Brighton & Hove City Council

Health & Wellbeing Board

Title:	**Health & Wellbeing Board**
Date:	**5 February 2014**
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 Service Officer 01273 291063 caroline.demarco@brighton-hove.gcsx.gov.uk

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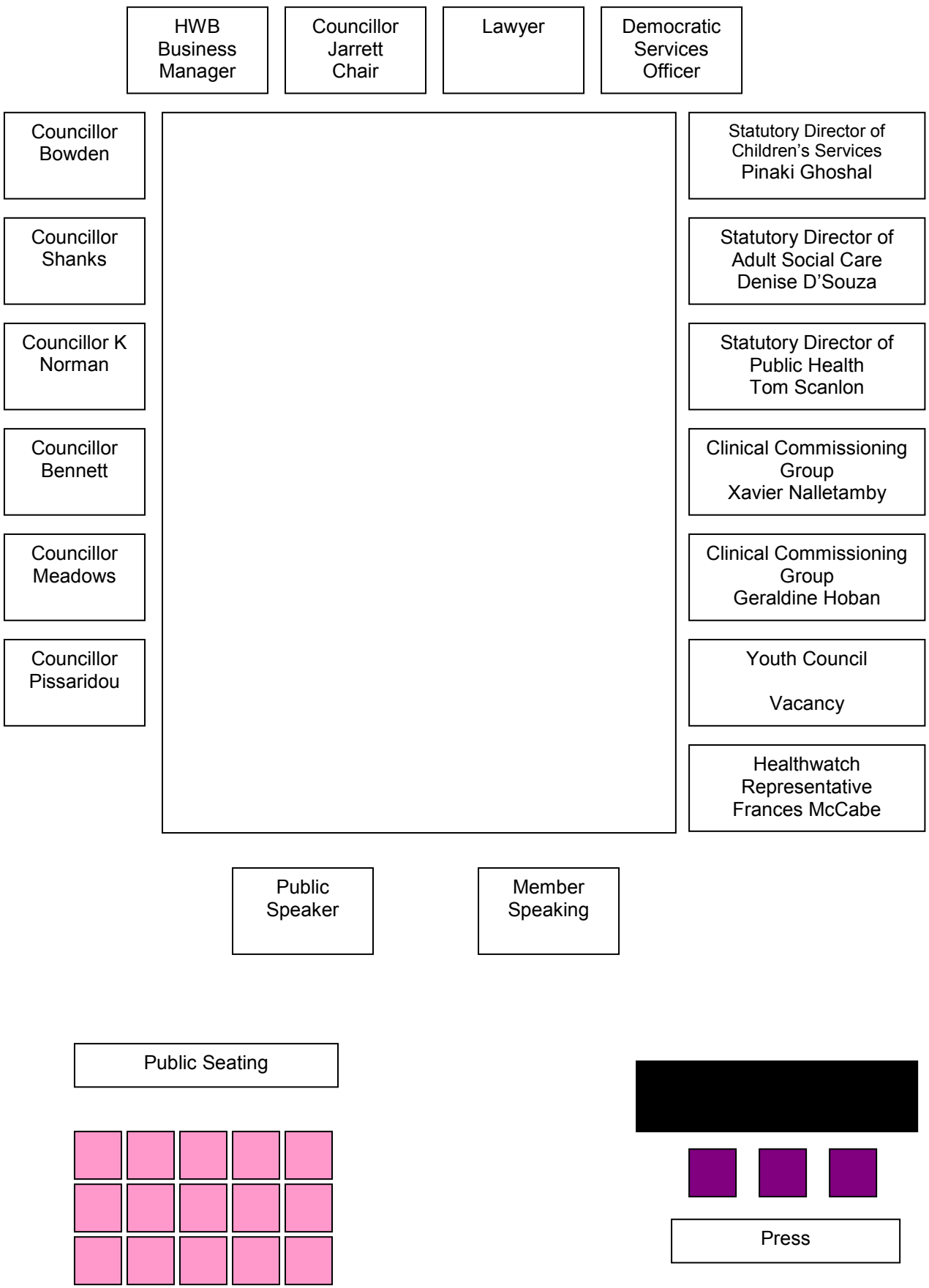
Health & Wellbeing Board



AGENDA

PART ONE **Page**

37. 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.

38. MINUTES **1 - 16**

Minutes of the meeting held on the 27 November 2013 (copy attached).

39. CHAIR'S COMMUNICATIONS

40. PUBLIC INVOLVEMENT

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 29 January 2014;
(c) **Deputations** – to receive any deputations submitted by the due date of 12 noon on the 29 January 2014.

41. 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

42. HAPPINESS: BRIGHTON & HOVE MENTAL WELLBEING STRATEGY **17 - 32**

Report of Assistant Chief Executive (copy attached).

Contact Officer: *Paula Murray* *Tel: 29-2536*
Ward Affected: *All Wards*

43. BETTER CARE FUND PLAN **33 - 60**

Report of the Executive Director of Adult Services, BHCC & Chief Operating Officer, CCG (copy attached).

Contact Officer: *Anne Foster* *Tel: 01273 574657*
Ward Affected: *All Wards*

44. PHARMACEUTICAL NEEDS ASSESSMENT **61 - 66**

Report of Director of Public Health (copy attached).

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

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HEALTH & WELLBEING BOARD

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Date of Publication - Tuesday, 28 January 2014

HEALTH & WELLBEING BOARD	Agenda Item 38 Brighton & Hove City Council

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING BOARD

4.00pm 27 NOVEMBER 2013

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Jarrett (Chair) Councillor K Norman (Opposition Spokesperson), Meadows (Opposition Spokesperson), Bennett, Bowden and Deane.

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, Frances McCabe, HealthWatch.

Apologies for absence: Councillor Pissaridou

PART ONE

25. PROCEDURAL BUSINESS

25A Declarations of Substitute Members

25.1 There were none.

25B Declarations of Interests

25.2 Councillor Deane declared that she was attending as a substitute for Councillor Shanks.

25C Exclusion of the Press and Public

25.3 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.

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

26. MINUTES

26.1 The Health & Wellbeing Board Business Manager referred to paragraph 16.6 in relation to Mr Rixon's supplementary question in respect of contract compliance. Mr Rixon still required a written response.

26.2 **RESOLVED -** That the minutes of the meeting held on the 11 September 2013 be approved as a correct record of the proceedings and signed by the Chair.

27. CHAIR'S COMMUNICATIONS

Healthwatch

27.1 The Chair welcomed Frances McCabe to her first meeting of the Board as Healthwatch representative.

27.2 Ms McCabe informed the Board that she had now been working as Healthwatch Chair for six working days. She had previously been Chair of Age UK, and was still a trustee at Age UK. She stressed that Healthwatch had to deal with an enormous range of issues and she noted that many issues concerning Healthwatch were mentioned in the agenda.

Change of date of next meeting

27.3 The Chair informed members that the date of the next meeting had been changed from 19 March to Wednesday 5 February 2014 at 4.00m in the Council Chamber, Hove Town Hall. A meeting was required before 14 February in order to sign off the Integrated Transformation Fund.

Youth Council

27.4 The Chair reported that this would be the last meeting to be attended Hayyan Asif as representative of the Youth Council. He thanked Hayyan for his contribution to the Board.

28. PUBLIC INVOLVEMENT

(a) Petitions

28.1 The Chair noted that there were no petitions from members of the public.

(b) Written Questions

28.2 Mr Ken Kirk asked the following question on behalf of Mr 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."

28.3 The Chair accepted the lack of empirical evidence and gave the following response:

"Like any other public body, the city council is required to follow the law, and EU procurement law obliges public sector bodies, at the end of the current contract period, to go to commercial tender for contracts over a certain size.

Public sector bodies are given little discretion in these matters, so analysis of the empirical evidence on the pros and cons of competitive tendering with regard to any specific contract is of questionable value when there is no option open to the council *other* than to go to tender.

However, when we do tender for sexual health services, our primary aim will be to improve services for local people by identifying the provider which can deliver the best possible quality, value for money and social value. As part of this we will ensure that the services commissioned address the sexual health needs of the population as identified in the local Joint Strategic Needs Assessment."

28.4 Mr Kirk replied that he could quote a speech given by the Chairman of Monitor which stated that there was no absolute obligation to go out to competitive tendering. Mr Kirk said he would make this paper available. There was no need necessarily to involve the private sector. He believed that reconfiguration was a cover for privatisation. Mr Kirk said he could give examples of privatised services that had fallen short of expectation. He mentioned Serco in Cornwall as an example.

28.5 The Chair replied that the Council would pursue a route that best met the needs of people in the City. He thanked Mr Kirk for the questions raised on behalf of Mr Baker.

28.6 **RESOLVED-** That the written question be noted.

28.7 Mr Ken Kirk asked the following question:

"The Brighton and Hove Health and Wellbeing Board has a duty to produce a Joint Strategic Needs Assessment for the city. If we project forward a number of years, based upon the evidence we have of B&H CCG's implementation of the Health and Social Care Act, then B&H healthcare system will be fragmented into a large number of contracts, some with third sector organisations, some with private health companies like Virgin Healthcare or BUPA, and those health services that private companies don't want, probably because there's no profit to be made, left to the publicly run NHS health trusts. However, what will be lost will be the coordination and cooperation that we now have in our unified NHS, with patient health as its only objective. For example, you may be aware that there's a likelihood that sexual health services will be offered to tender. Does hiving off sexual health services, with the staff currently employed in Sexual Health forced to become employees of a private company, fit will B&H H&WB's Joint

Strategic Needs Assessment? Is privatising Sexual Health services really an evidence-based approach to the strategic planning of Brighton and Hove's health and wellbeing needs?

"The policy intention [for JSNAs] is that local services which impact upon health and wellbeing will be based on evidence of local health and wellbeing needs and assets, including the views of the community; meaning that services and the way in which they are provided meet local needs." Section 3.3 'What are Joint Health and Wellbeing Strategies?' of Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf

28.8 The Chair gave the following response:

"The city council will be taking sexual health services out to tender in due course. However, we have not yet begun detailed planning around this procurement process, and speculating about the identity of the future provider of these services at this point would be unhelpful: it is important that the council is not seen to have pre-determined views in regard to the procurement of a contract. When we do tender for the contract we will ensure that the services commissioned address the sexual health needs of the population as identified in the local Joint Strategic Needs Assessment
In broader terms the question raises the fear that increased 'private sector' involvement in the provision of healthcare services will lead to a more fragmented provider landscape, with a negative impact upon planning and co-ordination across the local health economy. Whilst this is certainly a valid concern, it needs to be recognised that we have had a plurality of providers across health and care systems for a number of years and are well-used to co-ordinating the work of different providers from a variety of sectors."

28.9 The Chair added that there was no intention to definitely privatise any service. The Council were attempting to achieve the best result for the City. The existing configuration did not always achieve that aim. The greatest concern was to achieve quality and social value from contractors.

28.10 Mr Kirk stated that he considered that a service was being privatised that could remain within the NHS. He considered that reconfiguration was a cover for privatisation. He questioned whether it was really necessary to hive off the service to a private company. Mr Kirk referred to the corporate power of large companies who knew they could cut staff costs. Mr Kirk stressed that the Health & Wellbeing Board should ensure that any decisions were objective and evidenced based.

28.11 The Chair thanked Mr Kirk for his question and stated that the council would follow whatever evidence was available.

28.12 **RESOLVED-** That the written question be noted.

(c) Deputations

28.12 The Chair noted that there were no deputations from members of the public.

29. ISSUES RAISED BY COUNCILLORS AND MEMBERS OF THE BOARD

(a) Petitions

29.1 The Chair noted that there were no petitions from Councillors or members of the Board.

(b) Written Questions

29.2 Councillor Christina Summers asked the following question:

"As a councillor of one of the northern wards of the city and one that comprises some diverse and quite disparate communities that aren't necessarily linked geographically, I have been very concerned about what happens to the elderly population during severe winter weather when residential roads become impassable and are not treated by our gritters e.g. Coldean. I am concerned not only about their warmth (threatened further by soaring energy costs) but also their ability to come and go from their homes and safely access local amenities or, alternatively, be themselves accessible to those services that provide their daily needs.

I understand that information identifying who the elderly and vulnerable are and where they live is held by several agencies that may, or may not, work together and share that information. Notwithstanding the enormous legal stumbling blocks that exist preventing someone like myself from accessing that kind of information, could this board nevertheless consider any ways in which a councillor who has been elected by, and called to represent, these residents and who, by definition, works at grass roots level with them might somehow be entrusted with this information or, at the very least, included in any ongoing plans to improve the inclusion and wellbeing of the elderly and vulnerable most particularly during winter time?"

29.3 The Chair gave the following response:

"There are two important issues here: the need to support our most vulnerable residents at a time when there is growing pressure on finite public sector resources; and the need to keep sensitive data about vulnerable people confidential.

The council and its partners do recognise that more needs to be done to support vulnerable adults, particularly over the winter period. It is also clear that this support cannot be provided solely by statutory agencies – there is an increasingly vital role to be played by local communities here.

At the same time, we have to work within stringent legal guidelines for sharing information about vulnerable people, and these do restrict the ways in which we are able to operate.

We are actively exploring how we can appropriately help local communities to support the most vulnerable, and would be very happy to share details of this work with Cllr Summers and other interested ward Councillors, and to explore jointly how elected

members might be enabled to take a prominent role in building community resilience in this way."

29.4 Denise D'Souza referred to the Winter Service Pressures report which would be considered later on the agenda. There were ways the council could help local communities and share information. Tom Scanlon agreed that there were ways that the Council could assist ward councillors in reaching out to local communities.

29.5 Councillor Bowden stated that there already seemed to be informal ways of sharing data. He stressed that ward councillors could not serve their client base unless they were given the fuller picture. Sometimes councillors were given complex case studies from different agencies. There needed to be a discrete way of sharing information in order to help councillors in their work.

29.6 Councillor Summers concurred. She stressed that there needed to be a more preventative approach, rather than reactive work. She wanted ward councillors to be more involved with the wider winter planning work.

29.7 The Chair stated that there would be discussions with directors to see what could be done within the law.

29.8 Councillor Norman commented that the current situation was difficult for both councillors and officers. However, councillors could not expect to get full details of a person's disabilities and personal circumstances. He considered that it was best to get to know the ward and learn who was disabled and in need. He would not expect to receive detailed information.

29.9 Councillor Summers stressed that she wanted to know where people in need lived rather than receive detailed information.

29.10 The Chair informed the Board that officers would consult with ward councillors to see what was required.

29.11 **RESOLVED-** That the written question be noted.

30. INTEGRATED TRANSFORMATION FUND

30.1 The Board considered a presentation with slides from Denise D'Souza and Geraldine Hoban. The presentation set out the background to the Integrated Transformation Fund and the financial implications for Brighton and Hove. Members were informed how councils and CCGs develop and agree a joint plan and how they would be rewarded. The presentation stressed the need for joint working with providers.

