Who are we?

The Health and Wellbeing Board is a joint board of the Council and CCG which provides the strategic leadership for the health and social care in the city. Meetings are open to the public and everyone is welcome.

Where and when is the Board meeting?

This next meeting will be held in the **Auditorium - The Brighthelm Centre** on **Tuesday, 21 July 2015**, starting at **4.00pm**. It will last about two and a half hours.
There is public seating and observers can take part in an informal question and answer session with the Board prior to the formal meeting, starting at 3.30pm and they can leave when they wish.

What is being discussed and what decisions are being made?

The Board will consider two 'notices of motion.' The first will ask the Board to consider UNISON's Ethical Care Charter which was discussed as a full Council meeting in January 2014 and sets out standards for care and the payment of care workers. The second notice of motion relates to the 'Time to Change Pledge' which commits signatories to give equal priority to mental health as to physical health and address stigma.

The Board is being asked to make three decisions.

- The first is to support a community consultation on whether or not the city should extend tobacco smoke-free areas to beaches and parks.
- The Board will also be asked to decide on whether the contacts for Public Health Nursing Services should be extended until April 2017 during which time consideration can be given to how these services should be provided in the future.

These Public Health Nursing Services include Health Visiting, School Nursing, the Family Nurse Partnership and the Breastfeeding Support Services.

- The third decision asked of the Board is to consider approving the setting up of a cross party members' reference group to oversee proposals to amalgamate specialist provision for children with special educational needs and mental health difficulties.

The Board's remit and influence is wide, and so a number of other papers are also being brought to the Board for discussion and noting. These include reports on Child Sexual Exploitation, Housing Adaptations and the Better Care Fund. The Board will also be asked to support a transformation plan for Children and Young People's Mental Health and Wellbeing Plan and will hear the results of the Ofsted Inspection of local Children's Safeguarding. In October 2014, following an update on Cancer Screening in the city, the Board asked a small working group to provide a progress update and a paper will be presented to the Board outlining what has changed since. Finally, there have been concerns about GP closures discussed at the Board before when the Eaton Place surgery closed. Given the recent situation with Goodwood Court surgery the Board has asked NHS England to provide a report on GP practice closures and this will be discussed.

Health & Wellbeing Board
21 July 2015
4.00pm
Auditorium - The Brighthelm Centre

Who is invited:

Yates (Chair),K Norman (Opposition Spokesperson), Mac Cafferty (Group Spokesperson), Barford and G Theobald, Dr Xavier Nalletamby (Brighton and Hove Clinical Commissioning Group), Geraldine Hoban (Brighton and Hove Clinical Commissioning Group), Dr Christa Beesley (Brighton and Hove Clinical Commissioning Group), Dr Jonny Coxon (Brighton and Hove Clinical Commissioning Group) and Dr George Mack (Brighton and Hove Clinical Commissioning Group), Denise D'Souza (Statutory Director of Adult Services), Dr Tom Scanlon (Director of Public Health), Pinaki Ghoshal (Statutory Director of Children's Services), Frances McCabe (Healthwatch), Graham Bartlett (Brighton & Hove Local Safeguarding Children's Board) and Pennie Ford (NHS England)

Who is unable to attend:

Contact: **Mark Wall**
Head of Democratic Services
01273 291006
mark.wall@brighton-hove.gov.uk

This Agenda and all accompanying reports are printed on recycled paper

Date of Publication - Monday, 13 July 2015

AGENDA

Formal matters of procedure

This short formal part of the meeting is a statutory requirement of the Board

Page

1 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

The Chair of the Board will formally ask if anyone is attending to represent another member, and if anyone has a personal and/or financial interest in anything being discussed at the meeting. The Board will then consider whether any of the discussions to be held need to be in private.

2 CONSTITUTIONAL MATTERS 1 - 4

Report of the Monitoring Officer (copy attached).

Contact: *Mark Wall* *Tel: 01273 291006*
Ward Affected: *All Wards*

3 CHAIR'S COMMUNICATIONS

The Chair of the Board will start the meeting with a short update on recent developments on health and wellbeing.

4 MINUTES 5 - 16

The Board will review the minutes of the last meeting held on the 24 March 2015, decide whether these are accurate and if so agree them (copy attached).

Health & Wellbeing

5 FORMAL PUBLIC INVOLVEMENT **17 - 18**

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

(a) **Petitions** – to receive any petitions presented to the full council or at the meeting itself;
(b) **Written Questions** – to receive any questions submitted by the due date of 12 noon on the 14th July 2015;
(c) **Deputations** – to receive any deputations submitted by the due date of 12 noon on the 14th July 2015.

Contact: *Mark Wall* *Tel: 01273 291006*
Ward Affected: *All Wards*

6 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;

The Main Agenda

7 ETHICAL CARE CHARTER **19 - 24**

Notice of Motion referred from the Council meeting held on the 30th January 2014 (copy attached).

8 TIME TO CHANGE PLEDGE **25 - 28**

Notice of Motion referred from the Council meeting held on the 26th March 2015 (copy attached).

9 CONSULTATION ON EXTENSION OF SMOKE FREE AREAS **29 - 34**

Report of the Director of Public Health (copy attached).

Contact: *Roy Pickard* *Tel: 29-2145*
Ward Affected: *All Wards*

Health & Wellbeing

10 PUBLIC HEALTH NURSING COMMISSIONING FOR HEALTHY CHILD PROGRAMME 0-19 **35 - 40**

Report of Director of Public Health (copy attached).

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

11 RESPONSE TO CHILD SEXUAL EXPLOITATION (CSE) WITHIN BRIGHTON & HOVE **41 - 46**

Report of the Executive Director for Children's Services (copy attached).

Contact: *Pinaki Ghoshal* *Tel: 01273 290718*
Ward Affected: *All Wards*

12 HOUSING ADAPTATIONS SERVICE UPDATE **47 - 60**

Report referred from the meeting of the Housing & New Homes Committee on 17 June 2015 for information; together with an extract from the proceedings of the meeting (copy attached).

Contact: *Sarah Potter, Martin Reid* *Tel: 01273 29-3168, Tel: 01273 93321*
Ward Affected: *All Wards*

13 CHILDREN'S SERVICES OFSTED INSPECTION AND REVIEW OF LOCAL SAFEGUARDING CHILDREN BOARD 2015 **61 - 122**

Report of the Executive Director for Children's Services (copy attached).

Contact: *Carolyn Bristow* *Tel: 29-1288*
Ward Affected: *All Wards*

14 INTERIM REPORT: PROGRESS ON THE MERGING SPECIAL EDUCATIONAL NEEDS AND DISABILITIES (SEND) REVIEW IN CHILDREN'S SERVICES AND THE LEARNING DISABILITY (LD) REVIEW IN ADULT SERVICES **123 - 156**

Report of the Executive Director for Children's Services (copy attached).

Contact: *Lisa Brown* *Tel: 01273 293568*
Ward Affected: *All Wards*

Health & Wellbeing

15 UPDATE ON CANCER SCREENING IN BRIGHTON AND HOVE **157 - 162**

Report of the Director of Public Health (copy attached).

Contact: *Nicola Rosenberg* *Tel: 01273 574809*
Ward Affected: *All Wards*

16 BETTER CARE FUND UPDATE **163 - 176**

Report from the Clinical Commissioning Group (copy attached).

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

17 GP PRACTICE CLOSURES **177 - 182**

Report from NHS England (copy attached).
This paper provides the Health and Wellbeing Board with an overview regarding GP Practice Closures generally and specific information linking to two Practice Closures at Eaton Place Surgery and Goodwood Court Medical Practice.

18 CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING TRANSFORMATION PLAN FOR BRIGHTON AND HOVE **183 - 192**

Report of the Clinical Commissioning Group for noting (copy attached).

Contact: *Gill Brooks* *Tel: 01273 574635*
Ward Affected: *All Wards*

WEBCASTING NOTICE
This meeting may be filmed for live or subsequent broadcast via the Council's website. At the start of the meeting the Chair will confirm if all or part of the meeting is being filmed. You should be aware that the Council is a Data Controller under the Data Protection Act 1988. Data collected during this web cast will be retained in accordance with the Council's published policy (Guidance for Employees' on the BHCC website).

For further details and general enquiries about this meeting contact Democratic Services, 01273 2910636 or email democratic.services@brighton-hove.gov.uk

Health & Wellbeing

Public Involvement

The Health & Wellbeing Board actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public.

If you wish to attend and have a mobility impairment or medical condition or medical condition that may require you to receive assisted escape in the event of a fire or other emergency, please contact the Democratic Services Team (Tel: 01273 291066) in advance of the meeting. Measures may then be put into place to enable your attendance and to ensure your safe evacuation from the building.

Brighthelm has facilities for people with mobility impairments including a lift and wheelchair accessible WCs. However in the event of an emergency use of the lift is restricted for health and safety reasons please refer to the Access Notice in the agenda below.

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter and infra-red hearing aids are available for use during the meeting. If you require any further information or assistance, please contact the receptionist on arrival.

Fire / Emergency Evacuation Procedure

If the fire alarm sounds continuously, or if you are instructed to do so, you must leave the building by the nearest available exit. You will be directed to the nearest exit by council staff. It is vital that you follow their instructions:

- You should proceed calmly; do not run and do not use the lifts;
- Do not stop to collect personal belongings;
- Once you are outside, please do not wait immediately next to the building, but move some distance away and await further instructions; and

Do not re-enter the building until told that it is safe to do so.

Health & Wellbeing

1. Procedural Business

(a) Declaration of Substitutes: Where Members of the Board are unable to attend a meeting, a designated substitute for that Member may attend, speak and vote in their place for that meeting.

(b) Declarations of Interest:

(a) Disclosable pecuniary interests
(b) Any other interests required to be registered under the local code;
(c) Any other general interest as a result of which a decision on the matter might reasonably be regarded as affecting you or a partner more than a majority of other people or businesses in the ward/s affected by the decision.

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

If unsure, Members of the Board should seek advice from the Lawyer or Secretary preferably before the meeting.

(c) Exclusion of Press and Public: The Board will consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, that the press and public should be excluded from the meeting when any of the 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 from the Secretary to the Board.

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Formal details of the paper

1.1. Constitutional Matters – Health & Wellbeing Board

1.2 This paper can be seen by the general public.

1.3 21st July 2015

1.4 Mark Wall, Head of Democratic Services
Tel: 01273 291006
mark.wall@brighton-hove.gov.uk

2. Summary

2.1 To provide information on the Board's terms of reference.

3. Decisions, recommendations and any options

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

4. Relevant information

4.1 Article 6 of the council's constitution, incorporates a schedule of all the Committees/Sub-committees established in the new constitution together with a summary of their respective functions.

The Health & Wellbeing Board – Terms of Reference

4.2 A copy of the terms of reference for the Board is attached in Appendix A. These should be read in the context of the 'Introduction and General Delegations' included in the Scheme of Delegations to Committees and Sub-Committees at part 4 of the constitution.

Membership

4.3 The membership of the Board is as follows:

Voting Members:
5 elected Members & 5 CCG representatives.

Non-voting Members:
The Executive Director Children's Services, The Executive Director Adult Services, The Director of Public Health, A representative of Healthwatch, A representative of NHS England, the Chair of the Children's Local Safeguarding Board.

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

Programme Meetings

3.5 Ordinary meetings of the Health & Wellbeing Board are scheduled to take place on the following dates during 2015/16:

Tuesday 21 July 2015
Tuesday 15 September 2015 – Now a Partnership Event
Tuesday 20 October 2015
Tuesday 15 December 2015
Tuesday 2 February 2016
Tuesday 22 March 2016

3.6 Meetings of the Committee will normally be held at Hove Town Hall and will start at 4.00 p.m. For the 2015/16 municipal year, meetings will be held in the Brighthelm Centre, Brighton at 4.00pm due to renovation work at Hove Town Hall.

5. Important considerations and implications

5.1. Legal
The Council's constitution complies with the legal framework set out in the Localism Act 2011, the Local Government Act 2000 and other relevant legislation.

Lawyer Consulted: Elizabeth Culbert Date: 11 May 2015

5.2. Finance
The cost of holding the Board meetings at Brighthelm have been included in the overall Workstyles Programme for the move to Hove Town Hall and will be reported to the Policy & Resources Committee at a later date.

Finance Officer Consulted: Peter Francis Date: 11 May 2015

5.3. Equalities
There are no equalities implications associated with the report.

5.4. Sustainability
There are no sustainability implications associated with the report.

5.5. Health, social care, children's services and public health

6. Supporting documents and information

6.1 All Members considered and approved the constitution and the changes therein at the Council meeting on the 26 March 2015.

4.00pm meeting 24 March 2015

Council Chamber, Hove Town Hall

Minutes

Present: Councillor J Kitcat (Chair) Councillor K Norman (Opposition Spokesperson), Jarrett, Morgan and G Theobald, Dr Xavier Nalletamby, CCG, Geraldine Hoban, CCG, Dr Christa Beesley, CCG, Dr George Mack, CCG, Denise D'Souza, (Statutory Director of Adult Social Services), Tom Scanlon, Director of Public Health, Pinaki Ghoshal, Statutory Director of Children's Services, Frances McCabe, Healthwatch, Graham Bartlett, Brighton & Hove Local Safeguarding Children's Board and Deborah Tomalin, NHS England.

Apologies: Dr Jonny Coxon

Part One

62 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

62.1 There were no declarations of substitutes.

62.2 Dr Xavier Nalletamby declared an interest in Item 68 as he worked for a GP Practice as a GP. He had applied for and been granted dispensation by the Council's Monitoring Officer to speak and vote. Dr Christa Beesley declared an interest in Item 68 as she worked for a GP Practice as a GP. She had applied for and been granted dispensation by the Council's Monitoring Officer to speak and vote.

62.3 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.

62.4 **Resolved** - That the press and public be not excluded from the meeting.

63 MINUTES

63.1 **Resolved** - That the minutes of the Joint Children & Young People Committee & Health & Wellbeing Board held on 3 February 2015, and the Health & Wellbeing Board held on 3 February 2015 be agreed and signed as a correct record.

64 CHAIR'S COMMUNICATIONS

Section 75 Children

64.1 The Chair reported that Sussex Community Trust and Children's Services currently had a Section 75 provider agreement in place in relation to the delivery of integrated services for children and young people. This meant that Children's Services had been operationally managing the delivery of community health services for children and young people. This included for example, Health Visitors, School Nurses, and Speech & Occupational Therapists. The agreement ceased at the end of March 2015. The agreement primarily related to the integrated service delivery at the council's Children's Centres and the council's service for disabled children based at Seaside View. The Local Authority and Sussex Community Trust had held a number of meetings to ensure that the services that children and their families received were not disrupted. They had agreed that the current arrangements would continue until October 2015, agreed through a local Memorandum of Understanding that was now being finalised. Children and their families should experience no change in the service that they received. Over the next six months Sussex Community Trust and the council would agree longer term arrangements for the delivery of these services. In the autumn, the council and Clinical Commissioning Group would be bringing the overall strategy for children's health and wellbeing to the Health & Wellbeing Board.

Child Sexual Exploitation

64.2 The Chair stated that Members of the Health & Wellbeing Board would be aware of the publicity associated with child sexual exploitation in areas such as Rochdale, Rotherham and Oxfordshire. Recently central government had also provided further guidance for agencies that were tasked with tackling this issue.

Child sexual exploitation was taking place in the city of Brighton & Hove and in every city across the country. Council, police and health staff within the city were working closely with each other to identify victims and potential victims, provide support for them and to pursue perpetrators of Child Sexual Exploitation (CSE). The Local Safeguarding Board had agreed to take overall responsibility for the oversight of agencies that were tackling CSE. Recent developments had included the following:

- A detailed analysis that sought to identify young people within the city who are vulnerable to CSE, those who are currently being exploited and patterns and trends across the city to identify 'hot spots'
- Training and awareness raising, including across the council's secondary schools
- The development of a dedicated Missing children/Child Exploitation Team based at the MASH (Multi-Agency Safeguarding Hub) who would work with the most complex CSE cases
- Work to identify boys and young men who are victims of CSE, a group where there is under-reporting both nationally and in Brighton & Hove

At the last Local Safeguarding Children's Board (LSCB) meeting it was agreed that in addition to the scrutiny that would be applied by the LSCB itself that an annual report on Child Sexual Exploitation would be presented to the Health & Wellbeing Board so that the health and wellbeing system as a whole had the opportunity to assure itself that this issue was being properly addressed. The report would be presented to the next meeting of the Health & Wellbeing Board.

64.3 Councillor Jarrett raised the issue of the sexual exploitation of young adults. He stressed that there were incidences where sexual exploitation continued beyond childhood and action needed to be taken in these cases. Denise D'Souza concurred and stressed that Adult Social Care worked with colleagues in Children's Services regarding this issue. She would also be raising the issue with ADASS (Association of Directors of Adult Social Services).

Proposed Change to the Corporate Parenting Board

64.4 The Chair reported that the Corporate Parenting Board was currently an Advisory Board reporting to Policy & Resources Committee. This arrangement was established in 2013 in order to ensure that the Council's duties as Corporate Parent retained a high profile. The role, scope and membership of the Health & Wellbeing Board had now been significantly developed and it was proposed that the Corporate Parenting Board should report to it. This would be consistent with the Children's and safeguarding functions of the Health & Wellbeing Board and would ensure that the council's Health Partners were able to be fully engaged in the commitment to improving outcomes for children in care and care leavers.

The Board would report to the Health and Wellbeing Board at least twice annually. The proposal would necessitate a change in the Policy & Resources Committee and Health & Wellbeing Board Terms of Reference. All members of the Health and Wellbeing Board would be supported with training to enable them to undertake this function.

Update on Eaton Place

64.5 The Chair reported on an NHS England update as of 19 March 2015. Further to the NHS England update on the 9 March 2015 they could confirm that out of the original 170 vulnerable patients identified by Eaton Place Surgery, only 20 did not register with an alternative GP surgery themselves and had therefore now been assigned to a new GP practice in order to guarantee their immediate access to care. This did not prevent these patients from choosing to register with another GP surgery subsequently, should they wish to do so.

All children classified as "at risk" had registered with a new practice.
NHS England was currently awaiting updated registration figures following the completion of the de-registration process but it was estimated that there were 1,200 remaining patients who had yet to register with another GP practice. This included 180 patients who had applied to register with the Brighton Health and Wellbeing Centre. These patients had all been notified by the Brighton Health and Wellbeing Centre that their practice was no longer in a position to open a branch surgery at Eaton Place and had been given the choice of either completing their registration with the Brighton Health and Wellbeing Centre, as an out of area patient, or registering with another local GP practice.

NHS England would be undertaking a review of the process undertaken to maintain patient care, as result of the Eaton Place Surgery contract coming to an end following the retirement of the two GP partners there. NHS England would ensure that any appropriate learning was identified and shared appropriately with stakeholders.

64.6 Graham Bartlett stated that he had regular contact with NHS England but it had been difficult to obtain figures on Child Protection Plans or children in need in terms of registration. The Local Safeguarding Children's Board was keen to ensure that these most vulnerable children in the city received continuous GP care. Mr Bartlett was now satisfied that was the case but felt that there were lessons to be learnt for the future. The Chair replied that a report would be submitted to the Health and Wellbeing Board in July on the lessons learnt from the surgery closure.

64.7 Frances McCabe asked if the review of the process carried out by NHS England could show the cost in terms of money and time that could have been used differently. Deborah Tomalin replied that there would be an analysis of the cost of the closure.

64.8 Councillor Norman asked if a copy of the Chair's Communications could be circulated to members of the Board. The Chair agreed to this request.

Councillor Kitcat's last meeting

64.9 Councillor Norman thanked Councillor Kitcat for his good work in chairing the Board fairly and honestly. He wished Councillor Kitcat well in whatever he chose to do in the future.

64.10 The Chair confirmed that this would be his last meeting as Chair of the Board. The fact that the Board was coming together as a body for consensus decision making was powerful and exciting. However, the outcomes for citizens must change. The Board must not only carry out decision making collectively but to provide accountability and scrutiny to all the services being provided for the health and wellbeing of the citizens of the city.

65 PUBLIC INVOLVEMENT

65.1 There was none.

66 REDUCING LATE DIAGNOSED HIV INFECTION

Introduction

66.1 The Board considered an approved Notice of Motion from Council and a report of the Director of Public Health which was provided in response to the Notice of Motion of 11th December 2014 on the HIV Diagnosis – Halve it campaign. The paper described HIV infection in Brighton and Hove and the current initiatives to reduce the numbers of people diagnosed late and living with undiagnosed HIV infection. The report was presented by the Lead Commissioner HIV and Sexual Health.

Questions and Discussion

66.2 Councillor Norman informed the Board that he had proposed the Notice of Motion. Councillor Norman was grateful for the detailed report and was happy with the recommendations. He stressed that the council must keep on pursuing this important work.

66.3 Councillor Jarrett mentioned that the Terrence Higgins Trust was carrying out very good work on this issue. He asked if it would be more difficult for Brighton & Hove to achieve the Halve it aims as it already had a lower late diagnosis rate than the national South East average. The Lead Commissioner HIV and Sexual Health agreed it would be harder for the city but stated that there was a determination to reduce late diagnosis further.

66.4 Frances McCabe noted that the figures for black women were high and she asked if there was specific work with this group. The Lead Commissioner HIV and Sexual Health explained that the Terrence Higgins Trust had a dedicated African HIV Worker who worked with community and faith groups. NICE guidance was that in areas of high prevalence, all men being offered a blood test and all African women who were offered a blood test in primary care should be offered opt out HIV testing. People in risk groups were also offered HIV testing.

66.5 **RESOLVED:**

(1) That the approaches being taken to reduce late diagnosed HIV infection be noted and supported.

67 JOINT HEALTH AND WELLBEING STRATEGY

Introduction

67.1 The Board received a verbal update from Dr Tom Scanlon, Director of Public Health on the development of the Joint Health & Wellbeing Strategy. He reported that he was encouraged by the work to date. Officers were looking at broad strategies and priorities and receiving feedback. There had been discussions on how the council would engage with the public. Information would be available in a web based form and a report would be submitted to the Board in the Autumn. Members would be kept updated as work progressed.

Questions and Discussion

67.2 The Chair remarked that the strategy had been discussed at Brighton and Hove Connected. He asked if there had been a great deal of outreach in relation to the strategy. Dr Scanlon confirmed that there had been a considerable outreach.

68 DEVELOPING ENHANCED HEALTH & WELLBEING GP SERVICES

Introduction

68.1 The Board considered a report of the Public Health Principal, the Interim Primary Care Transformation Lead, and the GP Lead for Primary Care Quality and Public Health, which briefed members on the work to develop and enhance primary care in the city. Members were invited to provide feedback and were asked to support the overall process. The report was presented by Nicola Rosenberg, Public Health Principal and Suzanne Novak, Interim Primary Care Transformation Lead.

68.2 The Interim Primary Care Transformation Lead stated that the objective with the transformation was to improve health outcomes. General practices were being

asked to work very differently. Contracts were being aligned with GPs to achieve universal coverage and equal access to all patients. There was a need to expand GP capacity. Not having enough doctors impacted on the health of patients. There were ambitious plans to attract high quality GPs and there would be an emphasis on prevention of premature mortality. There was a desire for doctors to be able to have dedicated time with children and young people. The result would be an improved patient experience in primary care.

68.3 The Public Health Principal stated that the contract was based on GPs working in clusters as set out in Appendix 1 of the report. This was a five year contract.

68.4 The Interim Primary Care Transformation Lead explained that there would be six clusters across the City. They would each have shared values and objectives. There would be a transition year from April 2015

Questions and Discussion

68.5 The Chair stated that the report was clear and the audit on mortality was very useful.

68.6 Pinaki Ghoshal considered that having GP clusters was the right approach. However, he stressed that over the last couple of years a great deal of work had been carried out with schools across the city to develop a cluster based approach. The clusters in the current report were not geographically based and did not bear much relationship to other clusters arrangements across the City. He asked if there would be an opportunity to look at the proposed clusters to see whether there were other ways for these groups to come together that fit in with other arrangements. The Interim Primary Care Transformation Lead agreed that this was a valid point. She stressed that the priority was for GP practices to deliver services in groups. They were being asked to find people they could work with. It was hoped that eventually they would develop relationships with schools and other services and realise it would make sense to be more geographically coherent. In the meantime it had to be recognised that GPs had patients registered with them from all round the city.

68.7 Councillor Morgan stated that he thought a patient could only register with a GP surgery in their locality. He referred to the GP Clusters map on page 42 of the agenda and noted that there were huge gaps city wide. For example, when Eaton Place surgery was taken out there was an enormous geographical separation between the GP surgeries in an area where there was high deprivation. Councillor Morgan asked how practically did the strategy impact on that area and how these concerns would be addressed. The Interim Primary Care Transformation Lead explained that although GPs covered their geographical area, patients sometimes moved out of the boundaries. Any patient could register with any practice if this was agreeable to both parties. Populations overlapped quite significantly. There were concerns about practices closing and officers were hoping to carry out

assessments of health outcomes and were trying to identify problems. GPs were working at cluster level to address gaps. There was a desire to attract more GPs into the area and address the problems Councillor Morgan highlighted.

68.8 Denise D'Souza also expressed concern that the boundaries of the GP clusters did not align with other clusters in the city. She asked if the funding for this work was different from the Better Care Fund funding. This was confirmed to be the case.

68.9 Geraldine Hoban stressed the importance of having a skill mix in terms of clusters. Clinical leadership was essential to deliver change. Additional GP capacity was essential. There were also other skill mixes that were needed in the clusters. With regard to boundaries Ms Hoban stressed the importance of starting work on looking how to sensibly align other community services with the emerging clusters. There could then be a sensible configuration for integrated services in the city. In the meantime, the willingness of GPs to work together was a huge step forward.

68.10 Councillor Jarrett stressed that the hardest thing to alter was the GP practice locations and where their core patients lived. Altering local authority provider services might be simpler than rearranging where GP surgeries were sited. It was inevitable that some boundaries did not match but there was a need to be clear about procedures.

68.11 Frances McCabe raised the issue of the variability of the service. As there were so many discrepancies already she asked how officers were going to make sure that there was a fair service provided for everybody in the city. The Interim Primary Care Transformation Lead replied that this question had been discussed at the CCG. She explained that the City was not in an ideal situation regarding inequalities of health, provision and capacity. There was a need to make inequalities more explicit through baseline assessments and through asking the clusters to self assess with regard to their structures and outcomes. Clusters would develop action plans to address this. The CCG would test action plans to see if value for money was being achieved and to see if it was a good return for the taxpayer. The CCG wanted to see transparency at every step of the process and wanted to see Clusters addressing some of these inequalities.

68.12 Tom Scanlon stated that GP practices working together was a step forward and a big change in primary care.

68.13 **RESOLVED:**

1) That it is noted that the paper presents the plans for developing a new way of commissioning enhanced services from GPs for discussion and feedback. The new commissioning approach will be about developing more proactive and integrated primary care organised around clusters of practices to start in all areas by April 2016. It is agreed that an update on the progress of the new contract will be brought back to the Health and Wellbeing Board in July 2015.

2) That it is noted that the new commissioning approach will require a new contractual relationship with GP's, the details of which are currently being developed. It is agreed that contract management will be carried out jointly between the CCG and BHCC.

69 PHARMACEUTICAL NEEDS ASSESSMENT - FINAL REPORT AND THE PROCESS FOR FUTURE PNAS AND SUPPLEMENTARY STATEMENTS

Introduction

69.1 The Board considered a report of the Public Health Principal which presented a final Pharmaceutical Needs Assessment (PNA) 2015 report and the process for future PNAs and supplementary statements for approval by the Health and Wellbeing Board. The report was presented by Nicola Rosenberg, Public Health Principal.

Questions and Discussion

69.2 Councillor Theobald mentioned that he had previously raised the issue of where people could find pharmacies out of hours. He asked if the current report addressed this issue. The Public Health Principal confirmed that this matter was addressed in the report. The online portal and individual pharmacies would provide this information. The link to the online portal could be found on the CCG, Argus and NHS Choices websites.

69.3 **RESOLVED:**

1) That the final Pharmaceutical Needs Assessment (PNA) 2015 report is approved.

2) That the process for supplementary statements is approved and that the Director of Public Health, working in consultation with the PNA Steering Group, is given delegated authority to identify and implement any future amendments to the PNA and to bring back a full revised PNA to the HWB in 2018.

70 BETTER CARE SECTION 75 POOLED BUDGET

Introduction

70.1 The Board considered a report of the Executive Director of Adult Services, and the Chief Operating Officer which reminded members that the Better Care Fund was announced in June 2013 and set out the expectation that the Clinical Commissioning Group and Local Authority have agreed plans and pooled budgets to oversee the plans. The funding was not new money but would need to demonstrate that it is meeting objectives of the plans. The Health and Wellbeing Board would be

responsible for overseeing the agreement. The report was presented by Denise D'Souza and Geraldine Hoban.

70.2 Denise D'Souza referred to paragraph 4.2 of the report which highlighted the work that was progressing in a number of areas. Paragraph 4.5 detailed the budgets aligned to these schemes. The total spend was £19.6m.

Questions and Discussion

70.3 The Chair emphasised that this was the first Section 75 for this service. It was a step on the journey for integrating health and social care. Denise D'Souza stressed that GPs were also involved not just nurses and social care.

70.4 Tom Scanlon welcomed the report. He drew attention to homelessness and hoped this was an area which could be picked up in the Health and Wellbeing Strategy. The city was seeing an increasing number of homeless people and there needed to be a strong stream of work linking not only to health and wellbeing but to housing as well.

70.5 Denise D'Souza stressed that as the Better Care pooled budget progressed more funding would be added. For example, she would like to see money allocated for housing support and community care added to the Better Care Fund Programme.

70.6 George Mack stated that pooled budget was a tremendous opportunity but he was concerned that the work was very rushed. He stressed the need for sufficient robust governance and scrutiny. He supported the proposals but felt that the there was a need to get mechanisms right to control and manage the process properly.

70.7 Frances McCabe referred to performance measures particularly in relation to non-elective admissions. She questioned how robust the figures were and asked how confident were officers that a reduction could be achieved? Geraldine Hoban explained that some performance measures had been provided, for example non-elective admissions metric was a national mandatory outcome. The reduction of 3.7% was considered achievable. The other performance measures were comparing the city against benchmarks with other areas. The City was benchmarked very high with residential admissions compared to other areas. Reablement was less robust as a measure as the baseline was very complicated. Officers were very clear that there needed to be a reduction with delayed discharges of care. A local measure had not yet been set for patient/service user experience. An outcome measure was required that was patient determined. Officers would report back to the Health & Wellbeing Board on the delivery of all the measures.

70.8 Denise D'Souza referred to reablement figures. The figures were complex and there were two sets of baselines and two sets of data collected. The figures were out of kilter but the city put more people through reablement than many other local

authorities. There was a need to differentiate between people who needed a short recuperation and those who needed more assistance.

70.9 Councillor Morgan referred to the patient metric. He stressed that members of the public would want to know what this meant for them and their families in terms of how they measured progress, & how they interacted with the services. How would officers interact with the acute trusts and the mental health trust? Dr Christa Beasley replied that this was a valid point. There needed to be a difference to patients and their families. There needed to be a change in hospital care both in the acute trust and within the mental health trust. This was not part of the Better Care Fund plans yet but was part of the CCG plans.

70.10 **RESOLVED:**

1) That it is noted that the requirement that the Better Care Fund is operated as a pooled budget between the Clinical Commissioning Group (CCG) and the Council and that the mechanism for establishing a pooled budget, is through entering into a Partnership Agreement under Section 75 NHS Act 2006.
2) That the Executive Director Adult Services and CCG Chief Operating Officer are authorised to finalise and agree a new Section 75 Partnership Agreement between the Council and the Clinical Commissioning Group relating to the commissioning of health and social care services from a pooled Better Care Fund.
3) That it is noted that the Section 75 Agreement referred to paragraph 3.2 in the report will include the schemes and schedules as detailed in the body of the report and will take effect from 1st April 2015 with a three year term and with provision to review the Agreement after 12 months.

