for surge planning across the system. The governance, membership and terms of reference for this group are attached at Appendix 3.

The Programme Board is supported at a local level by the Urgent Care Task Forces (UCTF) of which there are two – one for the north and south of the patch. Urgent Care

Task Force (South) meets fortnightly to oversee the operational delivery of the surge plan. From November the UCTF will meet weekly to maintain to provide a coordinated oversight of any emerging system pressures.

4 Learning from last year

The local health and social care system experienced a very long and difficult winter and system pressures continued well into the spring of 2013. System pressures were compounded by:

- the unplanned long term closure of some community rehabilitation beds
- lack of clarity for the public how to access urgent care
- loss of public confidence in GP out of hours and the start of the new NHS 111 service
- confusion over roles and responsibilities in systems management and escalation

This resulted in a deterioration of the 4 hour A&E standard, unprecedented levels of 12 hour trolley waits and declining performance hospital handover delays.

A number of diagnostic and lessons learned sessions have taken place to inform the development of this year's plan. Key areas of focus for this year include:

- A more effective means of ensuring that clinicians know about the range of good quality services which act as alternatives to hospital and how to access them.
- A greater focus on creating capacity in primary care to manage urgent care
- Planning in advance to flex community bed/home based rehabilitation resource to meet levels of demand
- Building resilience and spare capacity in core staff groups e.g. nursing
- More capacity in community urgent care services that have been proven to work e.g. community rapid response capacity
- More coordinated support for care homes e.g. access to out of hours social care support
- Better information sharing between professionals about patients and greater use of technological solutions to share basic information such as medication
- A more effective escalation system – with clarity around roles and responsibilities and pre-agreed actions that are appropriate to the problem.

5 Escalation and System Management

5.1 Local escalation processes

Following learning from last year, the Programme Board members are in the process of revising the current escalation process for the Local Health Economy. This process will be consistent with and aligned to the Surrey and Sussex Pressure Escalation Framework (see Appendix 4) and the Brighton and Sussex University Hospitals Patient Flow and Escalation Policy and Procedure (see Appendix 5).

The revisions will ensure that:

- Robust multi agency plans are in place for a range of scenarios including acute trust pressures and cold weather affecting the whole
- The plans describes clear local actions (that are agreed and planned in advance) for each level of escalation by organisation which are appropriate to the scenario being managed
- There is a degree of visibility in terms of actions taken by each organisation
- There is seamless transition from Level 3 Red escalation which will be managed within the LHE to Level 4 Black

This is underpinned by a system wide agreement that management of severe pressure is a whole system responsibility and organisations may need to accept and manage additional risk.

The current draft will be tested at a Sussex Crisis Simulation Exercise Workshop in late October.

In addition, the local system is working in conjunction with NHS England to support the role out of the Capacity Management System (CMS) by mid-October. This will provide transparency and consistent reporting in terms of acute hospital pressures.

5.2 Business Continuity and Incident Response

As Category 2 responders the CCGs have a legal requirement to co-operate and share relevant information with other Category 1 and 2 responders. In practice, CCG's are responsible for coordination of the local health system including hospital trusts, community and social care, and for 'local' health incidents within that area, and for supporting the NHS England Area Team (NHS E AT) in their coordination of response to larger pan-Sussex incidents. The CCG along with its local partners therefore maintains 24/7 on-call arrangements. The details of this are attached at Appendix 6.

In Sussex, the multi-agency response to a major incident is likely to be coordinated by a 'Strategic Coordination Group', facilitated by Sussex Police at Police HQ, Lewes.

Within this, health operates at a pan-Sussex level via the NHS England Area Team, (NHS E AT), which coordinates links and response arrangements with all provider trusts, CCG's, Public Health England and major health partners, and provides a multi-agency link to the Sussex Resilience Forum. Sussex Health planning is strategically led and coordinated by the nationally mandated 'Local Health Resilience Partnership'. The Sussex LHRP is co-chaired by a Sussex Director of Public Health and the NHS E AT Operations Director.

Brighton and Hove City Council (BHCC) as a Category 1 responder maintains a duty 'Gold' director and has a Civil Contingencies Team with an on-call officer. The PH directorate includes a Resilience Manager who advises on health protection and multi-

agency resilience issues for the community of B&H, provides a resilience service to B&H CCG and who works in partnership with the LA Civil Contingencies Team.

All main providers including BSUH, SCT, SPFT and BHCC also have full major incident plans underpinned by internal escalation processes.

5.3 Flu Pandemic Planning

Sussex Resilience Forum maintains a multi-agency Pandemic Flu plan for Sussex, which is currently being updated by the SRF pandemic planning group, under the leadership of the PHE centre. Recent multi-agency planning guidance for pandemic influenza suggested that 'local' flu plans need to continue to be agreed to support the over-arching plans regarding provision of anti-viral collection points within local health economies (LHE's). The SRF group, including PHE and the NHS England Area Team are now awaiting updated health planning guidance for pandemic influenza to come from NHS England.

Public Health and the CCG are leading a city-wide planning group for Pandemic Influenza for the Brighton and Hove LHE that will ensure that each agency plans is able to effectively respond to the threat of flu pandemic across the LHE and cover all issues from the provision and coordination of antiviral collection points, to procedures detailing the vaccination of staff and vulnerable groups in the event of a pandemic.

5.4 Cold weather and snow contingency

All key providers within the LHE are required to have comprehensive cold weather and adverse weather plans. The Sussex Resilience Forum ensures there is an agreed multi-agency procedure for responding to all types severe weather events via its Adverse Weather Response Framework (Appendix 7).