30.2 Members were informed how the ITF would be managed. The DOH was considering what legislation was required for the ITF. Options would be laid out in the Care Bill. Members were informed of the draft template for developing an integrated plan and were informed about the national conditions.

30.3 Members were informed that plans needed to be in place by 14 February 2014.

30.4 Geraldine Hoban stressed that there was no new money for the fund. Money had to be redirected and used in different ways. This would involve working out of hours and looking to the voluntary and third sector. There would be a new model of care around frailty and an Integrated Frailty Delivery Board. There would also be an Integrated Homeless Delivery Board. Both boards would feed into an Integrated Transformation Fund Programme Board. A report on the Integrated Transformation Fund would be presented to the Health and Wellbeing Board on 5 February 2014.

30.5 Councillor Meadows referred to the slide on Financial Implications for Brighton & Hove. This stated that there would be £10.1m new money. However members had just been informed that there would only be existing money. Would the £10.1m be savings? Councillor Meadows noted that there had been a reference to pooled budgets. Would this be the same Section 75 pooled budget?

30.6 Geraldine Hoban explained that there was no new money. The £10.1m would come from the CCG budget. The money would be found from savings in the health budget. The current Section 75 agreement did not involve pooled budgets or shared risks. There were separate budget streams. The proposed pooled budget would be a truly shared budget and with shared risks.

30.7 Councillor Bowden asked for more information about timelines. He asked if the fund would be implemented next year or just before the next general election. Members were informed that there was a need to invest in pump prime community support services. Performance would be considered in the last quarter of 2014. There was an expectation that existing performance measures would be used.

30.8 Frances McCabe asked what levers were in place to ensure that there was adequate funding. Geraldine Hoban explained that the CCG had had to top slice an element of funding at the CCG to pump prime these investments. A war chest was being built up for next year. There were some levers and freedoms in how funding was received next year.

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

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

31.1 The Board considered a report of the Chief Operating Officer, CCG which informed members that the CCG had a requirement to share its commissioning intentions with stakeholders, partners, patients and the public and provider organisations. The report set out the emerging commissioning intentions of the CCG for the two year period 2014/15 and 2015/16.

31.2 Councillor Meadows asked if NHS England had similar plans and if so, whether they dovetailed with the CCG's plans? Councillor Meadows noted that dementia was missing from the report and asked why. Councillor Meadows referred to prescriptions and pharmacies. She mentioned that medicines were essential to patients in urgent care settings and patients who were discharged from hospital to their homes. Councillor Meadows asked what could be done to avoid cases where people had no medicines prescribed for days after discharge.

31.3 Councillor Meadows asked for an explanation of the second bullet point on page 39 of the agenda relating to medicine management ('medicines optimisation in care pathway redesign, and further integrating the medicines management team with the commissioning teams').

31.4 Geraldine Hoban explained that NHS England did have commissioning intentions. The CCG was working closely with the NHS England, Area Team to have closer alignment. It was critical that there was joined up working in the acute sector. Dementia was mentioned in the report in paragraph 4 of the Brighton and Hove Commissioning Intentions document (Community Services). The CCG did not commission pharmacies, however, the CCG did have to ensure that there is joined up working. There was a need to consider how people were supported. The bullet point under medicine management was about making sure people get the right and best medicines. This bullet point would be changed to make it clearer.

31.5 Fiona Harris, Head of Public Health Commissioning at NHS England, Area Team reported that NHS England did have commissioning intentions. NHS England commissioned pharmacies and some of the commissioning intentions related to pharmacies. NHS England would work closely with the CCGs.

31.6 Tom Scanlon noted that the CCG commissioning intentions document was a very integrated plan which integrated well with the JSNA. He suggested it would be useful to reference tobacco control and healthy weight in the CCG commissioning intentions.

31.7 Frances McCabe asked if work had been carried out on financial inequality. She referred to the pain clinic and expressed concern at the waiting times people had to endure.

31.8 Geraldine Hoban replied that the CCG would be interested in working with public health on the issue of inequality. The CCG would take as broad a perspective as possible to deal with inequality issues. There had been a great deal of feedback on pain management. Additional capacity had been brought into the acute sector. This was a short term fix for people waiting at the moment. Information on this issue would be provided to Healthwatch.

31.9 Hayyan Asif referred to the section on 'Developing Our Plans'. This referred to regular meetings with the third sector. He asked if there had been any meetings with youth groups and young people. The same section of the paper referred to a public event. He asked if this event would be youth friendly and what time it would be held. Hayyan mentioned that healthy weight and nutrition amongst young people was an issue, especially in schools. He asked if enough was being done especially in the 14-25 age group.

31.10 Geraldine Hoban replied that there had been engagement with youth groups. The CCG engaged with young people through the Section 75 arrangements. She noted the comments about the public event and undertook to check the timings. Public events often ran at different times to give people every opportunity to attend. All dates would be available on the CCG website.

31.11 Tom Scanlon agreed that the issue of healthy weight was worrying. There had been some success locally. There had been a reduction in weight in reception classes and year 6 in recent years. Work was being carried out in schools, but more work was required in secondary schools.

31.12 Councillor Meadows referred to the different ways of working that were proposed. She asked if this meant that GP's surgeries would open 7 days a week.

31.13 Xavier Nalletamby explained that there was work going on to help with winter pressures. Pop up surgeries were planned from Christmas until March 2014. The initiative would help prevent people going to A&E. Dr Nalletamby did not know if there would be 7 day working in general practice. There was recognition that an out of hours service was desirable.

31.14 Councillor Meadows asked where the pop up clinics would be located. Dr Nalletamby explained that there would be three pop up clinics in the centre, east and west areas of the city. The central location would be the current walk in clinic. The east area clinic would be the fracture clinic at the RSCH. Geraldine Hoban explained that the west area would be in the north Portslade area.

31.15 The Chair considered that a northerly part of the city also required access to a pop up clinic.

31.16 Councillor Bowden noted that the pop up clinics were in existing settings. He asked what would happen if someone from Portslade went to the Central pop up clinic. Would systems be in place to enable records to be shared?

31.17 Xavier Nalletamby confirmed that GPs in the pop up clinics would have full access to medical records.

31.18 The Chair confirmed that a report on the finalised CCG Commissioning Intentions would be submitted to a future meeting of the Health & Wellbeing Board for final sign off.

31.19 **RESOLVED** – (1) That the commissioning intentions of the CCG for the period 2014-2016 be noted.

(2) That the comments of Health and Wellbeing Board, as detailed above, be noted.

32. AUTISM STRATEGY: SELF ASSESSMENT

32.1 The Board considered a report of the Executive Director of Adult Services which reported that 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 required that local Autism Self-Assessments are "discussed by the local Health and Wellbeing Board by the end of January 2014 as evidence for local planning and health needs assessment strategy development and supporting local implementation work." The Department of Health intended to use the information gathered from all areas to inform a refresh of the Adults Autism Strategy in 2014. The report was presented by the Commissioning Manager, Learning Disabilities & Autism.

32.2 Councillor Bowden mentioned that a wide ranging report on autism had been produced by the Scrutiny Panel on Services for Adults with Autistic Spectrum Conditions. He asked if the current report took on the recommendations of the scrutiny report.

32.3 The Commissioning Manager confirmed that the Autism Strategy addressed all the questions raised by the Scrutiny Panel.

32.4 Councillor Norman stressed that not all the recommendations of the scrutiny panel were quick fixes. A great deal of work was required.

32.5 The Health & Wellbeing Business Manager informed the Board that the Commissioning Manager had reported to the Scrutiny Committee this summer on how the scrutiny panel recommendations would be implemented. This information would be sent to members of the Board.

32.6 Frances McCabe raised the issue of how people with autism were dealt with when using NHS services. The Commissioning Manager replied that this matter was dealt with in the report. Training on awareness would be a key role for the diagnosis service and may include informal training sessions for staff in GP practices.

32.7 The Chair asked for a progress report in 12 months to inform the Board about the implementation of the recommendations.

32.8 Councillor Bowden referred to autism in relation to the education system. The Commissioning Manager explained that the current strategy related to adults with autism. However there was a section on transition. Officers were working closely with Children's Services to ensure strategies were aligned.

32.9 Pinaki Ghoshal confirmed that there was a scrutiny panel on children with autism.

32.10 Councillor Bowden noted that the report referred to the need to engage with the Criminal Justice system. The Police Commissioner had asked for the police to have representation on the Health & Wellbeing Board. Councillor Bowden considered that they should have representation.

32.11 The Chair explained that there was no formal invitation for the police to attend the Board but there was an open invitation for the police to attend on an informal basis. It was agreed that the Chair and the Health & Wellbeing Business Manager would contact the Police Commissioner's office to establish what type of representation they required.

32.12 Councillor Meadows stated that she was relieved to see the strategy implemented. She thanked the Commissioning Manager for his work on the strategy.

32.13 **RESOLVED –** (1) That the content of the Brighton & Hove Autism Self-Evaluation report attached as Appendix 2 of the report be noted.

(2) That 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) be noted.

33. WINTERBOURNE VIEW IMPROVEMENT PROGRAMME -STOCKTAKE

33.1 The Board considered a report of the Executive Director of Adult Services which informed members how the requirements of the Winterbourne View Joint Improvement Programme were being delivered in Brighton & Hove and provided an update on local progress. The report was presented by the Commissioning Manager, Learning Disabilities & Autism.

33.2 Councillor Meadows was pleased to hear of one person who was moving back into the city after 9 years in hospital. This was a good achievement. She believed that smaller, family style homes were better for people with learning disabilities. Out of city placements can be very expensive. Councillor Meadows asked if any work was being carried out to bring people back to the city and if money from the Crisis Service could be used for this work.

33.3 The Commissioning Manager reported that moving people back to the city was complex as people required tailored services. Newly commissioned services are often required. Officers were pro-actively working on plans for individuals and funding issues are considered as part of this work.

33.4 Frances McCabe asked how extensive independent advocacy was in the service. The Commissioning Manager explained that independent advocacy was a requirement for every individual in specialist hospitals. There was also access for advocacy to people with complex needs in the city.

33.5 Frances McCabe asked if all people would be offered an advocate. The Commissioning Manager explained that it would depend on individual circumstances. It would not necessarily be offered to everyone.

33.6 Geraldine Hoban asked if out of area hospital placements were funded by the CCG. The Commissioning Manager confirmed that they were all CCG funded. Geraldine Hoban asked if patients were still the responsibility of the CCG when they returned home. The Commissioning Manager explained that the Department of Health expected the use of pooled budgets, but this was not in place locally. Therefore cases were dealt with on an individual basis to ensure appropriate funding arrangements were in place.

33.7 The Chair stated that the intention was to bring as many people as possible back to the city.

33.8 **RESOLVED –** (1) That 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 the report at as Appendix One be noted.

(2) That the progress made in Brighton & Hove regarding the future commissioning arrangements for people requiring treatment and assessment placements, be noted.

34. PUBLIC HEALTH SCHOOLS' PROGRAMME

34.1 The Board considered a report of the Director of Public Health which informed members that the proposed Public Health Schools' Programme took 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 reflected evidence based practice. The programme would be offered to all state schools including academies and free schools. It was anticipated that in due course the programme would be rolled out to colleges. The report was presented by the Public Health Programme Manager.

34.2 Pinaki Ghoshal endorsed the report which he considered a good example of joint working which would ensure the best programme for children and young people.

34.3 Councillor Meadows concurred and welcomed the report. She noticed however that more young people were taking up smoking whilst smoking was reducing amongst the adult population.

34.4 Councillor Bowden referred to paragraph 4.2 in relation to sexual health. He asked if more joint work was planned. He stressed that unless there was an education programme there would be a rise in teenage pregnancies and sexual disease.

34.5 Pinaki Ghoshal explained that although the council could give advice, it was up to governors to decide on the approach taken with regard to sex and relationship education.

34.6 The Chair expressed concern about the adult infection rate. He agreed that there was a need to start sexual health education at a young stage.

34.7 Tom Scanlon reported that a briefing paper was being prepared on this issue.

34.8 Hayyan Asif asked who had been included in the evaluation process. Tom Scanlon explained that the evaluation framework was not in place. It would be brought back to the Board next year. The Public Health Programme Manager explained that all state and free school, primary and secondary would be involved in the evaluation process.

34.9 Geraldine Hoban stressed that when the evaluation of schools was carried out; there was a need for joined up working. A forum would look at this work and report to the Children and Young People's Committee.

34.10 Hayyan Asif mentioned that the Healthy Schools Programme was not an appropriate name if it was used in colleges. The Public Health Manager replied that the name could be changed when the programme was presented to colleges.

34.11 **RESOLVED –** (1) That the report and the above comments from Board Members be noted.

(2) That the report be referred to the Children and Young People's Committee for endorsement.

35. WINTER SERVICE PRESSURES

35.1 The Board considered a report of the Director of Public Health which explained that the requirement for effective winter planning crossed different organisations and a wide range of services, such as highways, emergency planning, housing, adult social care, schools, and primary & secondary health care services. Some organisations produced their own detailed operational winter plans. The report described the preparations and connectivity in winter planning across the local authority and clinical commissioning group in Brighton and Hove. The report was presented by Dr Max Kammerling, Consultant in Public Health and Kevin Claxton, Resilience Manager.

35.2 Councillor Meadows referred to a scrutiny panel in 2010 which had asked for a winter plan for all council services. She asked how many of the recommendations of the panel had been incorporated into the current report.

35.3 The Resilience Manager explained that a great deal of work had been carried out since the scrutiny panel. The current report co-ordinated the good work that was taking place. The Consultant in Public Health explained that officers had checked to ensure that the report was consistent with the scrutiny panel recommendations.

35.4 Frances McCabe asked whether there would be co-ordinated planning. She stressed that flu epidemics could be serious and noted that the figure for staff uptake was low. She asked if large organisations provided the opportunity for staff to have flu vaccinations on the premises. If staff were not taking up flu vaccination this would not be giving confidence to members of the public. Ms McCabe suggested that the role of the voluntary sector could be considered. The voluntary sector carried out a great deal of work with vulnerable people. Ms McCabe referred to paragraph 3.2.5 in relation to pharmacies. Ms McCabe stated that both issues had now been resolved. Ms McCabe informed members that an urgent care report would be produced by the CCG and Healthwatch.

35.5 Tom Scanlon reported that there had been an uptake in flu vaccinations. Geraldine Hoban agreed that there had been a continued increase in uptake and targets on uptake had almost been met.

35.6 The Resilience Manager informed members that he was working closely with the Civil Contingency Team with regard to joint planning. With regard to the voluntary sector, there was an umbrella group of resilience groups for Sussex. There was now clarification that cold weather work would be carried out to all local pharmacies.

35.7 Councillor Norman referred to the issue of gritting during cold weather. He accepted that main bus routes were gritted, but stressed that a big issue to address was the fact that many older people lived in the outer areas of the city which were not gritted. This meant that many older, frail people could not leave their homes during periods of snow and ice.