71 EXPLORING OPTIONS FOR THE FUTURE OF COMMUNITY SHORT TERM SERVICES REHABILITATION BEDS

Introduction

71.1 The Board considered a report of the Commissioning Manager, Brighton & Hove CCG and the Commissioning Manager, Brighton & Hove City Council which explained that a new model was required for Community Short Term Services beds to meet the needs of people with high levels of complexity and dependency. The new model would have an outcomes based specification with clear lines of accountability. The proposal was to invite potential providers to put forward ideas/proposals of what the new model could look like. It would include how a potential provider could work with the CCG & the Council to deliver the service, and what role the interested party may see for themselves in the new model. The report was presented by Geraldine Hoban.

71.2 Geraldine Hoban explained that the total commissioning funding for 2014/15 was £4.615.

Questions and Discussion

71.3 Denise D'Souza welcomed the report. There was a need to have a more cohesive approach and to work in a different way with others.

71.4 Councillor Norman stated that he had seen a number of reports on this issue over a period of time. Each report was different which reflected the need to change. It was good to see this issue moving forward. He supported the proposals.

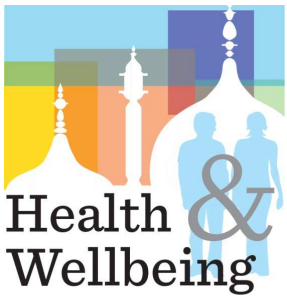
71.5 **RESOLVED:**

1) That approval is given for the Clinical Commissioning Group and the City Council to undertake preliminary engagement with potential providers of care to explore a new model of care in partnership.

The meeting concluded at 5.13pm

Signed Chair

Dated this day of



WRITTEN QUESTIONS

The following written question has been received from Mr. K. Kirk

"Board members will have seen an Argus article[1] about syringe needles in the toilet at the Level. I have heard recently of a case of a little girl injuring herself on a syringe needle in Queens Park. This coincides with the outsourcing of the Substance Misuse Service to Cranstoun/Surrey Borders NHS Trust, in particular, the fact the needle exchange venue has now moved location and the additional services that were offered to clients has new ceased. Apart from the need for the Council to safeguard children playing in Brighton and Hove parks –

a) How does the Council monitor the performance of the new SMS provider?

b) Are there any clauses in the new contract to take account of a degradation of the service? For example, is there a clause in the contract that can enforce the Council taking the service in-house following clear service failure?

c) The SMS service was exemplary and despite advice the Council went ahead with outsourcing. Will the Council take heed that, despite the promises made by alternative providers, outsourcing is so often followed by service inadequacy?"

1. http://www.theargus.co.uk/news/13328135.Mother_s_horror_at_needles_found_in_toilet_block_near_children_s_playground/

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1. Ethical Care Charter – Notice of Motion

1.2 Who can see this paper?
The paper is available to all members of the public.

1.3 21st July 2015.

1.4 Author of the Paper and contact details
Mark Wall, Head of Democratic Services
Tel. 01273 291006
mark.wall@brighton-hove.gov.uk

2. Summary

2.1 To consider the notice of motion referred from the Council meeting held on the 30th January 2014 detailed below; along with the briefing paper from the Executive Director for Children's Services (appendix 1).

3. Decisions, recommendations and any options

2.1 To note the action being taken to provide a future arrangements for the commissioning of care.

4. Relevant information

NOTICE OF MOTION

ETHICAL CARE CHARTER

"This council resolves to recommend the Adult Care and Health Committee to sign up to UNISON's Ethical Care Charter setting minimum standards to protect the dignity and quality of life for people who need homecare.

The charter will commit Brighton and Hove City Council to commission care solely from providers who:

- Give workers the freedom to provide appropriate care and be given the time to talk to their clients.
- Allocate clients the same homecare worker(s) wherever possible.
- Do not use zero hour contracts.
- Pay the Brighton and Hove Living Wage rate of £7.65 an hour
- Match the time allocated to visits to the particular needs of the client. In general, 15-minute visits will not be used as they undermine the dignity of the clients.
- Pay homecare workers for their travel time, their travel costs and other necessary expenses such as mobile phone use.
- Schedule visits so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time.

Supporting Information:
In December 2013, the London Boroughs of Islington and Southwark were the first Local Authorities in England to sign up to the Ethical Care Charter

http://www.unison.org.uk/content/conNewsArticle/4616

5. Supporting documents and information

Appendix 1 – Briefing paper from the Executive Director for Adult Social Care.

The Charter

1.1 The charter will commit Brighton and Hove City Council to commission care solely from providers who:

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- Do not use zero hour contracts.
- Pay the Brighton and Hove Living Wage rate of £7.65 an hour
- Match the time allocated to visits to the particular needs of the client. In general, 15-minute visits will not be used as they undermine the dignity of the clients.
- Pay homecare workers for their travel time, their travel costs and other necessary expenses such as mobile phone use.
- Schedule visits so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time.

Current Arrangements

2.1 The current home care contract is due to end by June 2016 and initial planning for the re-tender has begun. There are 12 home care providers on the current framework working in postcode areas across the city. An additional 6 providers were added on an approved providers list to increase capacity for home care in 2014.

2.2 Some aspects of the Ethical Care Charter are already included in current contractual arrangements:

I. Allocation of home care workers to maintain continuity for clients:

The current contract specifies that Providers must make every effort to ensure consistency for all service users by minimising the number of care workers employed to meet the needs of a single service user. This is monitored through various quality monitoring arrangements, including a specific performance Indicator that is measured using the Electronic Care Monitoring System to check that the number of care workers that have been sent to individuals are within an acceptable range for the intensity of the care package.

II. *Schedule visits so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time.*

Quality Monitoring arrangements include asking service users about their experience of care delivery including whether they feel rushed by their care workers. The contract monitoring process includes checking how the service is planned to ensure that adequate travel time is planned into the care workers rota and that service users receive the correct amount of time to meet their needs as described within their care plan.

III. *In general, 15-minute visits will not be used as they undermine the dignity of the clients.*

Approximately only 8% of all home care visits in Brighton and Hove are delivered in 15 minute blocks.

These visits are usually to provide a brief visit to support with medication or to make a hot drink before bed; they are not expected to be used for more intensive personal care tasks which require at least 30 minutes or longer depending upon individual needs.

IV. *Pay homecare workers for their travel time, their travel costs and other necessary expenses such as mobile phone use.*

Currently the Council does not make a separate provision for travel costs (mileage or time) for care workers however the set rate paid to providers for the current contract was determined through use of a care cost calculator which included a supplement to providers in recognition of travel time between calls and some providers pass this on to the care workers.

V. *Pay the Brighton and Hove Living Wage rate of £7.65 an hour*

At the time of the last tender in 2011 bidders were required to complete a cost evaluation as part of the tender process. Those providers who indicated that they paid more than the Local Living Wage received a higher score in the evaluation process.

Future arrangements

4.3 Planning for the new home care tender has already begun.

The new specification will be more out-come focussed with a much stronger requirement for providers to work with service users to design a support plan that will meet their needs in a flexible way.

4.4 This means that Adult Social Care is moving away from commissioning
Time and Task based services, hence there will no longer be a need to commission 15 minute calls.
Some service users may prefer to retain 15 minute visits as part of their support planning and as long as the provider is in agreement that this is reasonable for their required care there is no problem with this but the Council will no longer commission care in 15 minute blocks, arrangements will be more flexible and client led.

4.5 Similarly, providers will be able to work with the service user to vary the time and length of visits to better accommodate the needs and preferences of the individual. Adopting a less prescriptive more flexible approach to care provision should enable service users to have more autonomy in their care planning and will reduce the need for care workers to rush between calls.

4.6 Use of Electronic Care Monitoring will remain a requirement of the new contract to enable continued monitoring of important aspects of care provision such as continuity, punctuality and effective scheduling.

4.7 BHCC's use of a care cost calculator in setting a fair rate to pay providers was identified by the Equalities and Human Rights Commission as an example of good practice and this approach will be adopted again with the addition of travel time, travel costs and mobile phone expenses.

4.8 The new contract will also ensure that providers must pay at least the minimum living wage to their care workers.

4.9 In recognition that there will need to be a period of transition for some providers to move to fixed hour contracts there will be a requirement that at least a proportion of hours that are commissioned will be offered to care workers on fixed hour contracts and that Zero hours contracts will be phased out over time, unless specifically desired by care workers.

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1. Time to Change Pledge – Notice of Motion

1.2 Who can see this paper?
The paper is available to all members of the public.

1.3 21st July 2015.

1.4 Author of the Paper and contact details
Mark Wall, Head of Democratic Services
Tel. 01273 291006
mark.wall@brighton-hove.gov.uk

2. Summary

2.1 To consider the notice of motion referred from the Council meeting held on the 26th March 2015 detailed below;

3. Decisions, recommendations and any options

2.1 To determine whether any action should be taken in light of the notice of motion.

4. Relevant information

NOTICE OF MOTION

TIME TO CHANGE PELDGE

"This Council believes that mental health should be given equal priority with physical health as outlined in the government's mental health strategy implementation framework.

This Council resolves:

(a) To support Time to Change, the mental health anti-stigma campaign;

(b) To request that the Health & Wellbeing Board explores the adoption of the Time to Change pledge, better workplace practices and encourage others to do so as well."

Supporting information:

Mental health is an important part of wellbeing at work. The huge cost of mental health problems to employers is widely recognised and currently estimated at £1,035 for every employee in the UK. One in four people will experience a mental health problem in any given year. Nine out of ten people with mental health problems have experienced stigma and discrimination. Understanding is now growing that the fear of stigma and discrimination inhibits many employees from disclosing their problems and seeking help.

Time to Change is England's biggest campaign to end the stigma and discrimination faced by people with mental health problems. The campaign is run by the charities Mind and Rethink Mental Illness, and funded by the Department of Health, Comic Relief and Big Lottery Fund. It aims to work with all sectors and communities to encourage more open conversation about mental health and ensure that people with mental health problems can be equal and active citizens.

Time to Change combines a national campaign with community activity. It funds grassroots anti-stigma projects through its grants scheme, and supports people with experience of mental health problems to become active social leaders. It also works with the media, a wide range of organisations, BME communities and children and young people. It has been running since 2007 and its work is proven to be having a positive impact on public attitudes as well as reducing the discrimination that people health problems face.

Health & Wellbeing

5. Supporting documents and information

6.1 Briefing update from Director of Public Health.

Update: July 2015 (Public health)

Organisations are able to make a pledge to support Time to Change. This involves submitting an action plan describing our approach to tackling stigma and discrimination linked to mental health issues in the workplace. The action plan needs to address the following aspects of commitment by the organisation[1]:

1. Senior level buy-in
2. Accountability
3. Mental health policy
4. Peer support
5. Lived experience leadership
6. Social contact
7. Raising awareness
8. Mental health literacy
9. Support tools

Once our action plan is approved by Time to Change, we will be invited to sign up formally at a high profile event of our choosing.

We began work on an action plan in the autumn of 2015, following a commitment to do so in the Happiness: Brighton & Hove Mental Health and Wellbeing Strategy. This strategy is jointly owned by the Council and CCG. However, Time to Change was unable to commit resources to support organisational pledges between November 2014 and the end of June 2015. The opportunity to do so was offered again at the start of July 2015.

We will be developing an action plan as soon as possible.

Local authorities that have already pledged support for Time to Change in the South East are: Oxford City Council, East Sussex County Council, Kent County Council and Surrey County Council.

[1] https://www.time-to-change.org.uk/employer-pledge-faq

1. The Extension of Smoke-Free Spaces

1.1. The contents of this paper can be shared with the general public.

1.2. This paper is for the Health & Wellbeing Board meeting on the 21st July 2015.

1.3. Author of the paper and contact details:

Roy Pickard, Environmental Health Manager
Email: roy.pickard@brighton-hove.gcsx.gov.uk
Phone: 01273 292145

2. Summary

2.1. This paper discusses the health advantages and practicalities of extending smoke-free spaces in Brighton & Hove to include the city's parks and beaches.

2.2. Over the last twenty years, more and more Brighton & Hove residents have chosen to give up smoking or avoid beginning in the first place. However, smoking is still one of the city's leading causes of premature death and health inequalities, putting pressure on the NHS and causing needless suffering and distress.

2.3. To promote health and wellbeing it is vital that the City Council and its partners support healthy lifestyle choices and the extension of smoke-free spaces aims to do this.

3. Decisions, recommendations and options

3.1. For the Board to agree to a public consultation on extending smoke-free spaces to include parks and beaches, to gauge public support and to decide the design of the scheme.

4. Relevant information

4.1. According to the 2013 Household survey, smoking prevalence in Brighton & Hove is 25.2%, which is above the England average. Smoking rates are much higher amongst routine and manual workers and in Brighton & Hove the same survey showed that the prevalence in this group in Brighton & Hove is 36.3% compared to 35.7% in Portsmouth.

4.2. Smoking is the primary cause of preventable illness and premature death in the United Kingdom, accounting for over 80,000 deaths a year. Smoking harms nearly every organ of the body and dramatically reduces both quality of life and life expectancy. Smoking causes lung cancer, respiratory disease and heart disease as well as numerous cancers in other organs including the lip, mouth, throat, bladder, kidney, stomach, liver and cervix

4.3. Workplaces and substantially enclosed public areas in England have been smoke-free by law since July 2007. Smoke-free legislation in England forms part of the Health Act 2006. This means that it is against the law to smoke in the indoor parts of places such as pubs, bars, nightclubs, cafes and restaurants, lunchrooms, membership clubs and shopping centres.

4.4. The Children and Families Act 2014, which gained Royal Assent on 13 March 2014, allows Regulations to be made forbidding anyone from smoking in a car when children are present. The Smoke-free (Private Vehicles) Regulations 2015 have now been enacted and the measure begins on 1st October 2015 and will be enforced by the police and the Local Authority.

4.5. The Government's Tobacco Control Plan for England published in March 2011 states: "Local communities and organisations may also wish to go further than the requirements of smoke-free laws in creating environments free from second hand smoke, for example in children's playgrounds, outdoor parts of shopping centres and venues associated with sports and leisure activities. Initiatives such as these can also help to shape positive social norms and discourage the use of tobacco".

4.6. Second-hand smoke is particularly dangerous for children. Children exposed to passive smoke are at higher risk of respiratory infections, asthma, bacterial meningitis and cot death. Second-hand smoke has been linked to around 165,000 new cases of disease among children in the UK each year.

4.7. Children become aware of cigarettes at an early age. Three out of four children are aware of cigarettes before they reach the age of five, irrespective of whether or not their parents smoke[1]. Additionally, if young people see smoking as a normal part of everyday life, they are more likely to become smokers themselves[2]. It is estimated that second-hand smoke kills over 12,000 people every year in the UK from lung cancer, heart disease, stroke and the lung disease, Chronic Obstructive Pulmonary Disease (COPD).

4.8. A number of surveys have been carried out to understand people's attitudes towards smoking. One survey carried out in America in 2008 found that 88% of people believe that second-hand smoke is harmful to those who inhale it in outdoor areas, whilst 65% had been bothered by second-hand smoke exposure in outdoor areas in the previous year.

4.9. A 2014 YouGov survey found that 93% of people were aware that exposure to second-hand smoke has a negative impact on the health of both children and adults. The same survey found that 85% of people were aware that exposure to second-hand smoke increased the risk of a heart attack in adults.

4.10. A separate survey carried out in 2014, by ASH Scotland, found 74% agreed that smoking in children's play areas should be banned.

4.11. Brighton & Hove is developing a plan for promoting no smoking in certain outdoor areas and this was included in the first Joint Health and Wellbeing Strategy. The City currently has a voluntary ban on smoking in children's playgrounds. Currently 42 children's play areas have this voluntary ban. The extension of this ban is a logical progression.

4.12. Councils across the country are extending smoke-free spaces. The London Health Commission has recommended that all Royal Parks should become smoke-free and byelaws covering Parliament Square Gardens and Trafalgar Square should be amended to make them smoke-free. However, the London Mayor responded to this saying that he "was not in favour of measures that cross over into bossiness or nannying such as a smoking ban".

4.13. In 2012 Caerphilly Council banned smoking in 100 play areas as a result of a campaign called 'Young Lungs at Play', which was led by the local youth forum. Both Islington and Ealing Borough Councils have also introduced smoke-free playgrounds. Blackpool NHS,

backed by the local council, introduced a voluntary smoke-free ban in 13 parks and open spaces in 2012, and extended it in 2014, to help prevent children taking up smoking.

4.14. In Bristol, two busy harbour side squares became smoke-free zones in February 2015. Millennium Square and Anchor Square in Bristol, which are popular family destinations and often host cultural events, have been turned into voluntary cigarette-, cigar- and pipe-free areas. No formal enforceable ban has been imposed, but 11 signs dotted around the squares ask smokers not to light up and thank people for helping "keep Bristol smoke-free, healthy and clean".

4.15. The Scottish Government Tobacco Control Strategy requires local authorities to ban smoking around their buildings and grounds by 2015 and ordered them to examine where else this prohibition could be extended. Local authorities have been asked to focus on outdoor areas likely to be frequented by children, such as play areas and public parks, so that youngsters are not exposed to smoking behaviours outside.

4.16. Manchester City Council explored prohibiting smoking in their parks, however, in 2014, the leader of the council said that such a ban was unenforceable and too costly.

4.17. Internationally, smoke-free spaces have been successfully extended:

- **Canada:** The Vancouver Board of Parks and Recreation approved a smoking ban in the city's parks that came into effect on 1st September 2010, prohibiting smoking on 18km of the city's park beaches.
- **United States:** There are 232 local municipalities in 25 American states with 100% smoke-free beaches, excluding those with designated smoking areas[3]. This includes 56 in California and 39 in Maine's state park beaches. New York City recently signed a bill that prohibits smoking within the city's parks, beaches, and pedestrian plazas. The bill came into effect on 23rd May 2011 and includes 35 beaches covering 14 miles of the city.
- **Australia:** In the state of New South Wales, 5 city councils have smoke-free beaches, including Sydney's famous Bondi and Manly beaches. State-wide restrictions are in place in Queensland and Western Australia.
- **Hong Kong:** Outdoor smoking restrictions were introduced in 2007, banning smoking at public bathing beaches as well as a variety of other outdoor settings.

- **Italy:** The Veneto Region has created a smoke-free initiative, "Breathe by the sea", in the town and beach resort of Bibione. This scheme aims to promote healthy behaviour and preserve the health status of individuals and communities. It also aims to promote the protection of the environment, launch sustainable tourism in rural areas, position this particular recreational area as an area for healthy holidays and promote physical activity.
- **China:** In 2011, smoking was banned in all public spaces nationwide, including in hotels and restaurants. Recently, new rules came into effect that increased fines for breaking this law. Repeat offenders are named and shamed on a government website. The new law also cracks down on tobacco advertising across Beijing.

4.18. Opposition to extending smoke-free areas predominately comes from pro-tobacco groups. Their argument usually center on it being an attack on personal freedom.

5. Important considerations and implications

5.1. Legal

The control of smoking is under the remit of the Health Act 2006. The Act sets out a definition of which premises are to be included and what constitutes a criminal act. Section 4 allows for provision of additional designations as to what should be smoke free. Currently smoking in outdoor spaces is not covered under the Act. Consequently any restrictions on smoking in parks, beaches or other outdoor spaces will be voluntary and not be a criminal offence.

Lawyer: Simon Court Date: 9 July 2015

5.2. Finance

The costs of the consultation will be approximately £1500, with the majority being spent on publicising the consultation. This will be met from within existing budget resources.

Finance Officer consulted: Michael Bentley 19 June 2015

5.3. Equalities

Smoking is the greatest cause of health inequalities and premature mortality.

5.4. Sustainability

- Decrease cigarette litter such as cigarette butts, empty packets and wrappers to make areas more pleasant and to protect wildlife.

- To offer the potential for increased use of parks/open spaces and areas of the beach as they become more attractive places to visit.

5.5. Health, social care, children's services and public health

- Reduce child exposure to smoking and help with the de-normalisation of smoking. This in turn may mean children are less likely to start smoking.

- Reduce the risk of children putting toxic cigarette butts into their mouths.

- Reduce the risk of exposure to second hand smoke which will be beneficial to the health of all but in particular to children as second hand smoke will still linger even in open air.

- Reduce fire risk

6. Supporting documents and information

[1] Office for National Statistics (2013) 'General Lifestyle Survey Overview: A report on the 2011 General Lifestyle Survey'.

[2] Cancer Research UK (2013) 'Childhood smokers'. Available at: www.cancerresearchuk.org/cancerinfo/cancerstats/types/lung/smoking/#children

[3] American Nonsmokers' Rights Foundation (2015) 'Municipalities with Smokefree Beach Laws'. Available at: http://www.no-smoke.org/pdf/SmokefreeBeaches.pdf

The Health Act 2006.

The Government's Tobacco Control Plan for England (2011).

Office for National Statistics Household Survey 2013.

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Title of the paper
Public Health Nursing Commissioning Strategy

1.1. The contents of this paper can be shared with the general public.

1.2. This paper is for the Health & Wellbeing Board meeting on the 21st July 2015.

1.3. Author of the Paper and contact details
Lydie Lawrence, Public Health Programme Manager, Brighton & Hove City Council, Kings House, Grand Avenue, Hove BN3 2SL.
Lydie.lawrence@brighton-hove.gov.uk

2. Summary

2.1 The purpose of this paper is to outline a Public Health Nursing commissioning strategy for the delivery of the Healthy Child Programme 0-19 Years. From October 2015 the responsibility for commissioning Public Health services for children aged 0-5 years will transfer from NHS England to the Council. The existing services supporting the delivery of the Healthy Child Programme included in this report are:

- Health visiting service (for children aged 0-5);
- Family Nurse Partnership (FNP- a targeted service for first time pregnant mothers under the age of 19);
- Breastfeeding support service (Peer Support Programme; targeted work in areas of inequalities);
- School nursing service (for children aged 5-16).

Currently the services commissioned by the Council to support the delivery of the Healthy Child Programme (set out in the 3rd and 4th bullet points above) are delivered under a contract with Sussex Community Trust (SCT) which expires in October 2016. The health visiting and FNP services are delivered under a contract between NHS England and SCT which will transfer to the Council fromOctober 2015 and which, without extension, would come to an end on 31st March 2016.

Public Health are proposing that the services delivered under these arrangements are combined and commissioned under one Public Health Nursing contract from 2017/2018. This will require extension of the current contracts to 31st March 2017.

3. Decisions, recommendations and any options

3.1 That the Health & Wellbeing Board note the proposed Public Health Nursing commissioning strategy and authorise the extension of the above contracts with SCT until 31st March 2017.

4. Relevant information

4.1 Responsibility for commissioning health visiting services will transfer from NHS England to Local Authorities on 1st October 2015. In Brighton and Hove NHS England will transfer the commissioning responsibility to the Public Health Directorate. The transfer will include the commissioning of the FNP. The universal health visitor reviews will be mandated from the point of transfer, which means that Public Health must ensure each of the following universal reviews is implemented:

- Antenatal health promotion visit
- New baby reviews by 14 days
- 6-8 week assessment
- 12 month assessment
- 2 to 2.5 year old review

The health visiting and the FNP contract has a 12 month termination period and would come to an end on the 31st March 2016 if it is not extended. Public Health will not give notice to the provider immediately post transfer to ensure the service can meet the mandated universal elements.

Responsibility for commissioning the school nursing service was transferred to Public Health in the Council on 1st April 2013*.

Since then Public Health, in partnership with Children's Services have led a transformation of the service to ensure a delivery at universal as well as at targeted levels. There are now universal health reviews at school entry and at the key transition stage from primary to secondary school. Another universal contact is being developed at mid-teen when young people are embarking on the next transition stage. There is currently an extension to the existing contract until October 2016. A further extension is required until 31st March 2017.
* Currently there isn't a universal Public Health service for young people aged 16-19 in Brighton and Hove. The school nursing service stops at the end of secondary education. Public Health are scoping what a service or programme might look like for this age group. For example a Public Health College Programme could be developed in partnership with sixth forms and colleges to support the health and wellbeing of young people. The voice of young people will be essential in the design of a service or programme.

Public Health have commissioned breastfeeding support work since 2010.
Public Health fund the FNP under a contract currently held by NHS England as part of the health visiting contract.

Being contracted to deliver the health visiting, FNP, school nursing and breastfeeding services under the contracts outlined above, Sussex Community Trust (SCT) also work in partnership to deliver these services through a Memorandum of Agreement with Brighton & Hove City Council Children's Services.

4.2 There is a strong rationale for commissioning these services together for the provision of the Healthy Child Programme:

- Allow for stronger integration of the services, including the creation of a seamless pathway of support for children from birth;
- Ensure a seamless transfer of care and support for children and their families from early years to school;
- Enable the implementation of web and mobile technology working supported by appropriate infrastructure, information systems and governance in order to improve communication and access to the services;
- Allow for a shared-management structure for services;
- Enable to review the delivery model of these services more effectively and ensure they provide value for money.

4.3 **Commissioning process for combined services**

A benchmarking exercise was conducted by the Public Health Intelligence team to assess how the value of the health visiting services compares with other local authorities and whether these offer value for money in Brighton and Hove. Brighton and Hove was broadly comparable with statistical neighbours.

A market testing will be conducted in November 2015 by issuing a notice to potential providers. Testing the market will enable us to find out how many providers may be potentially interested.

An options appraisal exercise will be conducted once the market testing has taken place. A report will be produced to outline the options appraised, the benefits and risks associated with each option.

5 Important considerations and implications

5.1 Legal

The Health and Social Care Act 2012 provides for the transfer of the statutory responsibility for commissioning Public Health services for children aged 0-5 years to the Council from NHS England from 1st October 2015. This will involve the novation of the current contract between NHS England and SCT for the delivery of health visiting services, which is due to expire in 2016.

The proposal to extend the contract to 2017 amounts to a modification for the purposes of the Public Contract Regulations 2015 and given that the extension does not fall within one of the categories of modifications that can be made without a new procurement procedure, there will need to be publication of a contract notice relating to the proposed extension.

Lawyer: Natasha Watson Date: 9 July 2015

5.2 Finance

Value of the contracts:
Health visiting contract: £4,191,200
Family Nurse Partnership contract: £290,000
School nursing contract (including delivery of National Child Measurement programme): £1,037,383

Breastfeeding support work contract: £51,000

Total value per annum of the above contracts with SCT= £5,569,583

As referred to in the main body of the report the health visiting contract will transfer to Public Health on 1st October 2015. The Department of Health have advised that the funding to be transferred will be £2.111m (October 2015 to March 2016), which includes an amount of £0.015m for commissioning. The cost of the existing contracts has been budgeted for against the ring-fenced Public Heath grant for 2015-16.

The cost of the proposed extension is £5.570m (as set out above) and it is anticipated that this will be met from within resources allocated by the Department of Health in 2016-17. It should be noted that final allocations will be dependent on the amount of funding announced for Public Health in the 2015 Spending Review

Combining the commissioning of the contracts as outlined in this paper will ensure value for money as well as contribute to savings through shared-management structure between the combined services and will help inform future budget strategies.

Finance Officer: Michael Bentley Date: 9 July 2015

5.3 Equalities

Consideration for equalities and the reduction of health inequalities are explicit in the service specifications and integral to the delivery of the services. The Public Health universal services are delivered with a scale of intensity proportionate to the level of needs experienced by certain population groups including those needs arising from their protected characteristics.

5.4 Sustainability

There are no direct implications for sustainability. The Healthy Child Programme services aim to promote good health and wellbeing for children, young people and their families and so can contribute to the city's One Planet principle of Health and Happiness.

5.5 Health, social care, children's services and public health

These considerations are integral to the Public Health services outlined in this paper

6. Supporting documents and information

There are no supporting documents.

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Formal details of the paper

1.1. Response to Child Sexual Exploitation (CSE) within Brighton & Hove

1.2 *Who can see this paper?*
The report is available to all members of the public.

1.3 *21st July 2015*

1.4 *Author of the Paper and contact details*
Pinaki Ghoshal
Executive Director of Children's Services
Brighton & Hove City Council

2. *Decisions, recommendations and any options*

2.1 That the Board is assured that there is a robust and developing response to CSE within Brighton & Hove.

3. Relevant information

3.1 Over the last two years there have been positive developments across Brighton & Hove to tackle child sexual exploitation. This is in the context of significant national publicity and concern about the issue and questions locally about the responses within the city. Ofsted's inspection of Brighton & Hove City Council's services for children in need of help and protection, children looked after and care leavers (May 2015) noted that "work to identify and address child sexual exploitation is well established, of good quality and has

strong levels of multi-agency engagement. As a result, actions to protect young people from sexual exploitation are prompt and comprehensive." This paper provides a summary of what partners across the city have been doing thus far, and an update on the leadership and governance arrangements in place.

3.2 **Current actions to address CSE in Brighton & Hove**

3.3 In February 2014 Sussex Police undertook a strategic profile of CSE across Brighton & Hove, East and West Sussex. Operation Kite, launched in May 2014, is a Sussex police initiative around the reporting and identification of children and young people who are at risk of CSE across East and West Sussex and Brighton and Hove.

3.4 The LSCB provides free training around CSE to professionals working with children across the city. This training is provided by WiSE, who have over the past 6 months, been commissioned to deliver CSE awareness and recognition training to all children's social workers in the city.

3.5 Children's Services commissioned Alter Ego theatre company to perform 'Chelsea's Choice', an acclaimed play which highlights the serious and emotional impact of CSE, in the city's high schools during March 2015. Further performances are scheduled for July 2015 and all performances are supported by specialist social workers and police officers, to ensure that children are in receipt of appropriate supports and services afterwards.

3.6 A data mining exercise has been undertaken to explore patterns and trends around CSE across the city, so that 'hot spots' can be identified and appropriate supports put in place. Using the warning signs and vulnerability indicators developed by the Office of the Children's Commissioner and cross referencing with data available from children's social work, schools, and the Youth Offending Service, those young people with 4 or more indicators of CSE have been identified. In addition to testing the reliability of the current identification process, this data trawling will assist in highlighting those young people who might otherwise not be known in the context of CSE to statutory service.

3.7 Following the success of seconding a senior social worker to a police operation into CSE, in February 2015 Children's Services launched a specialist Missing and CSE team which is co-located at the Multi Agency Safeguarding Hub. This team works with the most complex children and young people identified as either persistently missing and/or at high risk of CSE. The team take an assertive outreach

approach to their work with young people, in recognition that this cohort can be some of the most difficult children and young people to engage.

3.8 Brighton and Hove has joined with Oxfordshire and Sandwell in a research project commissioned by the Office of the Children's Commissioner to evaluate the effectiveness of the 'Hear Me, See Me' CSE framework that they have developed. This is an opportunity for partner agencies to reflect on local responses to CSE and consider any learning from other areas.

3.9 Sussex Police have developed a Pan-Sussex Domestic Violence and Sexual Abuse Executive Group to have overall oversight of a range of issues across the police area, including CSE.

3.10 The identification of boys and young men who are victims of CSE is thought to be nationally under-reported. Within Brighton & Hove a task and finish group has been established with partners from across both statutory and voluntary sectors to devise ways of working together to improve early identification and prevention to this cohort of young people. The work of this group will feed into the Prevent and Identification CSE Group which is responsible for co-ordinating the multi-agency response to early identification and prevention of CSE within Brighton & Hove.

3.11 **Strategic oversight & governance arrangements**

3.12 Strategic governance and leadership of CSE has recently moved from the VAWG Board to the LSCB. An LSCB sub-committee, the CSE & Vulnerable Children's Strategic Group, monitors and challenges the work across the City in respect of CSE and other groups of vulnerable children.

3.13 Operational groups focused on prevention and the pursuit of perpetrators and early identification and support are established - the CSE Protect & Pursue Group and the CSE Prevent & Identification Group. Specific cases are discussed at a monthly Multi-agency CSE Meeting which works closely with the CSE Protect and Pursue Group.