In preparation for this winter, the memorandum of understanding for the Brighton and Hove transport hub has been refreshed involving all key partners. Triggers for mobilising the hub have been clarified along with providers own responsibilities regarding business continuity.

The BHCC Highways Winter Service Plan is attached at Appendix 8. This includes:

- The establishment of a winter maintenance service from 1 November until the end of March which will operate 24 hours a day, 7 days a week
- Plans for salt gritting the main network in advance of road frost, ice or snow
- the provision of salt/grit bins at outlying ungritted roads
- In prolonged snowfall, plans for snow ploughing and pavement clearance.
- Arrangements for road closures in conjunction with the police if they become impassable or road conditions become hazardous

This year's National Cold Weather plan is expected in Mid-October 2013. It is expected that the Met Office will continue to circulate cold weather and adverse weather alerts to all Civil Contingencies Act Category One responders, via Emergency planning Officers and on-call staff. At the CCG, the Resilience Manager will inform the CCG On-Call Manager.

SECAmb, BSUHT, SPFT, SCT & BHCC (including ASC) etc. will all be aware of such alerts via their EPO's and on-call staff, and should have planning and Business Continuity arrangements in place to ensure that Health professionals are adhering to the requirements of the National Plan, in checking on and where necessary, making arrangements for patients who may be vulnerable to the effects of cold weather.

The Council operates a duty officer system. The CCG has received and accepted assurance via the Brighton and Hove Resilience Manager from the Civil Contingencies Manager at BHCC that communications procedures between the Duty Officer, Civil Contingency Manager and Senior Directors during 'Out Of Hours' are robust and adequate.

Due to changes to the NHS this year, the CCG resilience Manager is seeking resolution to two issues which remain unclear:

- Whether NHS E AT will be informing all B&H Pharmacies (as well as GP Practices)
- Whether Brighton and Hove Adult Social Care will inform all Brighton and Hove care & nursing homes or only the ones they contract with.

If these issues are being managed, then the CCG will only be responsible for alerting other providers such as IC24 and local 3rd sector responders. A winter planning meeting has been timetabled for 10 am on Friday 9th November 2013 in order to give local agencies time to plan following release of this year's National cold Weather Plan.

Last winter a number of schemes were implemented as part of the Brighton & Hove Warm Homes Healthy People Programme 2012-13. The aim of the partnership was to reduce local excess winter deaths, the impact of cold homes on the health of local people and fuel poverty. The impact of these schemes has been evaluated however it is unclear as yet whether any central funding will be available consequently provisional plans are being made for funding/no funding scenarios.

5.5 Diarrhoea and vomiting / norovirus

A joint LHE plan is in operation to ensure there is consistent management of infection control across acute, primary and community settings. Specifically this includes a good practice agreement and joint discharge and referral documentation to highlight infection control status and risk to prevent inadvertent spread of infection and unnecessary closure of capacity (please see appendix 9)

All Short Term Service community beds provided by Sussex Community Trust and/or jointly with BHCC have a common evidenced based policy to manage infectious outbreaks. This builds on work progressed last winter and includes a daily contact from a specialist infection control nurse during an outbreak who can access immediate advice from the consultant in infection control and liaison with the Health Protection Agency. The aim of this approach is to ensure timely decision making and clinical accountability for closure; equality for patients and efficient safe reopening that is aligned with BSUH who have infection control management and monitoring policies in situ, supported by daily reporting processed.

6 Prevention

6.1 Immunisation of at risk groups

The CCG is engaged with all key agencies to ensure preparedness for the 2013/14 flu season, and to improve the local uptake of the flu vaccine. Last year Brighton and Hove achieved an uptake of 69% for over 65s and 50.5% for under 65s in at risk groups.

This year, the responsibility for commissioning flu vaccination programmes has passed to the NHS Area team, and we maintain close contact with them through our public health links.

The CCG has recognised that the efforts last year were not as successful as we wished, and has now agreed to fund further investment through enhancement of the Directly Enhanced Service which should provide additional nursing staff to target people who are housebound and who are most likely to miss out through their mobility problems.

Building on work from last year, the Area team is maintaining the vaccination programme in key hospital settings for patients with long term conditions. The target group this year is patients undergoing renal dialysis.

Monitoring of vaccine ordering in primary care is being carried out by the NSH Area Team, and we are looking for their assurance that the process is working successfully, and are ready to support them if specific problems emerge

Flu publicity will be led by Public Health England and Brighton and Hove City Council with a national campaign being distributed locally.

6.2 Immunisation of frontline staff

Main providers with the system are expected to deliver a significant improvement in staff vaccination rates this year moving towards a compliance rate of 75% for 2014. Last year's rates were as follows:

Organisation Name	% of vaccinated health care workers involved in direct

	patient care
Sussex Community NHS Trust	28.5%
Sussex Partnership Foundation Trust	39.5%
Brighton and Sussex University Hospital NHS Trust	30%
East Sussex Hospitals NHS Trust	27.1%
South East Coast Ambulance Service	40.8%

Staff vaccination programmes are in place across local provider organisations. Although uptake will be monitored by NHS England, we are also planning to monitor local providers via the Urgent Care Task Forces and Performance and Quality Boards. In particular we will be seeking assurances that providers have:

- Sourced sufficient levels of vaccinations based on an assumption that uptake rates will increase significantly this rather than last year's outturn
- Developed appropriate improvement plans that are over and above actions taken last year and informed by best practice e.g. use national resources such as NHS Employers Flu Fighters materials

Working in partnership with the local authority, we are also encouraging all Care Homes with Nursing to vaccinate their residents this year.