35.8 Councillor Norman stressed that many accidents happened in these outer areas and this occupied the emergency services and A&E. He did accept, however, that a great deal of good work was carried out by officers visiting vulnerable people in 4 by 4 vehicles.

35.9 Tom Scanlon reported that research had shown that grit was distributed where most accidents occurred. He stressed that there was a need to discourage older people from leaving their homes in periods of severe weather. There was a need to ensure that GPs, meals on wheels etc could reach older people during these periods.

35.10 **RESOLVED –** (1) That the range of activities are noted and that the Director of Public Health is given delegated responsibility to develop further mechanisms to ensure coordinated and integrated working.

36. DECLARATION ON TOBACCO CONTROL

36.1 The Board considered a report of the Director of Public Health which informed members that 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. On 23 October, Brighton & Hove City Council was invited to join Newcastle and sign up to the declaration.

36.2 The Chair stated that as the formal launch of the declaration would take place before full Council, it was now proposed to recommend that the Policy & Resource Committee adopt the declaration.

36.3 Councillor Bowden referred to the National Institute for Health & Care Excellence (NICE) guidance published on the morning of 27 November 2013 regarding smoking in hospital premises. He asked if this could be included in the declaration. He made the point that it would be virtually impossible to stop smoking in psychiatric units. Councillor Bowden also asked if the declaration could be extended to other partners such as City College. He considered that other committees should take note of the declaration as it was important to consider the matter holistically.

36.4 Geraldine Hoban asked if the CCG and health partners could sign up to a joint charter.

36.5 Fiona Harris, Head of Public Health Commissioning, NHS England Area Team stated that NHS England would be happy to take the lead to work in partnership with the Director of Public Health regarding smoking cessation and healthy workplaces.

36.6 The Chair suggested these matters could be pursued but it would take too long to be included in the declaration proposed in the report.

36.7 The Director of Public Health stated that a local charter with other organisations in the city would be an additional piece of work.

36.8 **RESOLVED –** (1) That Policy & Resources Committee be recommended to adopt this declaration.

The meeting concluded at 7.00pm

Signed Chair

Dated this day of

HEALTH & WELLBEING BOARD	Agenda Item 42 Brighton & Hove City Council

Subject:		**Happiness: Brighton & Hove Mental Wellbeing Strategy**
Date of Meeting:		**Health and Wellbeing Board**
Report of:		**Assistant Chief Executive**
Contact Officer:	**Name:**	**Paula Murray** **Tel: 29-2534**
	Email:	**paula.murray@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 a draft strategy document to the Board, to update the Board on progress to date and to check the direction of travel of the strategy development.

2. RECOMMENDATIONS

2.1 That the Health and Wellbeing Board agree to the proposal for Tom Scanlon to take a 'Champion' role for Happiness and mental wellbeing on behalf of the Board.

2.2 That the Health and Wellbeing Board approve the draft strategy and that the Director of Public Health be instructed to bring the final strategy back to the Board at its meeting on 11 June 2014.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 Following discussion and presentations to this Board, there was agreement to develop a new strategy and way of working in the delivery of services to improve mental health in the city. A steering group was formed to oversee this process comprising members from the Clinical Commissioning Group, Public Health and the local authority.

3.2 The focus of the Steering group has been both on the acute services provided directly to those with mental health needs and on the wider preventative agenda, with an attempt to synthesise those into a coherent approach.

3.3 In terms of the aim of the strategy to influence future commissioning of direct service provision for mental health services, there is still a degree of consultation with service users that needs to take place to inform any changes. This is taking place now with priority and targeted groups.

3.4 In terms of the aim of the strategy to engage a far wider range of partners, providers, organisations and individuals in support of activity that promotes happiness and mental wellbeing, the engagement work led by steering group members has already merged into implementation.

3.5 The process itself of developing the strategy has had the impact of raising awareness of mental health issues in the city across a broad audience, building on the work done in distributing and disseminating the Annual Public Health report of 2013.

3.6 The strategy will also provide an umbrella cover under which a wide range of activity that is already taking place in the city which furthers the agenda of: promoting happiness and mental wellbeing, tackling stigma associated with mental health issues and raising the profile of the universal importance of paying attention to the importance and impact of good mental health. Events such as the festival SICK that takes place in March, now in its second year, which focuses on health and wellbeing issues or World Mental Health Day which takes place in October for example.

3.7 Engagement with partner organisations has already led to commitments and new activity from the prioritisation of promoting mental wellbeing amongst young people as a priority objective by SoundCity, the city's music hub provider of music services for schools and young people to work with the Brighton Food Partnership and City Rangers Team. In another example, following a large scale seminar session led by the Director of Public Health with the city's Economic Partnership directed at employers in the city, MIND have been commissioned to run a number of sessions in specific workplace settings for organisations in the city on wellbeing of employees and to offer training to workplace volunteers to support the workforce.

3.8 In addition to engaging the widest possible range of partners to support this agenda, there are some other key planks to the delivery of the strategy.

3.9 The development of a series of online web pages dedicated to promoting happiness and mental wellbeing using the vehicle of the five ways: connect, be active, take notice, keep learning and give. The web pages will promote local opportunities for people in the city to engage in the five ways. We are fortunate in Brighton and Hove that there are many, many opportunities to volunteer, to learn and to be active. We have a vibrant and engaged community and voluntary sector and a prolific cultural sector. We have beautiful natural landscapes on every side and fantastic urban spaces and buildings as well to direct people towards. Our universities and colleges offer numerous opportunities and our city is small enough for people to be able to connect with others given the right signposting or support.

3.10 The appointment of a Champion for Mental Health is something that has been discussed already at Board level and there has also been a degree of public speculation on this. The proposal from the steering group would be for a 'champion' or nominated lead for this area on the Board, Tom Scanlon. This position would be supported by a network of further city champions across sectors, organisations and spheres of influence. This network would meet on

an infrequent but regular basis to revisit activity, success, challenges and creative ideas. One of the reasons to propose this element of the strategy is to maintain momentum, profile and attention on the agenda once the process of the strategy is completed. Agreement is sought from the Board for this aspect of implementation.

3.11 A further series of engagement sessions with wider ranges of partnerships and organisations are planned in the near future in the interests of promoting the strategy and the agenda of mental wellbeing: this will be the focus for a Senior Manager's Forum in the city council in March for example. This engagement work will not stop with the publication of the strategy either, but is part of its implementation and will continue to be led by steering group members and the champions network.

3.12 The events highlighted above such as SICK and World Mental Health Day will become regular and fixed points in the city's events calendar, and it is hoped there will be more.

3.13 In summary, parts of the strategy have taken off through the process of its engagement and in many areas met with open doors and creative ideas ready to go. Other elements will take longer to come to fruition and the process of integrating different ways of working and the priorities of the different organisations leading this work takes time.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 It would have been possible for the different organisations involved in leading the strategy development to continue to work separately and produce different strategies in parallel. It was decided amongst all and agreed by this Board that an integrated strategy that sought to create a coherent approach between direct services and broader preventative work, with an increased and broadened emphasis on early intervention and preventative work, was the better option.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 Community engagement and consultation are at the heart of the development of this strategy and the range of groups engaged or due to be engaged are included in appendix 2 of the draft strategy.

6. CONCLUSION

6.1 The work of the Steering Group has met with universal approval in all its engagement and continues to do so. The development of the Strategy is not a streamlined or cut and dried process and is also merging into implementation in places. The feedback and increase in activity and profile of work to support good mental health across the city, already justifies the initial decision of the Board to initiate an integrated Strategy and approach. The

process is taking longer than it might if separate organisations were to develop their own separate strategies, however, the outcomes will be more impactful.

7. FINANCIAL & OTHER IMPLICATIONS

7.1 Financial Implications
The strategy development will be funded with the agreed Council and CCG budgets and supported by partner organisations.

Finance Officer Consulted: Anne Silley *Date: 22/01/14*

7.2 Legal Implications
There are no legal implications arising from this report.

Lawyer Consulted: Elizabeth Culbert *Date: 22/01/14*

7.3 Equalities Implications
Much of the work promoted and developed by the work on the strategy will be targeted towards vulnerable groups at risk of poor mental health. These are outlined in more detail in the attached documentation.

7.4 Sustainability Implications
One of the main aims of the strategy is to embed good practices in terms of preventative and early intervention work to support the promotion of happiness and good mental health, in as many organisations and with as many partners as possible. This should have the impact in the longer term of reducing the demand on acute service provision and making better use of resources, in addition to being better for individuals. The emphasis on the 5 Ways as a means of improving happiness and good mental wellbeing, has a resonance and alignment with the principles in the One Planet Living framework.

7.5 Any Other Significant Implications
No significant other implications

SUPPORTING DOCUMENTATION

Appendices:

1. Draft strategy document

Documents in Members' Rooms
None

Background Documents
None

Happiness:
Brighton & Hove Mental Wellbeing Draft Strategy

Introduction

The City Council and Clinical Commissioning Group are developing a happiness strategy to improve mental wellbeing in Brighton & Hove. This document sets out what we are doing and why. The strategy is being developed in line with the National Strategy *No Health Without Mental Health and* aims to take a preventative approach by addressing the wider factors that influence mental wellbeing (such as green spaces and employment) as well as ensuring that we have responsive high quality services available The engagement plan at Appendix 2 shows how we are seeking views from local people.

What do we mean by mental wellbeing?

Our mental wellbeing is central to our overall quality of life and general health and is influenced by a wide range of factors – the strategy we are developing covers all ages from birth to death.

There is a growing body of evidence, reflected in the DH report *No Health Without Mental Health*, that there are strong links between people's physical health and their mental wellbeing and it is well understood that positive mental wellbeing is more than simply the absence of mental illness.

The World Health Organisation defines mental wellbeing as when

- an individual is able to realise his or her own abilities, cope with the normal stress of life, can work productively…and is able to make a contribution to his or her community.[1]

Similarly, the 2011 National Mental Health Strategy *No Health without Mental Health* defines mental wellbeing as:

- A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.[2]

What are we doing and why?

Improving mental wellbeing has been identified as a key priority for the City by Brighton & Hove Health and Wellbeing Board, in its strategy for the City Council and NHS.

[1] World Health Organisation. Mental health: a state of wellbeing. Updated December 2013. http://www.who.int/features/factfiles/mental_health/en/

[2] No health without mental health: a cross-government mental health outcomes strategy for people of all ages. Department of Health. February 2011. https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

Brighton & Hove currently has separate local strategies or plans for commissioning adult mental health services, children & young people's mental health services and for mental health promotion; all of these come to an end in 2013/14. It has been agreed by the Board that a single revised local strategy will be developed that encompasses mental health services but shifts focus to address the wider determinants of mental wellbeing and positive mental health.

Our ambition is to ensure that mental wellbeing is integral to everything we do in the city. The overall approach we will take is preventative (to avoid people getting ill in the first place) but we recognise that we also need high quality responsive services to support people when they are unwell.

- We want to move from an illness & treatment model to a holistic approach of promoting wellbeing and resilience.
- We want to make mental wellbeing part of everyone's business and tackle stigma.
- We want to engage with the whole person and respond to what people say they need and want.
- We want to improve mental wellbeing and emotional resilience in the city for all residents, but especially those with vulnerability to mental health problems.
- We want local leaders and providers of services to champion mental wellbeing.
- We want Brighton & Hove people to see mental wellbeing as a two-way street: happier people are healthier people who are able to contribute more to making the city a great place to be.

This builds on the Director of Public Health's Annual Report for 2012, *The Pursuit of Happiness.*[3] This report brings together a range of perspectives, including the results of a local survey, Health Counts. It reinforces the links between poor mental wellbeing and people's physical health, as well as the interrelationship with deprivation, and it summarises information about the distribution of wellbeing amongst different population groups within the city.

Why is this important for Brighton & Hove?

Brighton & Hove residents have higher levels of mental ill-health than the average for England, across a range of indicators. A third more people have a diagnosis of severe mental illness and nearly 10% more (aged 18 and over) have a diagnosis of depression, recorded by their GP. Twice as many people are admitted to hospital following self-harm and approximately a third more die by suicide. Increasing numbers of children and young people are being referred to Child and Adolescent Mental Health Services and presenting with self-harm at A&E.

City residents also report lower self-reported wellbeing in the Office for National Statistics annual survey. The proportion of people reporting high levels of anxiety the

[3] http://www.brighton-hove.gov.uk/content/health-and-social-care/health/public-health-annual-report

previous day is significantly greater than the national average; fewer people also report a high scores for life satisfaction, the things they do being worthwhile and how happy they were yesterday.

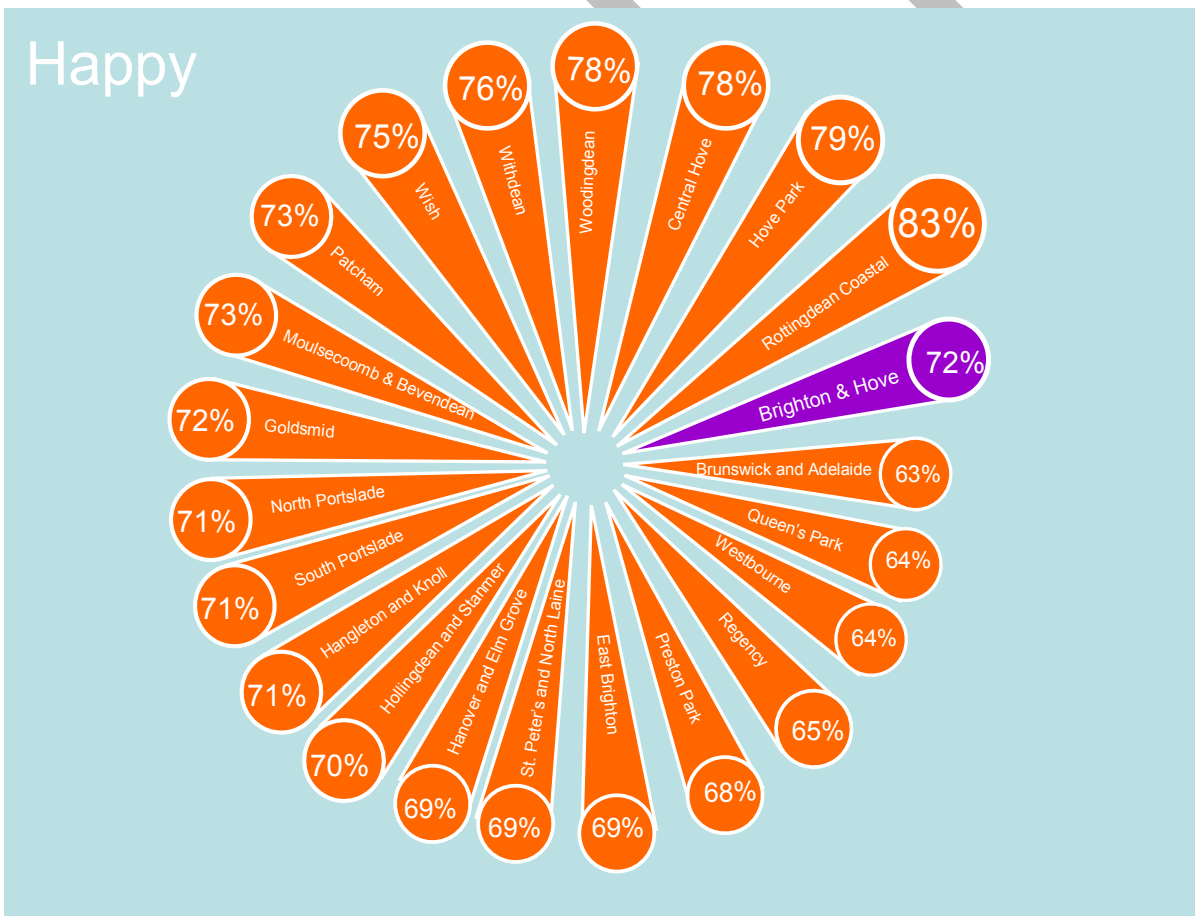
The recent economic downturn and changes to welfare benefits in the UK have only served to exacerbate this issue.