3.14 Currently Sussex Police and Children's Services commission WiSE to provide additional support for the victims of CSE. There needs to be an agreed approach to commissioning such support in the future. Following the establishment of the MASH and its steering group which includes Children's Services, Sussex Police and the CCG it is felt that rather than developing a new commissioning mechanism that this existing group could provide leadership here.

4. *Important considerations and implications*

4.1 Legal

Child sexual exploitation is the sexual abuse of children and as such public agencies across the city must work together to identify when it is happening, offer protection to the young people involved, support the victims and their families, and use all available powers to address it and pursue the perpetrators. Those powers can include civil powers by way of injunctions, court proceedings to ensure the child is removed to a safe place, powers to use the licensing regime to ensure unsuitable people are not in a position of trust, as well as pursuing perpetrators via the criminal justice system. The fact that a young person has reached the legal age of consent to sexual intercourse does not mean that they should not be taken as risk of sexual exploitation, and they are still defined as children for the purposes of the duties to promote the well being of children and protect them from significant harm under the Children Acts 1989 and 2004. Agencies should be familiar with the 2009 statutory guidance relating to safeguarding children from sexual exploitation. Local Safeguarding Children Boards (LSCBs) are responsible for ensuring that appropriate local procedures are in place to tackle child sexual exploitation. All frontline practitioners need to be aware of those procedures (including ones for early help) and how they relate to their own areas of responsibility. LSCBs and frontline practitioners should ensure that actions to safeguard and promote the welfare of children and young people who are sexually exploited focus on the needs of the child.

4.2 Finance

With reference to the recommendation of the report it should be noted that Children's Services currently budget for a specialised Missing and CSE team co-located in the Multi Agency Hub. The 2015-16 budget of £134k funds 1 full time Practice Manager and 2 full time Social Workers. Any and all costs attributable to the initiatives highlighted specifically in paragraphs 3.4, 3.5 and 3.6 and generally within the body of the report will be met from existing LSCB and Safeguarding budgets.

In the context of this report it should be noted that the Children's Social Work teams are currently under significant pressure with a

marked increase in the number of referrals. Consequently, at this time, we are anticipating an overspend in the region of £1.2m across this service area.

5 Supporting documents and information

None

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Formal details of the paper

1.1. Extract from the proceedings of the Housing & New Homes Committee meeting held on the 17th June 2015.

1.2 Who can see this paper?
The extract is available for all members of the public.

1.3 21st July 2015

1.4 Caroline DeMarco, Democratic Services Officer
Tel. 01273 291063
caroline.demarco@brighton-hove.gov.uk

2. Summary

2.1 The report from the Housing & New Homes Committee has been referred to the Health & Wellbeing Board for information together with an extract of the proceedings of the meeting.

3. Decisions, recommendations and any options

3.1 That the Health & Wellbeing Board note the report and comments referred for information from Housing & New Homes Committee.

4. Relevant information

4.1 Minute extract from the Housing & New Homes Committee meeting:

BRIGHTON & HOVE CITY COUNCIL

HOUSING & NEW HOMES COMMITTEE

17 JUNE 2015

MAIN MEETING ROOM – THE FRIENDS MEETING HOUSE

Present: Councillor Meadows (Chair) Councillors Hill (Deputy Chair), Mears (Opposition Spokesperson), Gibson (Group Spokesperson), Atkinson, Barnett, Lewry, Miller, Moonan and Phillips.

PART ONE

9. HOUSING ADAPTATIONS SERVICE UPDATE:

9.1 The Committee considered the report of the Executive Director Environment, Development and Housing which provided an update on the Housing Adaptations Service out-turn for 2014/15 including DFG investment in private sector housing and Housing Revenue Account (HRA) funded adaptations to Council homes. The report was presented by the Head of Housing Strategy Development and Private Sector Housing, and the Operations Manager.

9.2 Councillor Barnett requested that ward councillors who had been dealing with residents should be kept informed about works that would be carried out and not carried out. The Operations Manager replied that Access Point carried out the initial assessment. Housing Services was only involved after that stage. In some cases Access Point might trial equipment before providing more items. Any queries could be checked with the Major Adaptations Team.

9.3 Councillor Mears referred to paragraph 1.3 and stressed that savings could be made by keeping people in their own homes. Councillor Mears referred to paragraph 4.1 on page 39 (last bullet point) which stated that 'From 2009//10 to 2013/14, £0.666m in Private Sector Housing Renewal Assistance had been returned to the city council with 2013/14 showing the highest return with a total of £0.284m repaid. This was not currently recycled back into Private Sector Housing Capital Programmes.' Councillor Mears

asked for an explanation. Where did the money go? The Chair asked for a written response to be sent to Members.

9.4 Councillor Moonan endorsed the importance of the Disabled Adaptation Budget. The pressure to delay grants was counter intuitive. She asked if there were ways of assessing need. The Operations Manager replied that there were ways of assessing need and officers were not delaying approval of grants. There had been discussions with contractors and there had been some positive responses from a number of them. For example, there was the option of working and being paid later. Critical cases were being prioritised so there was no delay on site.

9.5 Councillor Miller echoed comments made about delayed payments. He did not agree with shifting funding to another year. He asked about the number and annual cost of extended warranties. The Operations Manager replied that she did not have figures to hand but agreed that there was a need to review how to manage warranties. Five year warranties on electrical equipment were costly. There was a need to revisit options.

9.6 **RESOLVED:-**

(1) That the outturn and investment in adaptations be noted.

(2) That the measures in place to manage the Disabled Facilities Grant (DFG) expenditure within budget over the next three years be approved.

(3) That the report be referred to the Health & Wellbeing Board, along with the concerns of the Housing & New Homes Committee as outlined above.

~~HOUSING & NEW HOMES COMMITTEE~~	~~Agenda Item 9~~ ~~Brighton & Hove City Council~~

Subject:		**Housing Adaptations Service Update**
Date of Meeting:		**17 June 2015 – Housing & New Homes Committee**
Report of:		**Geoff Raw, Executive Director Environment, Development & Housing**
Contact Officer:	**Name:**	**Martin Reid / Sarah Potter Tel: 29-0789**
	Email:	**Sarah.potter@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 Housing Committee (4 March 2015) resolved to continue to monitor and scrutinise Disabled Facilities Grant (DFG) applications. This report provides an update on the Housing Adaptations Service out-turn for 2014/15 including DFG investment in private sector housing and Housing Revenue Account (HRA) funded adaptations to Council homes.

1.2 Housing Committee has previously agreed a range of action to be taken to mitigate DFG capital expenditure pressures arising from increased demand and reduced Private Sector Housing capital budgets; noted the role of the Better Care Board in monitoring the allocation to the DFG from 2015/16; noted the role of the Housing Adaptations Service in undertaking proactive work to better manage demand through making best use of existing adapted and accessible housing stock and in increasing the supply of new build accessible homes. This report: updates on actions to mitigate capital funding pressures; the implementation of decisions made by Committee (10/09/14 and 04/03/15); and, other potential measures to manage the DFG expenditure within exiting budgets.

1.3 Brighton & Hove has rising demand for housing adaptations in the City as people live at home for longer with more complex needs. Ensuring that adaptations are done at the right time to support people to stay in, or return to, their own homes when they want to is a priority in the Housing Strategy 2015. A total of £2.63m was spent on delivering housing adaptations across all tenures (Council & private sector) in 2014/15 (£2.16m was spent in 2013/14). The 'Better outcomes, lower costs' (ODI/University of Bristol 2007) report and Audit Commission (2009) 'Building Better Lives – getting the best from strategic housing', provide evidence that investment in housing adaptations brings significant savings to Health and Social Care budgets, reducing residential care and hospital admissions and delayed discharges. The Audit Commission (2009) 'Building Better Lives – getting the best from strategic housing' found that spending between £2,000 and £20,000 on adaptations that enable an elderly person to remain in their own home can save £6,000 per year in care costs.

1.4 This work reduces pressures on more costly residential, supported or acute care that may otherwise be required through Children's, Adults Social Care or Health services and supports key Corporate Plan priorities.

2. RECOMMENDATIONS:

That the Housing and New Homes Committee:

2.1 Note the outturn and investment in adaptations;
2.2 Approve the measures in place to manage the DFG expenditure within budget over the next three years.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The Housing Adaptations Service improves the quality of life for children and adults with physical disabilities, their families and carers by enabling independent living through assessment and delivery of appropriate housing adaptations and assistance across all tenures in the City.

3.2 In addition to discharging Council statutory duties arising under the Care Act 2014 and the Housing Grants, Construction and Regeneration Act 1996 in relation to assessment of need and the delivery of major housing adaptations, the Service takes a preventative housing options based approach making best use of existing adapted and accessible housing and commissioning new wheelchair adapted homes to meet assessed needs.

3.3 The Service contributes to the delivery of the Housing Strategy 2015, adopted at Council on 26 March 2015, by ensuring that adaptations are done at the right time to help residents to remain independent in their own home. This supports Corporate Plan priorities to provide earlier, more accessible and preventative support to vulnerable people and their families and to promote independence and reduce the need for acute and residential care services.

3.4 In the private housing sector (rented and owner-occupier) major adaptations are largely funded through the Disabled Facilities Grant (DFG). Entitlement to a DFG is mandatory for eligible disabled people, the grant providing financial help for the provision of a wide range of adaptations ranging from stair lifts, level access showers and home extensions. The DFG grant limit is £30,000.

3.5 The allocation from government via the DFG was never been intended to meet 100% of local adaptations expenditure. Previously, Private Sector Housing Renewal Assistance (PSHRA) has provided significant top up to the DFG budget. In addition, discretionary assistance of up to £50,000 was available under our PSHRA policy to eligible applicants who required additional funding where the total cost of work exceeded the DFG limit or assistance to move to a more suitable property. There is no longer a Private Sector Housing capital programme. With increased demand this has contributed significantly to capital pressures arising.

3.6 Housing Committee 18 June 2014 considered a Housing Adaptations Service update report on the outturn in 2013/14 and budget commitments in 2014/15 and beyond. Committee were asked to consider the capital funding pressures going forward in light of the end of the Private Sector Housing capital programme and the options for managing rising demand for and expenditure on major housing adaptations where this was forecast to exceed the capital funding available. Committee agreed that an options paper come back to outline potential

measures to mitigate the future capital funding pressures identified. Committee noted that without reviewing alternative funding and delivery options it is likely that the capital provision will be fully spent and committed and the service would have to operate a waiting list.

3.7 Housing Committee on 10 September 2014 and 4 March 2015 considered update reports highlighting capital funding pressures in 2014/15 and beyond, particularly in respect of the DFG, and the options for managing the demand for and expenditure on major housing adaptations where this continued to be forecast to exceed the capital funding available. The pressure arises in light of rising demand, the mandatory nature of the DFG, and the end of any Private Sector Housing capital programme to 'top up' DFG funds.

3.8 Housing Committee approved a number of recommendations, including:

- Consulting with Registered Provider (RP) partners to seek a greater contribution from them toward the overall cost of adaptations to their homes.
- Greater use of the Council's Adaptations Framework Agreement of specialist contractors for adaptations in the private housing sector to reduce the average cost of works, speed up the process and achieve better value for grant.
- Consultation with Council tenants and key stakeholders on the introduction of an adaptations policy for Council tenants.

3.9 In addition, Committee were advised on the creation of the Better Care Fund which from 2015/16 includes £220m national DFG funding and the role of the Health & Wellbeing Board in determining the future Better Care Fund allocation linked to Health outcomes.

3.10 In March 2015 Housing Committee received an update report on the implementation of these recommendations and noted the Health & Wellbeing Board on 9 December 2014 considered the extract from the Housing Committee proceedings in September and resolved 'that the Board agrees that the allocation for the Disabled Facilities Grant will be monitored by the HWB as part of the governance arrangements for all schemes in the Better Care Fund.'

3.11 Committee has also noted the work of the Housing Adaptations Service to pro-actively support households to make informed choices about their housing options as a potential alternative to expensive and disruptive adaptations to their existing home and better manage demand for adaptations in Council and private sector through:

- Strong links with the Housing Development in the commissioning of new affordable accessible housing, working with Registered Providers (RPs) and private developers at pre-Planning design stages and seeking early nomination to and specification of new wheelchair accessible housing both for rent and part buy part rent. During 2014/15, 31 new wheelchair adapted homes were commissioned under the Affordable Housing Development Programme, 18 for rent and 13 for shared ownership.
- Working with City Regeneration on the New Homes for Neighbourhoods initiative, providing guidance on inclusive design principles to help maximise the amount of accessible and fully wheelchair adapted homes planned under

our estates regeneration programme, including new wheelchair accessible Council homes on sites such as Preston Road.

- Working with Home-move to support people through the housing application and lettings process, dedicating Occupational Therapy hours to accompany disabled applicants to view offers of Council and RP properties, advising on the suitability of the property in order to make best use of the adapted and accessible social housing stock through the Accessible Housing Register.
- Joint work on other HRA capital investment programmes to enable more wheelchair adapted and accessible homes, for example sheltered housing refurbishment, adapting one bed ground floor empty properties (6 completed 2014/15) and the loft & extensions scheme (2 completed 2014/15).
- Scrutiny of all applications for major adaptations costing over £10K at Major Adaptations Panel.
- Development of the housing options approach in the private sector through commissioning of the advice and support service for older and disabled people with the local Home Improvement Agency (HIA).

3.12 The outturn last year, 2014/15, is summarised below

2014/15	Budget	expenditure	Number of grants completed/adapts delivered
DFG	£1,074,996	£1,441,817	179 grants completed
HRA Adaptations	£1,150,000	£1,185,139	893 adapts delivered: 238 major adaptations 655 minors

Disabled Facilities Grant

3.13 In 2014/15 there were 179 grant completions. The average grant was £8,265. The average figure should reduce with more work ordered through the Adaptations Framework Agreement going forward. The budget overspend of £0.367m is expected to be met out of the 2015/16 confirmed allocation via the Better Care Fund of £0.911m.

3.14 The level of commitment against the DFG, i.e grants approved not paid in 2014/15, plus the expenditure to date provides a forecast spend 2015/16 of £1.048m. This exceeds the confirmed budget for the year.

Housing Revenue Account Adaptations

3.15 In 2014/15 the HRA Adaptations budget funded 238 major adaptations (those over £1,000) and 655 minor adaptations. The average HRA budget spend on a major adaptation was £4,470. The budget overspend of £0.035m will be covered by underspends elsewhere in the HRA capital programme. The budget for 2015/16 remains at £1.15m.

Measures in place to manage DFG expenditure within budget

3.16 The implementation of the recommendations approved by Committee in respect of the DFG, i.e. Registered Provider partners contributing toward the cost of adaptations in their homes and greater use of the Council's Adaptations Framework to achieve better value for grant, is anticipated to deliver estimated

savings of £0.102m this year (2015/16) and £0.276m the following year as outlined below.

3.17 Working together with the local Home Improvement Agency (HIA) we have confirmed that 65% of all grant assisted work in the private sector is to come through the Council's Adaptations Framework Agreement of specialist contractors. It is anticipated this will make a 20% saving on the average cost of an adaptation.

3.18 The consultation with RP partners on their contribution toward the cost of adaptations in their homes from 01/04/15 was broadly positive. The responses and confirmation of individual RP contributions is detailed below. Based on an average contribution of 40% it is estimated that RPs will contribute £54,000 in 15/16 and £146,000 in 16/17.

RP	Confirmed/response
AffinitySutton	Confirmed
Amicus Horizon	Confirmed – capped at a total annual contribution of £4,500
Guinness	No response to date
HydeMartlet	Awaiting final confirmation
MOAT	Confirmed contribution 40% of costs between £1,000 and £10,000 a maximum of £4,600 for projects of £10,000 no contribution to adaptations above £10,000
Orbit	No response to date
Sanctuary	Waiting final confirmation
Southern Housing Group	Confirmed

3.19 In addition to these measures the need to manage the DFG expenditure within budget going forward makes it necessary to implement a recovery plan for all possible savings and to action these in respect of all new DFG applications received from 1 April. The recovery plan includes the additional measures:

- A condition on all new grant approvals in 2015/16 to defer payment of the grant until April 2016.
- Reducing the level of Home Improvement Agency and other fees paid.

If budgets and demand remain at current levels (£0.911m), then implementation of all the measures outlined above will still leave significant budget pressures for Housing by the end of 2016/17 unless further mitigation measures are agreed or additional funding identified.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The finance options to manage the position on the DFG budget included:

- Use of other underspending capital budgets to offset the pressure – there were no underspending capital budgets identified to do this.

- Making a one off contribution from revenue to cover the pressure – no underspending revenue budgets identified to do this.
- Borrowing, paid back with interest over an agreed period – not considered on grounds of additional costs and because this scheme would not comply with the prudential code for borrowing.

4.2 In March, Committee considered the scope to include fully adapting for wheelchair use some Council properties identified as being 'suitable to adapt' when they become empty for re-letting. The Housing Adaptations Service, with the Tenants Disability Network (TDN), is mapping those areas most suitable to adapt and working together with the Housing Asset & Sustainability team to make best use of the capital investment to increase the supply of larger family homes and wheelchair accessible homes. This work is on-going.

4.3 The report to Committee in September included consideration of additional alternative options to mitigate budget pressures including those outlined below. It is proposed that these options remain under review with key stakeholders and are the subject to a further report back to a future Housing Committee on progress & outcomes. Additional options, and potential issues arising, include:

- In Brighton & Hove the provision of equipment such as stair-lifts, ceiling track hoists, is funded through the DFG route. In 2014/15, around 23% of the DFG budget was spent on equipment for adult and children's cases. Not all local authorities fund such equipment via the DFG. Given the DFG budget is under pressure to meet all types of work that the mandatory grant can cover looking at alternative funding for the provision of equipment would reduce the pressure on DFG. However, this risks shifting capital pressures onto other budgets.
- In Brighton & Hove the DFG is issued to include the cost of providing extended 5 year warranties on equipment i.e. any electrical equipment typically stair-lifts, hoists, automatic doors. All adaptations are covered by a 1 year warranty. The cost of extended warranties varies typically ranging from £400 for a stair lift up to £1,800 for a specialist height adjustable bath. Where the equipment is provided for private use within the home and the disabled person's own equipment it is their responsibility to ensure it is properly maintained and safe to use. Not funding the provision of the extended warranty under the DFG could reduce the overall DFG spend. However, this would result in a worse service and higher costs for the disabled person and risks shifting capital pressures on-to other budgets to fund in cases of hardship.
- Under the DFG process, we have previously accepted RP landlord applications on behalf of their tenants. These applications are not subject to a means test and we currently fund adaptations in RP homes up to the grant limit £30,000. The rationale for this approach was that it simplified the application process and increases the amount of adapted social housing available to those on the Council's housing register. In 2013/14 we approved 53 RP landlord applications of which 90% of those RP tenants were in receipt of a pass-porting benefit and entitled to a full grant in their own right. Accepting only RP tenants' applications rather than landlord applications would ensure the DFG was always issued subject to a means test and spent on those in greatest need of assistance.

- From 2009/10 to 2013/14, £0.666m in Private Sector Housing Renewal Assistance has been returned to the city council with 2013/14 showing the highest return with a total of £0.284m repaid. This is not currently recycled back into Private Sector Housing capital programmes. This repayment activity is likely to increase in future given the high level of renewal assistance funding achieved under the successful BEST bids to Regional Housing Board. Critically this capital recycled into private sector housing could provide a capital programme to continue to 'top up' the DFG allocation.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 Consultation with the Tenants Disability Network took place in January about the mapping of areas suitable to adapt.

5.2 The consultation with Registered Provider partners on their greater contribution toward the cost of adaptations in their homes began 6 February 2015, followed up 24 February and 25 March and with individual respondents.

6. CONCLUSION

6.1 The measures previously approved by Committee and the additional measures put in place for all new DFG applications this year are necessary to recover the financial position and manage within budget going forward.

6.2 There is a critical role for the Better Care Board in monitoring the allocation to the DFG by the Health & Wellbeing Board as part of the governance arrangements for all schemes in the Better Care Fund.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 The Disabled Adaptations budget within the general fund overspent for the year ending 31st March 2015 by £0.367m. The overspend is being funded from the grant for 2015/16 which is assumed to be £0.911m. Hence, there is only £0.544m left to fund the 2015/16 grants.

7.2 For 2015/16 there is already spend to date and a commitment to pay grant totalling £1.048m, leading to a forecast overspend of £0.504m (a budget pressure for the general fund). Unless immediate action is taken to either reduce spend or increase resources, this pressure will increase further if any more grants are paid in 2015/16.

7.3 An action plan was put in place in February 2015 to address this pressure going forward. The first step is to put a condition on all new grant approvals in 2015/16 to defer payment of the grant until April 2016. The plan also identifies new income from registered providers, ensures more work is procured through the framework agreement at cheaper rates as well as reducing fees. Given that commitments have already been made for 2015/16, some of these measures will

take time to generate savings. If all of the measures are successful, current estimates are that significant pressures (estimated at £0.400m) will still exist for this budget going forward to 2016/17 and therefore either new resources need to be identified or expenditure reduced further.

7.4 The HRA Capital Programme for 2015/16 includes a budget for £1.150m for Disabled Adaptations and is currently forecasted to spend within budget.

Finance Officer Consulted: Monica Brooks Date: 26th May 2015

Legal Implications:

7.5 The Housing Grants, Construction and Regeneration Act 1996 governs the administration of Disabled Facilities Grants. The measures outlined in the report to manage DFG expenditure are compatible with the statutory regime.

Lawyer Consulted: Name Liz Woodley Date: 22/05/15

Equalities Implications:

7.6 The overall reduction in DFG budget is likely to result in disabled private sector residents waiting longer for the completion of major adaptations with the associated risk of an increase in falls and injury in the home, hospital admissions, higher packages of care, early entry into residential care, and a loss of independence. In mitigation, potentially, the higher proportion of private sector work going through the Council's Adaptations Framework will be delivered by contractors already working with BHCC and engaged through regular contract review meetings.

7.7 Reduction in the level of fees paid to the HIA could result in the agency needing to reduce its operating costs potentially reducing the level of service it can provide to disabled people opting for casework and technical support with grant assisted work and to older and disabled people referred to the broader housing options advice and support services it offers.

Sustainability Implications:

7.8 None.

Any Other Significant Implications:

7.9 None.

SUPPORTING DOCUMENTATION

Appendices:

None.

Documents in Members' Rooms

None.

Background Documents

1. 'Better outcomes, lower costs' (ODI/University of Bristol 2007).
2. The Audit Commission (2009) 'Building Better Lives – getting the best from strategic housing'.
3. Housing Committee, Housing Adaptations Update Report, 18 June 2014.
4. Housing Committee, Housing Adaptations Update Report. 10 September 2014.
5. Housing Committee Housing Adaptations Update Report, 4 March 2015.

Crime & Disorder Implications:

1.1 None.

Risk and Opportunity Management Implications:

1.2 These are included in the body of the report where possible.

Public Health Implications:

1.3 The reduction in the DFG budget is likely to impact on the delivery of housing adaptations, the prevention of falls and injury in the home and the wellbeing of older and disabled people. Housing adaptations, assessed as necessary and appropriate, promote independent living, enabling disabled adults and children to live as independently as possible by facilitating access to or provision of essential facilities such as an accessible bathroom for safe bathing and toileting, kitchen for the preparation of food, safe access in to and out of the home and the provision of adequate heating or lighting for comfort and safety.

Corporate / Citywide Implications:

1.4 This work reduce pressures on more costly residential or supported care that would otherwise be required through children's or adults social care services and supports the following priorities in the draft Corporate Plan 2015-19 to help us deliver *"A good life - Ensuring a city for all ages, inclusive of everyone and protecting the most vulnerable"*:

- Coordinate services and spending better between public services to improve equality, for example through the Health & Wellbeing Board and the Local Housing Investment Plan.
- Invest in early intervention and prevention for vulnerable families to ensure better long term outcomes and reduce the cost of expensive interventions once families reach crisis.
- Keeping children and young people safe, at home and in learning and social environments.
- Providing better care services for older and vulnerable people, focused on personal choice and staying independent.
- Ensuring the city's housing stock is well managed and good quality, to support independence, health and wellbeing, and avoid homelessness.

Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Health Watch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Formal details of the paper

1.1. **Children's Services Ofsted inspection and review of Local Safeguarding Children Board 2015**

1.2 This paper can be seen by the general public

1.3 21st July 205

1.4 Carolyn Bristow, Service Development Officer
Tel. 01273 293736
carolyn.bristow@brighton-hove.gov.uk

2. Summary

2.1 To provide the committee with an update on the recent Children's Services Ofsted inspection and to provide assurance around action planning to ensure identified recommendations are followed up.

3. Decisions, recommendations and any options

3.1 That the committee note the Ofsted report given as appendix 1

3.2 That the committee note the Local Authority post Ofsted action plan given as appendix 2

4. Relevant information

4.1 In November 2013 Ofsted introduced a single inspection framework which focusses on the experiences and progress of children in need of help and protection, children looked after and care leavers. It looks at the effectiveness of local authority services and arrangements to help these children, including local authority adoption and fostering services. A review of Local Children's Safeguarding Boards was introduced alongside this new inspection framework.

4.2 Brighton & Hove City Council staff formed an Ofsted preparation group which looked at the new framework and managed a programme of work to improve services in light of the new requirements.

4.3 Brighton & Hove were notified on 13th April 2015 that the inspection team would arrive the next day. The inspection ran from 14th April to 7th May with initial feedback being given on 8th May.

4.4 During the inspection they looked at around 200 cases, met with 18 parents and grandparents, 16 adopters and carers and 48 children & young people.

4.5 The inspection report was published on 22 June 2015 and confirmed the judgements as:

Children's services in Brighton and Hove require improvement to be good		
There are no widespread or serious failures that create or leave children being harmed or at risk of harm. However, the authority is not yet delivering good protection and help for children, young people and families.		
The experiences and progress of children who need help and protection		Requires Improvement
The experiences and progress of children looked after and achieving permanence		Good
	Adoption Performance	Good
	Experiences and progress of care leavers	Good
Leadership, Management and Governance		Good
The Local Safeguarding Children Board is good		
The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children are good.		

4.6 The local authority considers the report to be fair and accept the findings and recommendations. Ofsted recognised that the authority had already identified all the areas that needed improvement and work has already been underway to change elements of service delivery.

4.7 The local authority post Ofsted action plan is given as appendix 2. This document is a requirement by Ofsted and must be submitted by 28th September. After that point the actions will be incorporated into our existing business plans for 15/16 and beyond. This will allow for consistent and focussed monitoring of movement and success, being reviewed quarterly at the Children's Services Performance Board.

4.8 So far 59 authorities have had their reports published. No authority has been judged to be outstanding.

- 14 are judged good (24%)
- 31 are judged to require improvement (52%)
- 14 are judged to be inadequate (24%).

4.9 Out of those 31 authorities that have been judged to be requiring improvement for their children's services provision:

- Only 1 has been judged good on the experiences and progress of children who need help and protection – this is a key deciding judgement
- 6 (19%) are judged good for the experiences and progress of children looked after and achieving permanence (including Brighton & Hove) whereas 25 are requiring improvement
- 13 (42%) are judged good for adoption performance (including Brighton & Hove), with the rest being inadequate or requiring improvement
- 8 (26%) are judged to be good in the experiences and progress of care leavers (including Brighton & Hove), with the rest being inadequate or requiring improvement
- Only 4 (13%), are judged good in leadership, management and governance (including Brighton & Hove) and only 25% of all inspected authorities were judged good on this measure.

4.10 The LSCB consider the review report to be fair and accept the findings and recommendations. Ofsted recognised that journey the LSCB has been on over the past two years and described a "rigorous approach to evaluating the effectiveness of safeguarding arrangements in all of its partner agencies".

4.11 So far 29% (17) of LSCBs have been judged as good overall, 49% (28) as requiring improvement and 22% (13) as inadequate. Evidence shows that good LSCBs tend to be characterised by:

- mature partnerships, agreed priorities and shared resources
- responsibilities clearly articulated between the chair, the LA CEO and DCS
- good links between partners' objectives and priorities and those of other local decision-making bodies (eg. health and wellbeing boards)
- a determination to improve frontline practice, using section 11 audits and mutual challenge.

5. Important considerations and implications

5.1 Legal

The report sets out how the Council intends to respond to the Ofsted report as it is required to do by The Education and Inspections Act 2006 (Inspection of Local Authorities) Regulations 2007.

Legal Officer Consulted: Andrew Pack Date: 13/07/2015

5.2 Finance

Local Authority: The actions contained within Appendix 2 will be incorporated into existing business plans for 15/16 and beyond and any costs will be met from Children's Services budgets. These budgets are currently under significant pressure with a marked increase in the number of referrals and an overspend projected in 2015/16

Finance Officer Consulted: Louise Hoten Date: 23/06/2015

LSCB: The cost of any / all initiatives or actions arising as a result of the recommendations made in this report will be met from within existing LSCB budget (2015-16 £166,830)

Finance Officer Consulted: Brian McGonigle Date: 26/06/2015

5.3 Equalities

Ofsted's inspection framework ensures that the safeguarding and voice of our most vulnerable children & young people is heard. Work with the Corporate Parenting Board, our Children in Care Council and direct work with those subject to a child protection plans was

particularly highlighted by Ofsted. Inspectors recognised that staff had been trained and encouraged to consider equalities issues in a child's life and to understand how this may impact on their wider experiences. This was seen as a strength and improvement since the last inspection in 2011.

5.4 Sustainability
Ofsted recognise that the changes that are currently being made in our social care teams are creating robust services that support families better. Our Early Help strategy and new arrangements are helping to better support families earlier in the process.

5.5 Health, social care, children's services and public health

6 Supporting documents and information

6.1 The voice of children, young people and their families is an essential part of our service delivery and work has progressed in the past 4 years to ensure this is consistent and genuine. The inspection report is very positive about the engagement with children and young people, in particular children in care and care leavers.

6.2 Ofsted are satisfied there are no widespread or serious failures in the local authority's services to vulnerable children and young people in the city. However, there is work to be done to ensure that we are delivering good and outstanding services for all. An improvement journey had begun before Ofsted's arrival and will now continue with reassurance that the right direction is being taken. If the improvements already undertaken continue then the quality of service and a future Ofsted inspection judgement should recognise that good services are delivered across all areas.

6.3 It is unlikely that this area of work within Children's Services will be inspected before 2018 as the city is considered to be a low risk Authority given that the judgement has not been Inadequate and also given that leadership, management and governance has been judged to be Good.

6.4 Appendices:

1. Brighton & Hove City Council Ofsted Inspection report - Inspection of services for children in need of help and protection, children looked after and care leavers and Review of LSCB

2. Local Authority post Ofsted inspection action plan – July 2015

Brighton and Hove City Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the local safeguarding children board[1]

Inspection date: 14 April – 8 May 2015

Report published: 22 June 2015

Children's services in Brighton and Hove require improvement to be good
There are no widespread or serious failures that create or leave children being harmed or at risk of harm. However, the authority is not yet delivering good protection and help for children, young people and families. Good leadership means that children and young people looked after, those returning home and those moving to or living in permanent placements outside of their immediate birth family have their welfare safeguarded and promoted.

1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Good
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Good
3. Leadership, management and governance		Good

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates two children's homes. Both were judged either good or outstanding in their most recent Ofsted inspection.
- The previous inspection of the local authority's safeguarding arrangements was in May 2011. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for looked after children was in May 2011. The local authority was judged to be adequate.

Local leadership

- The Executive Director of Children's Services has been in post since July 2013.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since April 2013.

Children living in this area

- Approximately 50,000 children and young people under the age of 18 years live in Brighton and Hove. This is 18% of the total population in the area.[3]
- Approximately 20% of the local authority's children are living in poverty.[4]
- The proportion of children entitled to free school meals:
  - in primary schools is 15% (the national average is 17%)[5]
  - in secondary schools is 14% (the national average is 15%)
- Children and young people from minority ethnic groups account for 16%[6] of all children living in the area, compared with 22% in the country as a whole.[7]
- The largest minority ethnic groups of children and young people in the area are Any other White Background (4.1%), and White and Asian (2.9%).[8]

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.
[3] Mid-2013 population estimates.
[4] www.gov.uk/government/collections/households-below-average-income-hbai--2.
[5] School census data, January 2015 (including academies and free schools).
[6] 2011 census.
[7] DC2101EW – Ethnic group by sex by age.
[8] 2011 census.