The City Council has made arrangements with the Healthy Living Pharmacies for their directly employed frontline staff to be offered vaccination. The negotiated rate per vaccine will also be available for staff of other private health and social care organisations if their employers chose to use the service. The communications teams from the various organisations will be working jointly to promote the programme.

6.3 Targeted intervention for at risk groups

This year's surge plan includes targeted intervention for a number of identified at risk groups:

- Targeted support for homeless hostels in the city to prevent admission and facilitate discharge from hospital
- Targeted training and education support for care homes in the city to encourage use of community alternatives to ringing 999 and
- Dedicated social care and mental health capacity in Integrated Primary Care Teams
- Roll out of IBIS for key at risk patient groups – COPD, dementia, end of life, mental health and falls

- A respiratory nurse in A&E to provide liaison with community respiratory teams and expedite discharge
- 7 day a week rapid access clinics

7 Capacity in Key Services

7.1 Joint system plans

The system around the BSUH catchment area are working together to deliver a joint improvement plan, following recommendations from ECIST, which aims to support sustainable delivery of the 4 hour A&E standard and also reduce the number of avoidable non elective admissions and A&E attendances. The improvement plan focuses on a number of key work streams including:

- Creating capacity in primary care to manage urgent care demand
- Anticipatory care i.e. coordinated and structured care of high risk
- Reducing avoidable ambulance conveyances
- Improving access to urgent care services e.g.
- Reducing avoidable admissions to hospital alternative community pathways e.g. shortness of breath, IV antibiotics
- Redesigning community short term services and integrating bed, community and community urgent care services

The local system has also agreed a range of investments from local social allocation and reablement resources and national surge planning monies. The detailed scheduled is available at Appendix 10.

7.2 Primary Care

GP's will continue to provide primary medical "essential services" between 8.00am and 6.30pm Monday to Friday, excluding public holidays. Outside of these hours the CCG commissions an out of hours GP service located at the Royal Sussex County Hospital. NHS 111 acts as the entry point for patients

Individual GP practice business continuity (and flu) plans will be checked individually with practices. This will identify any practices whose plans are not up to date or robust and will also focus on practice 'buddying' arrangements specifically designed to ensure service continuity, particularly for single handed and small GP practices.

The Walk-in Service at the Brighton Station GP led health centre is operated by Care UK, offers an 8am -8pm service everyday including Christmas and Bank Holidays. This includes a sexual health consultations/emergency contraception service that is open from 8am -7 pm. These services are well advertised locally.

Historic patterns of demand in Brighton and across other sites run by Care UK show that the Christmas and New Year period do not present a high demand. However, planning for additional staffing is contained within the company's contingency plan and includes pulling staff from sites nearby in Portsmouth and Wandsworth. Contact details for Care UK, in the event of escalation due to adverse weather or other situations, are contained in the on call information for the CCG on call managers.

This year's plan has a greater focus on creating capacity in General Practice to manage urgent care demand. Initiatives supported by the national A&E/surge funding include:

- The piloting of Dr First or similar systems in 6 practices across Brighton and Hove
- Saturday and Sunday morning pop up walk in clinics supported by access to practice systems
- Practice sign up to a set of urgent care standards e.g. a commitment to respond to a call from a consultant within 30 minutes
- A Primary Care Navigator role in A&E supported access to practices systems and/or Summary Care Records
- Continued development of the Urgent Care Dashboard and encouraging greater use by practices

We are also working with primary care to develop a range of specific actions to implement as part of the local escalation process which may include:

- Sending out an all practice e-mail on use of alternatives to A&E when the hospital is at "red"
- The cancellation of pre booked training sessions when the hospital is on "black"
- The development of metrics that measure business of primary care urgent care in primary care by examining same day appointments , telephone contacts and visits offered on a daily basis by a manageable number of volunteer indicator practices
- The development of a menu of appropriate responses that GP practices could make when the hospital is "black", including extra opening hours, telephone triage, cancelling routine clinics or appointments to increase urgent care capacity.

Local dentists will provide core services as per contract. This includes additional 'in-day' access slots procured during 2010, targeted at our areas of highest need. Emergency Dental Services are provided 7 days a week, including all bank holidays. Information with regarding the Emergency Dental Service will be included in all local winter communications plans.

Brighton and Hove is well serviced with 59 community pharmacies spread throughout the City. The majority are open until at least 6.30pm weekdays. Two pharmacies

(Weston's Pharmacy, Lewes Road, and Ashtons Pharmacy, Seven Dials) are open from 9am-10pm 365 days a year. The pharmacy at Sainsbury's, West Hove, has a 100 hour per week contract. Although many pharmacies do have reduced opening hours on the Christmas and New Year bank holidays – Weston's and Ashtons are both open all day with Sainsbury's, West Hove, and Boots, North Street, still available on most days, apart from 25th December.

All pharmacies have contingency plans and arrangements in place to ensure a service can still be provided even in times of adverse weather conditions.

7.3 Out of Hours

Integrated Care 24 (IC24) have appropriate contingency plans in place to ensure primary care out of hours and out of hours nursing services can be maintained and meet expected increases in demand over the winter period. Historic patterns of activity are routinely tracked and staff levels planned accordingly, including all bank holidays.