A wide range of information is available on the risk of poor mental health associated with demographic variables, geographic wards and life circumstances. The national strategy for mental health *No Health without Mental Health* lists high risk groups. In addition, the local Health Counts survey gives us rich detail on mental health, physical health and a range of lifestyle factors of around 2000 residents.

So, what do we know?

- **We have different levels of happiness across the city**

Residents in more affluent areas tend to report higher levels:



- **We have different levels of happiness across groups**

Brighton & Hove has disproportionate number of people in groups nationally identified as having a higher risk of mental ill-health, including:

- Homeless & insecurely housed
- Rough sleepers
- LG & B
- Transgender
- Vulnerable or looked after children and young people
- Victims of violence including domestic and sexual violence
- Older people living alone and socially isolated

We know that local residents with low self reported wellbeing scores or high risk of depression scores are at higher risk of poor mental health.

People who report higher levels of happiness also tend to report healthier lifestyles: for example, people who have never smoked are more likely to report higher scores for happiness.

- **We know that we can improve mental wellbeing**

At a personal level, the national strategy recommends the Five Ways to Wellbeing. These are ways that we can all develop our emotional resilience in day-to-day life, in ways that suit our individual circumstances.[4]

1. **Connect…** With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.

2. **Be active…** Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.

3. **Take notice…**Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

4. **Keep learning…**Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.

5. **Give…** Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing

[4] http://www.neweconomics.org/publications/entry/five-ways-to-well-being-the-evidence

yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.

What can we do about it?

This strategy focuses on improving resilience and mental wellbeing and preventing mental ill health.

- **At a personal level**

The Five Ways to Wellbeing give us a different way to think about building personal resilience. We want to adopt and embed this approach both strategically and operationally across the city so that it becomes part of everyone's business and everyone's daily life. Feelings of happiness, contentment, enjoyment, curiosity and engagement are characteristic of someone who has a positive experience of their life.

- **As a community: the two-way street**

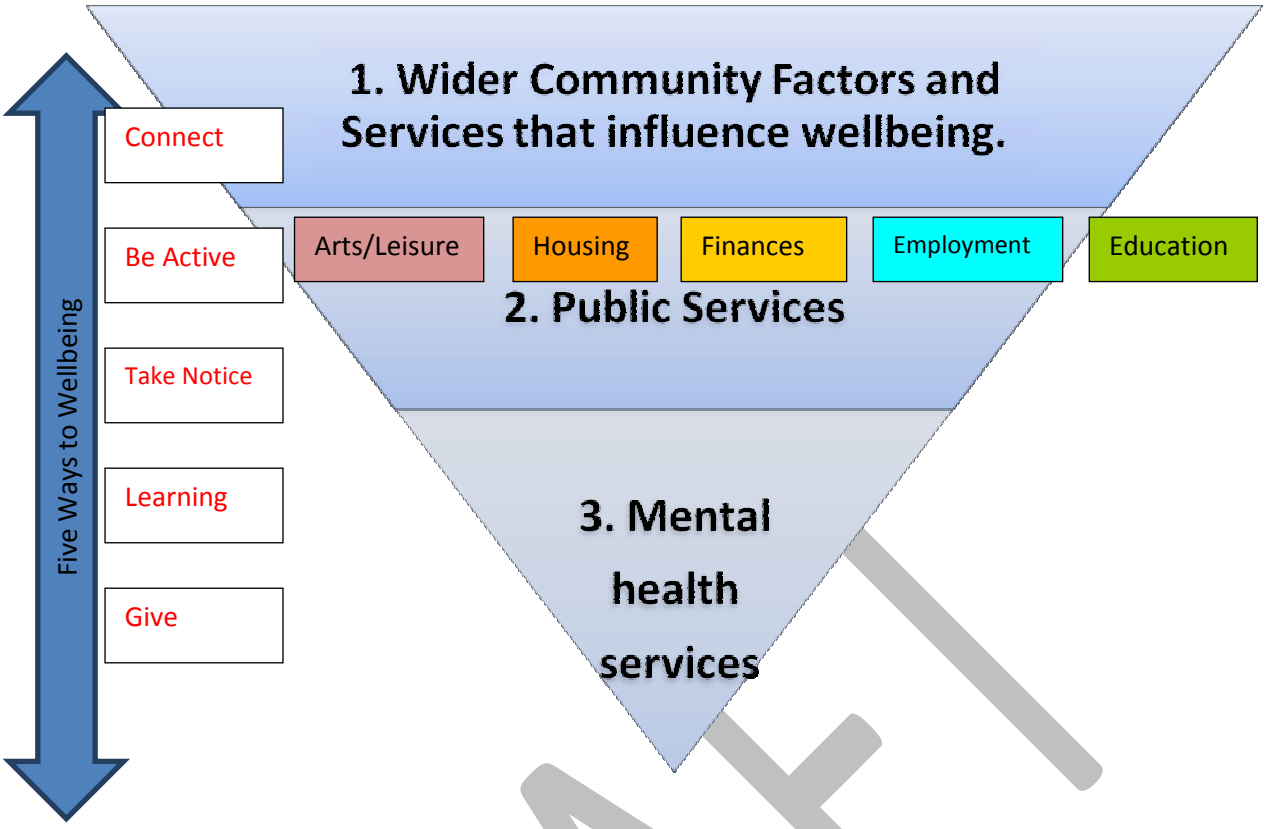
Equally important for wellbeing is our functioning in the communities where we live. Experiencing positive relationships, having some control over one's life and having a sense of purpose are all important attributes of wellbeing. Good quality housing, education, employment, transport and a strong sense of belonging to a place all lay the foundations for mental wellbeing.

Conversely, people whose mental health is good are able to learn better, to contribute more at work and in their leisure time, to make healthier choices about how they live and to help create a vibrant city.

The demographic groups at higher risk are often the subject of discrimination and an insecure sense of belonging to the wider community. Exclusion by virtue of health, education, identity or upbringing needs to be countered to enable good social functioning and a related sense of wellbeing. Many of these factors are influenced by health and council.

- **Through public services including health**

The diagram below shows how the prevention and wellbeing agenda is our priority for reaching everyone in Brighton & Hove, but builds on high quality services for the smaller number of people in need of more support.



Wider community factors and services that influence wellbeing
This includes: local employers, local neighbourhood & community groups, and voluntary organisations that support and promote wellbeing in their settings.

Public Services
Mental wellbeing should be an integral part of all services provided or commissioned by the NHS and Council. These include health services such as GPs, hospitals and community support and wider city services such as arts and leisure, housing and education.

Mental health services
High quality responsive services are needed to work with individuals with diagnosed mental health problems, both in hospital and in the community. This includes supporting recovery and developing resilience by working with individuals or groups at risk of developing problems or relapsing into mental ill-health. Specialist services also play a significant role in supporting communities and other public services in prevention of mental ill health.

- **Adult mental health services commissioning**

Our aim is to ensure that there is support available to **prevent** mental health problems developing in the first place but also to have responsive accessible services available when they are needed. We have started to extend the range of locations in which mental health support is available to include accessible venues such as GP surgeries, community & voluntary sector organisations and schools. We

want people to be able to get timely support from the most appropriate organisation, and to help secondary care mental health services, the voluntary sector and primary care to work together to provide a model of care shaped around the individual needs of a person so that they get the help that they need at the right time and in the best place for them.

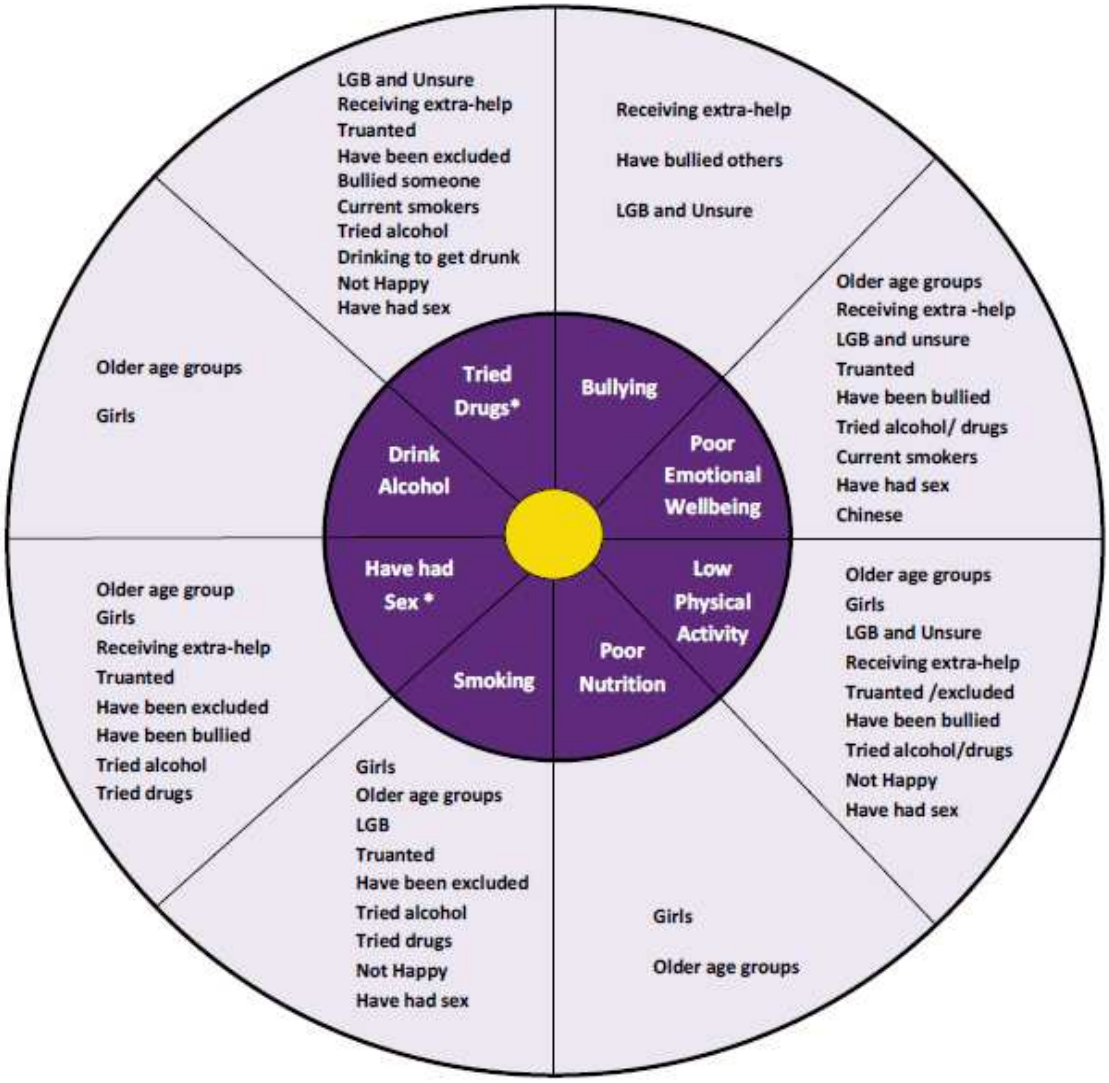
We also want to work in partnership with patient/service users and carers to have an equal voice in decision making. We want the support available to empower individuals and communities on their journey to recovery and again we want your views on the ways you would like care & support to be delivered in the future.

We want to have holistic services that provide support for both mental and physical health needs; to identify and treat physical health problems in people with serious mental illness, and to integrate mental health support within chronic disease management programmes. This should improve health outcomes and quality for people with long term physical or mental health conditions.

- **Children and young people's mental health services commissioning**

We also want to ensure we have the right services available for children and young people. We will seek to focus on early intervention and prevention and the role all services that come into contact with children and young people can play in supporting their wellbeing. We will promote parenting programmes that enable parents to support their child to develop positive wellbeing and work with early years providers at this crucial stage in a child's development.

We will ensure that our children's services workforce feels confident and equipped to support children's wellbeing for example in our schools and youth services. We will provide high quality support services for children and young people when they need them and tailored to their specific needs.



We know from our Safe and Well in schools secondary survey [5] that some groups are more likely to be vulnerable to a range of health risks and issues. Those that self report poor emotional wellbeing are more likely to:

- Be older
- Be receiving extra help in school
- Identify as LGB or unsure
- Have truanted
- Been bullied
- Have tried alcohol or drugs
- Be current smokers
- Be sexually active
- Be from some specific BME groups e.g. Chinese

[5] http://www.bhlis.org/surveys

We will be developing greater emphasis on services that can help children and young people when they first need it and as early as possible and will take an innovative approach to the use of IT for example online counselling and advice. We will focus on resilience building and particularly focus on young people aged 14-25 who are experiencing significant life changes and associated stresses; we know that many long term mental health issues begin at this age. We will also ensure our specialist mental health practitioners will be available for advice and consultation to children' services, parent carers and children and young people themselves. Where children and young people need to access mental health services we will continue to work with our providers to ensure timely and appropriate responses and services that children and young people tell us help them.

We will work closely with children and young people and their families in developing services and ensure that all provision is children and young people friendly.

Timescale for the strategy

A draft strategy will be developed over the winter and completed by the spring / summer 2014. The strategy will cover three years from 2014 – 2017, and it will continue to develop and be monitored during that period

Appendix 1: How will we know if we have succeeded?