- The proportion of children and young people with English as an additional language:
  - in primary schools is 13% (the national average is 19%)[9]
  - in secondary schools is 11% (the national average is 14%).[10]
- All of Brighton's minority ethnic communities grew significantly in number and proportion between 2001 and 2011, with the exception of the White Irish community. The largest increase in the number of people in an ethnic category between 2001 and 2011 is in the Other White category, which rose from 8,041 to 19,524.

Child protection in this area

- At 31 March 2015, 1,479 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,412 at 31 March 2014.
- At 31 March 2015, 309 children and young people were the subject of a child protection plan. This is an increase from 288 at 31 March 2014.
- At 31 March 2015, 16 children were living in a privately arranged fostering placement. This is a reduction from 17 at 31 March 2014.

Children looked after in this area

- At 31 March 2015, 481 children were being looked after by the local authority (a rate of 95.2 per 10,000 children). This is an increase from 465 (92 per 10,000 children) at 31 March 2014.
  - Of this number, 268 (or 55.7%) live outside the local authority area.
  - 39 live in residential children's homes, of whom 92.3% live out of the authority area.
  - Seven live in residential special schools,[11] of whom all live out of the authority area.
  - 387 live with foster families, of whom 56.1% live out of the authority area.
  - Five live with parents, of whom 20% live out of the authority area.
  - Eight children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 52 adoptions

[9] School census data, January 2015 (including academies and free schools).
[10] School census data, January 2015 (including academies and free schools).
[11] These are residential special schools that look after children for fewer than 295 days.

- 28 children became the subject of special guardianship orders
- 180 children ceased to be looked after, of whom 3.9% subsequently returned to be looked after
- one child or young person ceased to be looked after and moved on to independent living[12]
- no young people ceased to be looked after and are now living in houses of multiple occupation.

[12] Based on Reason LAC Episode Ceased.

Executive summary

The current leadership team has implemented well-targeted plans effectively and made steady improvements to the quality of children's social care. However, some core functions still require improvement to be good. The senior management team has recognised this. It is now making good use of performance and quality assurance processes and had identified the areas for improvement, recommended in this report, prior to the inspection. One of the areas requiring improvement is that too many children are becoming subject to a child protection plan for a second or subsequent time as a result of child in need work not being sufficiently robust. Plans to address these deficits through a new model of practice are well advanced. Positive improvements include the effective multi-agency safeguarding hub (MASH), where appropriate child protection thresholds are consistently well applied.

Elected members are passionate and actively involved as corporate parents. They engage well with young people and take their views seriously. Members take an active role in quality assurance activity and have an appropriate level of understanding of frontline practice.

Since the last inspection, the senior management team has largely changed. The vast majority of recommendations have been met but two issues remain. The quality of supervision and management oversight at team level remain as areas for improvement despite significant investment in specialised training. Examples of where improved practice is now embedded include the independent reviewing service and the routine consideration by social workers of children and families' diverse needs.

When children and young people go missing, the authority's response is not yet sufficiently consistent or robust. All young people looked after are offered a return interview but the intelligence from those interviews is not yet systematically drawn together and used as effectively as it could be. Managers are aware of this and are currently commissioning a service to address the issue.

Partnership arrangements work effectively at both strategic and operational levels. Work to identify and address child sexual exploitation is well established, of good quality and has strong levels of multi-agency engagement. As a result, actions to protect young people from sexual exploitation are prompt and comprehensive. The council has responded well to the risks of radicalisation and wide-ranging multi-agency work effectively identifies and monitors those involved. A wide range of specialist assessment and support services add value and impact to core services.

When children are at risk of significant harm, thorough, timely strategy meetings and child protection investigations effectively assess risks. Children are routinely seen and issues of consent are dealt with thoroughly. Multi-agency involvement is wide ranging and section 47 enquiries are of good quality and are clearly recorded. However, there are too many delays in convening initial child protection conferences and performance in this area has recently declined.

Social workers work well to support families to make positive and necessary changes through formal child protection processes. When child protection plans end, the support provided under child in need arrangements is not always sufficiently robust to help families sustain the improvements made.

Children in need cases are appropriately assessed and held by qualified social workers. Where statutory involvement is not required, children needing help benefit from an early help assessment to identify their needs. The needs of children with a disability are assessed comprehensively and they are provided with a wide range of services that meet their needs.

Management oversight in some teams is not rigorous enough and the rationale for making decisions is not always clear on case files. Supervision by some managers does not challenge social workers where the progress of plans is delayed or drifting. The allocation and completion of children in need assessments is not always prompt and too many assessments take too long to complete. Where allocation is delayed, children may not be seen as quickly as they should be.

Children looked after achieve well in education compared with their peers. The virtual school provides good support and oversight taking individual needs into account. Attainment at Key Stage 4 is particularly good compared with national averages and represents significant achievement since the last inspection. The attainment gap for children looked after at Key Stage 2 is narrowing. Good quality practice and strong assessments result in children being matched and placed with their prospective adopters in good time. Adoption is given appropriate consideration for all children needing permanence. The authority does not yet have a sufficiently robust system to track and monitor the promptness of permanency planning. Assessments of adopters are robust and timely. Adopters are able to access a wide-ranging offer of support and express high levels of satisfaction with the service they receive.

The authority has high aspirations for its care leavers and supports them well. This is reflected in the numbers of young people who are engaged in employment, education and training. Tenacious efforts are made to keep in touch with care leavers and young people value the support they receive. High numbers of care leavers remain with their foster families after they are 18. However, presently there are too few local foster carers for older young people with complex needs. The engagement of care leavers in service design and influencing future practice is good, with clear impact. A small number of care leavers experience a delay in being allocated appropriate supported accommodation.

Recommendations

1. Ensure that when children cease to be the subject of a child protection plan, their families are given the priority and support they need to maintain the changes they have made.

2. Ensure that where a child requires a child in need assessment they are seen and spoken to promptly.

3. Ensure that managers monitor and track the timely completion of assessments so that needs and risks are identified promptly.

4. Improve the timeliness of initial child protection conferences so that multi-agency plans to meet children's identified needs and reduce risks, can be put in place at the earliest opportunity.

5. Improve the quality of management direction and oversight of cases to reduce the drift in plans experienced by some children.

6. When children go missing from home, ensure that they are offered a visit on their return to assess risks they may have been exposed to and to inform plans for them. Centrally analyse the records of these visits to help reduce risks to other children and young people.

7. With partners, review the pathways for early help to reduce the high numbers of inappropriate referrals that are made to the MASH.

8. Ensure that frontline managers provide rigorous, reflective and risk-focused supervision to social workers. Establish a supervision audit cycle to oversee frequency and quality.

9. Recruit and retain sufficient numbers of foster carers to meet the needs of young people with complex needs.

10. Ensure that permanence planning is undertaken promptly and that a tracking system is implemented to monitor this.

11. Increase the availability of supported accommodation for care leavers so that young people are promptly allocated supported accommodation that meets their needs.

Summary for children and young people

- Brighton and Hove City Council has made a lot of progress since its last inspection but some things still need to be improved.
- When children are at risk of harm, social workers recognise it and quickly take all the correct actions to protect them. Managers need to become quicker at organising the meetings where it is decided whether a child needs to have a child protection plan.
- Social workers, police and other professionals in the city work well together to know which young people are at risk of being sexually exploited. If a young person is being exploited, they take the right actions to protect them.
- The council needs to improve the way it helps families to continue with the changes they have made after their children's child protection plans end.
- The managers of social workers need to improve their oversight to ensure that children's plans are making a positive difference.
- Social workers who inspectors talked to know the children they work with well and could show inspectors the work they had done with them.
- Social workers are good at quickly finding new families for children who need to be adopted. They are also good at explaining adoption to children and making sure they understand why they can't stay with their birth family.
- Children who are disabled have social workers who understand their needs and are good at assessing with them what services will help them and their families best.
- Children in care in Brighton and Hove do well at school and achieve good results in their tests. They do not get excluded very often and their attendance is good. Social workers support them to attend regularly if they find that difficult.
- The council needs to recruit more foster carers in Brighton and Hove, especially for young people who have many difficulties.
- When young people leave care they receive good support and are helped to become independent at a pace that suits them. Personal advisers are very good at keeping in touch with young people when they leave care.

The experiences and progress of children who need help and protection

The experiences and progress of children who need help and protection	Requires improvement

Summary

Children, young people and families receive an inconsistent response from the assessment team. Children at immediate risk of harm are responded to promptly. Other children, however, wait too long for assessments to commence and their needs to be understood, and for plans to be put in place to support them. Practice and intervention with families in the children in need teams is variable. High numbers of children become subject to a second or subsequent child protection plan or are re-referred to social work teams because lower level intervention is not always helping families to sustain improvements.

Practice managers do not consistently drive forward plans for children or provide appropriate challenge to workers about their practice. This means that some plans drift and children do not get the help they need when it is first identified.

Not all children who go missing from home are offered a return interview.

A wide range of early help services is available to children and their families. The coordination of these services through the early help hub is increasing the numbers of children who receive help. The local authority is beginning to review the impact of these services.

The recently established multi-agency safeguarding hub (MASH) ensures comprehensive information-sharing between agencies and makes prompt and appropriate decisions about whether families require social work or early help services. Not all professionals are clear about the thresholds for contacting the MASH, with high numbers of referrals re-directed to the early help hub.

Increasing awareness of child sexual exploitation by professionals from a range of agencies is leading to increased referrals to MASH and enabling help to be provided to children at an earlier stage. Effective monthly multi-agency child sexual exploitation (MACSE) meetings take place to consider all new referrals, have oversight of high risk cases and share information between professionals.

Good multi-agency work protects young people at risk of radicalisation. Comprehensive plans, effective use of legal orders and intervention work ensures they remain in this country and that their activities are closely monitored.

In response to local cases of female genital mutilation, prompt and effective partnership work has resulted in effective arrangements to reduce risk to children.

Inspection findings

12. The Early Help Partnership Strategy 2013–2017 clearly demonstrates the agencies commitment to providing early help support to families. A wide range of in-house and commissioned early help services are available. The partnership is beginning to evaluate this range of services to better understand their effectiveness in meeting children's needs and so reducing the demand on statutory services.

13. The MASH and an early help hub were both established in September 2014. A new threshold document published at the same time sets out referral pathways for both services. Some professionals remain unclear; since its introduction, on average 30% of referrals that come into the MASH with a request for a social work service do not meet the appropriate threshold. However, these referrals are swiftly forwarded to the early help hub for a comprehensive early help assessment. Engagement officers proactively contact families and professionals to coordinate early help support. As a result, increasing numbers of children and their families are offered an early help assessment.

14. Professionals working with children are supported by the early help weekly allocation meeting. This is a well-organised meeting that responds to and coordinates early help referrals effectively. Representatives from early help services attend the meeting and agree the most appropriate support that can be offered to families. Some services do have delays in allocating a service promptly to families, although professionals already known to families work hard to bridge gaps in these circumstances.

15. Social work expertise and advice is available in the MASH to support other professionals. The co-location of partner agencies ensures comprehensive information-sharing between a range of partner agencies that is timely and informs sound decision-making. In most cases, consent to share information is sought appropriately and where denied this is recorded clearly. MASH processes effectively identify children who are at risk of harm and cases are swiftly transferred to social work assessment teams.

16. When children are identified as being at immediate risk of harm by the MASH, the assessment teams take swift action. Strategy discussions are held promptly between police and social care practice managers. Their decisions are informed by detailed information shared by the MASH from a range of other partners. Child protection enquiries are comprehensive and risk is analysed well. Social workers see all children within the household alone and carefully consider their views and experiences. Threshold decisions about ongoing risk are appropriate, although timescales for convening a child protection conference are inconsistent and have deteriorated over the past 12 months. The percentage of initial child protection conferences taking place within 15 working days of a strategy discussion dropped from 77% in March 2014 to 52% in February 2015. This results in delay in multi-agency plans being drawn up to reduce risk within these families.

17. Despite the prompt response to children at high risk of harm, other children receive an inconsistent response from the assessment teams. This is a particular issue where risk or need is assessed by the MASH to be at a medium or low level. Some children wait too long for a single assessment of their needs to begin. At March 2015, only 49.7% of children had their needs assessed within an appropriate timescale. In cases sampled, the interval between the referral and the child being seen was too long, taking into account the reason for referral and known family history. A re-referral rate of 30% at 31 December 2014 is an improvement from 33% in 2013–14 but is higher than the national average of 23%.

18. Although many assessments are taking too long to complete, the majority of those seen are of good quality, with careful consideration of family history. There is little evidence of research being used in these assessments, but analysis is thoughtful and appropriate, with outcomes clearly identifying risk and needs of children well. Cultural and language differences are appropriately considered within assessments and services provided address the diverse needs of families. In the majority of cases seen, social workers listened to children and considered their thoughts, fears and wishes well in assessments. The views of fathers and those parents who do not live in the same household as the child are included in more recent assessments. Specialist assessment services such as the Early Parenting Assessment Programme, Looking Forward, the Clermont Unit and the children with disability team all bring additional robustness to assessments due to their individual specialism for particular areas of vulnerability. The emergency duty team responds proportionately to presenting risks and provides daytime staff with prompt updates on actions taken.

19. When children are the subject of child protection plans, there is increasing oversight by child protection chairs to ensure that plans are progressed. The majority of child protection plans are clearly focused on reducing identified risks to children. Core groups meet regularly to progress these plans, with generally good attendance from professionals who are known to the family. Parents are routinely invited and a large majority attend. Minutes from core group meetings are detailed but do not always provide an analysis of the impact on the child of the actions taken and make it clear to parents the success or otherwise of the progress being made.

20. Child protection conferences are well attended by professionals known to the child and where they do not attend reports are routinely provided by most agencies. Partner agency attendance and contribution are monitored effectively by the relevant agency safeguarding lead. This has resulted in increased contributions from GPs. Increasing numbers of children are supported to attend and contribute to child protection conferences and are routinely offered the support of an advocate. The local authority has recently surveyed those who have attended and is planning to respond to the issues raised in this survey.

21. High numbers of children are made the subject of repeat child protection plans. During 2014–15, this affected 81 children (22% of children subject to child

protection plans). This is a slight decrease from 2013–14 performance of 26.5%, but is higher than the national average of 16%. The local authority has analysed the reasons for the need for the repeat child protection plans. While some were found to have stepped down too early, following only a brief improvement, the large majority identify the recurrence of domestic abuse, parental mental ill-health or relapses in misuse of drugs or alcohol.

22. The prevalence of domestic abuse, parental drug or alcohol misuse and the impact of parental mental ill-health are known. Of the children made subject to a child protection plan from April 2014 to March 2015, 51.5% featured domestic abuse and 35.7% recorded parental mental ill-health. Parental drug and alcohol misuse were factors in 29.6% and 23.5%, respectively.

23. A range of services is in place to support those families where domestic abuse has an impact. These include services to support victims and children and statutory and non-statutory programmes for perpetrators of domestic abuse. Arrangements to share information between professionals and coordinate support to victims of domestic violence at multi-agency risk assessment conferences (MARAC) are effective.

24. Drug and alcohol services are available but services to support parents who have mental ill-health but who are not eligible for an ongoing service from adult mental health services are limited. The majority of services are primarily available when risks to children are high. The local authority is in the process of reviewing its commissioning arrangements to ensure that services are effective in helping families to sustain improvements when high-level risks have reduced.

25. Practice and intervention with families in the children in need teams is variable. When children's cases are stepped down from child protection plans, the support they receive is inconsistent. This means that families are not always supported effectively to sustain changes that they have previously made while subject to a child protection plan. This contributes to the high rate of repeat child protection plans.

26. Children subject to child in need plans are not given the same priority as those subject to child protection plans. Not all children who require a child in need plan have one in place. Initial plans that are in place are usually of good quality and well informed by assessment. Children's needs and potential risks are well identified. However, the subsequent work with families varies, is often reactive to crises within the family and does not always provide support in a timely manner to prevent such crises. Some cases are closed too early by the children in need teams and an arrangement for continuing support to the family is not in place. However, some good examples were seen where networking meetings agreed the range of support that would continue to be available to families when cases closed to social work services.

27. A major contribution to the inconsistency of practice is the weak quality of management oversight by practice managers in children in need teams.

Practice managers are not consistently driving forward plans and case discussion records make insufficient reference to the child's plan and whether it is having an impact in reducing risks and meeting children's needs. The rationale for decisions is rarely recorded. Managers' case direction is limited to identifying required tasks, often without clear timescales for their completion. This leads to drift and delay, particularly for children in need. Children at greatest risk benefit from challenging independent oversight by child protection chairs. Social workers report that they have regular opportunities to discuss cases in formal supervision, but that they are not always helped to reflect on the complexities of cases.

28. Children are routinely seen at home and alone and build trusting relationships with social workers through regular contact with them. Communication methods are carefully considered to meet individual children's needs and their stage of development. In many cases, particularly for children subject to child protection plans, direct work is helping children to understand their individual experiences and the plans for them. This enables their voices to be heard in plans to reduce the risks to which they are exposed. For very young children, purposeful observations are made of their interaction with parents.

29. Professionals across the partnership have a good awareness of child sexual exploitation. As a result, when children are identified as being at risk of child sexual exploitation, they are quickly referred to the MASH and escalated to social work teams. All young people identified as being at risk of child sexual exploitation are presented to the monthly MACSE meeting and the level of risk is agreed. These arrangements ensure that plans to reduce risk and support young people are routinely considered by a multi-agency group, including a local authority senior manager, who chairs the meeting. In addition, the meeting supports good information-sharing between agencies.

30. At the time of the inspection, 58 children were known to be at risk of or have suffered child sexual exploitation. Low numbers of boys are identified as being at risk of child sexual exploitation. The local authority recognises this as an area for development with its partners. The newly established joint police and social work Kite team works well with nine of the 14 young people at high risk of child sexual exploitation. The other five young people at high risk continue to receive support from social work staff with whom they have existing positive relationships. There are 35 young people assessed to be at medium risk of child sexual exploitation and nine at low risk. All of these children continue to be supported by multi-agency working arrangements and are allocated to a social worker. In cases seen by inspectors the coordinated support provided to these children is reducing the risks of child sexual exploitation effectively.

31. The WISE (What is Sexual Exploitation?) project undertakes direct work with young people and helps to reduce the risks of child sexual exploitation. Child and adolescent mental health services (CAMHS) do not currently provide therapeutic support to children affected by child sexual exploitation. However,

alternative spot purchasing arrangements are in place to provide this support to young people.

32. Not all children who experience episodes of being missing from home are offered a return interview. Practice and the analysis of return interview information are inconsistent. The local authority accepts that it cannot be assured that effective plans are put in place to reduce risks of further missing episodes or that potential risks of child sexual exploitation are identified as a result of this inconsistent practice. Funding has been secured to commission an independent provider to undertake all return interviews, including looked after children, to tackle this deficit.

33. The local authority maintains an up-to-date register of children missing school-based education. At the time of the inspection, 246 children were on this register. This includes 188 children who are electively home educated as well as those who receive home tuition due to their medical needs and those presently not on the roll of a school. The local authority has a clear definition of what constitutes children missing education that extends beyond those without a school place. The children missing education panel considers cases routinely and individual action plans are put in place with a nominated professional responsible for operational oversight.

34. Agencies demonstrate a tenacious approach in tracking children. The local authority takes decisive action to return children to school where home education is not meeting their needs and they are vulnerable. Good liaison and information-sharing between professionals is used to establish the whereabouts and status of children. Checks are routinely made with schools to confirm which children arrive at school. Cases where children do not appear in school are routinely followed up.

35. When 16- and 17-year-olds are at risk of homelessness, they are well supported by a range of youth services and many return home to live with their families. A small number of these young people are placed in suitable emergency accommodation before being referred to the MASH. At that stage, despite parents' consent, their legal status is not clear. When emergency accommodation is required outside of office hours young people are referred to the MASH the following day. Where these young people are vulnerable, they are referred promptly for a social work assessment. As well as being provided with accommodation, including becoming looked after where appropriate, young people are offered an advocacy service and appropriate support.

36. Good arrangements are in place to respond to cases when allegations are made about professionals who work with children. The local authority designated officer's (LADO) comprehensive awareness-raising activity has resulted in a range of referrals from various statutory and non-statutory agencies, including sports groups and faith organisations. Some recent joint working initiatives with the council's licensing department are also raising awareness of the LADO role.

Good quality multi-agency work underpins all work by the LADO and helps to protect children.

37. Effective work identifies children living in private fostering arrangements. They and their carers are assessed by social workers to ensure arrangements are safe and needs are identified. This is mainly due to increased awareness of local language schools that arrange for children from abroad to live with local host families under private fostering arrangements. Appropriate support to privately fostered children is in place in almost all cases, although not all children are visited as regularly as they should be.

38. The local authority, with its partners, have reacted promptly to local cases of concern by raising awareness and putting in place effective arrangements to reduce the risk to children at risk of female genital mutilation. In addition, well planned measures have been taken in response to the identification of a growing risk of radicalisation for some young people in the city. Wide-ranging and good quality partnership meetings develop, implement and monitor comprehensive plans to meet the needs of such young people. The authority has proactively used wardship proceedings to effectively restrict international movement of young people at high risk.

The experiences and progress of children looked after and achieving permanence

Key judgement	Judgement grade
The experiences and progress of children looked after and achieving permanence	**Good**

Summary

Robust work is undertaken to identify children at risk of becoming looked after. A range of services provides effective support to maintain them with their families where this is the right plan and is possible. Effective work with partners has resulted in cases where children need to be protected by court orders progressing through legal proceedings without delay. This enables children to be secure about their future and minimises uncertainty.

Effective work is undertaken to identify and reduce risks for children looked after who are most vulnerable to going missing, sexual exploitation and substance misuse. Children looked after are routinely offered an interview when they return from a missing episode.

The education of children looked after is supported well by a strong virtual school, resulting in high school attendance and no permanent exclusions. Educational attainment for children looked after at Key Stages 2 and 4 is strong. Children looked after have positive health outcomes as a result of good quality health assessments and plans. The council works well to provide services that support children's emotional well-being and mitigates against delay in accessing CAMHS.

The sufficiency duty is met, although recruitment to increase numbers of in-house foster placements has had limited impact. Foster carers receive good quality preparation and are well supported. Placement stability for young people with complex emotional and behavioural needs is not yet good enough.

Children placed for adoption are carefully and swiftly matched to appropriate adoptive parents and are well prepared for adoption. Assessments of prospective adopters are of at least good quality and are robust. Wherever possible, siblings are placed together.

Care leavers are supported to make a successful transition to independence and are well informed about their entitlements. Young people leaving care are encouraged to remain in care until they are 18 and a high number remain living with their foster carers in 'staying put' arrangements after that time. A higher proportion of care leavers are in education, employment and training than those in similar areas and in England overall. The participation of care leavers and looked after children is good and they influence service development.

Inspection findings

39. The local authority takes robust action to identify children and young people on the edge of care and, with partners, provides a wide range of effective services to prevent them becoming looked after. For example, the Early Parenting Assessment Programme assesses and supports young parents pre-birth and following the birth of their child. It is highly valued by colleagues and service users. In addition, family group conferences are used effectively to engage wider family members to address concerns about children.

40. Children most at risk of becoming looked after are considered at the children's social care planning panel, which determines whether additional work is required or whether to initiate a legal planning meeting. In all cases seen, children were looked after by the local authority where it was in their best interests. Thresholds for children to become looked after are appropriately and consistently applied by local authority staff. High numbers of children are looked after and the authority is aware that this is mainly due to increasing numbers of adolescents being accommodated.

41. Few children looked after return home to live with their parents on a planned basis. A small number of older looked after children (16–17-year-olds) return home on an unplanned basis. This means these returns are not informed by a social work assessment and support plan. Social workers do however provide ongoing monitoring and assistance and the young person's care placement is maintained while stability is tested.

42. Effective strategic and operational work with the Children and Family Court Advisory and Support Service (Cafcass) and the courts results in good and timely performance, with care proceedings completed in an average of 28 weeks. This is enhanced by the local authority legal adviser jointly chairing the Local Family Justice Board. Assessments and reports prepared by social workers for court proceedings are of a high standard overall. Social workers are supported by good advice from legal services in preparing them. The local authority promotes and supports family members effectively to become special guardians, with 132 children subject to an order as of 31 March 2015.

43. In almost all cases, children looked after are seen regularly by social workers who know them well and who see them alone where appropriate. Social workers develop positive and sustained relationships with children looked after in most cases. Case loads are manageable and allow time to undertake direct work. Historically children had too many changes of social worker and this meant work such as life story work was interrupted too often. Managers are currently implementing a new model of working that will minimise case transfer points and further support continuity of social worker for looked after children.

44. Where the permanence plan is for children looked after to remain within their extended family, network assessments to consider connected persons are of

good quality and include a detailed analysis of strengths and vulnerabilities. Plans to manage identified risk factors are included and appropriate.

45. A significant proportion (42% in the year ending December 2014) of young people looked after enter care as adolescents, with a range of risk-taking behaviours that includes substance misuse, going missing and criminal activity. For a few young people, this behaviour is directly linked to radicalisation and they make up a significant proportion of looked after young people known to the youth offending service. These young people benefit from the involvement of a wide range of professionals, including from the national anti-radicalisation intervention programme. Social workers are able to build positive relationships with the majority of young people that helps the young people to understand the consequences of their behaviour. In a few cases, despite strong efforts, social workers struggle to engage effectively with these young people.

46. Five young people became looked after as a result of being remanded in custody. In these cases, the council makes good efforts to visit young people and support them by facilitating contact with their relatives. The youth offending service works closely with the support through care team and with independent reviewing officers (IROs).

47. Risks to children looked after who go missing from care and those at risk of child sexual exploitation are promptly recognised, assessed and addressed by social workers. Information-sharing between partner agencies and parents and carers is well established and results in effective care plans that target and reduce risks. Following episodes of children going missing, return interviews are routinely offered and recorded by children's social workers. Information obtained from these interviews is used effectively to inform plans to reduce risk to the children. Secure accommodation is used appropriately where risks are high and alternatives are not sufficiently protective. Four young people have been placed securely in the last year.

48. Children looked after's initial health assessments are not as timely as they should be, particularly for children over the age of five. However, review health assessments are timely and of good quality, demonstrating that actions from previous assessments are acted on. Good multi-agency involvement informs health assessments and plans.

49. Social workers for children looked after who have emotional health issues access CAMHS promptly for an assessment, but the wait for treatment is often too long. Positively, and to mitigate against this delay, the authority provides a range of good quality services such as Clermont, which offers a selection of therapeutic interventions and assures prompt access.

50. The virtual school provides good support and oversight of children looked after's education. Each child is known well and good plans take their individual needs into account. Data are used effectively to review children's progress and the virtual school intervenes to help when their progress falters.

51. Children aged 11 and 16 achieve well compared with their looked after peers in similar areas and in England overall. Between 2012/13 and 2013/14, children's attainment at age 11 improved in reading, writing and mathematics to above statistical neighbours and the England average. In 2013/14, over 54% of children in care achieved Level 4 or above in these subjects compared with 44% of children looked after in other areas. The attainment of children at Key Stage 4 is good, with 26% gaining five GCSEs including English and mathematics in 2013/14 compared with 14% in England. This represents good improvements since the 2011 safeguarding and looked after children inspection, when attainment at Key Stage 4 was identified as a weakness.

52. Children in care make good progress from their starting points. Between the ages of five and 11, data shows that a good proportion make the progress expected of all children in reading, writing and mathematics. Further good performance is demonstrated at Key Stage 2 in 2013/14, when the attainment gap between children looked after and their peers narrowed by 10% from the previous year to 27% and was smaller than the attainment gap for children in care in similar areas.

53. Most personal education plans (PEPs) are of good quality and schools now routinely take the lead in completing them. In the few that are not good, children's views are not well represented and target setting is not always sufficiently detailed. The proportion of children looked after with an up-to-date personal education plan has improved, from 74% in October 2014 to 84% in April 2015. The pupil premium is used effectively to support children's academic progress and personal development, for example through providing additional tuition.

54. Children looked after's attendance at school is good and is overseen effectively by the virtual school, which intervenes at the first indication of a concern. Effective joint working between schools and social workers ensures that problems are identified at an early stage and that support packages are put in place to prevent exclusions. As a result, there have been no permanent exclusions of children looked after for five years.

55. Around three quarters of children looked after attend a good or outstanding school. Where a school is judged less than good, careful consideration is given to the individual circumstances of the child and the progress they are making before disrupting their education.

56. Children are supported and encouraged very well to participate in positive activities outside of school. The virtual school runs six after-school clubs including dance, athletics and table tennis. Here, children and young people develop new friendships and learn new skills.

57. Children looked after live in a good range of safe placements that are effectively overseen and monitored. Placement stability is not yet good but is improving. The rate of children having three or more placement moves is

11.9%, and is moving positively towards the national average level of 11%. The performance figure is distorted by the fact that when independent foster carers transfer to the council this registers as a placement change even though the child has not moved. Longer-term stability is showing an improving trend at 68.5% in February 2015 compared with 62.7% in April 2014.

58. Over half (55.7%) of children and young people looked after are placed outside of Brighton and Hove, but most live within 20 miles of the city. These young people are not disadvantaged by this and are able to access the same range of services as those living locally. Social workers visit young people regularly and most are able to maintain local school placements. Providers' inspection grades are routinely monitored and individual cases are reviewed where there are concerns about the quality of care or where inspection outcomes deteriorate.

59. Although sufficient placements are available and young people's views are taken into account when placements are made, the local authority recognises the need to recruit more local foster carers. Investment in council employed staff to tackle this has not been as effective as hoped for. There is particular need for carers for adolescents and an independent provider has been commissioned to develop recruitment strategies and increase the number of available placements.

60. The fostering panel is suitably structured, with appropriate representatives from diverse backgrounds. It carries out its core functions robustly and is well supported by an effective panel adviser. Legal advice is readily available where required. The panel is chaired by a committed and experienced chairperson. Reports to the fostering panel are of a high standard and the agency decision-maker considers each case thoroughly. As a result, decision-making is timely and robust.

61. Foster carers are well prepared, trained and supported by supervising social workers. They access a range of training to update their knowledge and awareness of issues affecting looked after children.

62. When children become looked after, the quality of care plans for them is good. In the vast majority of cases, they are comprehensive and appropriately detailed. However, not all care plans include specific actions to be taken or clear enough measures of progress. Care plans are reviewed effectively and in a timely way. Children are encouraged to have ongoing contact with their own families and friends wherever this is safe and appropriate. Where young people are able to express their views, these are taken into account in both case and placement planning.

63. The IRO service works well and effectively ensures that children's care plans progress without delay. The functions of IRO and child protection conference chairs were separated in September 2014 with a positive impact for children and their families. Additional IROs are now in post, which has resulted in manageable caseloads of around 70 children per IRO. As a result, IROs carry

out their core duties effectively and also engage with children looked after outside of their reviews to establish meaningful relationships and monitor the progress of their care plans.

64. IROs routinely provide constructive feedback to social workers, recognising good practice and raising management alerts where practice is below the standards required. A formal management alert system is used effectively to highlight concerns and ensure that improvements take place. For example, in several cases, IROs appropriately challenged or prompted social workers and managers to ensure that work was undertaken effectively, such as convening strategy meetings where children looked after were missing and ensuring that risk assessments were up to date.

65. The independent visiting service is a strength and benefits children looked after. There are 46 well trained and supported independent visitors who are matched to looked after children, and a further 32 currently being trained. Children looked after also benefit from good work to address issues of diversity delivered by the intensive placement team.

66. Case recording is not always good and at times is too brief. This is particularly the case for the recording of statutory visits and the representation of children's views and opinions. However, in the disabled children's service, recording is of good quality and is purposeful.