Additional capacity plans focus on extra clinicians during predicted busier shift times such as early evenings and daytimes at weekends and bank holidays.

Capacity and demand are reviewed routinely on Mondays at locality corporate meetings and on Thursdays at Operations Conference Call. Emergency meetings of the EMT are held if demand exceeds capacity and thereafter at daily conference calls throughout the crisis period.

All IC24 cars are fitted with winter tyres at the start of October for the winter period and wheel chains available. Brighton has the use of 3 cars, 2 of which are 4x4 as well as the access to 4x4 assistance. IC24 are seeking to collocate some of their 4x4 vehicles at the Royal Sussex County site. There are 7 other cars in use for the oohs period within the East Sussex Locality

GP out of hours will also continue to support:

- A redirection pathway from adult and paediatric A&E
- A weekend review clinic which is bookable by health professionals.

The out of hours nursing service operates from 8pm to 8am 7 days a week including Tuesday 25th December and Wednesday 26th December and Tuesday 1st January 2013. Staff are not permitted annual leave during the long Christmas Bank Holidays and are aware that that the service may request flexibility over other leave arrangements.

Additional night sitting and 'pop in' capacity will be in place via the out of hours nursing service to provide additional support to Community Rapid Response Service (CRRS) and to facilitate discharge from A&E.

A number of other services operate out of hours. Where these are directly accessible by the public they are linked into the NHS Pathways Directory of Service as a potential disposition for NHS 111. This includes:

- Professional Support Line (for clinician urgent care referrals)
- Community Short Term Services – bed and community based rehabilitation
- Community Rapid Response Service
- Independence at home (in-house homecare service)
- Hospital Integrated Discharge Team (including social care)
- GP led health centre
- Roving GP (operating until 9pm weekdays)
- Social workers aligned to Community Rapid Response Service/Carelink to provide emergency and out of hours social care

7.4 Services preventing admission

All community services will as a minimum be provided in accordance with planned activity levels and contractual requirements. Certain key services will be bolstered with additional capacity funded by A&E improvement/surge funding.

Roving GP/Intermediate care medical cover (provided by IC24) has a substantial number of shifts covered by salaried GPs to ensure continuity of care and robustness of service delivery. Additional sessional GPs are available to provide cover where needed. The service is able to flex according to activity as the RGP and ICS GP can support each other and provide contingency. As part of the surge funding, the operating times of the roving GP will be extended until 9pm on weekdays to more closely align with those of the CRRS.

The **Community Rapid Response Service** (CRRS) functions 7 days a week until 8pm. This service provides a 2 hour urgent assessment and intervention service to prevent admission to hospital for up to 3 days. Surge funding is being used to provide additional capacity within the service to take an additional 5 referrals per day and to more effectively respond to peak periods of demand e.g. Fridays.

Age UK (Brighton and Hove) work closely with CRRS to support patients for up to 2 weeks, when they are in crisis. They provide general care as well as a sitting service 7 days per week. The plan is to increase the capacity of this service to respond to the anticipated winter surge demand from CRRS. This additional capacity will also support patients waiting for packages of care in their usual place of residence, and thus enable patients to be discharged from both an acute bed and/ or the CRRS (which provides support for up to 72 hours) in a timely and safe way.

The **Integrated Primary Care Teams** (IPCTs) which support clusters of practices to proactively manage patients with long term conditions is now well established. Since last winter, the service has increased nursing, therapy, social care management and

mental health nursing capacity. The service also has a target of getting 500 anticipatory care plans on the IBIS system by mid-November.

The **Professional Support Line** (PSL) is the single point of access for all community urgent services and operates 8am to 8pm 7 days a week. Further assurances are being sought from the current provider, SECAMB, on plans to ensure robust service delivery over the winter period.

The **Rapid Access Clinic for Older People** (RACOP) provides multi-disciplinary consultant led geriatric assessment to prevent hospital attendance and / or admission as well as support timely discharge from an acute bed. The surge funding will increase capacity within the service and enable specialist dementia support.

7.5 Acute Hospital Services

BSUH have well established mechanisms in place to flex bed capacity up and down to meet demand, but there is a clear limit to the maximum capacity that can be open. Clinical operation reviews of predicted and actual demand progress take place three times a day. An operational look forward monitors all capacity issues and plans for the following week on all aspects in demand on capacity. This includes the management of mismatches between elective and emergency demand. A rolling 6-week emergency admission predictor is used; and this predicts the position one week ahead for planning and is supported by the implementation of a real time bed state that monitors patient flow, and is expected to be fully operational in 2013.

Duty rotas will be completed 6 weeks in advance of the Christmas/New Year period. Annual leave will be tightly managed and a rota is developed to use minimal agency staff over the period. Regular recruitment into nursing vacancies has resulted in a reduction of vacancies and consequent use of agency staff. A full on call rota is in place providing 24/7 cover by all professional groups as required is in place, especially from support services e.g. Pharmacy service, Therapy staff, Pathology services, Imaging.