We will measure our success by using a range of quality outcome indicators including mental health, public health, adult social care and children's Outcomes Frameworks, including:

- Self-reported wellbeing(PHOF)
  - people with a low satisfaction score
  - people with a low worthwhile score
  - people with a low happiness score
  - people with a high anxiety score
- Better emotional well-being of looked after children (PHOF)
- Reduced hospital admissions for self-harm (PHOF)
- Increased employment for people with a mental illness(PHOF & NHSOF)/ proportion of adults in contact with secondary mental health services in paid employment (ASCOF)
- Reduction in proportion of people in prison with mental illness (PHOF)
- Adults in contact with secondary mental health services who live in stable and appropriate accommodation (PHOF)/ proportion of adults in contact with secondary mental health services living independently without the need for support (ASCOF)
- Improving outcomes for planned procedures – psychological therapies (NHSOF)
- Reduction in premature death for people with serious mental illness -under 75 mortality rate (PHOF)/ under 75 mortality rate in people with serious mental illness (NHSOF)
- Reduction in the suicide rate (PHOF)
- Patient experience of community mental health services (NHSOF)

Other outcome indicators are relevant to the causes of emotional wellbeing, for example:

- Reduced differences in life expectancy and healthy life expectancy between communities
- Children in poverty
- Pupil absence
- 16 -18 year olds not in education, employment or training
- Employment for those with long term health conditions
- Statutory homelessness
- Utilisation of green space for exercise/ health reasons
- Social connectedness
- Older people's perception of community safety

Appendix 2: ENGAGEMENT STRATEGY Proposals/action to date

	Details	***Action to date***	***Planned actions***
1 Engagement with partners	Two way solution-focussed discussions with providers of services in five initial priority areas: • Employers and workplaces • Green spaces and growing • Arts and culture • Sports and leisure • Children and young people These should establish examples of good practice, raise awareness and invite commentary on how mental wellbeing and happiness could best be promoted in these settings. This should include discussion of the Five Ways, and of wider barriers and enablers. The format could be stakeholder workshops, events or a range of more informal discussions. A summary of recommendations from each area will be included in the wider consultation and the strategy document.	Employers – Event at the Metropole on 3 December 2013 chaired by Tony Mernagh and including a presentation by Tom Scanlon on the Happiness PH Annual Report. Engaged discussion from the floor about improving mental wellbeing in the workplace. Green spaces – Initial meetings with the City Rangers team and with Brighton Food Partnership. Several mental health promotion small grants awarded on this theme. Meeting with Andrew Comben on the links between mental wellbeing and Arts, culture & heritage. The Basement's SICK! Festival addresses mental health issues, including stigma. A second festival will take place in March 2014.	Consultation events for: Providers of mental health services for children and young people; Providers of adult mental health services; Green spaces and growing. Further work on sports and activity links.

	Details	*Action to date*	*Planned actions*
2 Engagement with service users and vulnerable groups	The CCG's 'Gateway' or excluded groups will be consulted on how their constituents could improving mental wellbeing in their communities. Recommendations and key themes will be written up for inclusion in the strategy.	Briefing meeting with Gateway leads, including distribution of a questionnaire for focus groups.	By 31 March 2014: All Gateway groups to meet and provide reports. 6 – 8 further focus meetings to be held for additional relevant population groups; one for GPs.
3 Engagement with the public	Online survey on how to improve mental wellbeing in the city, based on general questions developed for Gateways.	Initial work on survey, including piloting, begun.	Survey to be published on consultation portal. Two public consultation meetings to be held before 31 March 2014. Analysis of themes and key 'asks'.
4 Webpages	A public facing webpage about the Five Ways, signposting to key sites for each Way: e.g. Sports and Activity for 'Be active'. Once launched, this could be a gateway for surveys, twitter campaigns or interactive question & answer opportunities.	An options paper on developing a Five Ways page on the City Council website has been developed and funding identified.	Provider to be identified and development work undertaken. Maintenance needs to be built into the budget and planning.

HEALTH & WELLBEING BOARD	Agenda Item 43 Brighton & Hove City Council

Subject:		**Better Care Fund Plan**	
Date of Meeting:		**5 February 2013**	
Report of:		**Executive Director, Adult Services & Chief Operating Officer, CCG**	
Contact Officer:	**Name:**	**Anne Foster, Head of Commissioning, CCG**	**Tel: 01273 574657**
	Email:	**Anne.foster5@nhs.net**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The purpose of the report is to provide details of the Brighton and Hove Better Care Fund Plan. It is a national requirement of the Better Care Fund that plans are approved by the relevant Health and Wellbeing Board.

2. RECOMMENDATIONS:

2.1 That the Health & Wellbeing Board approves the proposals for the Better Care Fund Plan for Brighton and Hove as set out in Appendix 1 and 2 of this report.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The Better Care Fund (previously referred to as the Integrated Transformation Fund) was announced in June as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and take the integration agenda forward at scale and pace.

3.2 The Better Care Fund provides an opportunity to improve services to some of the most vulnerable residents, placing them and their carers at the centre of their own care and provide an opportunity of expansion of care in community settings.

3.3 The vision for our frail population is to help them stay healthy and well by providing "whole person care", promoting independence and enabling people to fulfil their potential. Services will be seamless and co-ordinated. They will be delivered at home or in community settings wherever possible, avoiding unnecessary attendances at A&E, admissions to hospital and to long term care. Services will offer more choice and more flexible support to enable a more

person centred approach. Organisations will work together to achieve better outcomes for people, and make the best use of available resources

3.4 In Brighton and Hove we are using the term "frailty" to identify the client groups most likely to benefit from more integrated care. The definition of frailty that we are using at this stage to encompass the breadth of needs is "*a state of high vulnerability for adverse health outcomes, including disability, dependency, falls, need for long-term care, and mortality*." (Fried, Ferrucci, Darer, Williamson, & Anderson, 2004)[1]

3.5 A piece of scoping work is being undertaken between January and March 2014 to identify the potential client groups that could most benefit from "whole person care". Although advancing age brings with it a greater susceptibility to frailty, some younger people particularly those with complex needs are also frail. Given the particular demographics of the Brighton and Hove population with high levels of mental illness & homelessness the approach to frailty will be broader than old age and will reflect the wide range of needs of our population.

3.6 The Better Care Plan for Brighton and Hove is enclosed in Appendix 1.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Every council and CCG is required to develop a Better Care Fund Plan in line with the national guidance. Each area is expected to identify local priorities for inclusion and demonstrate how the plan meetings the following six national conditions:

- Plans to be developed jointly
- Protection for social care services
- 7 day services to support patients being discharged and prevent unnecessary hospital admissions at weekends
- Better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessment an d care planning
- Agreement on the impact in the acute sector

4.2 Brighton and Hove has used the term "frailty" to identify the client groups most likely to benefit from more integrated care. Some of the potential characteristics for frailty include

- People with dementia
- People who are homeless
- People who are housebound
- People with multiple long term conditions
- People at end of life
- Care home residents

[1] http://consultgerirn.org/topics/frailty_and_its_implications_for_care_new/want_to_know_more

4.3 As outlined in paragraph 3.5 scoping working is currently being undertaken to analyse in more detail the potential population groups that could be included in the integrated model of care. The output of the scoping work will be an option appraisal to inform the preferred model.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 The Brighton and Hove vision for an integrated frailty model of care is based on feedback from public, patients, service users and carers. A key theme that has emerged from Clinical Commissioning Group and Brighton and Hove City Council public events is that whilst there are many excellent care and support services available in the City they do not always work well in terms of an overall system of care centred around keeping people well at home. Further details are contained in Appendix 1 Section d)

5.2 Formal arrangements to obtain on-going feedback will be put in place as an integral part of the Brighton and Hove Better Care Programme plan to ensure that service user and carer views drive the new model of care. This will include public meetings, the use of GP practices patient participation groups as well as a formal service user and carer reference group.

6. CONCLUSION

6.1 Brighton and Hove City Council and the CCG are required to produce a Better Care Fund Plan in line with the national guidance for approval by the Health and Wellbeing Board.

6.2 The detail of the plan is attached in Appendix 1.

6.3 The detail of the financial information will follow and will be sent to members of the Health and Well Being Board before the meeting on 5th Feb 2014.This will be added to the report as Appendix 2.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 In 2015/16 the Better Care Fund Plan will be created from the following funding streams, a significant proportion of which is already being spent by the local authority on joint health and social care priorities.
The sums currently allocated to Brighton & Hove in this way are identified in the table below.

Table: Analysis of Better Care Fund Plan Funding Streams

Funding Stream	National 'Pot'	Brighton & Hove's Allocation
NHS Funding	£1.9 billion	Yet to be advised by DH
Carers Break Funding	£130 million	£ 600,000
CCG Reablement Funding	£300 million	£1,400,000
Adult Social Care Capital Grant	£129 million	£ 674,000
Disabled Facilities Grant (Capital)	£225 million	£ 727,000
Current transfer from NHS to Social Care	£900 million	£4,608,000
Additional transfer from NHS (2014/15)	£200 million	£1,024,000

The pooled Better Care Fund budget for 2014/15 is £5.622m

Provisional figures in relation to Brighton & Hove's allocation for 2015/16 were released by NHS England on 20th December 2013 as below:

	£m
NHS Brighton & Hove CCG	18.065
Social Care Capital Grant	0.684
Disabled Facilities Grant	0.911
Total Better Care Fund	**19.660**

7.2 An element of the fund will be dependent on performance and outcomes have been agreed to monitor achievements against. There are risks associated with the performance nature of the funding and a risk mitigation approach will be agreed between partners.

7.3 The proposed use of the Better Care Fund which has been agreed between partners is detailed in Appendix 2. (To follow - see 6.3 above).

7.4 The timelines for preparing these financial proposals has been very tight and therefore consideration has been given to maintaining flexibility where possible to make adjustments as the planning process becomes more detailed.

Finance Officers Consulted: Anne Silley/Catherine Vaughan Date: 24/01/14

Legal Implications:

7.5 On 12th December 2013 full Council approved amendments to the terms of reference for the Health and Wellbeing Board "to agree and sign off local plans required to access the Integrated Transformation Fund (ITF), the first of which to be signed off and submitted by 31st March 2014". This report seeks sign off from the Health and Wellbeing Board for the first local plan, in accordance with the Board's new powers. The local plans must be approved by the Health and

Wellbeing Board in order to meet the Government's requirements to access the fund.

Lawyer Consulted: Elizabeth Culbert *Date: 23/01/14*

Equalities Implications:

7.6 An equalities impact assessment will be carried out once more detailed plans have been developed for the integrated models of care.

7.7 The development of integrated models of care will potentially affect staff from a range of health social care and independent sector providers. Further more detailed assessment will be carried out as the integrated work plan develops.

Sustainability Implications:

7.8 The Better Care Fund aims to provide funding enable each local areas manage pressures and improve long term sustainability.

7.9 The CCG, as part of its authorisation process committed to developing a Sustainable Commissioning Plan. The CCG sustainability Plan includes the following priorities which are relevant to the Better Care Fund:

- 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.
- Facilitating enablers such as the roll out of electronic prescriptions;

SUPPORTING DOCUMENTATION

Appendices:

1. **Brighton and Hove Better Care Fund Plan**

2. **Brighton and Hove Better Care Fund – Outcomes & Finances (to follow)**

Documents in Members' Rooms

None

Appendix 1

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Brighton and Hove City Council**
Clinical Commissioning Groups	**Brighton and Hove Clinical Commissioning Group**
Boundary Differences	**The City Council and CCG boundaries are coterminous**
Date agreed at Health and Well-Being Board:	**05/02/14**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£5,631**
2015/16	**£18,065**
Total agreed value of pooled budget: 2014/15	**£5,631**
2015/16	**£18,065**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Brighton and Hove Clinical Commissioning Group
By	Dr Christa Beesley
Position	Chief Clinical Accountable Officer
Date	

Signed on behalf of the Council	Brighton and Hove City Council
By	Catherine Vaughan

Position	Executive Director of Finance & Resources
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Brighton and Hove Health & Wellbeing Board>
By Chair of Health and Wellbeing Board	Rob Jarrett
Date	<date>

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Our Better Care Plan in Brighton and Hove focuses on delivering an integrated model of care for frailty across the City as we believe this is the cohort of people most likely to benefit from an integrated system. In Brighton and Hove we have taken a broad definition of frailty rather than just focus on older people who are frail. The definition we are using is "*a state of high vulnerability for adverse health outcomes, including disability, dependency, falls, need for long-term care, and mortality*." (Fried, Ferrucci, Darer, Williamson, & Anderson, 2004)[12]

A vision for a more integrated model of care for our frail population was originally initiated by the Urgent Care Clinical Forum – a group of clinicians and social care colleagues representing providers across primary, community and acute settings, the independent social care sector, and the community & voluntary sector. The Forum has been working on a new model of care for frailty since September 2013 and their driving principle was to ensure that a new model was co-designed and underpinned by a widespread coalition of professional opinion.

Two Implementation Boards – one focusing on frailty and one focusing specifically on homelessness are now up and running to take forward the vision developed by the Clinical Forum. These Boards comprise senior clinical and executive level representation from all partner agencies including Brighton and Sussex University Hospital Trust, Sussex Community Trust, Sussex Partnership Foundation Trust, independent sector Nursing Homes, the Community & Voluntary Sector, Adult Social Care and 3 CCGs working around the catchment population of BSUH i.e. Brighton and Hove, Horsham and Mid Sussex, and High Weald, Lewes, Havens.

A Better Care Programme Board for the City has produced and signed off the Plan. (currently this Board comprises Health, Social Care and Housing representation but membership is being broadened to include Provider representation)

A bi-monthly meeting of CEOs across the City – chaired by the CEO of Brighton and Hove City Council will take place following an initial meeting to ensure senior level support to this large scale change programme. The high level Plan was presented to CEOs at its January meeting and they have agreed to consider ways

[1]

[2] http://consultgerirn.org/topics/frailty_and_its_implications_for_care_new/want_to_know_more

to enable further integration of services. CEOs (or their representatives) will be part of the Better Care Programme Board.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The Brighton and Hove vision for an integrated model of care is based on feedback from public, patients, service users and carers drawn from a wide range of sources including:

- **In February 2013, Age UK Brighton and Hove recorded patient and service user experiences within Community Short Term Services, which is a multi-provider service for intermediate care focussing on avoiding unnecessary hospital admissions and supporting timely discharge from hospital for reablement and rehabilitation. The focus was on systems, processes, and user understanding and satisfaction with care. The outcome of this feedback formed a baseline and has informed future integrated model planning.**
- **Public events where feedback was sought on key service areas. Themes emerging from specific events on 14th May 2013, 15 October 2013 highlight that whilst there are many excellent care and support services available in the City they are not always working well in terms of an overall system of care centred around keeping people well at home.**
- **A City wide Carers Survey undertaken in November 2012 identified 3 key areas for improvement:**
  - **Increase in social contact for carers**
  - **Better and more accessible information and advice**
  - **More respite options**
- **The Adult Social Care City Summit Event "Have Your Say" was held on 11 June 2013. This was attended by 80 people across the city including those who use services, carers and interested citizens. Some key themes were identified including:**
  - **The need for different services working closely together**
  - **Choice and control in terms of directing care (for example through the use of personal budgets)**
  - **Information needs to be easy to access and understand.**
- **The City's vision for the Integrated Model of Care is described as part of the CCG's Annual Operating Plan for 2014/15 and 2015/16. A public event was held on 13 December 2013 attended by 59 people to gain feedback and input to shaping the plans. One of the workshops asked views on the development of integrated care and key themes were:**
  - **There was broad support for a more integrated model of care and in particular the need for a system of care co-ordination was identified.**
  - **There was potential to expand the role of the community & voluntary sector in terms of a partnership working with health and social care services in an integrated model of care**

Further Public consultation events and feedback mechanisms will be put in place as an integral part of the Plan to ensure that service user and carer views drive the

new model of care.