67. The views of children looked after are well represented through a long-established Children in Care Council (CICC). This is well structured, with three groups comprising different age bands of young people from diverse backgrounds. The young people are rightly proud of the wide range and high quality of materials that they have produced to inform others of what they do, including the pledge. A good example of their influence is the published guidance on pocket money for children looked after. The CICC is well supported by committed and enthusiastic staff, some of whom are care leavers. They ensure that children looked after participate in a range of positive activities – including being on the corporate parenting panel and staff interviews, as well as being part of a music band.

The graded judgement for adoption performance is that it is good

68. The local authority places children for adoption in good time and matches them carefully to adoptive parents who can meet their needs. Prospective adopters are recruited through a variety of means and a diverse range of adopters are recruited. Of the adopters approved in the last year, almost a third were identified as LGBT (lesbian, gay, bisexual or transsexual), which is a good reflection of the diverse local population. Performance on the adoption score card is broadly in line with both the England average and statistical neighbours. The average time between a child entering care and moving in with its adoptive family is 592 days, which is better than the national average. The average time between a local authority receiving court authority to place a child and the local authority deciding on a match is 225 days, which is slightly worse than the national average of 217 days.

69. In the past year, 52 adoption orders have been granted and 42 children have been matched with adoptive parents. At the point of the inspection, there was only one child waiting to be matched to prospective adopters. Where family finding processes are unable to match a child with prospective adopters, a suitable permanent alternative is secured within an appropriate timescale. The number of children for whom this change of plan is the case is broadly in line with statistical neighbours and the national average, at 15% of those with an adoption plan.

70. The local authority performance for placing children over the age of five is 8%, which is higher than both statistical neighbours and the national average. Family finding for all children, including those over the age of five, is proactive and thorough, with careful consideration of available families and robust matching. Good use is made of the National Adoption Register, newsletters and activity days, as well as web-based services such as 'Be My Parent' and 'Adoption Link'.

71. Currently, there is no mechanism for tracking whether permanence plans are in place by the second review, which makes it difficult to monitor performance in this area. The senior management team is aware of this legacy and has plans to introduce a measure in the care planning panel that monitors and quality assures all key care planning points.

72. Adopter assessments are sound, with good consideration given to strengths and potential vulnerabilities. This supports and informs the matching process. Child permanence reports are detailed and identify all of a child's known needs, with the rationale as to why adoption is the preferred option set out clearly. The child's needs and the prospective adopters' ability to meet those needs are articulated well in matching documents. An effective plan to support any identified vulnerabilities is included. Consideration is given to siblings remaining

together and the rationale for decisions about this is based on assessments carried out by those with sufficient expertise.

73. Good efforts are made to ensure that contact is maintained with siblings where this is in the child's interests. Letterbox contact is supported by the local authority and advice is offered to both birth and adoptive families about appropriate content. Letterbox contact is encouraged with wider birth family members where this is appropriate.

74. The chair of the adoption panel is suitably independent. The panel is made up of experienced professionals and adoptive parents. Discussions held by the panel demonstrate probing questioning and robust exploration of relevant issues. The agency adviser provides effective quality assurance to ensure that only good quality work is presented to the panel. The panel demonstrates a positive impact on practice, for example the introduction of a more robust format for connected persons assessments. The agency decision-maker provides prompt scrutiny of panel recommendations and ensures that children are appropriately matched with a family that will meet their needs.

75. Families are able to access effective post-adoption support. There have been no disruptions of adoption placements prior to the adoption order being made for the last six years. The Adoption Support Steering Group is effective in encouraging organisations within Brighton and Hove to be 'attachment aware'. The implementation of an adoption 'passport' that details the offer from organisations across the city is an impressive recent development that provides easy access and support for families at a universal level.

76. Families report that post-adoption support has improved recently. An effective three-tier system works well so that families access a range of universal or targeted services through to a comprehensive post-adoption support assessment. Twenty-four post-adoption support plans were completed in 2014–15 and a further 18 assessments are in progress. Many more families access support at tiers one and two. This support includes an active toddler group, a group for LGBT parents, workshops and training.

77. A commissioned evidence-based training programme for adoptive parents is offered at tier two. It is well received by workers and families, with 38 adoptive families benefiting from the programme over the last year. Additionally, families can access the services of a psychotherapist if they are experiencing complex family difficulties.

78. The virtual school takes a strong, proactive role and provides good support to all children who have been adopted, as well as those who are subject to a special guardianship order. Schools are encouraged to be proactive in identifying adopted children so that the pupil premium can be used appropriately to support them. An easily accessible helpline for schools and adopters provides valued support to adopted children who are having difficulties in school. The local authority has identified that adopted children and

those on special guardianship orders underachieve in school. As a result, the steering group is successfully encouraging schools to use a PEP style review tool to ensure that adopted children's achievement improves.

79. Children are effectively prepared for adoption with careful planning of the introduction process. Children's wishes and feelings are comprehensively considered and sensitive life story work is undertaken. A range of direct work tools is used to assist children to understand the process and develop a secure attachment with their new parents. Children are given a well set out, child-friendly plan and a 'narrative' that details their journey into care and to adoption. They also receive good quality, honestly written later-life letters to help them fully understand the circumstances leading to their adoption as they get older.

The graded judgement about the experience and progress of care leavers is that it is good

80. Personal advisers are tenacious in their support for care leavers aged over 18 as well as those who leave care before their 18th birthday. Effective joint working between social workers for children looked after and personal advisers promotes positive transitions to adulthood for looked after young people aged 16 to 18, including those with moderate levels of learning disability. Transition arrangements for care leavers are good and clearly set out, including those for young people with profound disabilities or complex needs.

81. The local authority demonstrates a strong commitment to supporting young people in their transition to adulthood, with the percentage of young people who remain looked after until their 18th birthday higher, at 78% in March 2014, compared with other similar areas and the England average. This is further evidenced by the number of care leavers who remain living with their foster carers under 'staying put' arrangements, with 39 young people (22%) currently in such arrangements. The option of staying put is actively encouraged for all young people as part of pathway planning at the age of 16 and a half. The local authority also provides continuing support to young people who remain in education post-18 who were subject to special guardianship orders or child arrangement orders. Currently, 13 young people aged over 18 are being supported in such arrangements.

82. Personal advisers know young people well, visit them regularly and are committed to staying in touch with them. As a result there was only one care leaver that the local authority was not in touch with at the time of the inspection. Care leavers report that they value this support.

83. Care leavers report that they feel safe in their communities and in their accommodation. They are supported effectively to access safe housing, with 91% of care leavers aged 19 to 21 living in suitable accommodation. The

detailed joint protocol between children's social care and housing services ensures that the accommodation needs of care leavers are met. Care leavers are assisted to apply for a range of supported housing from both local authority and voluntary sector providers. A shortfall in the capacity of supported accommodation means that some young people wait too long to get the most appropriate accommodation to meet their needs. The local authority is aware of this and has already started the process of commissioning appropriate services, such as a new supported lodgings scheme.

84. Overall the quality of pathway plans varies from requiring improvement to good. Some lack specificity and sufficient emphasis on timescales to achieve objectives such as the development of independent living skills. Where plans and reviews require improvement, evidence of managerial oversight is not sufficiently robust. Senior managers identified the issue prior to the inspection and measures are now in place to quality assure and sign off pathway plans and reviews on a regular basis. Risk to young people is identified and assessed well, including the risk of sexual exploitation and going missing. These assessments, however, are not integrated into the young person's pathway plan. Young people's views are well represented within pathway plans and reviews.

85. Issues of diversity, such as ethnicity, faith and sexual orientation, are sensitively considered and inform assessments and plans. Good examples include careful consideration being given to appropriate placement matches in order to support young people's cultural and religious beliefs.

86. The majority of care leavers are supported effectively to develop skills to prepare them for independence. A range of approaches is used, including individual one-to-one support from personal advisers and independence living skills training provided in supported accommodation. In addition, the accredited independent living skills scheme is offered to all young people and is a pre-requisite for supporting a young person's transition to independent accommodation after a period in supported living. Ten care leavers have completed this course in the last six months.

87. The local authority is committed to preventing homelessness for young people. This is achieved by strong partnership working between children's services, housing and the youth service, where young people's needs are central to decision-making. A good joint protocol places emphasis on a proactive approach to preventing homelessness and care leavers are encouraged to access supported accommodation before moving to independent living. In those situations where it is assessed that the most suitable option for a care leaver is independent living, general needs housing is applied for and those young people are given the highest level of allocation priority.

88. In the event of homelessness, the use of bed and breakfast is avoided for care leavers wherever possible. In the last six-month period, no care leaver has been placed in bed and breakfast accommodation. In exceptional circumstances

when bed and breakfast accommodation is used in an emergency, an immediate referral to the youth advice centre tenancy support team ensures that such placements are subject to risk assessment and prompt action is taken to identify a suitable alternative.

89. The health needs of care leavers are effectively responded to and they are supported to register with universal health services. A specialist nurse located within the support through care team undertakes all review health assessments for young people aged 16 to 18. This enables the nurse to build a trusting relationship with young people that helps them to be more confident in engaging with mainstream health services once they are over 18. Although dedicated to the 16 to 18 years age group, the specialist nurse provides advice and support to any care leaver to help them access a range of services, including sexual health, substance misuse and mental health.

90. The quality of the care leaver's health passport, developed by the specialist nurse and a care leaver, is very good. It provides an individualised record of medical history for young people as well as being a young-person-centred resource and access guide for health services. This health passport is currently being rolled out to all care leavers following a positively received 2014 pilot scheme.

91. The local authority currently provides well-planned support to eight care leavers who are pregnant and 27 who are parents. These young people access an appropriate and wide range of universal services in the community, in addition to specialist health visiting support through the family nurse partnership.

92. The local authority has high aspirations for its care leavers. Personal advisers, social workers and specialist staff provide consistently good support over time to support their career aspirations. When current circumstances, such as early parenthood, prevent young people from taking up further training or employment, their long-term needs are considered and planned for effectively.

93. Good performance is evidenced in the rate of those aged over 19 in education, employment and training. Performance for this age group in 2013–14 was 65%, a much higher proportion than in similar areas and in England overall. For the year 2014–15, local data demonstrate that good performance is being maintained. The local authority has a range of good initiatives that support care leavers in their job-seeking journey, including a partnership with the Department for Work and Pensions and Brighton Job Centre. Further, the authority's investment in two dedicated posts in the support through care team and the Youth Employability Service ensures that effective, well-targeted support is provided to young people who are not in education, employment and training.

94. The virtual school's development of a post-16 personal opportunity plan effectively supports young people aged 16 plus to plan their next steps in education, training or employment. The virtual school strongly promotes

university as an option for care leavers by arranging visits with young people as well as undertaking awareness-raising with foster carers. The local authority ensures that young people attending university get good financial support while they are students. There are currently 17 young people at university and a further five planning to attend at the start of the next academic year.

95. An active apprenticeships programme within the council has led to care leavers successfully completing work placements in environmental health, the international team, legal services and parks. Good outcomes are demonstrated by examples such as one care leaver securing a full-time position after successfully completing a three-year carpentry apprenticeship with a local company. Another has completed an apprenticeship with the advocacy service. However, too few care leavers currently benefit from such placements, with only four care leavers in apprenticeships across the city.

96. The council ensures that care leavers' involvement and participation within the council is good. Care leavers influence service delivery and development; they are involved in the CiCC, the corporate parenting board and member training. Their views have shaped the development of the leaving care assessment, pathway plans, the health passport and the pledge 'Leaving Care Promises and Aims' and a range of other material such as financial support leaflets and guidance. As a result, young people are helped to make a successful transition to adulthood by clear information about their history and their entitlements.

97. The local authority is proactive in seeking the views of their care leavers through a wide range of activities that include 60-second surveys, questionnaires and moving on from care interviews. These are used effectively to inform and shape service developments as well as providing a forum for young people's views to be heard and responded to. A good example is the 'Ask Report Change Programme', where care leavers are involved in the inspection of the quality of children's homes and independent fostering agencies commissioned by the local authority. The Young Ambassadors Programme provides another example, where young people are involved in recruitment and have been involved in interviewing for key posts. Care leavers value these approaches and their achievements are celebrated through a range of initiatives including an annual awards ceremony. The authority's commitment to taking account of and learning from their care leavers is further evidenced by the employment of two care leavers into key posts (resource officer and participation worker). These young people provide inspiration for care leavers and their engagement with other young people across the city ensures that the experiences of young people in care and care leavers are understood and that their voices are heard.

Leadership, management and governance

Key judgement	Judgement grade
Leadership, management and governance	Good

Summary

Senior leaders have planned, and are implementing, an ambitious programme of cultural change and improved practice standards. Their priorities are to make changes sustainable and to have a skilled workforce delivering good quality services to children and families. Elected members are equally ambitious, and support the plan led by the Executive Director of Children's Services. Political leaders and senior officers understand their roles and have a clear line of sight to the frontline. Commitment to vulnerable children at all levels is high. Elected members exercise appropriate scrutiny and use their influence well. Participation and user engagement are key strengths, with the involvement of children and young people genuinely sought, achieved and valued. Leaders are active corporate parents.

Effective strategic partnership working is demonstrated by the MASH and is delivering prompt and appropriate responses to referrals. The early help hub is further evidence of strategic vision coming to fruition and benefiting families. Senior managers and their partners work well together, making best use of combined skills to identify and protect those at risk of child sexual exploitation and radicalisation.

Workforce development is a significant priority and a well planned and resourced offer of training supports the planned cultural change. Training is linked to learning from serious case reviews and also to strengthen the new model of practice that is at an advanced stage of planning.

Looked after children live in homes where their needs are being met. Leaders take good account of what is important to looked after children and young people, and are strong and proud corporate parents. Appropriate steps are being taken to improve the stability of relationships between looked after children and their social workers and to sharpen the focus on permanence planning for children of all ages. Work is underway to recruit more local foster carers for the most challenging young people. Local leaders demonstrate success in securing permanence for high numbers of children through adoption and special guardianship orders. Ambition for care leavers is high and the support and care these young people receive ensures that they feel safe where they live and that they make good progress in their lives.

Vulnerable children do not yet receive a consistently good service. However, leaders and managers now use performance and quality assurance processes effectively and as a result have already identified all the key areas where practice needs to improve.

Inspection findings

98. Creating the right culture and environment for sustainable change is a firm priority for the current senior leadership team and the journey towards being good in all areas has been steady but decisive for the past 12 months. Prior to the appointments of the present Chief Executive, Executive Director of Children's Services and Assistant Director Social Care, the senior leadership team lacked stability. This has meant legacy issues within services that were weak or poorly coordinated have made sustained improvement difficult to achieve. Current directorate and team plans clearly identify improvements that are still needed.

99. Ambition is high but realistic, and sustainable changes are being made. For example, the introduction of the MASH has improved the coordination and speed of the first response to vulnerable families. The strategic vision for early help is now clear and the coordination of services at this level has been enhanced by the implementation of the early help hub. The IRO service, which historically did not have sufficient capacity to deliver all its core functions, has been strengthened and contributes effectively to raising standards.

100. Leaders are outward-looking and are learning from other organisations in their thinking about models of practice and new ways of working. Through the pilot 'teaching partnership', stronger links are being forged with local universities in order to improve the preparation and experience of social work students. The 'transformation of social work' programme has been informed by the careful consideration of models of practice in other areas. Commitment to improving long-term outcomes is exemplified by 'Looking Forward', a programme to help mothers who have had children removed and adopted to plan and care for subsequent children.

101. The Health and Wellbeing Board is a well-functioning group with a helpful balance between partners and political leaders. Priorities are appropriately focused on vulnerable children and are aligned to those of the local authority. Key leaders are well engaged, including the LSCB chair. The board is taking appropriate steps to understand key local and national issues such as child sexual exploitation.

102. Elected members from the three parties who hold political power are well informed and exercise appropriate scrutiny through the Children and Young People's Committee, the Health and Wellbeing Board and the Child Review Board. Service and performance information is shared and analysed, enabling members to maintain a good understanding of the delivery of services to local families. Members have been well briefed about key issues such as child sexual exploitation and radicalisation. The Chief Executive chairs 'One Voice', a group that brings together a range of ethnic and faith communities to raise and address issues of prejudice, extremism and inequality.

103. Political leaders and senior officers and the chair of the LSCB work together well, with regular informal and formal meetings and detailed discussion about key issues such as findings from multi-agency audits. The Chief Executive and lead member are well engaged with staff, local services and young people. The lead member is an active member of the LSCB, Corporate Parenting Board and the adoption panel, and regularly attends the Health and Wellbeing Board.

104. In some areas, sufficient improvement has not yet been achieved, for example in the consistency of response to children who go missing from home. A peer review, undertaken in November 2014, identified some key areas for improvement in missing from home practice. The local authority understands its weaknesses in this area and an action plan is in place to address them.

105. Further improvement is also needed in the length of time it takes for social workers to complete single assessments. Additional staff have been appointed to meet the demands created by high and rising referral rates. Management information is increasingly being used to track and oversee these assessments and there is a drive to improve timescales without compromising quality. Timescales are gradually improving.

106. Commissioning activity is undergoing positive and considerable change. All services above £75,000 are being re-commissioned in line with a new overarching commissioning strategy. New arrangements ensure that the clinical commissioning group is more actively engaged. The approach to commissioning and de-commissioning of services is increasingly analytical, with a range of data and evaluative information including the joint strategic needs assessment being used to inform decision-making.

107. A creative but at times reactive approach to commissioning has led to a high number of diverse in-house and externally commissioned services across the city. Such services are effective in helping families and are much valued by them. A strong commitment to youth work has led to the re-shaping of services and now includes the Youth Employability Service (previously Connexions). These services are in high demand and are central to the offer of help to local teenagers, including those who are experiencing instability in their families or their communities. Commissioned services are evaluated, but the wider impact on children, young people and families is not consistently understood, particularly in relation to key strategic priorities.

108. The sufficiency strategy is up to date, clear and coherent, with appropriate priorities linked to present and future need. Steps are being taken to address gaps, for example through the commissioning of an independent company to increase the number of in-house foster carers for older and more challenging young people. The 'payment by results' element of this arrangement demonstrates a commitment to achieving value for money.

109. The performance framework is well embedded and the quarterly performance board rigorously analyses key performance indicators, progress against

performance targets, risk actions, learning from complaints and audits and key people data. Helpful context and commentary is included. Managers are held to account for poor performance and the move to a culture of continual improvement is well underway. Management information is accessible, helpful and comprehensive, although not all managers at all levels use it consistently or effectively. Additional resource has been invested to help managers understand, interpret and use this data more effectively.

110. The quality assurance framework is well established, with learning routinely identified and disseminated from a range of sources including complaints and regular themed and deep-dive audits. The Executive Director of Children's Services and the lead member have undertaken auditing as part of this process. The audits undertaken by the local authority for this inspection were analytical and appropriately challenging. The local authority has a clear understanding of what good and poor practice look like.

111. Members of the corporate parenting panel demonstrate a sound understanding of the key issues facing looked after children and care leavers. The board is well attended by looked after children and care leavers, council members from all parties, foster carers, the virtual school and the clinical commissioning group. It is focusing on the right things, considering key issues such as education and health systematically and in detail, while also ensuring that looked after children can bring the issues that are most important to them (such as pocket money).

112. The appointment of a graphic designer and participation worker with Brighton and Hove care experience has led to the creation of high quality young-people-friendly documents such as the council's pledge to children in care, and has increased the reach and depth of engagement. These young adults care deeply about their work. Their involvement in the corporate parenting board has strengthened the voice of young people in this process and is bringing about meaningful change.

113. The local authority responds to complaints in a well-organised and open way. Where it identifies wider practice issues, it takes steps to introduce and embed the necessary changes. A series of complaints from parents who do not live with their children has led to new practice guidance for staff. It includes helpful information about parental responsibility and clear expectations for how these parents should be engaged with processes such as child protection conferences. In cases seen by inspectors, the engagement of parents within these families is increasingly effective. The Executive Director of Children's Services takes an active interest in complaints and uses this to increase his knowledge of what is happening within key social work teams.

114. Participation and user engagement is strong, with the involvement of children and young people genuinely sought, achieved and valued. For example, during 2014, 12 young people completed accredited interview training. A total of 17 young ambassadors were actively engaged in the programme and participated

in interviews for 13 key posts such as the head of the virtual school, the assistant director and LSCB lay members. The Children's Services Participation and Engagement Strategy has been developed with the involvement of young people, staff and a multi-agency working group including public health and representatives from the community and voluntary sector. It demonstrates that the local authority is committed to protecting and further strengthening this area of already good practice.

115. The children's services workforce is relatively stable, sickness rates are improving and the use of agency workers low. Social workers and other practitioners care about their work with children and families and about the council. Caseloads are manageable overall and staff feel well supported by their teams and their managers. The vision for the new model of practice is coherent, with the right balance of care for social workers, relationships with families and performance management. It is being introduced in a measured way through constructive engagement with staff.

116. Decision-making, supervision and management grip at team level are not consistently rigorous. In too many cases, this is delaying desired improvement. Senior managers are aware of this through regular case auditing and the new model of practice has been designed to address this. Within tracked cases, where management oversight has been poor, there is evidence of recent improvement leading to plans being back on track and progressed. It is crucial that inconsistencies in management oversight and case supervision are addressed effectively if services for children who need help and protection are to be good.

117. The Assessed and Supported Year of Employment (ASYE) programme for social workers is well established, with 123 newly qualified social workers (NQSWs) being supported in the last five years. Support to the current cohort of 22 is coordinated by an experienced social care manager who confidently oversees and mentors her virtual team. Some of these NQSWs have previously experienced support and care that is less than good, with insufficient supervision or high caseloads. The ASYE manager has acted swiftly to improve their experience.

118. Although currently filled by an interim post-holder while a permanent appointment is made, the principal social worker (PSW) role is well established and at an appropriate level to have influence and reach. There are effective links with regional PSWs for sharing good practice and joint initiatives.

119. The training offer is comprehensive and staff working with families at all levels of need are well supported to attend training events. However, social workers are not always able to talk confidently about how they assess the impact of neglect within families and the training offer for staff who are making important judgements and decisions about risk in this area needs to be strengthened.

120. There have been three serious incident notifications to Ofsted in the last two years, two of which have led to the commissioning of serious case reviews. Neither has yet been concluded. While awaiting the findings of formal case reviews, the local authority is taking appropriate steps to care for staff alongside acting on any immediate learning.

121. The local authority has a strong strategic and operational partnership with local schools. Through a schools safeguarding audit in 2014 it has maintained a good understanding of each school's safeguarding profile. This informs developments such as anti-bullying strategies and has enabled targeted support to be provided, for example in supporting schools to help pupils with emerging self-harming behaviour.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good
The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children are good.

Executive summary

The LSCB has rapidly developed over the last two years from a local-authority-dominated board to a transparent, learning-focused multi-agency LSCB. The LSCB effectively monitors and influences improvements in frontline multi-agency safeguarding practice.

The LSCB undertakes its statutory responsibilities carefully and thoroughly. Its members recognise that not all elements of multi-agency safeguarding practice are yet of a consistently good standard, but there is a clear understanding of where further improvements are required. For example, the LSCB is aware of gaps in service responses to children who go missing. It has provided suitable challenge but has not yet been assured that the necessary improvements are in place.

The LSCB should build a better understanding of the effectiveness of early help services. Additionally, the board should further scrutinise numbers of repeat referrals and child protection plans.

The LSCB routinely scrutinises data in relation to children becoming looked after, although it needs to give more focus to looked after children living outside the authority area and improve its understanding of why thresholds for care or accommodation are reached.

The LSCB has strong leadership and effective governance arrangements, featuring senior managers from partner agencies chairing the majority of its sub-groups. The board now has a strong multi-agency influence and expertise for its oversight and evaluation of practice, providing an increasingly informed and diverse picture of particularly vulnerable groups of children and young people in the city.

The LSCB is outward-looking and ambitious to accelerate its momentum and influence as an improvement and change agency in the city. It has a strong presence in schools, the voluntary and private sector and in the city's health economy. The LSCB is demonstrably open to the suggestions and challenge of lay members and imaginatively seeks out feedback from children and young people on both how safe they feel and how the LSCB can incorporate their ideas in influencing its priorities and service development.

Recommendations

122. The LSCB should collate and analyse information from missing return interviews to improve knowledge of any common locations, trends and patterns.

123. The LSCB should build a better understanding of the effectiveness of early help assessments and interventions to ensure that children and young people with additional needs receive timely responses and that emerging difficulties are addressed at an early stage.

124. The LSCB should continue to scrutinise and influence the reduction of both the high number of repeat referrals and child protection plans, ensuring that partnership agencies understand and apply the local threshold criteria.

125. The LSCB should improve its links with the corporate parenting panel to provide greater focus to looked after children living outside the authority area and to better understand why thresholds for care or accommodation are reached.

Inspection findings

126. The LSCB has revised its governance arrangements to clarify and improve the rigour and accountability of its sub-structure and leadership group. An LSCB constitution and compact underpins the new arrangements, strengthening the responsibilities of partner engagement in, for example, multi-agency audit programmes and their attendance at LSCB meetings. Concurrently, the LSCB, led by the chair, has successfully delivered cultural reform from a predominantly process-focused, local-authority-led board to an outcome-based, multi-agency forum where partners routinely interrogate and challenge performance information.

127. LSCB members across the range of partner agencies welcome the positive cultural shift. This enables the board to identify and share cross-cutting intelligence and knowledge about particularly vulnerable groups of children and young people and to develop appropriate strategies and actions. Recent examples include stronger responses to radicalisation and the earlier identification of young people exposed to the risks of child sexual exploitation.

128. The chair has constructive relationships with other key strategic boards, both influencing their plans and holding them to account. Recent collaboration with the Health & Wellbeing Board contributed to the decision to review CAMHS and the emotional health and well-being services in the city. This arose from a learning review regarding a young person with self-harming behaviours.

129. The involvement of the Chief Executive and Director of Children's services is integral to the board's effective functioning. For example, they led a multi-agency section 11 challenge event in 2014 to rigorously test the compliance of partner agencies with core safeguarding policies and to increase levels of

engagement with the safeguarding agenda. A good example is the additional funding secured by the clinical commissioning group for a specific post to work with general practitioners to improve their identification and responses to domestic abuse as a consequence of an LSCB multi-agency audit on domestic violence and abuse.

130. The LSCB business plan focuses strongly on improving fundamental indicators of effective safeguarding including child sexual abuse and exploitation. The plan also considers how well children and young people participate and engage with services they are involved with. The LSCB has a well-considered three-year business planning cycle to achieve sustained improvements in an appropriate set of priorities. Measures of progress via multi-agency audits are included. The business plan does not provide a focus on children looked after living outside the local area and this is a shortfall. It is regularly reviewed at full board meetings and at leadership group meetings. The chair is aware that the board should be steadily focused on its core priorities.

131. The LSCB has a good quality assurance framework, supported by a complementary learning and improvement framework. This means that a planned approach is in place to measure the effectiveness of key safeguarding priorities. The monitoring and evaluation sub-committee leads on the design, implementation and reporting of planned multi-agency audits. Four good quality audits were undertaken in 2014, highlighting for example drift in some child in need plans and the lack of consistently robust and reflective supervision. Audit recommendations are rigorously pursued and repeat audits are scheduled to test whether improvements are sustained.

132. The LSCB has made tenacious efforts to develop a multi-agency performance management framework by adding relevant qualitative information to its core performance data, for example from the findings of single- and multi-agency audits. Contributing agencies provide commentaries explaining data trends and variances. The LSCB recognises that further refinement of performance information will be a gradual process and is working purposefully to increase the range and impact of its multi-agency intelligence.

133. The LSCB has a rigorous approach to evaluating the effectiveness of safeguarding arrangements in all of its partner, community and voluntary agencies. Compliance with safeguarding procedures and policies is widespread and analysis identifies themes for further development including, for example, improved work with fathers and male partners and better supervision of safeguarding leads. A safeguarding audit in schools achieved an excellent 100% rate of return. Findings identify that a large majority of primary and secondary school pupils in the city feel safe in their schools. Only a small minority of schools are identified as needing to take action to improve their safeguarding policies and procedures.

134. A comprehensive learning and improvement framework is strongly aligned with the multi-agency audit programme. The framework is informed by intelligence

from section 11 audits, agency annual reports, audit findings and the recommendations of serious case reviews and learning reviews. The LSCB Monitoring and Evaluation Subcommittee considers the 12 multi-agency child protection and children in need cases audited each quarter by the local authority, alongside themed audits targeted in the annual programme. Audit findings and recommendations are systematically and comprehensively disseminated across the partnership. The intelligence from completed audits, serious case reviews and learning reviews is used effectively to inform the content of specialist multi-agency training programmes, achieving a circular, joined-up model of learning and improvement.

135. Serious case reviews are commissioned in accordance with statutory criteria and thresholds applied correctly. The LSCB has adopted the Social Care Institute for Excellence methodology for undertaking both serious case reviews and learning reviews to better understand agency actions and effectively identify key learning outcomes. This leads to targeted and achievable action plans. The implementation of action plans is closely monitored. Learning review action plans receive the same level of scrutiny and attention as serious case reviews. Two serious case reviews have recently been commissioned and are in preparation, one has been recently completed and another is near to conclusion. Four learning reviews and two single agency reviews have been completed recently. Learning from reviews is appropriately cascaded to the workforce through a series of events for practitioners and frontline managers as well as through e-newsletters, e-bulletins and through LSCB members themselves.

136. The Child Death Overview Panel is effective in scrutinising serious incident notifications and has strong links with the serious case review sub-group. The panel has identified a small number of modifiable factors in reported child deaths, largely concerning co-sleeping arrangements for infants. The panel has also improved communication protocols between specialist tertiary hospital trusts and the local health system following the death of a young person with a complex health condition. This illustrates the panel's capacity to identify and achieve safeguarding improvements in other strategic bodies.

137. The LSCB's influence was instrumental in the formation of the MASH, the most recent threshold document and the development of the early help hub. The board is satisfied that all families that are referred are offered early help assessments and interventions at the weekly allocations meeting. The board has a multi-agency audit of early help and thresholds scheduled for September 2015, a year following the implementation of the early help hub. This audit is planned to evaluate overall effectiveness and is not in response to any concerns about thresholds.

138. An effective child sexual exploitation strategy and action plan is in place. A strategic sub-committee and two operational sub-groups are addressing child sexual exploitation through improved identification of potential victims. In addition, protection of victims is robust and prosecutions and disruption are

pursued with determination by partner agencies. A recent multi-agency audit observed that effective identification of risk factors concerning boys and young men are underdeveloped. The LSCB has achievable plans to improve the identification of children and young people at risk of child sexual exploitation at earlier stages, and their prevention and early identification sub-group is well positioned to progress this.

139. The LSCB has anticipated that numbers of identified victims will expand and is accordingly preparing to survey and challenge agencies about how they intend to meet this increasing demand. The WiSE (What is Sexual Exploitation) Project in the city recently undertook an intensive outreach awareness-raising exercise with young people and venue managers and staff, visiting bars and clubs across the city's night-time economy. This endeavour demonstrates the effectiveness of the LSCB's wide-ranging approach to addressing child sexual exploitation in the city.

140. The LSCB thoroughly evaluates intelligence and cross-cutting themes regarding particular groups of vulnerable children through an overarching vulnerable children's sub-group. The group considers the effectiveness of multi-agency responses to young people affected by, for example, forced marriage, modern slavery, radicalisation, female genital mutilation and other specific vulnerabilities. The sub-group has enlisted the services of a national charity and the lesbian, gay, bisexual and transgender lead from Community Safety to assist in identifying young gay men who may be at risk of sexual exploitation through, for example, visiting a local public sex site. The board has an appropriate action plan to further scrutinise and understand the effectiveness of services delivering return-from-missing interviews.

141. The LSCB's child protection liaison group identifies, through the presentation of case examples, difficulties in multi-agency frontline practice that require a swift multi-agency response. This arrangement enhances the capacity of senior partnership managers to achieve timely improvements within the safeguarding system. Recent examples have included improving the content of GP reports to child protection conferences and an improved risk assessment pathway for non-mobile babies who present with injuries.