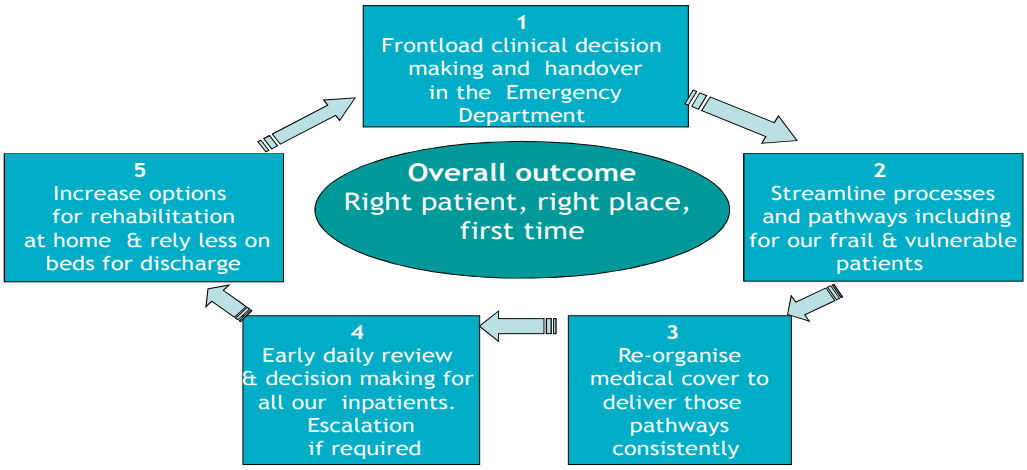
Elective admissions over Christmas and New Year period will be reduced over Bank holidays but otherwise will continue as normal. Planned trauma lists will be increased over this time, to meet the usual peak in capacity demand.

Arrangements are in place to continue the management of elective work and to maintain the achievement of the 18 week target including:

- A weekly (Wednesday) 18 week meeting to monitor performance and implement agreed actions
- A reduction in waiting time for first outpatient appointment allowing greater flexibility in the remainder of the 18 week pathway
- Alternative providers identified to take patients from existing waiting lists identified as required

In the event that the 18 week target was at risk a Recovery Group would be formed to agree and monitor a plan to regain performance.

£835k of the surge funding allocated to BSUH will be used to improve and enhance practice enabling delivery monitoring by means of mile stones, measureable KPIs. The schemes are closely linked to the ECIST work for which there are five key work streams



BSUH are working with key stakeholders in the system to ensure a robust plan for the forthcoming winter. This will draw on experience from previous years and ensure there are plans in place to meet the expected levels of demand. A dashboard of performance and process measures is in place and in use to provide assurance around progress to the wider system. The dashboard looks at both key performance and safety and quality indicators. This work will continue at pace and alongside other initiatives to improve quality, safety and dignity.

BSUH will provide timely updates in relation to performance and the impact that the monies is having on our patients. There will be agreed named staff that will be responsible for ensuring that the impact is measureable and reported.

Escalation plans have been updated and circulated with clear actions taking in to account previous years and experiences.

6.1.1 Single Sex Compliance

BSUH is compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice.

Patients who are admitted to the hospital will only share the area where they sleep (i.e. section or bay of a ward) with members of the same sex, with same-sex toilets and

bathrooms close to their bed area. Sharing with members of the opposite sex will only happen when clinically necessary (for example in our Critical Care units) or when patients actively choose to share (for example in the Sussex Kidney Unit.)

BSUH will also set up an audit mechanism to make sure that it effectively classifies any of its reports and will publish the results of the audit in the annual Quality Account.

6.1.2 Critical Care

Critical care networks and communication processes are in place.

Bed capacity for HDU has increased this year to 8 beds at RSCH. Transport and escalation plans are fully in place and used regularly. SECAmb responds to requests for critical care transfers (inter hospital) as an emergency response based on the needs of the patient. The critical care facilities on both sites are used flexibly to meet the demand.

7.6 Learning Disabilities and Mental Health

The extended break over the Christmas and New Year period can result in vulnerable people becoming isolated. Contingency plans will be in place for such individuals and these are available through e-CPA (SPFT electronic clinical recording tool) which is available to all SPFT staff including those working in the Crisis Resolution Home Treatment (CRHT) service, A&E Liaison staff, Assessment and Treatment Service, Enhanced Brighton Urgent Response Service, Assertive Outreach and the Living well With Dementia Service.

Both Mill View and the Nevill Hospitals will be operating at full capacity across the winter period for the provision of adult and older people with mental health problems.

The Assessment & Treatment Services operate normal working hours 9-5 Mon to Friday, (except BHs). The Assertive Outreach Team (AOT) operates extended hours for identified clients.

CRHT & A&E Liaison operate 24/7, as is access to on call consultants and Approved Mental Health Professionals. The Enhanced Brighton Urgent Response service is fully operational and available 24/7 working from Mill View Hospital between 8am- 8pm and outside of these hours from the RSCH.

The Living Well with Dementia Service is available 7 days a week 8am-8pm for people with dementia.

The Lighthouse (service for personality disorders) operates 7 days a week.

When 'normal' bed capacity is full there are agreed escalation plans e.g. leave beds, urgent clinical reviews, and accelerated discharge with support from CRHT. In-patient wards are identified as priority, with professional leads providing clinical interventions.

The Brighton and Hove Wellbeing Service is open Mon - Friday 9am to 5 pm, closed weekends and bank holidays. There is a facility for this service to respond to respond to priority referrals within 5 days of referral.

The Brighton & Hove Memory Assessment Service is open Mon- Fri 9-5 closed weekends and bank holidays.

Staffing capacity is planned according to previous activity levels, to ensure adequate staff are in place. The main risk to the service is staff sickness, in this event the community services would need to concentrate on priority referrals, and routine referrals would take longer to be seen which may end up in a breach in waiting to be assessed / treated.