A Service User and Carer Reference Group is in the process of being established to co-ordinate the engagement activity for integrated care in the City. The group will include representation from a range of representative bodies, patients, service users and carers drawn from our Patient Participation Groups and Health Watch. Lead representatives from the Reference Group will be members of the Frailty and Homeless Implementation Boards.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Urgent Care Clinical Forum Terms of Reference	**The clinical forum that developed the vision for an integrated model of care for frailty.**  TOR Urgent Care Clincial Forum.doc
Integrated Frailty Board Terms of Reference	**The Board that will take responsibility for scoping the vision in more detail and implementing the model of care**  Integrated Frailty Board ToR 20 Jan 20:
Homeless Integrated Pioneer Bid	**A bid was submitted to be one of the Integrated Pioneer site to develop an integrated model of care for the homeless. Although we were not selected as one of the Pioneer sites, the implementation of the model will be one of the key work programmes that will form part of the Better Care Fund.**  Homeless - Integrated Pioneer Bi
Adult Social Care Modernisation Board Terms of Reference	**This Board oversees the major developments for Adult Social Care and will link with the Integrated Frailty Board**

	 ASC Modernisation Board Terms of Refer
Adult Social Care City Summit Event 11 June 2013 "Have Your Say"	**Summary Report Detailing Stakeholder Feedback from the Adult Social Care City Summit Event to discuss the future of Adult Social Care**  City Summit report - June 2013.pdf
Service Map	**A map which shows graphically some of the range of community health and social care services currently available.**  Frailty map.pptx
Doctor Foster Hospital Guide for Surrey and Sussex	**An annual publication that highlights issues of NHS performance. It includes comparative analysis of emergency admissions to hospital.**  Dr Foster Guide.pdf
Protection for Adult Social Care	**Report to Health & Well Being Board September 2013 detailing areas of spend on the NHS transfer to Adult Social Care**  \HWB Board report on social care allocati
Community Short Term Services Service Specification	**Six local providers[3] of services work in an integrated way to deliver community short term services in the City**  Community Short Term Services Service
Integrated Primary Care Team Service Specification	Integrated Primary Care Teams are multi-disciplinary teams that provide pro-active care to people with long term conditions

[3] Sussex Community NHS Trust, Brighton and Hove City Council, Brighton and Sussex University Hospital Trust, Age UK, Integrated Care 24 and Victoria Nursing Homes

	and/or who are frail. The focus of teams is to keep people well at home and avoid emergency admissions to hospital.  IPCT Service Specification Jan 201‹
Better Care Plan : Report to Health & Wellbeing Board February 2014	 Brighton & Hove Wellbeing Board Repc
Ageing Well chapter of the 2013 JSNA	The 2013 JSNA highlighted the need to raise the profile of older people in the City and develop a joined up approach to service provision that places older people firmly at the core and emphasises prevention and early intervention  JSNA Ageing Well chapter 2013

2) VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The vision for our frail population is to help them stay healthy and well by providing "whole person care", promoting independence and enabling people to fulfil their potential. Services will be seamless and co-ordinated. They will be delivered at home or in community settings wherever possible, avoiding unnecessary attendances at A&E, admissions to hospital and to long term care. Services will offer more choice and more flexible support to enable a more person centred approach. Organisations will work together to achieve better outcomes for people, and make the best use of available resources

The vision is based on the following principles:

1. Supporting people to stay well
2. Supporting carers
3. Encouraging people to maintain their independence;
4. Care built around the person, based on need and accessible 24/7;
5. A coordinated, proactive, preventative approach
6. The ability to respond quickly and flexibly when people have a change in need

There are a number of factors that will enable us to deliver the vision:

- **The Community & Voluntary sector will play an active role in supporting people to stay well**
- **There will be an emphasis on reabling care, including the use of assistive technology to support people to maximise their independence.**
- **People will be empowered to direct & personalise their care and support based on their individual needs.**
- **GP Practices will be at the heart of co-ordinating people's care with support from a multi-disciplinary team**
- **Care will be co-ordinated in a single place to ensure service users and carers only need to tell their story once. This will be supported by electronic sharing of data with all involved in providing care.**
- **Care Co-ordinators will take responsibility for active co-ordination of care for the full range of support (from lifestyle support to acute care)**
- **Service users and their carers will be listened to and drive the model of care**
- **Access to professional support will be available 24/7**

Within Brighton and Hove we have some excellent examples of integration between health and social care, for example multidisciplinary hospital discharge

teams, community short term services, mental health and dementia services and multi-disciplinary, multi-agency, integrated primary care teams. However, at a system level services are fragmented and do not always address the holistic needs of an individual. Previous mapping and consultation work has also identified that the system is not well set up for individuals who have multiple or complex needs. Not all community services are available 24 hour a day 7 days a week & in addition the complex web of services mean that it is not always clear which service or organisation should be accessed. We know this sometimes means that people attend A&E and are admitted to hospital as these are services people are familiar with and are generally known to be available 24/7. However these services do not always provide the best outcomes for people in that they can often reduce rather than increase independence. There is scope to provide more pro-active community care in an integrated way to support people staying well as well as providing a quick response in a crisis.

The proposed changes in the Care Bill will align with the outlined Vision: Importance will be placed on improving people's overall wellbeing, which shifts the emphasis to a system which promotes preventive and supportive measures. Other aspects of the Bill including better advice and information, consideration of the support needs of wider communities and legal entitlement of informal carers will support the need for a more coordinated and integrated way of working

In the future, it is our intention that the model of care around frailty will look very different. GPs (as the profession with responsibility for co-ordinating care around elderly frail) will be supported in their role by a multi-disciplinary team (MDT) wrapped around clusters of practices. In order to develop this MDT we will build on the Integrated Primary Care Teams (IPCTs), embed them more with Practice staff and extend their scope to cover all frail people registered at those practices.

We will increase the capacity and skill mix within the integrated teams and extend the membership of the multidisciplinary team to consistently incorporate mental health/substance misuse and social care staff and facilitate a more formal involvement of independent care providers and the community & voluntary sector in the partnership. Links to other council colleagues will be developed (e.g. housing, public health, communities team) to make sure people receive a suitable response, and to make best use of the skills and resource in local areas

We will reshape the model of care by bringing relevant staff out from the acute setting and embed them in the community team so that their remit is to in-reach to hospital when people require an acute stay. These core teams based around clusters of GP Practices will have rapid access to specialist support when required. Each frail person will have a designated "care co-ordinator" drawn from within the Integrated team. Depending on the specific needs of the frail person the care co-ordinator could be from any profession within the MDT – including the third sector.

For specific cohorts of frail people e.g. homeless residents the model of care will be bespoke to their needs and may include greater use of out-reach models of care

and support with housing related issues. In order to facilitate this new model of working staff from a range of organisations will come together into one team with a single line management structure, shared patient records and single assessment processes. We have agreed with all our partners in the City that we will pilot this integrated model in 2014-15 around a cluster of GP practices in order to test out the model and ensure lessons learned inform the full roll out across the whole city in 2015/16.

A stakeholder event has been planned for early March where the details of the Integrated Teams and ways of working across the wider system will be finalised to inform the creation of the pilot.

In addition to the pilot during 2014-15 we will start to pump-priming the whole system organisational and infrastructure development required (for example development of integrated IT systems, use of new technologies as well as supporting staff and organisations with change management) in readiness for a fully integrated model of care from 2015-16 onwards.

The presentation to the Health and Wellbeing Board attached in section (e) details a case study - Rachel Smith - a 64 year old woman living in extra care housing. It describes the current organisation or care and support and a vision of how things would look when care structures are more fully integrated.

For the frail person at the centre of this new way of working it will mean in practical terms:

- **I am supported to stay well: Rachel will have access to coordinated community based services and activities to support her to maintain good physical and mental health. This will mean she is less isolated, and her quality of life will improve. Rachel will also receive better Information about how to stay well – Locally Brighton and Hove has implemented a website called 'It's Local Actually' that provides information on thousands of local services, clubs, activities that are close to where the citizen lives. The main emphasis is reducing social isolation and encourages the use of social activities.**

- **I am encouraged to maintain my independence: Rachel would be offered a period of intensive, re-abling homecare and identify suitable Telecare and other equipment and work with her to get used to a new way of managing her personal care to build her confidence and improve her level of independence.**

- **The care is built around me. Rachel will have a named GP and a Care Co-ordinator who will co-produce a care plan and co-ordinate all aspects of care and support with her. A single care record will be used by professionals and care workers who are involved in her care to ensure Rachel only ever has to tell her story once. There will be continuity of care and support seven days a week.**

- **<u>My health conditions are under control.</u> Rachel will be provided with simple devices (Telehealth/ Telecare) and support to allow her to self-manage on a daily basis.**

- **<u>I am supported in a timely way when my needs change:</u> The Care Co-ordinator will pro-actively ensure that services are in place that can be flexible to respond swiftly to Rachel's changing (e.g. if she has a fall)**

As a result of these changes Rachel feels more supported to stay healthy and well and confident in the care she is receiving in her community and home. Her condition is better managed and her reliance on hospital services including the A&E department is significantly reduced. If she does require a stay in hospital she will be supported to regain her independence and discharged as soon as they she is ready to leave with continuity of care managed through the "Care Co-ordinator".

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Aim: To provide "whole person" care and support to people in their own homes and communities with care that:

- **Is co-ordinated around individuals and targeted to their specific needs**
- **Maximises independence by empowering people to manage their own health and wellbeing.**
- **Improves outcomes (for example a reduction in premature mortality for people with serious mental illness and improved quality of life e.g. better management of long term conditions)**
- **Enables quick recovery after periods of ill-health**
- **Improves the service user and carer experience**
- **Avoids unnecessary admissions to hospitals and care homes.**
- **Provides a responsive service 24/7**

To achieve this we will Pilot the Integrated Model with a cluster of GP practices and use learning from this to inform the full roll out across the City. This will include:

- **Building on the new requirement in the national GP contract from 1 April 2014 to provide a named GP for patients aged over 75 and those with complex needs.**
- **Investing in operational management infrastructure to oversee the management and organisation of care from the various providers**
- **Investing in Care Co-ordinator roles that take responsibility for organising**

care around the specific needs of the individual.

- **Ensuring ability to respond to an individual's change in need in a timely and appropriate way**
- **Maximising opportunities for the independent care sector and the well-developed local community and voluntary sector to be an active partner in service delivery**
- **Working with public health and other council colleagues to ensure a joined up system of community support**
- **Working towards a single integrated care record**

Aim: To improve the quality of the services received by the individual

- **Individuals will have access to a team ensuring right care by the right person in a timely fashion**
- **There will be a reduced risk of delay in support and resulting harm by reducing hand offs**
- **There will be reduced incidents of harms (pressure injuries, falls, etc.) by facilitating access to professional advice and a continuum of support commensurate with fluctuating need**
- **Sharing of knowledge and skills across the traditional professional and organisational boundaries leading to a higher level of generic skills reducing the need to have multiple individuals to deliver care but insuring access to specialist advice when required**
- **Improved governance by sharing policies and procedures and improving clarity of responsibilities and accountabilities**

<u>How we will measure these aims and objectives?</u>

We will work with colleagues in Public Health to quantify the benefits we should expect to see from more integrated care – including identifying measures of success as defined by our service users and we will evaluate the impact of our Pilot in achieving these.

<u>What measures of health gain will you apply to your population?</u>

Improved coordination of integrated care should result in an improvement in the following measures:

- **Reduction in volume of emergency activity in hospitals – both hospital admissions and A&E attendances**
- **Reduced length of stay in hospital**
- **Reduction in volume of residential and nursing care placements.**
- **Improved service user and care satisfaction**
- **Increase in proportion of people feeling supported to manage their long term condition**
- **Increased diagnosis rates for people with dementia**
- **Improved quality of life – reported by service users and carers**

The details of the metrics and trajectories are detailed in the Outcomes Section of this Plan.

c) Description of planned changes
Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

CCG and Adult Social Care Commissioning priorities already reflect an intention to support people to stay well, and where they do require health or care services, there will be an emphasis on making best use of current resource to maintain independence. Achievement of the vision will require significant change across all current health and social care providers.

<u>GP practices</u> will need to further develop collaborative arrangements with neighbouring practices to ensure services can be provided consistently and at sufficient scale to make them economically viable. They will play a central role in the co-ordination of care and to achieve this they will need to develop greater more formal multi-disciplinary team working arrangements with other health and care organisations.

<u>All providers of care</u> will need contribute to the development of integrated teams aligned to GP Practice. This will mean that all providers of care and support will need to ensure that their systems can link to deliver integrated care to individuals

<u>From a commissioning perspective</u> the CCG and BHCC will need to further develop integrated commissioning arrangements as well as develop more innovative approaches to commissioning and contracting of integrated models of care that aligns financial incentives to improved outcomes.