142. Local multi-agency safeguarding procedures are well coordinated by the Pan-Sussex Procedures Group. Updates are quickly inserted and disseminated, including specific local additions. A recent example was the development of procedures regarding radicalisation that are particular to Brighton and Hove. The procedures are easily navigable on the LSCB website platform. Informal feedback indicates that staff find the procedures a valuable resource; a formal survey of compliance will be undertaken later this year.

143. The LSCB is an active and influential participant in informing and planning services for children and young people. Prominent examples include an effective challenge made to NHS England following the unexpected closure of a general practice in one of the most deprived parts of the city. The LSCB chair

has been influential in attaining the inclusion of safeguarding content in the Health and Wellbeing Strategy and also in assisting the scoping of the Safeguarding Adults Board's duty to ensure effective transitions for vulnerable young people into adult services, using evidence from case reviews to highlight gaps.

144. The LSCB multi-agency annual training programme ensures that training content is carefully designed to deliver specialist courses that complement learning priorities in the business plan and the learning and improvement framework. Practitioners are aware of the LSCB training offer and many spoken to have recently attended training. Staffing difficulties have impeded plans to improve post-course evaluations and the impact of training on improved practice. The LSCB is ambitious to recover progress following the imminent recruitment of a new training manager. The poor attendance of some agencies at core LSCB safeguarding courses has been challenged by the chair.

145. The board has made meaningful progress with effective and innovative initiatives to improve the engagement of children, young people and their families and also to increase public understanding of the board's work. Prominent among these is an accessible, informative and interactive website featuring Twitter, allowing LSCB members and the chair to have a wide range of ongoing exchanges with the board's audiences. Followers include parent groups, schools and teachers.

146. The good quality LSCB annual report reflects the board's learning and self-evaluative ethos. Priorities requiring further attention are highlighted, such as the provision of better performance information from some partner agencies and improving the content of referrals to the LADO. The effectiveness of local services are appropriately reported in summaries of completed multi-agency audits.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of eight of Her Majesty's Inspectors (HMI) from Ofsted.

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Children's Services Ofsted Inspection 2015

Brighton & Hove City Council: Post Ofsted inspection action plan – July 2015

	Ofsted recommendation	Actions needed	Which 15/16 business plan(s) are the actions captured in?	Monitoring arrangements	Success criteria
1	**Ensure that when children cease to be the subject of a child protection plan, their families are given the priority and support they need to maintain the changes they have made.** *High numbers of children are made the subject of repeat child protection plans* *When children's cases are stepped down from child protection plans, the support they receive is Inconsistent* *When the child protection plans end, the support provided under child in need arrangements is not always sufficiently robust to help families sustain the improvements made.*	• Management oversight of child in need plans will be improved through service redesign and auditing activity. Longer term cases are being reviewed by CP Chairs or IROs. • CP chairs have been instructed to exercise caution when stepping down cases involving the toxic trio (MH,DV and SM) of issues to avoid step down from child protection plans too soon	Safeguarding and Offending Business Plan Safeguarding and Quality Assurance Business Plan	Performance Board	When a child has been removed from a child protection plan the appropriate support is given to maintain change within a child in need framework or by step down to appropriate Early Help service

Children's Services Ofsted Inspection 2015

	Ofsted recommendation	Actions needed	Which 15/16 business plan(s) are the actions captured in?	Monitoring arrangements	Success criteria
2	**Ensure that where a child requires a child in need assessment they are seen and spoken to promptly.** *Practice and intervention with families in the children in need teams is variable.* *A re-referral rate of 30% at 31st December 2014 is an improvement from 33% in 2013-14 – but higher than the national average of 23%* *Child in need plans – Children's needs and potential risks are well identified. However, the subsequent work with families Varies, is often Reactive to crises within the family and does not always provide support in a Timely manner to prevent such crises. Some cases are Closed too early*	• Practice guidance and management oversight through supervision and auditing will ensure that children are always spoken to in a child in need assessment at the earliest opportunity	Safeguarding and Quality Assurance Business Plan	Senior Leadership Team	Children's views are prioritised at the early stage of a child in need assessment.

Children's Services Ofsted Inspection 2015

	Ofsted recommendation	Actions needed	Which 15/16 business plan(s) are the actions captured in?	Monitoring arrangements	Success criteria
3	**Ensure that managers monitor and track the timely completion of assessments so that needs and risks are identified promptly.**				
	Despite the prompt response to children at high risk of harm, other children receive an inconsistent response from the assessment teams. *Some children wait too long for a single assessment of their needs to begin*	Management oversight to be improved to ensure that Single Assessments are appropriately monitored	Safeguarding and Offending Business Plan	Performance Board	To ensure the meeting of local timescales for single assessments according to need
	Children looked after's initial health assessments are not as timely as they should be, particularly for children over the age of five.	This will be taken up with SCT		Corporate Parenting Board	Children over the age of five will receive health assessments within timescales
	CAMHS for LAC is accessed promptly for an assessment but the Wait for treatment is often Too long	This will be addressed through the CAMHS review by the CCG		Corporate Parenting Board	LAC children will receive appropriate treatment without undue delay

	PEPs - In the few that are not good, children's views are not well represented and target setting is not always sufficiently detailed	Work taken forward by the Virtual School		Corporate Parenting Board	
Ofsted recommendation		**Actions needed**	**Which 15/16 business plan(s) are the actions captured in?**	**Monitoring arrangements**	**Success criteria**
4	**Improve the timeliness of initial child protection conferences so that multi-agency plans to meet children's identified needs and reduce risks, can be put in place at the earliest opportunity.** *There are too many delays in convening initial Child Protection Conferences and performance in this area has recently declined.*	• Ensure proactive management of child protection conference planning to meet timescales • Current administrative review as part of service redesign has suggested key actions to help improve timeliness and reduce activity levels with regards planning conferences	MASH and Assessment Business Plan	Senior Leadership Team	Child protection conferences are held within timescales

	Ofsted recommendation	Actions needed	Which 15/16 business plan(s) are the actions captured in?	Monitoring arrangements	Success criteria
5	**Improve the quality of management direction and oversight of cases to reduce the drift in plans experienced by some children.** *Management oversight in some teams is not rigorous enough and the rationale for making decisions is not always clear on case files. Supervision by some managers does not challenge social workers where the progress of plans is delayed or drifting.* *The quality of supervision and management oversight at team level remain as areas for improvement despite significant investment in specialised training.* ***(see also point 8)*** *The managers of social workers need to improve their oversight to*	• Implementing the service redesign to remove a layer of management and achieve clarity over areas of responsibility for managers • Tracking activity is undertaken by the Care Planning Panel chaired by Assistant Director • Auditing activity under the Quality Assurance Programme will focus on the quality and oversight of plans • All Pathway plans have quality assurance oversight by Team Managers to ensure they are robust and clear on actions whilst being young person friendly and involving the views of the young person to improve outcomes. • All pathway plans are reviewed	Safeguarding and Offending Business Plan	Performance Board	Outcomes for children demonstrate robust management oversight and timely delivery of interventions to achieve change for children

	ensure that children's plans are making a positive difference. *Practice Managers do not consistently drive forward plans for children or provide challenge to workers about their practice.* *A major contribution to the inconsistency of practice is the weak quality of management oversight by practice managers in children in need teams. Practice managers are not consistently driving forward plans and case discussion records make insufficient reference to the child's plan and whether it is having an impact in reducing risks and meeting children's needs. The rationale for decisions is rarely recorded. Managers' case direction is limited to identifying required tasks, often without clear timescales for their completion. This leads to drift and delay, particularly for children in need. Children at greatest risk benefit from challenging independent oversight by child protection chairs. Social workers report that they have regular opportunities to discuss cases in formal supervision, but that they are not always helped to reflect on the complexities of cases.*	as a minimum every 6 months and authorised by the IRO and Team Manager			Auditing activity evidences a. 100% of pathway plans reviewed within timescales and b. that the pathway plans are outcomes based and achieved

	Case recording is not always good and at times is too brief. *Evidence of managerial oversight is not sufficiently robust.* *Decision-making, supervision and management grip at team level are not consistently rigorous. In too many cases, this is delaying desired improvement.* *It is crucial that inconsistencies in management oversight and case supervision are addressed effectively if services for children who need help and protection are to be good.* *Overall the quality of pathway plans varies from requiring improvement to good*				

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	Ofsted recommendation	Actions needed	Which 15/16 business plan(s) are the actions captured in?	Monitoring arrangements	Success criteria
6	**When children go missing from home, ensure that they are offered a visit on their return to assess risks they may have been exposed to and to inform plans for them. Centrally analyse the records of these visits to help reduce risks to other children and young people.** *Not all children who experience missing episodes from home are offered a Return interview.*	• Establishment of Independent Return Interviews PAN Sussex are due to commence in 2016/17. In the interim capacity in Kite Team is to be extended to provide return interviews • Children regularly missing from home/care are subject to effective scrutiny and monitoring and have effective risk management plans in place and links to CSE are made • Review of the Brighton & Hove Missing Policy	Safeguarding & Quality Assurance Team Plan	Senior Leadership Team	All children who go missing from home are risk assessed following a return interview and appropriate action taken

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	Ofsted recommendation	Actions needed	Which 15/16 business plan(s) are the actions captured in?	Monitoring arrangements	Success criteria
7	**With partners, review the pathways for early help to reduce the high numbers of inappropriate referrals that are made to the MASH.** *Not all professionals are clear about the thresholds for contacting the MASH, with high numbers of referrals re-directed to the early help hub.*	• Convene second Early Help Managers Conference in September 2015 to review tasks identified at initial meeting April 2015 • Resolve process issues through existing Early Help Hub Pathway Group and Management Information Group • Take proposals to Early Help Partnership Strategy Board in Autumn 2015 • Finalise arrangements with the LSCB for a joint Early Help Partnership Conference in November 2015 • Report to CYP&S Committee	Children's Services Directorate Plan Early Help Business Plan	Performance Board Early Help Partnership Strategy Board Stronger Families Stronger Communities Senior Management Team	Fewer better coordinated pathways for early help: complete rationalisation, design and implementation of integrated service pathways coordinated by the Early Help Hub Confirm acceptable baseline for referrals to the MASH re-directed to the Early Help Hub. Agree and achieve improvement targets

Children's Services Ofsted Inspection 2015

	Ofsted recommendation	Actions needed	Which 15/16 business plan(s) are the actions captured in?	Monitoring arrangements	Success criteria
8	**Ensure that frontline managers provide rigorous, reflective and risk-focused supervision to social workers. Establish a supervision audit cycle to oversee frequency and quality.** *The quality of supervision and management oversight at team level remain as areas for improvement despite significant investment in specialised training.* *Decision-making, supervision and management grip at team level are not consistently rigorous. In too many cases, this is delaying desired improvement.* *It is crucial that inconsistencies in management oversight and case supervision are addressed effectively if services for children who need help and protection are to be good.*	• Review of the Quality Assurance Framework and suite of performance management data in order to provide robust performance management and oversight • A review of the current supervision arrangements in line with the new model of practice way of working • Team Managers are expected to observe the individual supervision sessions for their group of Practice Managers • Implementation of the social work service redesign	Safeguarding and Quality Assurance Team Plan	Senior Leadership Team	Auditing activity will confirm reflective and risk focused supervision on a regular basis

Children's Services Ofsted Inspection 2015

	Ofsted recommendation	Actions needed	Which 15/16 business plan(s) are the actions captured in?	Monitoring arrangements	Success criteria
9	**Recruit and retain sufficient numbers of foster carers to meet the needs of young people with complex needs.**	• We have commissioned IMPOWER on a payment by results basis to work alongside our Fostering Team to improve our market share of fostering placements.	Value for Money Action Plan	CS Modernisation Board	Market share improves from 50% and the targets are: 65% = adequate 75% = good 85% = excellent

Children's Services Ofsted Inspection 2015

	Ofsted recommendation	Actions needed	Which 15/16 business plan(s) are the actions captured in?	Monitoring arrangements	Success criteria
10	**Ensure that permanence planning is undertaken promptly and that a tracking system is implemented to monitor this.** *The authority does not yet have a sufficiently robust system to track and monitor the promptness of permanency planning.* *Currently, there is no mechanism for tracking whether permanence plans are in place by the second review* *When children become looked after - Not all care plans include specific actions to be taken or clear enough measures of progress.*	• From July 2015 the Care Planning Panel chaired by the Assistant Director will also track cases through to permanence • Early consultation is offered to CIN Social Workers by the Permanence Planning Lead Practice Manager	Family & Friends Team Plan	Senior Leadership Team	Drift and delay in permanency planning is minimised

Children's Services Ofsted Inspection 2015

	Ofsted recommendation	Actions needed	Which 15/16 business plan(s) are the actions captured in?	Monitoring arrangements	Success criteria
11	**Increase the availability of supported accommodation for care leavers so that young people are promptly allocated supported accommodation that meets their needs.** *A small number of care leavers experience a delay in being allocated appropriate supported accommodation.* *Placement stability for young people with complex emotional and behavioural needs is not yet good enough* *Placement stability is not yet good but is improving.*	• Working with the Council Housing Commissioner and other providers to commission a wide range of appropriate supported lodgings placements • Careleavers are able to access affordable social housing when they are assessed as ready and able for independent living – use of the Joint Housing Protocol • Supported Accommodation Panel to ensure consistent and transparent allocation of supported housing based on assessment of need •	Support Through Care 18-25 Team Plan	Senior Leadership Team	Joint commissioning with Housing provides a greater range of options that are better suited to the needs of careleavers All careleavers requiring supported housing are allocated according to need The use of and time spent in unsuitable accommodation is significantly reduced

In case of query please contact the Children's Services Service Development Officer on 01273 293736 or Carolyn.bristow@brighton-hove.gov.uk Early HDate of issue: July 2015

1. Title of paper:

Interim report: Progress on the Merging Special Educational Needs and Disabilities (SEND) Review in Children's Services and the Learning Disability (LD) Review in Adult Services

(The joint SEND and LD reviews)

1.1 This paper is open to the general public

1.2 Date of Health & Wellbeing Board meeting
Tuesday 21st July 2015

1.3 Author of the Paper and contact details:
Report of: Pinaki Ghoshal, Executive Director, Children's Services
Contact Officer: Regan Delf, Assistant Director (Children's and Adult Services) Tel: 01273 293504 Email: regan.delf@brighton-hove.gov.uk

2. Summary

2.1 This paper updates the Health & Wellbeing Board on the history and progress of the two reviews in Children's and Adult Services and sets out the direction of travel going forward.

2.2 On 3 February 2015, the SEND review and its recommendations were presented to a joint meeting of the Health & Wellbeing Board and the Children's Committee. At the meeting of the Health & Wellbeing Board that followed the joint meeting, the outcome of the Learning Disability Review & "A Good, Happy and Healthy Life" - a strategy for Adults with Learning Disabilities in Brighton & Hove was presented and the direction of travel was approved.

2.3 The Executive Summary of the SEND review, the Learning Disability Review and the Adult Learning Disability Strategy 'A Good, Happy and Healthy Life' are attached to this paper.

2.4 Since that time, a decision has been made to merge and synchronise the two reviews, creating a temporary one year Assistant Director post to bring the two reviews together and to oversee the implementation phase. The new temporary AD began work in the latter part of May 2015.

2.5 As this project spans the work of the Health & Wellbeing Board and the Children's Committee and crosses the work of two directorates, a recommendation of the report is to form a cross party reference group of members. This would enable representatives of both Board and Committee to steer the unified review through the implementation phases.

2.5.1 **Why bring the two reviews together as one?**
Key new legislation has impacted on the work of Children's Services (The Children and Families Act 2014) and the work of Adult Social Care (The Care Act 2014). Both Acts have introduced sweeping reforms and a need for cultural change. Key elements of both Acts overlap, notably:

i. A increased focus on ensuring that families and service users are at the core of all we do
ii. An increased focus on transition and preparation for adulthood, with an extension of responsibility in Children's Services for young people with SEND up to 25 years of age if they meet eligibility criteria
iii. A new focus on identifying and meeting the needs of carers
iv. A requirement for joint commissioning approaches and closer partnerships with health in particular
v. Personalisation of approaches
vi. Empowerment of parents and service users through extended personal budgets and direct payments
vii. Requirement for much improved independent information, advice and guidance

2.5.2 In addition both Children's and Adult Services spend above the national average on services for SEND and Adults with Learning Disabilities. In the context of diminishing council resources and budgets under constant pressure, both services need to find the means to reduce costs while implementing good quality but more cost effective provision. This requires considerable creativity and a need to listen closely to families and service users as a priority as well as a drive to ensure that value for money is a core principle in all developments.

2.5.3 The two reviews have both made progress in implementing agreed actions and progress reports against recommendations are provided in summary below.

3. Decisions, recommendations and any options

i. The Board is asked to note this report and approve the direction of travel

ii. The Board is asked to note that concrete proposals to amalgamate specialist provision for children with SEN and disabilities, including behavioural, emotional and mental health difficulties, will be presented to the Board in October

iii. The Board is asked to approve the setting up of a cross party members' reference group to oversee both reviews during the implementation phase

4. Relevant information

4.1 SEND Review in Children's Services – progress on recommendations

4.1.1 Recommendation 1: To improve joint commissioning between Health and Council Services

i. A draft of a new joint commissioning strategy for Children's Services has been produced by a partnership working group of officers from Children's Services, Adult Social Care, Public Health and the Clinical Commissioning Group (CCG). Plans are in place for a wide consultation event on the draft strategy in September and following consultation, the draft strategy will be presented for approval at the Health & Wellbeing Board meeting in October.

ii. There is also a parallel working group producing a broader draft joint commissioning strategy covering all age ranges and the Children's group have been working in collaboration with this group to ensure consistency and a unified approach. The aim is for this draft also to come to the Health & Wellbeing Board meeting in October.

4.1.2 Recommendations 2 and 3: To integrate and re-structure specialist provision for children and young people with special educational needs and disabilities across education, health and care services

i. These very wide-reaching proposals have been the subject of much further work and consultation. The aim here following extensive consultation with families and professionals is for an innovative re-organisation of provision with the child and family at the centre.

ii. A crucial point from the outset is that there is no intention via the SEND review proposals to reduce the number of specialist placements for children with SEN and disabilities

iii. The savings from this aspect of the review will come from innovative integration of services to provide a holistic response to a child's needs and the needs of his or her family across the waking day. This creates the potential to make substantial savings through greater integration and efficiency, including a substantial re-organisation of the accommodation needed with the aim of releasing some buildings while improving accommodation in others.

iv. A conference for all stakeholders on 13 March included presentations from three providers of excellent integrated provision from different Local Authorities and provided a platform for innovative thinking in relation to a model in the city.

v. Detailed and specific proposals for integrated specialist provision for children with all special educational needs and disabilities including those with behavioural, emotional and mental health difficulties will be presented to the Health and Wellbeing Board in the autumn.

4.1.3 Recommendation 4: To improve learning and achievement for children with SEND

4.1.3.1 SEN support services

Progress is being made in bringing together the range of SEN support services in the city (for example the Autistic Spectrum Disorder Support Service, the Sensory Needs Service, the Literacy Support Service, the Educational Psychology Service) under one integrated management. The post of Principal Educational Psychologist/Head of Learning Support will be advertised shortly. A new structure will provide a flexible response to the needs of schools and families with an efficient management structure and an emphasis on interventions most valued and with proven effectiveness.

4.1.3.2 Challenge visits to schools re SEND

In terms of improving the identification of SEND and raising standards, challenge visits from an expert in the field, who is also a National Leader in Education, have begun across our secondary schools and will continue into the autumn term. An experienced adviser will also begin working with identified primary schools in the autumn to provide equivalent

challenge and support in this area.

4.1.4 Recommendation 5: Improving the Transition to Adulthood

Progress here includes the bringing together of the SEND and LD reviews and action plans across Children's and Adult Services under a temporary Assistant Director spanning both Directorates. The governance of both reviews is being merged.

A transition working group is tackling improvements to be made in preparing young people for adulthood and supporting the extension of the new statutory Education, Health and Care Plans from 0-25 years.

In addition the intention is to offer post 19 education from September 2016 to some young people with learning disabilities in local maintained provision. This will be linked with the FE sector and will provide a vocational pathway for young people with opportunities for supported internships and apprenticeships.

4.1.5 Recommendation 6: Improving the response to the emotional and mental health needs of children and young people

Children's Services are supporting the CCG in their full system review of children's emotional and mental health services.

The CCG review started in March 2015 with the aim to be complete by September 2015, leading to the local Transformational Plan and a business case outlining any changes required, as part of the commissioning cycle and commissioning intentions for 2016/17.

Meantime however, a rising tide of concern in our secondary schools in particular about the emotional and mental health of pupils has led to a pilot new way of working being established. Pilot secondary schools from September 2015 will have a Primary Mental Health Worker (PMHW) from the Community Child and Adolescent Mental Health Service (CCAMHS) attached to the school for half the week with the aim of increasing the school's skills, confidence and resilience in dealing with lower level emotional and mental health needs. The aim is by collaboration between the PMHW and school pastoral staff to facilitate early intervention and preventative working. This should in turn prevent the substantial delays that can occur in the waiting list system

for CAMHS services, reduce anxieties amongst staff, young people and their parents and enable very specialist resources in the tier 3 CAMHS team to be preserved for the most needy young people.

Applications from secondary schools have been received and the pilot will be launched from September 2015. Capacity allowing a further pilot with a primary cluster of schools will begin in January 2016.

5. Adult Learning Disability Review and Strategy: progress on recommendations

5.1 An Operational Group has been set up to develop and implement a Delivery Plan to deliver on the objectives contained in the new strategy "A Good, Happy & Healthy Life" and achieve the necessary savings identified from the ASC budget. A Terms of Reference has been developed for the Operational Group and is attached.

5.2 In order to be effective and ensure that people with learning disabilities, family carers and other stakeholders feel engaged and informed, a clear communication strategy is being developed to support the work of the group (as recommended by the LD Review).

5.3 There are four priority workstreams identified:

- Personalisation & Independence workstream
- Community & Day activities workstream
- Good Health workstream
- Respite and & Short-breaks workstream

5.4 The **Personalisation and Independence workstream** is focussed on supporting people to move on through accommodation services to achieve more personalised outcomes. Through a better use of resources this work will provide the most opportunity for efficiencies and has the following broad activities:

- Deliver proactive re-assessments and support plans to deliver better outcomes and savings through personalisation
- Clients will be identified based on individual need linked to strategic priorities, e.g. supporting people to be as independent as possible, supporting people to access local services

- New procurement process are being developed to commission alternative service options in the most effective and efficient way

5.5 The **Community & Day activity** workstream will focus on ensuring that the person's independence is maximised in community based services through:

- Working with providers to find opportunities to share support and share resources
- Empower providers to develop new service models using new mechanisms and responsibilities such as e.g. Individual Service Funds and greater involvement in Support Planning.
- Reduce the resources put in by the Council and increase the control for providers.
- Develop work with accessing employment and learning

5.6 The **Good Health** workstream is focussed on reducing health inequalities by ensuring people with learning disabilities can access mainstream health services and receive specialist support when needed. Activities include:

- Improving access to and outcomes from primary care services
- Improving pathways and access to mental health services
- Reviewing the Community Learning Disability Team to meet best practice standards and improve capacity prevent and respond to crisis

5.7 The **Respite and Short-breaks** workstream aims to review and improve the support that respite services offer to family carers and to people who need short-term support in a crisis, through

- Reviewing services in this area
- Exploring alternatives service models
- Support a number of different agendas in terms of crisis support, carers support, transitions and prevention of admission.

6. First Priorities for the Merged SEND and LD reviews

6.1 As the two reviews merge, plans are already in place to make improvements and find efficiencies through effective shared planning, including budget planning.

6.2 First areas for merging action planning across Adult and Children's Services include:

- Pooling resources where this is helpful and creates flexibility across Adult and Children's Services and with Health partners
- Adopting the same system for an equitable and fair allocation of resources and direct payments
- Smoothing the transition from Children's to Adult Services by better preparation for adulthood and pathways to supported internships, apprenticeships and longer term employment
- Combining the Autism strategies and plans across Children's and Adult Services to have one approach for autism across the age range
- Encouraging inclusive practice in mainstream society and through universal services such that people with SEND and LD do not have to rely on scarce 'specialist services' and can live and thrive within the wider community
- Looking at options for outsourcing services where these can be provided more cheaply and to a good standard in the community and voluntary sector or the private sector
- Tackling the need for high cost placements where children and adults have very complex needs and challenging behaviour by improving local services including mental health and behavioural support services

7. Important considerations and implications

7.1 Legal

7.1.1 Children's

i. Part 3 of the Children and Families Act 2014, introduces a new, single, system from birth to 25 for all children and young people with SEN and their families. Section 26 of the Act requires local authorities and local CCG's to work in partnership and make arrangements for commissioning special educational provision, healthcare provision and social care provision for children and young people with SEN for whom the Authority is responsible. It does not specify the form which the arrangements should take as this should be agreed locally.

ii. Local authorities have a statutory duty to keep their arrangements for special educational provision under review pursuant to S27 of the Children and Families Act 2014, which requires the Authority to consult with a defined list of parties, including children and young people with SEN and disabilities and their parents, academies, early years providers, children's centres and Youth Offending Teams. Local Authorities are also under a new duty to have regard to the relevant Joint Strategic Needs Assessment and Health and Wellbeing Strategy when carrying out reviews under this section.

iii. The proposals will assist in implementing key elements introduced by the 2014 Act including:

- The introduction of Education, Health and Care Plans (EHCPs) to replace Statements of SEN, to be co-constructed between families and the Local Authority;
- The extension of the remit for EHCPs from 0-25 years (currently 0-19 years) and the extension of the statutory nature of Plans into all forms of further education, training and apprenticeships;
- The introduction of 'personalised budgets' to be available to families where children have EHCPs attracting 'top-up' funding (i.e. above the level of delegated funding for SEN normally provided by schools);
- The requirement to publish a 'local offer' of services and provision available for SEND;
- New requirement to commission education, health and social care services and provision jointly with Health (CCG, Public Health and NHS England Area Team as appropriate).

iv. Decision making on further proposals will need to be informed by an appropriate consultation process and equalities impact assessment. The specifics of the required decision making process will be the subject of bespoke legal advice, dependant on the nature of the proposal.

Lawyer consulted: Natasha Watson Date: 16/1/2015

7.1.2 Adults

i. It is a function of the Health and Wellbeing Board to exercise the social services and health functions of the Council in respect of adults with Learning Disabilities and therefore a constitutional requirement for it to approve the strategy and monitor progress in developing and implementing the same. The Delivery Plan resulting from the review of services under the strategy must ensure adherence to the duties under the Care Act 2014 in respect of promoting wellbeing, prevention services and arranging services to meet assessed needs. The Plan should ensure continuing compliance with the Human Rights Act 1998. Any aspects of the ongoing review and final proposed Delivery Plan arising that require Board approval will necessitate further report(s) and recommendations.

Lawyer Consulted: Sandra O'Brien Date: 25/06/15

7.2 Finance

7.2.1 Children's

i. The recommendations included in this report are currently at a high level. As the review develops further it will be necessary to detail specific and costed proposals that achieve best value and are affordable within the financial constraints operating across all agencies. It will also be necessary to ensure that the proposals are compliant with the relevant funding regulations, particularly where Dedicated Schools Grant (DSG) funding may in future be used to support provision currently being delivered through core council funding.

ii. The recommendations state that the intention is to retain at least the same number of specialist placements for children with SEN and disabilities but to re-structure and re-organise provision. This approach will safeguard DSG high needs block funding levels whilst, at the same time, delivering greater economies of scale resulting in reduced unit costs. This is critical in achieving identified savings targets in 2015/16 and beyond.

Finance Officer consulted: Steve Williams Date: 26/06/2015

7.2.2 Adults

i. Implementation of the strategy is expected to result in improved Value for Money, drive efficiencies, and deliver lower unit costs that compare more favourably in benchmarking with other local authorities. The current social care budget for people with learning disabilities is over £30m. Savings identified in the 2015/16 budget strategy aligned with this review total £2.4 million and plans have been developed to deliver against this. In addition there are significant in year emerging pressures and unachieved savings from previous years where mitigating actions are being developed but there is a risk to delivery in 2015/16.

Finance Officer consulted: Anne Silley Date: 26/06/2015

7.3 Equalities

i. Equalities Impact Assessments have been completed in relation to the SEND and LD reviews and action planning and are regularly reviewed.

7.4 Health, social care, children's services and public health

i. These areas are covered within the paper, the central theme of which is improved integration of services across health, social care, children's services and public health

8. Supporting documents and information

1. The Executive Summary of the SEND review

2. The Executive Summary of the Learning Disability Review

3. 'A Good, Healthy and Happy Life' – a strategy for Adults with Learning Disabilities in Brighton and Hove

SEND Review Report Executive Summary

January 2015

(SEND – Special educational needs and disabilities, including BESD – behavioural, emotional and social difficulties)

Report for Joint Meeting of the Children's Committee and the Health and Wellbeing Board on 3 February 2015

Brighton and Hove Clinical Commissioning Group

Executive Summary

Introduction

On 2 June and 10 June 2014 respectively the Children and Young People's Committee and the Health and Wellbeing Board agreed to a review of Disability and SEN services, including related health services. Adult Social Care has also begun a review of provision for adults with learning difficulties and disabilities. The two reviews are linking improved services for young people with disabilities over the transition to adult services.

While some of this review's recommendations are high level at this stage, taken together they represent an ambitious vision to transform provision for special educational needs and disabilities (SEND) and behavioural, emotional and social difficulties (BESD) in the City. The vision is of fully integrated provision and services across education, health and care and a personalised approach to each child and family.

In addition the aim of the recommendations is to move from the current position of broadly average outcomes for children and young people achieved at above average cost to excellent outcomes within a context of child and family-centred best value streamlined provision.

Recommendations

1. Joint Commissioning

That a new Joint Commissioning Strategy is finalised between the council (Children's Services, Adult Services and Public Health) and the Clinical Commissioning Group (CCG), to cover all provision and services to be secured for children with SEND and BESD.

2. Integrated Service Delivery

That in parallel with integrated commissioning of provision and services for SEND and BESD, there should be a commitment to the development of integrated and inclusive service delivery across education, health and care/ disability services with families at the centre and specifically:

2a. Early Years: That proposals be developed to integrate provision for children with disabilities in the Early Years by creating inclusive specialist nursery provision within one or more existing mainstream nurseries and re-locating relevant health and care services to the new provision or provisions and brought back to the Board and Committee in the summer of 2015.

2b. SEND Provision 5 – 19+: That proposals be developed to integrate provision for children with disabilities and complex, severe and profound special educational needs of school or college age, extending the remit of specialist and mainstream provision to include greater opportunities for inclusion, extended day/respite and residential facilities with relevant health and care services co-located on site and brought back to the Board and Committee in the summer of 2015.

2c. BESD: That proposals be developed to integrate existing educational, health and care provision for children and young people with BESD, including mental health needs, to provide extended day and potentially residential facilities with a strong focus on further education and vocational routes and brought back to the Board and Committee in the summer of 2015.

3. Support for Families with Disabled Children

That an extended specialist family support service be developed from within existing services so that professionals will work alongside families to tackle in situ the challenges linked to significant special needs and associated challenging behaviour.

3a. That a clear and transparent set of criteria is published for determining the basis on which families of disabled children receive respite and short break services, plus other disability and care support, and that these criteria are fairly and consistently applied by means of a representative panel.

3b. That the direct payment budget for families of children with disabilities is increased significantly to include the budget for most respite and short break services provided by the council and the community and voluntary sector, such that real choice is extended and services can market themselves directly to eligible families.

3c. That a joint agency policy on direct payments to families across education, disability, care and health services in both Children's and Adult Services is published so that families and young adults can make more holistic choices about provision in all areas of their lives.

4. Learning and Achievement for Children with SEND

That schools and colleges with lower than expected outcomes for children with SEND and wider achievement gaps receive challenge and support visits from expert advisers commissioned by the LA with a view to raising standards and promoting vocational and further education opportunities for young people with SEND and BESD and especially in secondary and post 16 provision.