Across all Mental Health services, in adverse weather situations e.g. snow, vulnerable people are visited at home and non-clinical staff are redeployed to provide ancillary functions.

7.7 Ambulance Services - 999 and PTS

SECAMB operate a nationally recognised REAP (Resource Escalation Action Plan) system, incorporating six levels of escalation which triggers actions based on system pressures. This is attached at Appendix 11. The REAP level is kept under constant review by the operational management team.

SECAmb will expect to receive as much notice of adverse weather through its Contingency Planning and Resilience Department. The system in place captures all the severe weather warnings from whichever source and sends them through to the single point of contact (SPOC) email (CP&R@secamb.nhs.uk) or the SPOC Tactical Advisor number (0773900765). The on-call Tactical Advisor will then deal with the alert in the most appropriate manner. Should the alert relate to pre-warning telecons then these will be attended to by the SECAmb representative and will promulgate the actions throughout SECAmb. Notice of weather concerns could trigger the standing up of Mission Control along with preparedness and distribution of in-house 4x4 vehicles along with the procurement of additional 4x4 capability if required.

The Resourcing Escalatory Action Plan (REAP) will form the backbone of the Trusts response; as part of the REAP procedure an Emergency Operations Centre (EOC) on day surge process has been established that will provide the Trust with short notice capability to surge several vehicles. This system has been enhanced since the introduction of the single Computer Aided Dispatch (CAD) which enables deployment across SECAmb.

SECAmb operate NHS Pathways in all 3 EOCs which enables more patients to receive a more appropriate response, providing advice or more local services to be used to conclude episodes of care over the telephone, at the patient's home or at an alternative treatment centre other than an acute setting. It is anticipated that utilisation of this

triaging tool which is linked to a directory of locally available services will reduce A&E attendances. Alongside this SECAmb have additional clinical advice/support within the EOC's and has contingency plans to increase the numbers of clinicians at times of increased demand along with expanding the conditions where advice can be provided.

Additionally SECAmb are implementing a number of projects which support the system wide programme to reduce the number of avoidable conveyances to A&E:

- Supported conveyances –providing additional support to ambulance staff in their decision making regarding whether to convey a patient into secondary care or whether the patient can be supported at home through primary or community care services. This support would be provided by a senior clinician from the Secamb control room.
- Using the IBIS system i.e. loading care plans onto the IBIS system to help them to manage the patient in the community, where clinically appropriate rather than automatically conveying them to hospital.

SECAmb have in-house 4x4 vehicles with patient carrying capability and these can be supplemented with additional hired in vehicles if required. All trust ambulances have snow tyres fitted as standard and these can be further enhanced with the addition of 'snow shoes'.

Patient Transport Services

It is SECAmb's intention to provide a reliable and responsive patient transport discharge service to the acute trusts as commissioned. Plans have identified that when there is a demand for discharges, due to adverse weather, there is also a corresponding reduction in out-patient activity, therefore PTS capacity to key patient groups, including discharges should be maintained. The PTS managers with geographic responsibility for the particular area work with the local providers to identify and agree priorities and manage demands.

The PTB provides a central screening, booking and coordination centre for Sussex. This service is available for all PTS requests including out patient appointments, discharges, admissions etc. In addition the PTB organises the repatriation of patients any where in the country or from anywhere in the country back to Sussex.

The PTB is centrally based in Worthing with 85% of staff living within 15 minutes walking distance it is able to operate as LHE central transport Hub for non emergency transport coordination. The PTB can be contacted via email or through 0300 111 21 31. We also have a dedicated discharge line which will be used in the event of adverse weather conditions 01903 890651.

The PTB also has on site coordinators currently based at Chichester, Brighton and Eastbourne however should they not be able to get to their designated sites they also

have the capability to work from home with full access to the PTB booking service and phones linked into the dedicated discharge line.

PTB and PTS managers will monitor performance and responsiveness of service while maintaining close links with colleagues in the acute trusts, particularly when the health system is challenged, on an hour by hour basis if necessary.

Access to reliable PTS remains a concern for the LHE and despite work to review current arrangements it is unlikely these will deliver any material benefits in time for winter. Plans are therefore in place to secure additional dedicated private vehicles via surge funding to support BSUH and discharges to and from community STS beds.

7.8 Hospital Handovers

Whilst progress has been made in validating handover data, both BSUH sites continue to experience significant levels of handover delays. The surge plan includes funding to support improvement including Hospital Ambulance Liaison Officers at both sites and a nurse post to greet ambulances in the Princess Royal A&E.

Performance is being closely scrutinised at the BSUH Single Performance Conversation and the Urgent Care Programme Board however SECAMB and BSUH have yet to:

- reach agreement on governance arrangements and triggers for instigating cohorting in the A&E departments
- present a comprehensive joint plan that assures commissioners performance will improve.

7.9 NHS 111

Only superficial winter plans have been received from SECAMB regarding the NHS 111 service. Commissioners have been advised that the full winter plan will not be available until the end of October. The plan, as provided, does not provide any assurance about the service's ability to manage surges in demand, in particular over the peak holiday period. This concern is being formally raised with the provider via the lead contracting CCG.

7.10 Access to intermediate care and social care

Community Short Term Community Short Term Services (CSTS) are accessed by clinicians and professionals across Brighton and Hove via the Professional Support Line. CSTS will be provided in accordance with planned activity levels and contractual requirements.