Key Stages

1) **<u>December 2013</u>. Recruitment of Joint Programme Manger to work across the CCG and the Local Authority to support the implementation of the integrated models of care**

2) **<u>January to March 2014</u>. Diagnostic Scoping Work to identify the target population to be included.**
   - **At minimum this is expected to cover the estimated 5% of the population (15,000 people) with multiple, often complex mental or physical long-term conditions often compound by being elderly or frail**
   - **It may also include some or all of the estimated 20% of the population (60,000 people) with a moderate mental or physical long term condition who may benefit from a more co-ordinated approach to their care.**

3) **<u>April 2014 to March 2015 – Strengthen Existing Service Provision</u> specifically:**
   - **Investment in capacity of integrated teams**
   - **Investment in primary care and step down facilities for homeless care;**
   - **Establishment and Roll Out of Personal Health Budgets**
   - **Increased 7 Day a Week Working**
   - **New GP contract for patients aged 75 and over and for those with complex needs to have a comprehensive and co-ordinated package of care via an accountable GP.**

4) **<u>April 2014 onwards – Pilot the Integrated Frailty Care Model with a cluster of GP practices.</u>**
   - **Investment in multi-disciplinary team operational management structure**
   - **Care Co-ordinator Roles introduced**
   - **Maximise role of the Independent care sector and the Community and Voluntary Sector in partnership working in delivering care**

5) **<u>April 2014 onwards – Support for Transformational Change</u>**
   - **Invest in organisational development support for front line staff**
   - **Organisational Development Programme for Senior Leaders (commissioners and providers) through NHS IQ**
   - **Invest in IT infrastructure to create single record**
   - **On-going feedback from service users to drive service model**

<u>6)From April 2015</u>
   - **Evaluation of the pilot to inform Full Roll Out of the Integrated Care Model**

The plan has been developed jointly between BHCC and CCG and priorities for investment have been based on the local needs of our population. In particular the approach to frailty is not just about older people but will include a variety of population cohorts with complex needs that could benefit from more integrated care.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

It is anticipated that providing more integrated and pro-active care in the community will reduce the need for hospital based emergency and planned care. At a national level it is expected that hospital emergency activity will reduce by about 15% as a result of the development of Integrated Care. (NHS England (2013) Everyone Counts Planning for Patients 2014-15 to 2018-19)

However Brighton and Hove already has a comparatively low rates of emergency hospital admissions, we are in the lowest quintile nationally for non-elective

admissions and for non-elective admissions for primary Ambulatory Care Sensitive conditions therefore limiting the scope for further savings. More detailed data analysis is detailed in section e of this report. The total expenditure on non-elective admissions and A&E attendance for Brighton and Hove residents and Brighton and Sussex University Hospital Trust is £4.2 million. It is estimated that a further reduction of 10% on our current baseline could be realised. We also expect that by more proactive management of people with complex needs and long-term conditions we can avoid a number of elective procedures and realise efficiencies from working in a more integrated way across acute and primary/community care.

We therefore expect a saving of between £8.3 and £10m to be realised from current spend, the majority of which will be in the acute sector.

If we do not see the impact of more proactive integrated community provision on the acute sector immediately we do have a contingency reserve to cover the risk over a longer transition period.

e) Governance

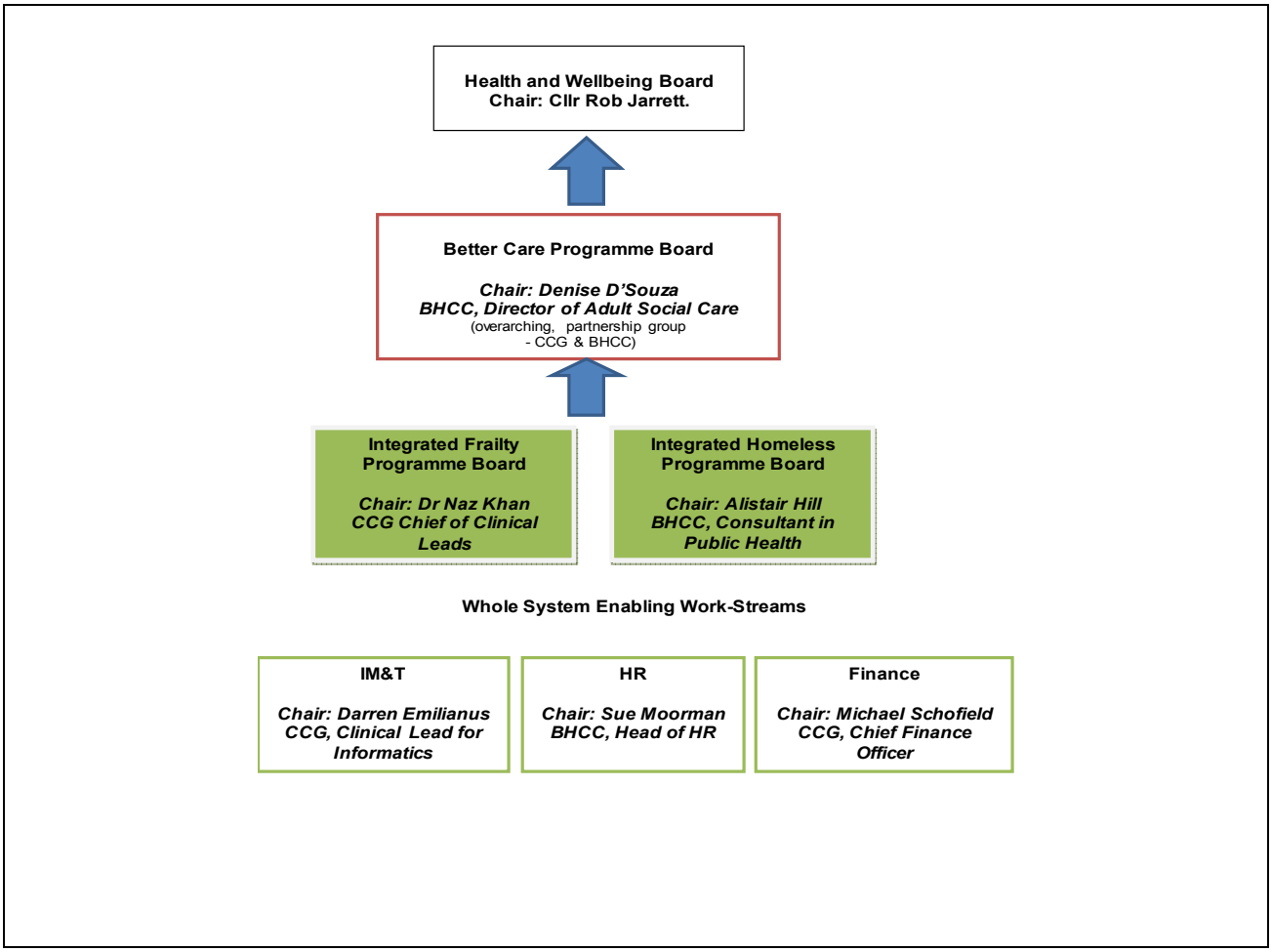
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Brighton and Hove CCG and Brighton and Hove City Council already have well-established joint commissioning and partnership arrangements which provides a solid foundation to develop further integration of care. However, it is recognised that the Better Care programmes of work will require both an acceleration of pace and a more transformational and innovative approach to deliver improved outcomes within the required timescales.

A Better Care Programme Board has been established to oversee the Better Care work programmes. Its main purpose is to provide system wide leadership and accountability for delivery of the Better Care Agenda across Brighton and Hove health and care economy. Overseeing the work of the various Integration Programme Boards the Better Care Programme Board will ensure the vision and requirements of Better Care are implemented. The Brighton Better Care Programme Board is accountable to the Brighton and Hove Health and Wellbeing Board.

The Adult Social Care Modernisation Board will also include consideration of the Better Care Programme and will ensure that the work undertaken in response to the introduction of the Care Bill links to the Better Care Programme Board. Sub Groups of the Modernisation Board will ensure they consider links and overlaps.

Implementation Boards for Frailty as well as a specific Board for Integrated Homeless Care will report in to the Better Care Programme Board. Whole System Enabling Work-streams for IM&T, HR and Finance will support the overall programme. The governance structure is detailed below.


Health and Wellbeing Board
Chair: Cllr Rob Jarrett.
Better Care Programme Board
Chair: Denise D'Souza
BHCC, Director of Adult Social Care
(overarching, partnership group
- CCG & BHCC)
Integrated Frailty Programme Board
Chair: Dr Naz Khan
CCG Chief of Clinical Leads
Integrated Homeless Programme Board
Chair: Alistair Hill
BHCC, Consultant in Public Health
Whole System Enabling Work-Streams
IM&T
Chair: Darren Emilianus
CCG, Clinical Lead for Informatics
HR
Chair: Sue Moorman
BHCC, Head of HR
Finance
Chair: Michael Schofield
CCG, Chief Finance Officer

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Protecting Social Care services in Brighton & Hove means ensuring a focus on supporting the most vulnerable people in the city. Safeguarding Adults remains priority. Where people do require services, there is an emphasis on short term reablement services to enable them to fulfil their potential. In the context of growing demand and budgetary pressures, new and innovative approaches will be required to support people with their care needs. Increasingly, people are purchasing their own care services using their personal budgets and so different solutions will need to be available for them. The eligibility criteria for services will not change, but there will be an emphasis on preventive services that help keep people healthy and well. The local plan for Brighton & Hove includes:

- **Maintaining current eligibility criteria for adult social care services**
- **a continuation of existing services such as early supported discharge and rapid response services**
- **spending on adult social care to maintain essential services**
- **investments in new services such as additional staffing for bed based short term care services**
- **a joint winter contingency the proposals for which will be jointly agreed by health and social care and used to provide additional investment in core services to mitigate winter pressures.**
- **Support for the independent care sector to ensure timely discharge form hospital**
- **To develop a flexible funding resource that would enable health and social care providers to respond effectively in a coordinated way to changes in demand across systems**

However the vision for the future is for integrated or "joined-up" models of care to support people at home with maximum independence. This approach is expected to benefit individuals and their communities as well as the local health and care economy as a whole.

By pro-actively supporting people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own care wherever possible in their own homes this enables a better use of overall resource.

Please explain how local social care services will be protected within your plans.

All of the funding currently allocated in 2013-14 under the Social Care to Benefit Health Grant has been maintained to enable Brighton and Hove City Council to maintain the current eligibility criteria to provide:

- **Timely assessment**
- **Care management to facilitate timely discharge from hospital**

- **Service delivery to people who have substantial or critical needs**
- **Information and Sign-posting to those who are not eligible for ASC services**
- **Funding services in the Community & Voluntary sector**
- **Services with a reablement focus**
- **Increase the number of assessments**
- **Further investment in rehabilitation/re-ablement (including Telecare) to reduce hospital admissions and admissions to residential and nursing home care**
- **Support for carers**
- **Additional home care support to facilitate hospital discharge**

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Many of the health and social care services to support hospital discharge are available 7 days a week. This includes:

- **<u>Integrated Primary Care Teams (IPCT's)</u> that provide pro-active care keeping people well at home**
- **<u>Community Short Term Services (CSTS)</u> that provide rapid assessment and time-limited support to:**
  - **Prevent avoidable hospital attendances and/ or admissions;**
  - **Support service users to recover from a spell of illness/injury following a stay in acute hospital; and**
  - **Maximise a service user's independence through rehabilitation and re-ablement**
- **<u>Brighton Urgent Response Service and Crisis Resolution Home Treatment Team</u> for people with urgent mental health needs**
- **<u>Living Well with Dementia Service</u> – that provides a 7 day a week service including crisis response**
- **<u>Independence at Home</u> - the council's home care service**

In addition to maintaining the 2013/14 levels of funding further investment has been made in 2014-15 to Deliver 7 Day Services in Adult Social Care

All of the services are commissioning jointly between the CCG and BHCC and provided jointly by health and social care and community and voluntary sector providers.

Additional funding has been made available in the Winter of 2013-14 to facilitate 7 day services in health and social care and this will be consolidated within the Better Care Programme, this includes:

- **General Practice Pop-Up Clinics Available at Weekends and Bank Holidays**
- **Additional Capacity in Community Short Term Services**
- **7 Day Week Medical Consultant Support in Dementia Services**
- **Safe Space in the Council where homeless people can go extended to 7 day working**

This learning from this winter will be used to assess how successful the additional resource has been in terms of facilitating discharges from hospital and reducing avoidable emergency admissions and enable the CCG and BHCC together with partnership organisations to assess what additional capacity is required on an on-going basis.

In addition to this plans are for:

- **Additional Therapy Capacity in IPCT's**
- **Additional Therapy Capacity in Community Short Term Services to enable 7 day a week working including a dedicated ambulance**
- **Incentivise home care providers and care homes to enable more timely discharge over 7 days, and to put support mechanisms in place for them to respond to requests effectively.**

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All health services use the NHS number as the primary identifier in correspondence.
The Council system (OLM Carefirst) has the functionality to include the NHS number but the current primary identifier is the Carefirst number. Current performance is that approximately 52% of people using services have their NHS number on the Carefirst system.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

The Council is committed over the next year to a programme that will ensure the NHS number is provided on the system along side the Carefirst number as a primary identifier. Currently this is being progressed through ;

1. The opportunities provided through the Zero Based Review which will go live on 1/4/14 to promote the use of the NHS number within services.
2. Discussions with systems providers that would support a full data collection re the NHS number.
3. Exploring opportunities within integrated services to support the NHS number being used as a primary identifier, and the programme within this document will support this work
4. Developing regular performance reporting that will monitor performance re use of the NHS number across all services and which can be used within our data quality programme.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to adopting systems based upon Open API'S and Open Standards.

During 2014/15 our 47 GP Practices will begin to upgrade to GPSoC-R products which have Open APIs (dependency on HSCIC to deliver capability) on which multiple suppliers can build record viewing and remote recording solutions.

Multi agency record viewing systems are currently being explored.
We are also deploying Clinical Correspondence projects to handle GP->Provider correspondence utilising open standards such as ITK. XML, Coded and Non-Coded CDA.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice and in particular requirements set out in Caldicott2.

We have an established Information Governance framework and we are committed to maintaining five rules in health and social care to ensure that service user confidentiality is maintained. The rules are:

- **Confidentiality and information about service users should be treated confidentially and respectfully**
- **Members of a care team should share confidential information when it is needed for the safe and effective care of an individual**
- **Information that is shared for the benefit of the community should be anonymised**
- **An individual's right to object to the sharing of confidential information about them should be respected**
- **Organisations should put policies, procedures and systems in places to ensure the confidentiality rules are followed**

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Risk stratification of practice population is a core element of the Integrated Primary Care Team delivery model which is currently supported by the Risk Profiling and Case Management Directed Enhanced Service that profile the top 2% of patients most at risk of emergency hospital admission.

Each GP practice identifies individuals at risk of admission using a predictive tool (the urgent care clinical dashboard) and organises multi-disciplinary team meetings inviting the relevant community practitioners from health social care

(both physical and mental health). An action plan is produced for each patient discussed and where a patient is identified as suitable for case management a lead professional is be identified. This could be a member of the practice team or IPCT, as appropriate to each individual patient.

This approach to joint assessment and care planning will be built upon and extended as more integrated models of care are developed.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Ability to transfer resources from acute sector to fund new integrated models of care within the required timescales	High	CCG non-recurrent funding available to support transformational change
Buy in From Front Line Staff to deliver Integrated Models of Care	Medium	Full sign up from senior level across all partners. Organisational Development Support key part of the Better Care Plan Comms strategy being developed jointly across all agencies.
Providers not able to make required workforce changes in relation to capacity and capability	Medium	The Better Care Programme Board will work with providers and oversee the development of an integrated workforce plan.
IM&T- ability to create a single care record to support the service change	Medium	Establishing a multi-agency IM&T Group to oversee the whole system adoption of a single care record
Length of Time to Implement Changes – given complexity of change and wide range of organisations involved	High	Agreed to Pilot First – Phase 1 of the Plan to ensure learning prior to full roll out.
Uncertainly for Adult Social Care in relation to the cost pressures of the Care Bill and how this will impact on investment plans	High	Adult Social Care Modernisation Board will review investment plans for the Care Bill and for the Better Care

Competing demands for Adult Social Care to implement the Care Bill, the Modernisation agenda and the reduction in the council's budget	High	Development of an integrated plan to include competing priorities
Continued pressure on hospital and lack of community response may lead to an increase in nursing home placements	High	Development of coordinated robust community services to respond to demand.