4a. That the SEN education and learning support services in the city (Educational Psychology Service, Pre-school SEN Service, Behaviour and Inclusive Learning Team, Literacy Support Service, Speech and Language Support Service, Autistic Spectrum Condition Support Service, Sensory Needs Service) are co-located and combine to form one 'communication and support service' with unified professional leadership and management.

4b. That consideration be given to co-locating some relevant health professionals and particularly speech therapists and occupational therapists with the combined service to enrich the integrated support on offer

4c. That the combined new 'communication and support service' promotes partnership working between families and schools by offering support to both as routine, enabling planning across home and school and involving parents as well as school staff in training, support, advice and guidance.

4d. That the combined service works with early years providers, schools and colleges to ensure reliable and consistent identification of SEND, including BESD.

4e. That specifically the support for families with autism is extended to provide more keyworking and expert advice and guidance to parents and young people at all stages of a young person's life as required and in line with the recommendations in the council's ASC Scrutiny Report of April 2014.

4f. That a refreshed, cohesive and well-publicised workforce development offer for mainstream and special schools and associated professionals across all services is developed by the new integrated service offering high quality training, advice, consultation and guidance in all main areas of SEN based around a tiered model of 'universal', 'targeted' and 'specialist input' depending on need and circumstance – that this programme of support

is open to parents as well as professional staff and where appropriate is co-produced with parents and young people.

5. Transition to adulthood

That a reorganisation of SEND service delivery across Children's and Adult Services in partnership with Health Services facilitates transition to 25 years for children and young people through to adulthood, acknowledging both the extended age range for Education, Health and Care Plans to 25 years and also the very real and significant concerns of families about transition to adulthood and adult services.

6. Emotional and mental health

That the Children's Services Directorate works in partnership with the CCG to support the forthcoming Joint Strategic Needs Assessment in the area of emotional and mental health and the forthcoming review by the CCG of emotional and mental health services for children and young people, including young adults, across the city.

6a. That Children's Services acknowledge the serious concerns being raised by schools and families about resources for promoting emotional and mental health by strengthening the support via the Early Help Hub and from the council's community Child and Adolescent Mental Health Service (CAMHS) team to further develop skills and expertise amongst school staff via training, support and guidance.

Context

All local authorities have a statutory responsibility to keep SEND provision under review in order to be able to respond to changes in need amongst the population of children and young people**.** The last major review of SEND provision in the city was in 2009 and of BESD was in 2011.

The 2013 Joint Strategic Needs Assessment (JSNA) of the health and well-being of the community provides more recent data and has been used as part of the evidence base for the review.

With the introduction of widespread SEND reforms from 1st September 2014 in the Children and Families Act and the current financial context for the council, the timing was right to take stock and review once more the direction of travel and the value for money being achieved for the very significant spend in this area.

This review commenced in June 2014 with a wide remit to consider all identification, assessment, services and provision for pupils with SEN and disabilities within the context of new legislation and the need for continuous improvement. This included consideration of related health services, including those supporting mental health. Simultaneously a related review of provision for pupils with behavioural needs, including social, emotional and mental health needs, across the city was initiated. As the two reviews have worked closely together and have reached similar conclusions about key principles underpinning future direction, and given the overlap, the findings and recommendations of both are contained in the attached report.

The work of the review has been overseen throughout by a Governance Board consisting of parents/ carers, young people and senior officers from Children's Services, Adult Services, Public Health and the CCG plus a representative headteacher.

Scope of the Review

The four areas covered by the scope and remit of the SEND review and the linked BESD review are listed below, with the needs and views of children, young people and families at the heart of each:

- SEND provision, including provision for BESD needs
- Integrated health, care and disability provision for children and families
- Introduction of the SEND reforms (new Children and Families Act 2014)
- Joint commissioning and delivery of services with Health partners

The review has also included further response to the recommendations of the council's Scrutiny Panel in Autistic Spectrum Condition (ASC) from April 2014.

Vision

Brighton and Hove City Council is committed to ensuring that all our vulnerable children and young people have the very best start in life and the best possible outcomes as they move into adulthood. Our vision is to provide inclusive fully integrated disability, care, health and education services of high quality to children and young people with special educational needs and disabilities, including behavioural, emotional and mental health difficulties. Services will be personalised to each child and family. Families will have as much choice and control over services and provision as possible. Streamlined, well-integrated systems and efficiencies will enable the vision to be achieved within the value for money framework which the council is required to operate.

Principles

1. To engage parents and young people effectively at all levels of strategic and decision-making forums and to keep families at the heart of all we do.
2. To ensure the best possible outcomes for children and young people with SEND and BESD as children and into adulthood.
3. To promote inclusive fully integrated education, health, care and disability provision of high quality ranging from 0-25 years.
4. To ensure the most effective joint commissioning of services across education, health, care and disability services.
5. To ensure excellent practice in identification and assessment of SEN and disability
6. To deliver high quality provision and services within a value for money context, acknowledging need for on-going efficiencies in council spending.
7. To improve transition arrangements to adulthood and ensure extended assessment and provision from 19 to 25 years.
8. To provide choice for families and facilitate best use of integrated personalised budgets and direct payments.

Value for Money

Many children with SEND and BESD will have very complex and challenging needs and there is a commitment to ensuring sufficient resource to meet those needs in all areas of their lives.

However there is a critical need to secure best value for money given the high levels of spending in this area and the council's need to operate within new budgetary restraints given reductions in central government funding now and into the future.

The attached finance table to this report shows that just over £21 million from the Dedicated Schools Grant High Needs Block is spent on educating children with SEND and BESD in addition to the £12.5 million of delegated funding from the Schools Block which is distributed to schools according to a formula to meet the needs of children with SEND at a preventative and school-based level.

From the council's General Fund, just over £6.5 million is spent on care and disability services for children with disabilities plus home to school transport.

In addition, over £5.5 million is spent by the CCG on paediatric, therapy and mental health services.

In terms of numbers of children and young people with SEND overall, there are just under 8000 children and young people on school SEN registers (21.7% of pupils), of which 994 have Statements of SEN (now converting to Education, Health and Care Plans). There are 335 children and their families currently supported by the Integrated Children's Disability Service.

National benchmarking data across Local Authorities shows that Brighton and Hove spends more than the national, south east and statistical neighbour averages on additional support for children with High Needs and on SEN support services (see table below). The funding for short breaks for disabled children overall is recorded as just below the national average. However levels of short break funding for children who are recorded as 'looked after' are well above the national average and at the maximum for all authorities.

	Total Schools Budget (before Academy recoupment)	High Needs Budget	Top up funding - maintained providers	Behaviour support services	SEN support services	Short breaks (respite) for 'looked after' disabled children*	Short breaks (respite) for disabled children
ENGLAND - Average (mean)	£4,996	£293	£130	£6	£34	£5	£17
ENGLAND - Average (median)	£4,918	£293	£123	£2	£31	£1	£17
Minimum	£4,445	£154	£64	£0	£14	£0	£7
Maximum	£5,563	£360	£140	£36	£46	£36	£32
Brighton and Hove	£5,100	£332	£130	£5	£40	£36	£14
Statistical Neighbours	£4,897	£263	£111	£10	£29	£8	£19
South East	£4,859	£296	£123	£8	£30	£8	£16

(Data extracted from Government Section 251 Local Authority Benchmarking)

Higher than average funding for children with SEND is not matched currently by higher than average outcomes educationally, or through to adult life.

The review is seeking to improve provision and outcomes for children and young people, while also making savings by:

- Providing an alternative to expensive out of city education and care placements via integrated education, health and care provision in the city
- Reducing management costs by integrating and streamlining provision and services
- Introducing efficient and flexible financial arrangements by enhancing the pooling of budgets across education, care and health services and by increasing options for direct payments for parents and carers
- Saving on transport costs by providing specialist inclusive provision for education, health and care needs that is locally based

Research

The review has taken account of a wide range of national and local policy and good practice guidance plus relevant information, research and data.

In addition, a range of visits to and contact with other in other local authorities has taken place in the maintained, independent and non-maintained sectors and including health and care provision.

Close links have been maintained throughout with schools and with partner agencies in health, including mental health, at both commissioner and provider level.

Consultation

An extensive consultation process has taken place at all stages of the review so far. This has included an online survey for all stakeholders, including parents and young people. There have also been many consultation meetings and events with a wide range of stakeholders including families and professionals in the council, with schools and school governors, within health and with the Community and Voluntary Sector (CVS).

The following are messages that have come through strongly from the consultation process from parents, young people and professionals.

Key Findings from the Review

1. Joint commissioning

> 'Different professionals and services are not very holistic. Many only see the area they are working with, overlooking other issues that children may have because they cannot understand their significance' (parent)
>
> 'We have to tell the same story over and over again many times sometimes in a big meeting where it can be intimidating - I think that it has become accepted by professionals that parents cry a lot and it shouldn't be the norm' (parent)

The law now requires joint commissioning:

> *'Local Authorities and clinical commissioning groups (CCGs) must make joint commissioning arrangements for education, health and care for children with SEN or disabilities (S 33, SEN Code of practice, referring to section 26 of the Children and Families Act 2014)'*

Strategic capacity and oversight will need to be found well into the future from services across the council, including Public Health, health partners in the CCG and parent and young person representatives to meet the new legislative requirements for children with SEND. A new Children's Strategy in development between the council and the CCG needs to include a joint commissioning strategy for children and young adults with SEND to make a positive and significant difference to the commissioning of quality flexible and responsive integrated services from 0-25 years.

While the CVS services commissioned by the council and the CCG make a very valuable contribution to meeting SEND, BESD and mental health needs, there is a need for better integration of their work with the work of council and health services, for clearer outcomes measures aligned to council and health sector priorities and for more strategic procurement of contracts. This includes a refreshed policy on re-tendering where contracts are long-standing and where there is a need to test whether best value continues to be obtained. Given there are several contracts with the CVS across the SEND and mental health areas,

arrangements that enable contractual dealings with a lead contractor, coordinating the work of other contractors, can be more efficient and should be explored. Additionally CVS respite and short break services should be available in most instances for parents to purchase when they are eligible for direct payments.

Integration of education, health and care support

> 'Currently services are pushing us from pillar to post, not considering the effects on us as parents or our child' (parent)
>
> 'Why not locate key services with members of different teams in offices actually sitting next to each other – this increases the likelihood of us getting it right for families as a team around them' (professional)

While much provision across education, care, disability and health is of high quality, impact is still diluted by elements of fragmentation and 'silo delivery' of services across providers, teams and agencies. As a consequence there are unnecessarily high costs associated with duplication and unnecessary levels of management. It is the view of the review that better and more responsive services could be commissioned at a significantly reduced cost.

Opportunities to create a flexible and responsive workforce are currently limited by the way services are separately led and managed in many areas.

Parents rightly feel that services are not as well aligned as they could be and require a great deal from parents in terms of re-telling their children's life histories repeatedly to different professionals and making the connections themselves across professional groups to bridge communication gaps and support joint planning.

There is a strong desire to be inclusive in Brighton and Hove schools. There is recognition that children and young people with BESD achieve better outcomes when educated in their local mainstream schools, but schools report that behavioural difficulties are the greatest challenge they face in terms of inclusion and particularly because the successful management of behaviour is essential to achieving high academic standards for all.

On-site BESD provision run by schools has been successful in retaining a significant number of children and young people with BESD in mainstream who might previously been excluded. Further investment from schools in this area is needed to ensure all young people can access in-school support at times of difficulty when they cannot manage full integration into mainstream classes.

School staff believe in early intervention but there is a perception of high thresholds for access to those services that support children with BESD which can militate against preventative working. Similarly, schools feel that cases can be closed by agencies when needs are still on-going and when school staff continue to need support.

There remains a need for flexible, responsive and effective off-site provision which caters for a range of age groups and needs, and collaborates in an integrated way with support agencies.

Support for families of children with disabilities and complex needs

> 'I am so scared that she will really hurt herself or us and the only time anything will improve is if something serious happens' (parent)
>
> 'Direct Payments allow us to spend time with our other daughter and enables our daughter with additional needs to pursue leisure activities with the support she needs in a more

independent and age appropriate way. The outcome of this provision is improved social and emotional resilience which enables our daughter to lead a more ordinary life' (parent)

Where children have complex needs, including challenging behaviour, there is a need for improved access to bespoke support, including more intensive expert professional support at home and in the community, to manage behaviours that can cause family breakdown over time. This is particularly the case for families facing challenging behaviours that can arise as a consequence of ASC.

Further action is needed to empower parents via personal budgets and direct payments to buy services that meet their children's needs. Parents need real options to purchase services offering support and respite run by the council and the CVS or to use the money elsewhere. Direct payments across SEN, disability and health need much greater coordination to allow parents to purchase holistic support across their child's life as needed.

Learning and achievement: SEN support services for children with SEND and BESD

'I worry enormously about my son's education in the future – the difference between him and his peers is becoming more apparent. He has a one to one helper but he is often put with children who are disruptive – in other words his assistant is used to help his teacher as much as him' (parent)

'I think the support provided is fantastic. We have never had a problem with any of the service provided by our teacher of the deaf, our speech and language service or our family support worker'(parent)

'We want to work together as a cohesive group, as a learning community, to join up our expertise to offer schools the best service.' (teacher from the learning support services)

Identification of SEND and BESD in the city needs to be more robust and consistent. Identification of SEND (which includes BESD) is, and has been over recent years, rather higher than the national figure at 21.7% (January 2014 census) where the national average is 17.9%. However there is a very wide range of practice across schools even taking into account associated socio-economic factors. The range of identification of SEN across the city's schools is from 4.5% to 75%, raising some issues for further exploration at individual school and school cluster levels.

The educational achievement of children and young people with SEND continues to be a source of concern in the secondary and post 16 sectors particularly. The high levels of funding for SEND are not being sufficiently effective at improving outcomes and life chances into adulthood. While at the end of primary school, children with SEND in Brighton and Hove taking national tests do better overall than the national average for children with SEND, outcomes are still much lower than for all children and gaps in achievement are too wide. At the end of secondary school, achievement in the city is currently lower than the national average and young people with SEND have poorer further education and vocational outcomes than all children. Additionally gaps in achievement between those with and without SEND at the end of secondary school are wider in the city than nationally. There is a very serious need to address the issue of achievement gaps and secondary and post 16 outcomes for our young people with SEND by raising ambition and improving skills across all schools and learning support services.

SEN learning support services, while often of high quality individually, are currently too fragmented in their structure and management and can lack sufficiently robust focus on improving overall learning and achievement outcomes for children with SEN and disabilities. Opportunities for creating a flexible and responsive workforce to meet the widest range of needs can be lost as a consequence. Additionally there is a need for the learning support

services to work with schools in addressing issues of reliable and consistent identification of SEND.

Specialist professional support, advice, guidance and training at all stages of a child's life should be equally available to families and schools. Families feel that sometimes schools have access to support from specialist services that excludes them. This is clearly unhelpful as planning to meet a child's needs will be most effective when crossing home and school. It is essential that families should be fully included in all developments and planning to meet the needs of their children.

There is some way to go before parents are treated fully as partners in plans to meet their children's needs and they are not always fully included in advice, guidance, training and planning between professionals in relation to their children.

Services for children with ASC need to increase further their responsiveness to families, as well as to schools and to offer bespoke support and guidance to families when they encounter the inevitable challenges associated with this developmental disorder.

Families of children with autism are particularly concerned that there is an improved integration of support across school and home. It is often the case that children and young people with ASC may appear to be coping at school but are very stressed by the demands made on them, leaving families to cope with high levels of anxiety, distress and sometimes challenging behaviour at home.

Practitioners feel that successful inclusive practice is dependent on the expertise and resilience of the staff in schools and thus an investment in the systematic and comprehensive development of the school workforce is needed.

Transition to adulthood

> 'How frightening it is to move from child to adult services' (young person)
>
> 'Whilst we are continually dealing with each of the problems that come along, we also have real concerns about the our child's future - in terms of her managing as an adult - if she will be able to be independent - and where she will get support in the future?' (parent)

New requirements to support children with complex SEND from 0-25 years need to be embraced fully by council services and by partners to overcome problems associated with multiple different threshold points for services at 16+, 18+, 19+.

Gains made by children and young people with SEND often do not translate into successful experiences in adult life, and thus there is a need to restructure the way services are planned across Children's and Adult Services to ensure a more successful and streamlined transition to adulthood.

There is a need to develop more options for education from 16-25 years to acknowledge the extended age range in the new legislation.

This is an area of great anxiety for families and this needs to be acknowledged and addressed as a priority.

Emotional health and wellbeing

'My son suffers from behavioural difficulties and we have virtually no help with this - we have no idea who we could ask and it has quite a profound effect on our lives and family' (parent)

'more training and support is needed for support and teaching staff to help children with emotional and mental health needs, including those relating to Autistic Spectrum Condition' (school)

There is a widespread perception amongst children and young people, families and professionals that mental health services are not sufficient or sufficiently responsive to current levels of need and have not kept pace with the lives of our young people today. Services need to be more responsive to the dangers of internet use and the impact of social media and cyber bullying on self-esteem or the connection with the worrying rise in self-harm. Services need to increase the speed and manner of response to the changing world of social media, acknowledging the issues but also using new forms of e-communication in offering services (e.g. online counselling) that young people find easier.

Mental health services for young people need to operate out of hours to be responsive to crises as in adult services. Young people at serious risk are vulnerable because services are not currently as available as they need to be outside of normal working hours.

Conclusion

The SEND review, including a review of behavioural needs in the city, has focussed recommendations around:

- Empowering parents, children and young people by putting them at the heart of provision and increasing direct payments
- Integrating provision from 0-25 years across agencies to improve the holistic service to children and young adults while reducing management and unit costs
- Increasing the support to parents and families to manage more challenging and complex needs
- Improving partnership and joint commissioning between agencies

The review seeks endorsement for the recommendations. In relation to those proposing integrated provision and services, a radical re-organisation is required to meet the vision here and to realise the savings.

Timeline

All recommendations, except those to be brought back in the summer term 2015, are for immediate implementation and should be in place by September 2015.

Those recommendations where it has been indicated that they require a second stage to draw up more detailed proposals would have the following timetable, subject to feasibility:

- Detailed proposals to Children's Committee and Health and Wellbeing Boards in the summer term 2015
- Consultation on more detailed proposals in the autumn term 2015
- Implementation from September 2016

Appendix: Summary budget breakdown of spend of SEND provision and services

Provision Includes:	Current Services:	Costs
Education – Special schools *DSG High Needs Block* *Downs View includes post 16 funding from EFA*	Cedar Centre Downs View School Downs Park School Hillside School Patcham House School Homewood College	£1,216,726 £2,889,734 £1,744,629 £1,588,919 £ 809,779 £1,241,321 **£9,491,108**
Alternative provision *DSG High Needs Block*	Connected Hub Pupil Referral Unit	£ 476,000 £ 977,000 **£1,453,000**
Mainstream schools delegated funding including 'top up' *DSG High Needs Block*		**£1,400,000**
Special facilities *DSG High Needs Block*	Carden Hove Park Longhill Swan Centre Bevendean West Blatchington (included in Downs Park above)	£240,950 £195,000 £280,000 £242,840 £126,000 £215,408 **£1,300,198**
Support services *Mainly DSG High Needs Block ,some General Fund*	Behaviour and Inclusive Learning team Speech & Language Service (incl ICAN) Autistic Spectrum Condition Support Service (included in Downs Park above) Literacy Support Service Sensory Needs Service Educational Psychology Service Preschool SEN Service	£198,000 £333,840 £150,000 £308,000 £526,720 £912,000 £729,360 **£3,157,920**
Home to School SEN Transport Costs *General Fund*		**£1,900,000**
Extended Day Provision Pre-School / Breakfast Club Options After School Clubs *General Fund*	Brighton and Hove Inclusion Project Crossroads Cherish Extratime/YMCA Extratime Carers Grant	£ 11,507 £ 26,707 £ 41,000 £ 183,513 £ 57,582 **£ 320,309**
Residential – Full-Time and Respite Options *General Fund*	Drove Road Tudor House Barnardos Link Plus Barnardos Carers Agency temporary respite placements Outreach Service	£1,049,260 £ 584,370 £ 315,452 £ 28,809 £ 46,500 £ 205,740 **£2,230,131**
Agency Placements *General Fund* Agency placements *DSG High Needs Block*	Social care Education	**£1,592,700** **£3,525,590**
Emotional health and wellbeing *General Fund*	Community CAMHS team	**£315,000**
Social Work *General Fund*	Disability Social Work Team Keyworking Transitions team	£ 920,360 £ 90,560 £ 64,000 **£1,074,920**
Direct Payments *General Fund*		**£534,500**
SEN & Youth Employability Service *General Fund and DSG High Needs Block*		**£985,000**

Early Years Additional Support *DSG High Needs Block*	Inclusion and sensory needs support	**£285,520**
Parent support *(DSG)* and the disability register Compass card *(General Fund)*	Amaze: Core contract: Additionally funded:	**£177,000** **£85,788**

Additional Budgets *All General Fund*			
Out of School Childcare	£ 15,000	Preventative Payments	£61,400
Individual Budgets	£ 15,200	Young Carers	£18,146
Adaptations	£ 80,200		
		Total	**£189,946**

Relevant health services commissioned by the CCG

Therapy and health services	Specialist disability nursing Speech and Language therapy Physiotherapy Occupational therapy Audiology Paediatricians	£ 336,000 £1,002,000 £196,000 £ 298,000 £ 251,000 £ 816,000 **£2,899,000**
Mental health services	Tier 3 CAMHS Commissioned from the community and voluntary sector	£2,500,000 £287,667 **£2,787,667**

Brighton and Hove Council

Learning Disability Review
October 2014

Executive summary

Jenny Anderton
Jo Poynter
Neil Morrisroe

Executive Summary

The severe financial pressures facing Adult Social Care, now and in the future, combined with growing complexity of needs and rising expectations are testing commissioners and providers alike to transform the sector into one fit for the 21st century.

In August 2014 Brighton and Hove Council Adult Social Care and the Clinical Commissioning Group, as part of the Health and Wellbeing Board commissioned an independent review of Learning Disability Services. The review was commissioned to consider:

- the impact of demographic trends and patterns on the future service provision
- how services are currently commissioned
- the configuration of services to meet current and future needs of the people with complex needs

The objectives identified were:

- Consider national policy and requirements in relation to the commissioning and provision of Learning Disability Services.
- Identify current expenditure in relation to Learning Disability provision and how this may be affected by future demands and changes in policy.
- Whether commissioning plans meet current best practice standards and whether services offer the best outcomes in community settings
- Formulate an action plan to support Brighton and Hove to meet the future commissioning intent.

The Review looked at range of information, met a number of different people and covered a number of areas.

Policy context:

The implementation of the Care Act will require the Council to take on new functions, including the legal requirement of people to have a personal budget and ensure that people have access to a range of services that prevent their care needs from becoming more serious.

From a national perspective, there are specific, ongoing financial pressures associated with services for people with a learning disability. The proportion of ASC expenditure directed to learning disability services continues to rise at the same time as needing to improve planning from childhood and improve the safety and quality of care.

Needs Assessment:

Brighton and Hove has seen an increase in the demand for all services and the JSNA (2011) estimated that there would be a 12% increase in the numbers of people with a severe or moderate disability by 2030.

Political context:

The Council, made up of three parties with no one majority and political decision making under a committee system, where there is no overall control, has impacted on the delivery of service change. There has been a lack of decision making about the future of Learning disability services, with the Council having a paternalistic approach to people with a learning disability and feels that people need to be kept safe.

Strategic vision and direction:
A number of people felt that communication, consultation and decision making was particularly weak and, in the past there had been no clear strategic plan or overarching commissioning intention. There needs to be a move toward committed leaders, with a will to drive through change, combined with a sensitive and robust approach to change management, which will then, enable positive change to happen in Brighton and Hove.

Commissioning:
Brighton and Hove clearly have a talented and well-resourced commissioning team able to lead changes to learning disability services, but it has apparently been difficult driving through the personalisation agenda and change in service development and design with the in-house providers. There needs to be a shift in culture and every opportunity taken for people to see personal budgets as a real alternative to traditional services. The commissioning intention needs to reflect this, to enable providers, both in house and private, to develop the market to meet current and future need.

Budget and budget management:
Brighton and Hove Council is facing savings of £6m per year for Adult Social Care over the next three years and there is agreement, at all levels of the organisation, that unit costs for people using Learning Disability services are more expensive than comparator councils (see CIPFA data).

The pressures facing Learning Disability services are not are not seen to be as great as other service areas and as a result there appeared to be a complacent view to budget management, with managers not taking responsibility for meeting efficiency savings and seemingly taking a very simplistic view that each service should meet the same level of savings. This includes those services which are providing value for money, promote independence, social inclusion and are seen by people who use them as important.

Current market position:
Many of the current learning disability services are shaped by the fact that Brighton and Hove Council directly provide services. A significant proportion of the overall budget, 22.5% (2014/15) is spent on these services. There is a strong and skilled independent sector who feel that they are not able to compete with the in-house services on a level playing field and the council protect their own services at the cost of developing the market to meet current and future need.

People who use services:
The message from people who use services was very clear and simple. They want to be able to live independently, use public transport and have the opportunity to work. They want access to services that will support them to achieve this. *"It makes me feel very proud to come here on my own on the bus". I learnt to do this with a travel buddy, we need more of them".*

Family carers:
The most compelling message from the family carers was that they need someone to make a decision about the future. Even a message they don't want to hear is better than no message at all.

Current service provision:
The city has a skilled workforce committed to working with people who have a learning disability. In-house services however appeared to be protected from changes made in other service area by the Council and have not universally embraced the vision of a person led approach.

There are a range of service providers in the city, both in-house, provided by the council and commercial/third sector providers and a marked difference in the costs of these services, the in-house services are comparatively higher than the other providers.

Some services seem to lack ambition for service users, being service led rather than person centered, with relatively low number of people using Direct Payments or having personalised budgets or the use of telecare. Others have clearly developed a strong offer for service users e.g. Employment Team.

Recommendations:

The review has highlighted a number of areas for consideration:

1. Vision:

- To develop an agreed clear vision that is rooted in peoples' aspirations and priorities which stresses the promotion of independence, personalisation and social inclusion. This would include developing cross-party consensus and a commitment to transforming learning disability services.
- Once agreed, elected members and senior leaders should embrace and communicate a vision of Learning Disability Services and ensure that this vision is understood by everyone.
- Leaders at all levels communicate the vision at every opportunity, and make it real in the way they behave.
- That councilors remain actively engaged in setting high expectations and tracking progress.

2. Commissioning:

- Increase the synergy between Micro and Macro commissioning and ensure that services are led by the strategic commissioning team rather than the Learning disability team, being able to Micro commission through use of the in house providers.

2.1 Macro commissioning:

- An overarching strategic plan which sets out the vision and future direction of the learning disabilities service, is agreed, has sign up and is driven through regardless of obstacles that get in the way.
- Costs:
  - Continue the work on reviewing the cost of local services, and ensuring that they are cost effective, meet the assessed needs and are best value. To also take a whole system approaches i.e. the transport review and the impact of any outcomes and direct current resources to service that promote independence & social inclusion and are seen by people who use services see as important.
  - Commissioners to commission services with the whole budget and ensure that financial and other benchmarking is systematic across all services.
  - In partnership with all providers use the opportunity of efficiency savings to redesign and change the market.
- Commissioners are explicit about the outcomes they want services to achieve for people, and track these systematically.
- Develop a clear understanding of the local workforce, its size, shape, mobility and skill sets.
- As part of the integration with the NHS, review the whole commissioning system, including respective roles and responsibilities.
- Building the role of other council commissioned and provided services, such as leisure and transport, in helping people live full lives.

2.2 Micro Commissioning (assessment and support planning):

- **The relationship between macro and micro commissioners to be clearer, to ensure that macro commissioners are made fully aware of any trends or issues.**
- The introduction of personal budgets and direct payments should be seen as the first option for everyone regardless of the complexity of need.
- Support to people is based on identified need rather than best fit in existing services.
- Develop genuine person-centered planning, which is based on an ethos of citizenship and inclusion, and leads to tailored co-designed approaches.
- People are supported to access a range of networks, relationships and activities, to maximise independence, health, well-being and community connections.

3. Engagement and communication:

- Develop a clear engagement and communication strategy.
- Staff are positively encouraged to reflect on what they do, and to make suggestions about innovations and improvements.
- Actively engage people who use services and carers in the co design, development, commissioning, delivery and review of local support
- Be clear with people who use services and their family carers what decisions they can and cannot influence.
- People who use services and carers are informed at the outset of proposed changes to services; this would include the rationale, decision making process and timescales.
- There should be regular progress reports and communication about any decisions made.
- Through the involvement process, ensure council staff and partners understand and own the transformation agenda.

4. Providers:

- In-house provider managers to be responsible and accountable at all levels for spend and ensuring that they keep within budget and make efficiency savings where agreed.

Conclusion:

Brighton and Hove has a workforce which is talented, skilled and committed. The challenge is to make sure that this talent and skill is maximised and directed to serving as many people as possible, at the same time as promoting the individual's independence and meeting changing need. A clear well-articulated vision, strong leadership at all levels throughout the organisation and working with the energy, commitment and professional skills of staff will bring about innovative and new ways of meeting individuals' needs.

A good, happy and healthy life is our plan for adults with learning disabilities in Brighton & Hove, 2015-2019

More details are in A good, happy and healthy life: the delivery plan

"Staff respect my son and understand his needs, which means he can make progress and have fun. Knowing he is happy and safe means I can do the same!"

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June 2015

A good, happy and healthy life

Our plan for adults with learning disabilities in Brighton & Hove, 2015-2019

"Being independent means enjoying your life, going out to work, going out on your own"

NHS
Brighton and Hove
Clinical Commissioning Group

Brighton & Hove City Council

A good, happy and healthy life

Our plan for adults with learning disabilities in Brighton & Hove

Being my own person

1. I have a place I can call home
2. I can work and learn
3. I can get out and about and travel
4. I can try new things and go to new places
5. I get good information and advice

How will we make this happen?

- Equal access to housing that meets people's needs
- Access to technology and equipment that promotes independence
- Access to employment opportunities
- Access to learning opportunities
- Opportunities for independent travel
- Access to good information and advice
- Support for people with social care needs to be as independent as possible
- Support for vulnerable people to feel safe

How will we know it is working?

- People tell us they are happy with their living situation
- More people have their own tenancy
- More people are in voluntary work and employment
- People have opportunities to learn new skills
- People can access community services
- People have opportunities to try new things
- People tell us they can get good information and advice
- People tell us they feel safe
- People feel confident reporting concerns

Feeling a part of things

1. I can see my friends and family when I want
2. I can choose to have a relationship
3. I feel part of my community
4. I can use all the services in my City
5. I am involved in decisions that affect me

How will we make this happen?

- Support people to live locally
- Involve families in decision making
- Good support to family carers
- Opportunities for making and keeping friendships
- Support and advice for people with relationships and parenting
- Promote equal access to all services
- Work in partnership to improve community safety
- Include the views of people with learning disabilities in decision-making at every level

How will we know it is working?

- Fewer people live in out of area services
- People and family carers tell us they are involved and satisfied with services
- People tell us they have the friends and relationships they want
- Evidence that people are involved in community based activities
- The needs of people with learning disabilities are included in all plans and strategies that affect their lives
- There are a range of ways for people with learning disabilities and family carers to affect decision-making
- Increased uptake of carers assessments

My choices, my decisions

1. I am able to make decisions
2. I feel listened to and treated with respect
3. I am in control of my money
4. I can plan for my future
5. I can choose how I am supported

How will we make this happen?

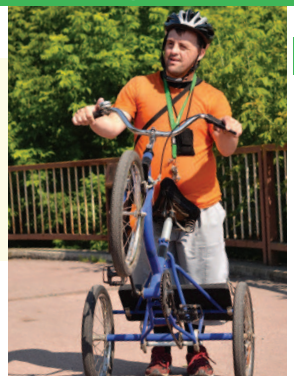
- All services understand the Mental Capacity Act
- Respect people's right to privacy and confidentiality
- Put people at the centre of assessments & support plans
- Make sure social care services provide good quality and reliable support
- Make sure all social care services are good value
- Make sure there are fair and open processes for allocating resources
- Offer a Personal Budget to all people with social care needs
- Plan with people as their health and social care needs change

How will we know it is working?