Services will flex their staffing within existing resources to cover bank holidays and weekends ensuring that 'pinch points' are reduced as much as possible. Surge funding and the winter contingency from the Social Care Allocation are being used to provide additional capacity in key services including:

- 7 day a week social work resource aligned to the CRRS to be used flexibly when patients are in crisis. Importantly the social workers will be able to ensure patients are supported when they require adult health and social care services.
- Additional homecare capacity to supplement CSTS ensuring there are there are enough homecare workers available to respond rapidly to peaks and troughs across winter across 7 days of the week
- increased capacity and availability of community equipment access 08.00-20.00 for 7 days per week
- a dedicated discharge vehicle for CSTS to support patient flow from an acute bed to CSTS and if required from CSTS to another care setting a dedicated discharge vehicle will be available for CSTS patients
- additional CSTS beds available through the winter surge with flexible admission criterion and a particular focus on dementia or cognitively impaired patients, and access to appropriate rehabilitation facilities.

All services within CSTS have developed clear escalation plans and policies to cover likely issues such as cold weather, snow, capacity issues, and the closure of CSTS beds

7.11 Social care joint arrangements

Adult Social Care is a core member of the weekly Urgent Care Task Force. All the Brighton and Hove system plans incorporate actions related to social care and local authority services commissioned and include:

- Management of reduced capacity and staffing over winter (including use of care crew/ relief staff)
- Management of planned annual leave for the winter and Christmas period (includes new Annual leave booking protocol)
- Flexibility between directly provided 'bed' services to ensure maximum efficiencies
- Clear onward pathways being developed to independence at home (homecare) to support Community Short Term Services and rapid response service
- ASC to participate in Transport Hub to support movement of critical staff and access to vulnerable service users when severe weather significantly disrupts transport systems in the city.
- Increased levels of homecare capacity accessible 7 days a week, and improved access to home care through reviewing current processes.
- Increased access to care home capacity (including nursing) 7 days a week

- Information and intelligence related to available care home capacity accessible to BSUH 7 days a week

Good processes are in place to support timely hospital discharges including rapid access to packages of homecare, 7 days a week access to assessment services, care pathways for housing issues.

Social work teams will be covering short term services over the Christmas week to avoid delays in assessments and applications for care provision. There should be normal cover over 24th, 27th and 28th.

8 Communications

The CCG has developed and implemented a comprehensive public campaign to improve awareness of where they should go if they are unwell or have an accident and to try and encourage people with less serious problems to use services other than A&E. We are working closely with BSUH and neighbouring CCGs to make sure we have a coordinated approach to this campaign.

At this year's PRIDE event we, with the help of SECAMB, St John Ambulance and LGBT HIP, handed out 3000 flyers all over the city telling people the exact location of the Brighton Station Health Centre and the main pharmacies. We have distributed similar information at Sussex and Brighton Universities Fresher's Weeks with adverts in student papers and presence at Fresher's fairs.

The campaign, themed around celebrating the everyday heroics of people using the health system correctly, will include short animated films to be shown in key locations, a mobile phone optimized web site and game; and radio and bus stop advertising. Click here to go to the site - . www.wecouldbeheroes.nhs.uk.

Flu publicity will be led by Public Health England and Brighton and Hove City Council with a national campaign being distributed locally. The Cold Weather Plan is also being launched by Pubic Health England alongside a communications toolkit to support local work on the Keep Warm, Keep Well theme. Alongside messages for the public, the CCG is developing a mobile enabled web based directory of urgent care services. This will be available to local GPs and other clinicians in the city. We have held a networking event with BSUH clinicians and community services to develop a greater understanding of the range of community alternatives in the city. We are seeking to replicate this session with GPs and care home providers.

9 Key Risks and Mitigation

Risk Area	Risk Score	Mitigation	Adjusted Risk Score
Sustainable delivery of 4 hour A&E standard	20	Continued scrutiny of delivery of ECIST plans by acute trust via local assurance group Ensuring focus on key risk areas affecting performance e.g. surgical pathways, timely discharge, mental health etc. Continued oversight and leadership by members of Urgent Care Programme Board supplemented by operational focus at weekly Task Force meetings	12
Ability to make best use of surge money in a sufficiently timely way to impact on winter	16	Prioritisation of surge money on key risk areas. All bidders required to complete project plans and provide regular update on progress Close monitoring of use by UCPB to ensure programmes are delivering on time and achieve desired impact UCPB to determine use of slippage money	12

Risk Area	Risk Score	Mitigation	Adjusted Risk Score
Lack of effective escalation policy	16	Rewrite of local policy to align with Surrey and Sussex policy to include: • Robust multi agency plans for a range of scenarios including those affecting the whole system • clear local actions (that are agreed and planned in advance) for each level of escalation by organisation which are appropriate to the scenario being managed • a degree of visibility in terms of actions taken by each organisation • seamless transition from Level 3 Red escalation which will be managed within the LHE to Level 4 Black. Testing at Sussex Crisis Simulation Exercise Workshop in late October. Implementation of CMS to provide transparency and consistent reporting in terms of acute hospital pressures.	12
Ability of PTS to meet demand and capacity over winter period	16	Review of current contract and escalation to provider of key issues by lead commissioner. Sourcing PTS capacity from independent sector providers to support discharge from hospital and to expedite discharge from CSTS beds	12