HEALTH & WELLBEING BOARD	Agenda Item 44 Brighton & Hove City Council

Subject:		**Pharmaceutical Needs Assessment**	
Date of Meeting:		**5 February 2014**	
Report of:		**Dr Tom Scanlon, Director of Public Health**	
Contact Officer:	**Name:**	**Dr Max Kammerling**	**Tel: 07894 340590**
	Email:	**Max.Kammerling@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The Health and Wellbeing Board (HWB) has a statutory responsibility to produce and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a Pharmaceutical Needs Assessment (PNA). NHS England use the PNA in deciding if new community pharmacies are needed and to inform decisions on which NHS funded services should be provided by pharmacies. The regulations require every HWB to publish its first PNA by 1st April 2015. This report sets out the proposed approach that will be taken to meet this duty in Brighton and Hove.

2. RECOMMENDATIONS:

2.1 That the Health and Wellbeing Board notes its statutory requirement to produce and keep up to date the PNA as set out in 3.6.

2.2 That the Health and Wellbeing Board instructs the Director of Public Health to:

- produce a revised PNA for approval by the HWB by 1 April 2015 (and subsequent updates) and
- develop and maintain a process to identify any changes to pharmaceutical services and consider if they are substantive enough to require a revised PNA or whether this would be a disproportionate response to those changes.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The Pharmaceutical Needs Assessment (PNA) is a comprehensive statement of the need for pharmaceutical services of the population in its area. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 ("the Regulations") set out the legislative basis and requirements of the Health and Wellbeing Board for developing and updating the PNA as well as the responsibility of NHS England in relation to "market entry".

3.2 The provision of NHS Pharmaceutical Services is a controlled market. If someone (a pharmacist, a dispenser of appliances, or in some circumstances and normally in rural areas, a GP) wants to provide NHS pharmaceutical services, they are required to apply to NHS England to be included on a

pharmaceutical list. Since April 2013 pharmaceutical lists are compiled and held by NHS England. This is commonly known as the NHS "market entry" system.

3.3 Under the Regulations, applications for inclusion on a pharmaceutical list must prove that they are able to meet a pharmaceutical need as set out in the relevant PNA. There are two exceptions, one for services provided by distant selling (e.g. internet pharmacies), and the second is an application for needs not foreseen in the PNA.

3.4 NHS England will use the PNA when making decisions on applications. Such decisions are appealable and decisions made on appeal can be challenged through the courts.

3.5 NHS England must maintain up to date lists of persons within an area offering a pharmaceutical service. NHS England must consult, giving 45 days for a response, the relevant Health and Wellbeing Board when an application for a new pharmacy or change to an existing pharmacy is received within 2km of the area served by a Health and Wellbeing Board.

3.6 The requirements of the Health and Wellbeing Board are as follows:

3.6.1 HWBs are required to produce **the first PNA by 1 April 2015.** The Regulations set out the minimum information which must be included in the PNA, matters that must be considered when making the assessment and the process to be followed (including a statutory 60 day consultation period). In the interim period the Regulations make provision for use of the PNA published by the HWBs former PCT(s) to inform market entry decisions.

3.6.2 HWBs are required to publish a revised assessment within **three years** of publication of their first assessment; and

3.6.3 HWBs are required to publish a revised assessment as soon as is reasonably practical after identifying significant changes to the availability of pharmaceutical services since the publication of its PNA unless it is satisfied that making a revised assessment would be a disproportionate response to those changes. In addition the Health and Wellbeing Board is required to maintain an up to date map of provision of NHS Pharmaceutical Services.

3.7 The current position regarding the PNA is described below:

3.7.1 A PNA for Brighton and Hove was published by NHS Brighton and Hove in February 2011. A copy of the PNA can be found on the Brighton and Hove Local Information Service website at http://www.bhlis.org/resource/view?resourceId=1412

3.7.2 In March 2013 the PCT Pharmaceutical Committee reviewed the 2011 PNA and published a Supplementary Statement which states that a revised PNA was not required at that point (and would be a disproportionate response). A copy of the Supplementary Statement is available at http://www.bhlis.org/resource/view?resourceId=1413

3.8 It is recommended that the HWB instructs the Director of Public Health to produce a draft PNA for approval by the HWB by 1st April 2015. The Director of Public Health will establish a PNA steering group by March 2013 to oversee this process. The steering group will be chaired by a Consultant in Public Health. Proposed membership of the group includes representatives of BHCC Public

Health Directorate, East Sussex Local Pharmaceutical Committee, NHS England, Brighton and Hove Clinical Commissioning Group and Healthwatch.

3.9 The priority actions for the group will be to:

- Agree terms of reference and membership
- Agree and maintain a process to
    - identify any changes to pharmaceutical services and consider if they are substantive enough to require a revised PNA or whether this would be a disproportionate response to those changes
    - publish any supplementary statement required
    - maintain a map of local pharmaceutical provision
- agree a timetable and project plan for producing the updated PNA

3.10 A revised PNA will be circulated to the HWB as part of the statutory consultation. A final version will be presented to the HWB for approval by 1 April 2015.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Publication of a PNA is a statutory requirement for the Brighton and Hove Health and Wellbeing Board. The specified option is recommended as an efficient and effective method to fulfil these duties.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 The Regulations set out the requirements for consultation on PNAs. When making an assessment for the purposes of publishing a pharmaceutical needs assessment, each HWB must consult the following about the contents of the assessment it is making:

(a) Local Pharmaceutical Committee

(b) Local Medical Committee (c) any persons on the pharmaceutical lists and any dispensing doctors list for its area;

(d) any Local Pharmaceutical Service chemist in its area with whom the NHS England has made arrangements for the provision of any local pharmaceutical services;

(e) Healthwatch, and any other patient, consumer or community group in its area which in the opinion of the HWB has an interest in the provision of pharmaceutical services in its area; and

(f) NHS trusts or NHS foundation trust;

(g) NHS England and

(h) neighbouring HWBs

There is a minimum period of 60 days for consultation responses.

6. CONCLUSION

6 The Health and Wellbeing Board has a statutory requirement to produce and keep up to date the PNA, including the production of a revised PNA by 1 April 2015. The proposed process will enable its duties to be met.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 The cost of producing the PNA including public involvement and consultation will be met by the ringfenced Public Health Grant. The initial estimate for these elements is £20k and this will be reflected in 2014/15 Public Health Business Plan for 2014/15.
Finance Officer Consulted: Anne Silley Date: 14/01/14

Legal Implications:

7.2 The statutory requirement and prescribed process for the HWB to publish a PNA is set out in the body of the report. The proposals in the report are consistent with ensuring that the HWB is in a position to discharge its duties.
Lawyer Consulted: Elizabeth Culbert Date: 16/01/14

Equalities Implications:

7.3 The PNA will have regard to the Equality Act 2010 and an Equality Impact Assessment will be undertaken in relation to the revised PNA.

Sustainability Implications:

7.4 There are no specific implications arising from this report

Corporate/citywide Implications:

7.5 The PNA is a key tool for identifying what is needed at a local level to support the commissioning intentions for pharmaceutical services. This will enable the provision of appropriate health services as part of the delivery of local health and social care strategies, including the Health and Wellbeing Strategy.

Any Other Significant Implications

7.6 None.

SUPPORTING DOCUMENTATION

Appendices:

1. Map of Brighton and Hove Pharmacies as at January 2014

Documents in Members' Rooms

1. None.

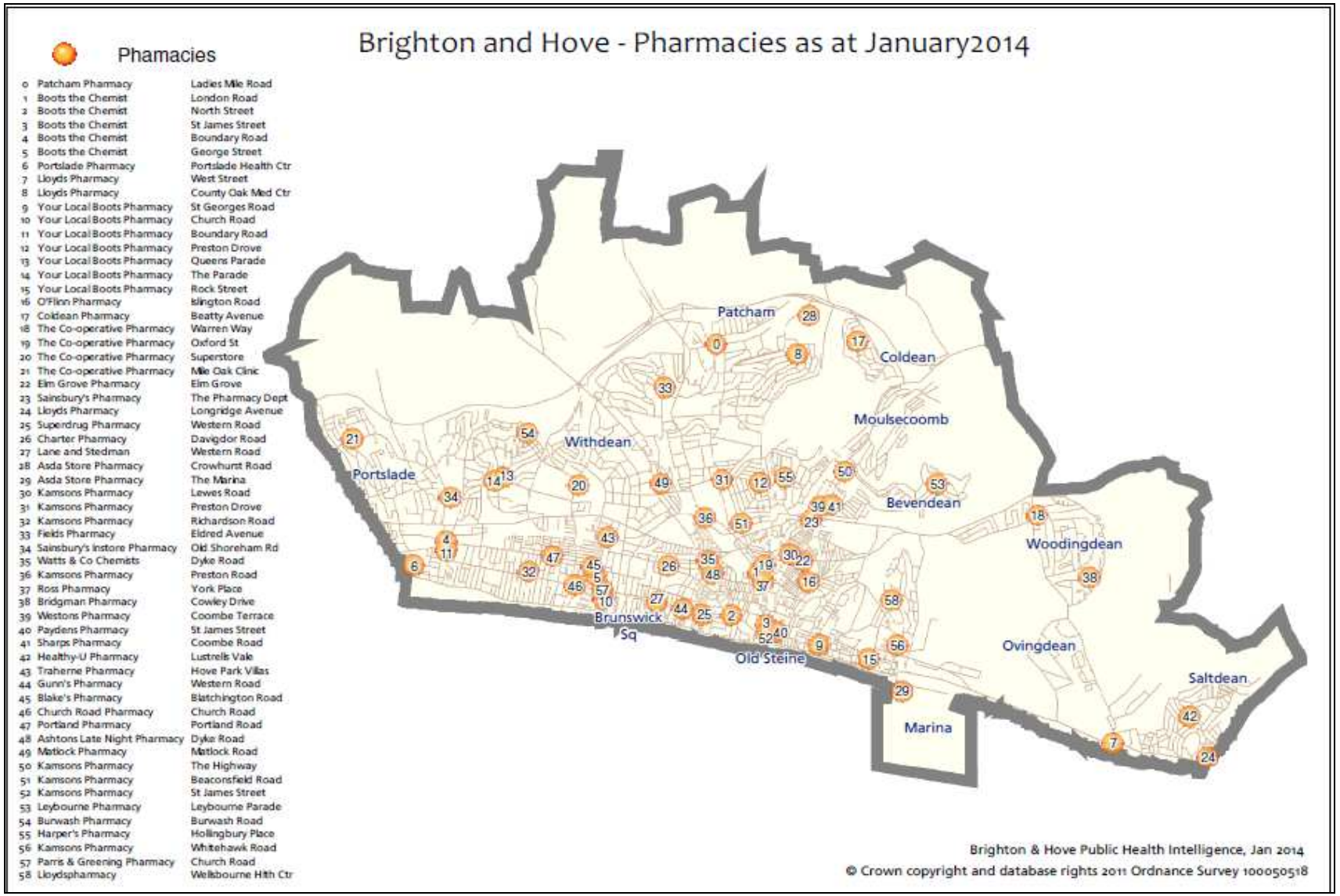
Background Documents

1. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

2. Brighton and Hove Pharmaceutical Needs Assessment 2010

3. NHS Brighton & Hove Pharmaceutical Needs Assessment Supplementary Statement – March 2013

Appendix 1


Brighton and Hove - Pharmacies as at January2014
Phamacies
0 Patcham Pharmacy Ladies Mile Road
1 Boots the Chemist London Road
2 Boots the Chemist North Street
3 Boots the Chemist St James Street
4 Boots the Chemist Boundary Road
5 Boots the Chemist George Street
6 Portslade Pharmacy Portslade Health Ctr
7 Lloyds Pharmacy West Street
8 Lloyds Pharmacy County Oak Med Ctr
9 Your Local Boots Pharmacy St Georges Road
10 Your Local Boots Pharmacy Church Road
11 Your Local Boots Pharmacy Boundary Road
12 Your Local Boots Pharmacy Preston Drove
13 Your Local Boots Pharmacy Queens Parade
14 Your Local Boots Pharmacy The Parade
15 Your Local Boots Pharmacy Rock Street
16 O'Flinn Pharmacy Islington Road
17 Coldean Pharmacy Beatty Avenue
18 The Co-operative Pharmacy Warren Way
19 The Co-operative Pharmacy Oxford St
20 The Co-operative Pharmacy Superstore
21 The Co-operative Pharmacy Mile Oak Clinic
22 Elm Grove Pharmacy Elm Grove
23 Sainsbury's Pharmacy The Pharmacy Dept
24 Lloyds Pharmacy Longridge Avenue
25 Superdrug Pharmacy Western Road
26 Charter Pharmacy Davigdor Road
27 Lane and Stedman Western Road
28 Asda Store Pharmacy Crowhurst Road
29 Asda Store Pharmacy The Marina
30 Kamsons Pharmacy Lewes Road
31 Kamsons Pharmacy Preston Drove
32 Kamsons Pharmacy Richardson Road
33 Fields Pharmacy Eldred Avenue
34 Sainsbury's Instore Pharmacy Old Shoreham Rd
35 Watts & Co Chemists Dyke Road
36 Kamsons Pharmacy Preston Road
37 Ross Pharmacy York Place
38 Bridgman Pharmacy Cowley Drive
39 Westons Pharmacy Coombe Terrace
40 Paydens Pharmacy St James Street
41 Sharps Pharmacy Coombe Road
42 Healthy-U Pharmacy Lustrells Vale
43 Traherne Pharmacy Hove Park Villas
44 Gunn's Pharmacy Western Road
45 Blake's Pharmacy Blatchington Road
46 Church Road Pharmacy Church Road
47 Portland Pharmacy Portland Road
48 Ashtons Late Night Pharmacy Dyke Road
49 Matlock Pharmacy Matlock Road
50 Kamsons Pharmacy The Highway
51 Kamsons Pharmacy Beaconsfield Road
52 Kamsons Pharmacy St James Street
53 Leybourne Pharmacy Leybourne Parade
54 Burwash Pharmacy Burwash Road
55 Harper's Pharmacy Hollingbury Place
56 Kamsons Pharmacy Whitehawk Road
57 Parris & Greening Pharmacy Church Road
58 Lloydspharmacy Wellsbourne Hlth Ctr
Patcham
Coldean
Moulsecoomb
Withdean
Portslade
Bevendean
Woodingdean
Brunswick Sq
Old Steine
Ovingdean
Saltdean
Marina
Brighton & Hove Public Health Intelligence, Jan 2014
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