Risk Area	Risk Score	Mitigation	Adjusted Risk Score
Ability of NHS 111 to meet demand and capacity over peak periods	12	Lead commissioner has formally written to provider requesting comprehensive surge within 2 weeks.	12
No improvement in hospital handover performance	16	Implementation of HALO role and PRH nurse from surge funding. Continued scrutiny of handover improvement plans by local assurance group and SPC.	12
Non delivery of flu immunisation targets for provider staff	12	Monitoring of providers by NHS E Monitoring of local providers via the and Performance and Quality Boards. In particular we will be seeking assurances that providers have: • Sourced sufficient levels of vaccinations based on an assumption that uptake rates will increase significantly this rather than last year's outturn • Developed appropriate improvement plans that are over and above actions taken last year and informed by best practice e.g. use national resources such as NHS Employers Flu Fighters materials	9

HEALTH & WELLBEING BOARD	Agenda Item 36

Subject:		**Declaration on Tobacco Control**	
Date of Meeting:		**27 November 2013**	
Report of:		**Director of Public Health**	
Contact Officer:	**Name:**	**Tom Scanlon**	**Tel: 29-6555**
	Email:	tom.scanlon@brighton-hove.gov.uk	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report sets out to inform the Health and Wellbeing Board about the Declaration on Tobacco Control.

2. RECOMMENDATIONS:

2.1 That the health and wellbeing board recommends that the Full Council adopts this declaration.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 In May 2013, Newcastle City Council passed a declaration setting out their commitment to tackle the harm smoking causes to communities. This has become known as the Local Government Declaration on Tobacco Control and has been endorsed by, among others, the Public Health Minister, Chief Medical Officer and Public Health England.

3.2 On 23 October, Brighton & Hove City Council were invited to join Newcastle and sign up to the declaration.

3.3 The Declaration will commit our councils to:

- Reduce smoking prevalence and health inequalities
- Develop plans with partners and local communities
- Participate in local and regional networks
- Support Government action at national level
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Monitor the progress of our plans
- Join the Smokefree Action Coalition

There will be a formal launch of the Declaration in early December in Parliament.

3.4 Tobacco remains the single greatest cause of preventable deaths in England – killing over 80,000 people every year, more people each year than obesity, alcohol, road accidents and illegal drug use put together. Thousands of children also suffer harm as a result of smoking. Not only are 17,000 children under the age of five admitted to hospital every year as a result of passive smoking but

Cancer Research UK also estimate that 430 children in England start smoking every day.

3.5 Although smoking has fallen from 40% to 20% since 1980 there has been little change within our poorest communities and smoking is responsible for half the difference in life expectancy between the richest and poorest. There can be no doubt that, in the context of our public health responsibilities, smoking is the greatest challenge facing us today. Locally in Brighton & Hove the Health Counts Survey for 2012 reported that 14% of adults in Brighton & Hove smoke daily and 9% smoke occasionally.

3.6 In response, this declaration has been developed to provide a very visible opportunity for local government: to publically acknowledge the significant challenge facing us; to voluntarily demonstrate a commitment to take action; and to publish a statement of our declaration to protect local communities from the harm caused by smoking. The Declaration includes a specific and important commitment to protect health policy from the influence of the tobacco industry. This is an obligation already placed on local authorities through the World Health Organisation treaty on tobacco – however, this declaration reminds us of our obligations and restates our commitment.

3.7 This report will go to Full Council for formal adoption. A copy of the Brighton & Hove City Council Declaration on Tobacco Control can be found at appendix 1.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The Declaration is being considered for adoption across all of Sussex and Surrey and in effect it does not commit us to do anything more than we are doing at present.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 The tobacco control alliance, is chaired by Tim Nichols Head of Regulatory Services, Planning and Public Protection, officers from various council departments including trading standards, public health, seafront office, parks and gardens, taxi licensing, and environmental health, smoking cessation workers, health professionals and councillors; they support this measure.

6. CONCLUSION

6.1 The Health and Social Care Act 2012 provides a transition towards the establishment of a new public health system and confirms the Government's vision for the new public health role in local authorities. Under this new framework, local authorities are responsible for tobacco control and smoking cessation services.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 The 2013/14 public health budget for smoking cessation and tobacco control is £810k. The Declaration reinforces the work the Council is undertaking and is not expected to lead to an increase in the cost of the planned activities.
Finance Officer Consulted: Anne Silley *Date: 12/11/13*

Legal Implications:

7.2 The proposals in the report are consistent with the Council's new public health responsibilities, set out in the Health and Social Care Act 2012.
Lawyer Consulted: Elizabeth Culbert *Date: 12/11/13*

Equalities Implications:

7.3 In the context of Public Health responsibilities, smoking is the greatest challenge facing us today and is a major contributor towards health inequalities.

Sustainability Implications:

7.4 Local authorities should embed new public health functions into all their activities, tailoring local solutions to local problems, and using all the levers at their disposal to improve health and reduce inequalities.

Any Other Significant Implications

7.5 Public health is committed to protect local communities from the harm caused by smoking.

SUPPORTING DOCUMENTATION

Appendices:

1. Proposed Brighton & Hove Declaration on Tobacco Control.

Documents in Members' Rooms

1. None

Background Documents

1. None

Proposed Declaration to be agreed by Brighton & Hove City Council December 2013

The Brighton & Hove City Council Declaration on Tobacco Control

We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

As local leaders in public health we welcome the:

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health organization's framework convention on Tobacco control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and
- Endorsement of this declaration by central government and Public Health England.

We commit our Council from this date ……to

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities
- reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reducing the harm caused by tobacco.

Signatories for the Council

Leader of the Council

Director of Public Health

Chief Executive