- All health and social care services comply with the Mental Capacity Act
- 100% of health and social care services have accessible complaints processes
- 100% of social care services complete annual service user surveys
- 100% of people with social care needs have a Personal Budget
- There is a plan for transition for all young people with social care needs from age 16
- People can access independent advocacy when they need it
- People tell us they have control over their daily life
- 100% of Support Plans clearly involve people
- 100% of social care services involve people in recruitment

Healthy and happy

1. I know how to make healthy choices
2. I can be fit and active
3. I can have fun
4. I get good health care
5. I can get good mental health care if I need it



How will we make this happen?

- Provide good information to support people to understand their health needs & make informed choices
- Promote equal access to leisure services and community activities
- Equal access to all health and mental health services
- Support equal access to healthcare with specialist learning disability support where needed
- Training to support staff & families to understand and respond to health and mental health needs
- Ensure services respond to people's changing health needs

How will we know it is working?

- Data shows that people are accessing disease prevention, health screening, and health promotion
- More people take part in physical activity
- Every eligible person with a learning disability can have an annual health check
- More people are a healthy weight
- People report high levels of health, well-being and quality of life
- People report they are engaged in activities they enjoy
- Evidence of reasonable adjustments in health and mental health services
- 100% of learning disability social care providers are signed up to the Health Charter

1. **Formal details of the paper**

1.1. **Update on Cancer Screening in Brighton and Hove**

1.2 **Who can see this paper?**
All

1.3 **Date of Health & Wellbeing Board meeting**
July 21st 2015

1.4 **Author of the Paper and contact details**
Dr R M Kammerling, Consultant in Public Health Medicine, Screening and Immunisation Lead for Surrey and Sussex, PHE/NHSE
m.kammerling@nhs.net
Nicola Rosenberg, Public Health Principal
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2. **Summary**

2.1 Following the presentation to the Board in October 2014, a Task and Finish Group met to consider the issues raised by the presentation, and to ensure there was sufficiently joined up working between the organisations involved in helping support the national cancer screening programmes.

This paper shows the actions in relation to the recommendations made in October 2014.

3. **Decisions, recommendations and any options**

3.1 To note the actions taken in response to the issues raised.

4. **Relevant information**

4.1 A paper was presented to the Health and Wellbeing Board on 14th October 2014, and the Board asked for a Task and Finish Group to consider the issues raised in the report. The task and finish Group has met, and completed its task.

4.2 The membership included NHSE/PHE as the commissioners of screening services, the CCG, the Local Authority and HealthWatch. The Group met once, and considered that actions were well in hand to address the issues raised.

Issues raised and actions

NHS England and the embedded PHE team to:

Issues	Actions
• Commission screening programmes and ensure that all partners work collaboratively across the system;	Screening Programme Boards now regularly invite CCG and local authority attendance.
• Work with programmes and local partners to ensure that the service is offered in ways which increase the likelihood of uptake;	NHS England staff regularly review initiatives at a national level which show themselves to be successful, and support any local action – for example, the links between the CCG and the Bowel Screening Hub to personalise the screening invitation letters.
• Support the breast screening service in the recruitment of key staff to reduce round length to 36 months and to maintain service quality for screened and symptomatic patients;	This continues to be part of the contracting/performance discussions between NHS England and the service. Early indications show an improvement in round length over 14/15,and achievement of the national target by March 2015.
• Provide Local Authority public health and CCGs with timely data;	This continues to be a challenge, with data being produced six monthly. Recent changes in the organisational structure and management approach within NHS England mean this will improve to a 3 monthly cycle in the course of 15/16.
• Ensure improvements in the quality of cervical smear taking.	NHS England/PHE are in the process of developing a strategy on smear quality and are entering into discussions with key colleagues in the CCG, to gain their active support.

Brighton and Hove City Council Public health Directorate to:

Issues	actions
• Continue to raise public awareness of screening programmes targeting those living in the more disadvantaged areas and those groups that evidence suggests are less likely to take up screening (such as people from BME groups, people with learning difficulties, lesbian women and, for bowel cancer screening, men);	BHCC commission SCT to increase awareness of screening programme targeting disadvantaged areas. As the current contract ends December 2015 there will be a review of programme performance and plans are being made for future commissioning.
• Improve understanding of screening by signposting to existing literature in minority languages and for patients with learning disabilities;	BHCC with the CCG has updated local posters and leaflet materials to improve awareness of cancer in the city. BHCC and CCG reviewed websites where minority languages and easy read versions were available. SCT are aware of all these materials and have hard copies to share with groups. It was agreed that it was not necessary to duplicate the materials already out there by reproducing them.
• Ensure there is a particular focus on bowel cancer screening - the newest of the three cancer screening programmes - where uptake rates are lowest working closely with the Sussex programme manager;	This work has been led by the CCG, who are working closely with the Bowel Screening Hub to test out personalised letters of invite from the GP, rather than the hub. The CCG has also commissioned a social marketing project to focus on behaviour change interventions with target communities to increase uptake.
• Ensure sexual health clinics continue to be commissioned to provide opportunistic cervical screening.	This is included in the service specification. There remain concerns that women can no longer choose to have their smears carried out in a sexual health clinic. This is a national issue, rather than a local one,

	although locally, we are still trying to assess if this is a specific problem for local women

The CCG to:

Issues	Actions
• Ensure GPs are aware of screening rates in their practice populations, particularly for cervical screening which is mostly delivered in general practice, and encourage practices to increase uptake through sharing best practice;	Screening rates were shared with all practices and there were discussions around how to increase uptake during peer to peer quality meetings Jan / Feb 2015. There are screening targets to monitor the progress for the new integrated outcomes based contract for practices to start April 2016.
• Identify issues at practice level where uptake of cervical screening is poor;	Following the peer to peer quality meetings, the practices put together action plans for improving on particular outcomes. These plans are being monitored and feedback is given to practices.
• Consider strategies for targeting those who DNA the breast and bowel cancer screening programmes in conjunction with NHS England;	The CCG has commissioned a social marketing project to look at increasing attendance for breast and bowel screening.
• Maximise the efficient use of existing primary care and laboratory staff resource by avoiding duplication of cervical smears	A more detailed programme of work is being developed by NHSE, in coordination with CCG staff.

4.3 In addition an in depth Cancer Awareness survey of 3000 residents was undertaken Jan – March 2015 to assess the changes in levels of awareness since the first survey was undertaken in the city in 2010.

4.4 The recent survey showed that the majority respondents claimed they were aware of both the NHS breast cancer and cervical cancer screening programmes (84% and 81% respectively). As expected, awareness is significantly higher amongst female residents. Consistent with earlier trends, awareness of the programmes is lowest amongst residents living in the most deprived area.

4.5 Significant improvements have been made in terms of awareness of the NHS bowel / colorectal screening programme (62% now aware compared to 32% in 2010). The proportion aware has increased significantly across all demographic groups and different deprivation areas.

Update on performance

4.6 The October 2014 paper showed uptake for the year to march 2014. Data for the year to March 2015 has yet to be published, so it is not possible to update these in detail. However, a number of key points are flagged below:

Cervical screening

4.7 Brighton and Hove continues to demonstrate poor take up of the offer of screening. Recent publicity and local efforts may have begun to tackle this, but formal data to show this is not yet available.

Breast screening

4.8 The long standing problems which have resulted in the increased length of time between screens have largely been tackled. Although the service struggles to ensure women are screened within 36 months, it is achieving a rescreen period of 38 months, and more recently, the service ensures an offer of screening within the three year target to all those eligible. However, this will take some time to impact on the current cumulative data and we anticipate a steady improvement year on year. It will take 3 years before the maximum impact will be identifiable through the national data.

Bowel screening

4.9 Overall, the CCG continues to meet national targets, but the variation at practice level remains. A new form of screening, involving offering an endoscopic examination where the inside of the body is examined using an endoscope (a long thin, flexible tube) of the lower part of the bowel, to people when they turn 55 is being rolled out gradually across the area. By treating lesions found at this examination, the chances of developing cancer later on are significantly reduced.

4.10 A new screening test for blood in the stools has been piloted nationally. It is a simpler test than the current one, and is likely to be rolled out widely as a national initiative. This has been found to increase uptake rates.

5. Important considerations and implications

5.1 Legal

There are no legal issues raised by this paper, which is for information only.

Lawyer consulted: Jill Whitaker 6th July 2015

5.2 Finance

There are no direct financial implications arising from this report

Finance Officer consulted: Michael Bentley 6th July 2015

5.3 Equalities

More deprived areas are likely to have poorer uptake of screening programmes. The bowel and breast programmes have been tasked with undertaking a health equity audit of their service, and are linking to the Council Public Health information team. This audit will then be used to inform an action plan to tackle the identified inequalities. The task is part of the contracting CQUIN arrangement, whereby a small proportion of the total budget is put aside and only paid after successful delivery of the stages of the audit.

The BHCC commissioned SCT project focuses on those living in more deprived areas.
Equalities Officer consulted: Sarah Tighe-Ford 6th July 2015

5.4 Sustainability

Early diagnosis of cancer prevents the need for more complex treatments.

5.5 Health, social care, children's services and public health

The planned new contract with GP practices working in clusters of practices strengthens support for patients to attend cancer screening. This new contract further supports the actions made in this paper and is joined up with public health local commissioning with GP practices.

6. Supporting documents and information

Attached documents: None

1. Formal details of the paper

1.1 Better Care Fund Update

1.2 This paper can be seen by the general public.

1.3 This paper is for the Health & Wellbeing Board meeting on 21st July 2015

1.4 Author: Geraldine Hoban, Chief Operating Officer, Brighton and Hove Clinical Commissioning Group (Geraldine.Hoban@nhs.net)

1. Summary

This paper describes in brief the Better Care Fund for Brighton and Hove, provides a breakdown of the Section 75 pooled fund and updates the Committee on performance and delivery of the Better Care Programme.

2. Decisions, recommendations and any options

The Committee is asked to note the contents of this paper.

4. Relevant information

The Better Care Fund was announced in June 2013 and sets out the expectation that Clinical Commissioning Groups and Local Authorities will agree plans and pool funding to oversee the integration of care and support for frail older people. It is believed that better, more integrated care will alleviate the need for other health and social care services (principally emergency admissions into acute care). Health and Wellbeing Boards are responsible for overseeing local agreements.

In Brighton and Hove our collective vision for Better Care is to help people who are vulnerable or frail optimise their health and independence by providing more pro-active, preventative services.

The unique demography of Brighton and Hove has lead us to believe that a focus on people who are elderly and frail alone will not deliver the sort of health improvements needed for our most vulnerable communities nor have the necessary impact on statutory service provision. For this reason we are working to a broader definition of frailty and incorporating those with complex care needs or a vulnerability to adverse health outcomes, whatever their age. We estimate that approximately 5% of our adult population will be defined as significantly frail.

There are a number of key workstreams associated with our integration programme:

1. Integrated Care. We are strengthening the infrastructure of primary care to enable greater collaboration between clusters of General Practice. They will be responsible for a greater role in identifying frail and vulnerable people via a new case-finding tool and clinically co-ordinating care around these patients. We are increasing the capacity and skill mix within integrated community teams and extending the membership of multi-disciplinary teams working at cluster level to consistently incorporate mental health, substance misuse, social care staff, carers, independent care providers and the third sector.
2. Integrating Care around the Homeless. A similar multi-disciplinary approach as outlined above has been developed but with a specific focus on homeless people. Based around our homeless GP Practice in Morley Street it includes a range of out-reach services provided by the third sector to ensure care and support is delivered in the most appropriate way.
3. Protecting Social Care. This ensures a focus on supporting our most vulnerable people in the City, maintaining eligibility criteria for adult social care, implementing the Care Act and extending support for carers.
4. Personalising Care. Introducing more bespoke care plans which better meet the individual needs of frail people through the improved use of tele-care, community equipment and the roll out of personal health budgets.
5. Early identification and support for people with dementia. Lack of diagnosis limits access to the relevant care and support and increasing the rate of diagnosis is a key element of our Better Care Plan. We are investing in additional capacity in our memory assessment services and supporting a programme of work in General Practice as well as strengthening support services for people with dementia.
6. Keeping People Well. Adult Social Care, the CCG and Public Health are working together to ensure service providers in the community and third sector support people to make and maintain positive lifestyle behaviour changes by either offering healthy lifestyle information or signposting as appropriate.

The aim is through more proactive care to avoid spend in the acute and long term care sector and to move this resource to more integrated primary care and community services.

There are five national Better Care metrics which relate our local Better Care programme:

I. Reduce non-elective admissions by 3.7% (equivalent to 956 admissions a year)
II. Reduce permanent admissions to care homes by 13.3% (equivalent to 32 admissions a year)
III. Improve the proportion of older people who are still at home 91 days after discharge from hospital into re-ablement services to 89.1%
IV. Reduce delayed transfers of care from our Acute Hospital by 5.2% (equivalent to 308 fewer delays a year)
V. Increase our dementia diagnosis rate to 67%.

Appendix A is the first version of a report that will come to the Better Care Programme Board and Health and Wellbeing Board on a quarterly basis. It provides an update on the delivery of our transformation programmes, outlines our performance against national targets and highlights key risks.

In terms of our performance, whilst we have seen a reduction in the number of emergency admissions by 106 during the last quarter of 2015/16, this is below the target of 225. The period during and following Christmas 2015 was one of significant pressure for the NHS generally. With our acute trust under increased pressure and significant numbers of patients with higher levels of acuity we opened additional community beds and flexed criteria wherever possible to enable swift discharges. Despite a previous downward trend in permanent admissions to nursing homes we have, over the past year seen an upturn in these numbers. Our intention is that services under the Better Care and Urgent Care Programmes will keep people independent and at home for longer, decrease lengths of stay in hospital and assess people's long term care needs at home rather than in a hospital setting thereby decreasing our high dependence on residential care. Our dementia diagnosis rate, has improved significantly from the baseline of 35% two years ago to 58%. Whilst this is a significant improvement we have not yet achieved the target of 67% and an action plan to address this has been developed. Delayed transfers of care, whilst declining in previous years have begun to increase. This is against a very low baseline when compared to comparative areas but is still moving in the wrong direction. We are currently in the process of re-commissioning our intermediate care beds to enable more streamlined assessment and discharge arrangements for people requiring step down care.

With regards to the delivery of our transformational programmes, there is some detail to be worked through on updating our project plans for 2015/16 as a result of aligning two significant programmes of work - proactive care and frailty into one - integrated care. This is the most far reaching and ambitious programme of work which has already seen the establishment of six GP clusters for the City and the procurement of a case finding tool. Over the next six months we will begin to properly define and identify the 5% of our population who are complex and with the extended multi-disciplinary teams, plan and co-ordinate their care more proactively. This will commence within one cluster in September and then roll out to city wide coverage over the coming year

The detail of our pooled budget is described in Appendix B.

We are required to pull together an agreement outlining our Better Care Programme, describing our pooled budget arrangements and setting out how we manage financial risk and share commissioning resources. This Section 75 Agreement has been worked on by both the CCG and Council and now with the lawyers for the final check. It is expected that this document will be signed off by the end of July.

5. Important considerations and implications

5.1 Legal

There are no legal implications arising from this update. Legal services are leading on finalising the Section 75 Agreement which will come to the next Health and Wellbeing Board in full.

5.2 Finance

The Better Care Fund Budget equates to just over £20m annually for the City. Appendix 1 sets out the detailed breakdown of the pooled budget and also outlines non-recurrent investment outside of the formal pooled fund available for pump priming transformational change. The Council's Pooled Fund Manager will, in collaboration with the CCG Finance Lead produce quarterly finance reports for the Health and Wellbeing Board going forward on expenditure against this budget.

5.3 Equalities

An equality impact assessment will be completed on specific commissioned services within the overall programme.

5.4 Sustainability

A sustainability assessment has yet to be completed.

5.5 Health, social care, children's services and public health

Health, social care, and public health are all key members of the Better Care Programme Board and have been fully involved in the development and delivery of the Better Care Plan.

6 Supporting documents and information

The full Better Care Fund submission can be found at: www.brightonandhoveccg.nhs.uk/sites/default/filesresources/better_care_fund_plan_part_1final_10dec14.pdf.

Appendix A – Better Care Performance Summary Report Jun 2015

Appendix B – Better Care Pooled Budget and Non-Recurrent Investment 2015/15

Appendix A

Better Care Performance Summary June 2015

1. Introduction

This report provides the Health and Wellbeing Board with an overview of performance against national targets, national conditions and local measures associated with delivery of the Better Care Programme.

2. National Targets & Conditions

There are 5 national metrics which are used to monitor performance of the Better Care programme:

1. Reduce non elective admissions
2. Reduce permanent admissions to care homes
3. Proportion of older people who were still at home 91 days after discharge from hospital into reablement services
4. Reduce delayed transfers of care by
5. Increase dementia diagnosis rate

There are also six national conditions which must be met. They are as follows

1. Plans jointly agreed
2. Social Care has been protected
3. 7 day services are available
4. Data is shared across settings
5. Joint approach to assessments and care planning is in place
6. Agreement on the consequential impact of changes in the acute sector

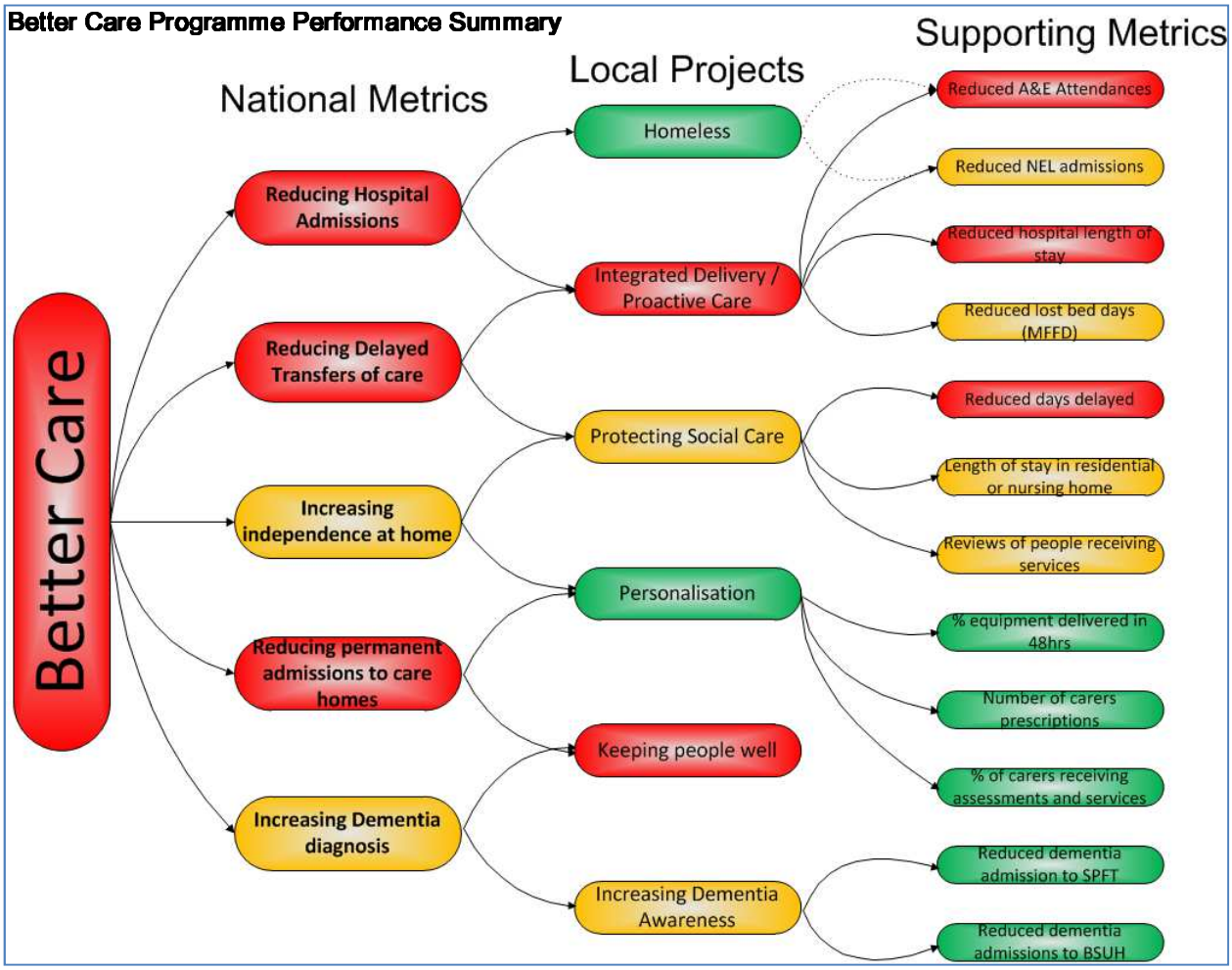
In Brighton and Hove there are 4 programmes of work, supported by 3 enabling workstreams, which collectively will deliver the Better Care Programme requirements.

The following report outlines local performance and highlights risks to programme delivery.

3. Current Performance

The diagram below illustrates the national and local metrics used to measure the performance of the better care programme, each item is coloured according to current performance i.e. red indicates delivery of less than 60% of plan, amber between 60% and 80% and green 80% or above.

Since last quarter the overall programme status has moved from AMBER to RED. This is because performance against two of the national targets deteriorated (permanent admission to care homes moved from GREEN to RED and Dementia Diagnosis moved from GREEN to AMBER). In addition the Keeping People Well local project moved from GREEN to RED.



4. Performance against the national targets

The current performance against the national targets in 2014/15 is contained in the table below:

Metric Description	Plan	Actual	RAG	Reason for under performance
Reducing Hospital Admissions - Non elective admissions	-225	-106	RED	The number of emergency admissions to hospital decreased by 106 in the last quarter of 2014/15. This reduction was not as significant as we had planned (225). The less than planned reduction was due to a delay in the role out of the Better Care Programme and its associated projects.

Metric Description	Plan	Actual	RAG	Reason for under performance
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	1,583	2,969	RED	The number of delayed transfers of care was declining during the two year period 2012/13 – 2013/14 however in 2014/15 this trend was reversed and a steady increase was observed.
Increasing independence - Proportion of older people who were still at home 91 days after discharge from hospital	48	4	AMBER	The numbers of people still at home 91 days after discharge into reablement / rehabilitation services has declined significantly in the previous two years and the slight improvement in 14/15 has halted this decline. This indicator needs to be viewed alongside a second indicator which measures how many people leaving hospital are able to access reablement / rehabilitation services, this indicator has consistently shown that people have a high level of access in the city. We will again seek to run a report this year on the reasons people where no longer living at home after 91 years. It is of note that in 2013/14 the key reason why performance dropped from 12/13 was because more people had died once they had gone home.
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	-30	29	RED	After several years of steady reductions in the number of people permanently admitted to residential and nursing home the number of admissions year on year actually increased in 2014/15, particularly in the latter half of the year. This is of concern given both our aim of supporting people in the community and the financial impact on the Council. Whilst there is no available evidence that any of these placements were inappropriate the Council will be undertaking a more detailed analysis looking at additional data such length of stay, the split between residential and nursing care, the setting people were in prior to admission and whether any of these admissions could have been avoided if other services had been available. We will also be benchmarking with regional and national colleagues once the full data set is available. (note ; this indicator is being reported in Better Care using the definitions used in previous years to enable valid year on year comparison. The national definition for this indicator changed in 14/15.)
Increasing Dementia Diagnosis - Dementia Diagnosis Rate (%)	67%	58%	AMBER	The improvement delivered as a result of primary care audit was less than anticipated. Plans are in place to improve performance to 67%.

5. Local Programme Delivery & Delivery of the National Conditions

Of the four delivery workstreams one is rated as **GREEN**, two as **AMBER** and one as **RED.** The table below summarises the status of each workstream and rationale for the RAG rating.

WORKSTREAM	SUMMARY OF STATUS
Integrated Delivery Overall RAG Rating: **Detailed Plan required** 	**Workstream Co-ordinator - Natasha Cooper** • Frailty and Proactive Care have been aligned and now referred to as 'Integrated Care' – implementation plan required • Engagement underway for the Experience Led Commissioning pilot. • Homeless project have raised an issue around premises which may affect the ability for the new service to go-live as planned in May 2016.
Personalisation Overall RAG Rating: **On track** 	**Workstream Co-ordinator – Neil Francis** • Workstream Coordinator working with Project Leads to develop PIDs. • Outstanding issue to be resolved regarding the Telehealth Lead • A request has been made for a view on the budget lines for this workstream.
Protecting Social Care Overall RAG Rating: **At risk** 	**Workstream Co-ordinator – Anne Hagan** • Workstream is rated amber due to minor delays and risk status; particularly relating to the Care Act Implementation and recruitment of social workers. • Financial modelling to be undertaken to mitigate financial risk of increased expenditure from the Care Act. • PIDs to be developed to scope work for phase two and agree milestones.
Keeping People Well Overall RAG Rating: **High risk** 	**Workstream Co-ordinator – Annie Alexander** • Workstream is rated red because it did not effectively mobilise or agree deliverables in phase one. • The MyLife project fell under this workstream though has now transferred to Comms & Engagement. • A paper outlining proposed projects is due to be presented to the Board by the Coordinator by the end of June.

6. Risks

There are three key risks associated with the delivery of the Better Care Programme:

Description	Score	Mitigation Plan & Recommendations
1. Integrated Delivery Workstream There is a risk that without an agreed service specification for Integrated Care, the Integrated Provider Board may not have a clear mandate or direction to support implementation of the new service model.	*3 x 3 = **9*** 	A clear commissioning spec is now being worked on by the new Commisioning Lead. A Clinical Lead Rachel Cottam has now been appointed to help provide leadership to this programme of work.

		A detailed programme of implementation is being produced. The first meeting of the Integrated Provider Board has now taken place and pace and clarity of direction is being strengthened.
2. Increase in Non-Elective Activity There is a risk that the recent performance figures showing an increase in the number of non-elective admissions may result in a loss of confidence in the viability of the programme, financial implications under section 75 and continued poor performance.	*4 x 3 = **12*** 	A detailed programme of urgent care recovery has been produced under the auspices of the System Resilience Group. A joint PMO process to oversee delivery of partners' work programmes has been established – overseen by a new Interim Director for Performance and Delivery.
3. Recruitment & Workforce There is a risk that current recruitment and workforce issues affecting Providers across the city may result in the inability for the programme to realise the transformational change outlined in the original plans.	*4 x 3 = **12*** 	There are no mitigation plans in place, however it is recommended: • The Integrated Provider Board be tasked with the specific role of workforce development and planning for Integrated Care • A risk owner should be assigned.

7. Recommendations

The Health and Wellbeing Board are asked to note current performance.

Appendix B Better Care – Detailed S75 pooled budget for Better Care.

			Total £
1	Integrated Delivery Workstream		
	Natasha Cooper (CCG)		
	1.2	Integrated Care (Sarah Bartholomew)	
		Proactive Care (Primary Care)	1,500,000
		Additional Care Managers working across the City localities 7 days per week	145,000
		Additional Mental Health nurses (IPCT)	100,000
		Additional therapy capacity (IPCT)	150,000
		Additional nursing capacity (IPCT)	160,000
		Additional therapy in Integrated Primary Care Teams	283,392
		3 Social Workers in IPCT's	120,000
		Baseline IPCTs	7,076,532
		SCT increase in IPCT late shift nursing to support Collaborative working with CCRS	111,000
		SCT in-reach IPCT Frailty Co-ordinator £100K	100,000
		Incentivising care homes and homecare providers to respond 7 days per week	69,000
		Pharmacy (IPCT)	105,288
	1.3	Homeless Model (Linda Harrington)	607,000
2	Personalisation Workstream		
	Neil Francis		
	2.3	Integrated Comm. Equipment (Anne Richardson-Locke)	1,338,784
	2.4	Supporting Carers (Gemma Scambler)	
		Carers Reablement Project (previously known as Carers Befriending)	40,000
		Alzheimer's Society – Information, Advice and Support for Carers	50,000
		Alzheimer's Society – Dementia Training for Carers	10,000
		Sussex Community Trust – Carers Back Care Advisor	34,000
		Amaze – Carers Card Development	10,000
		Carers Centre – Adult Carers Support	128,000
		Carers Centre – Young Carers Support	32,000
		Crossroads – Carers Support Children and Adults	47,000
		Carers SDS Breaks and Services – spot purchase budget	25,000
		Carers Centre – End of Life Support	18,000
		Amaze – Parent Carers Survey	1,000
		Dementia	22,000
		Carers SDS Breaks and Services – spot purchase budget	100,000
		Crossroads – Carers Health Appointments (previously known as Carers Prescriptio	75,000
		Working Carers Project - ASC Supported Employment Team	60,000
		Hospital Carers Support – IPCT Carers Support Service	54,000
		Carers Support Service - Integrated Primary Care Team (ASC Staff)	185,000
		Carers	554,000
3	Protecting Social Care Workstream		
	Anne Hagan		
	3.1	Care Act Implementation (Philip Letchfield)	
		Maintaining eligibility criteria	2,904,000
		Protection for Social Care (Capital grants)	484,000
		Disabled facilities grant (Capital grants)	911,000
		Additional social workers for Access Point	70,000
		Telecare and Telehealth (Capital grants)	200,000
		Additional call handling resource for CareLink out of hours	35,000
		Additional Telecare and Telehealth resource	200,000
		Protection for Social Care	1,189,000
4	Keeping People Well		
	Annie Alexander		
		Retention of preventative services	300,000
		EMBRACE	50,000
		Information Prescriptions	100,000
	4.X	Dementia	
		Dementia Plan	250,000
		2 Band 6 RMNS for care home in reach / Dementia Patients	81,000
		TOTAL	20,084,996

Better Care Fund Enablers

The schedule below details the funding earmarked in CCG budgets (outside of the pooled fund) to support of the establishment of Better Care schemes.

Supporting Workstreams

	Comms	Recurrent	Non recurrent	Total
A	Programme Support		£ 70,000	£ 70,000
	Total	**£ -**	**£ 70,000**	**£ 70,000**

	Enagagement	Recurrent	Non recurrent	Total
A	Community development support	£ 75,000		£ 75,000
A	Case studies	£ 10,000		£ 10,000
H	Community navigator	£ 135,000		£ 135,000
A	Experience led commissioning		£ 60,000	£ 60,000
H	Brefriending expansion	£ 137,000		£ 137,000
	Total	**£ 357,000**	**£ 60,000**	**£ 417,000**

	Business Intelligence	Recurrent	Non recurrent	Total
A	DMIC data collection - system build	£ -	£ 180,000	£ 180,000
A	DMIC data collection - maintenance	£ 70,000		£ 70,000
H	Associated hardware	£ -	£ 40,000	£ 40,000
	Total	**£ 70,000**	**£ 220,000**	**£ 290,000**

	IM&T	Recurrent	Non recurrent	Total
A	Project Managers - IM&T Implementation		£ 110,000	£ 110,000
A	Programme Co-ordinator		£ 40,000	£ 40,000
A	Business Process Analysis		£ 40,000	£ 40,000
A	Data Cleansing / NHS No - BHCC	£ 8,000		£ 8,000
A	Data Cleansing - SECAMB	£ 30,000		£ 30,000
A	Data Cleansing - SPFT / SCT	£ 20,000		£ 20,000
A	Specialist Support	£ 20,000		£ 20,000
A	Primary Care Pro-active Frailty Risk Strat	£ 60,000		£ 60,000
A	BH Ph1 Social Care (to NHS and NHS to Social Care)	£ 186,000		£ 186,000
A	BH Ph2 SPFT	£ 115,000		£ 115,000
A	BH Ph3 SCT / BICS	£ 100,000		£ 100,000
A	BH Ph4 BSUH - Royal Sussex	£ 115,000		£ 115,000
	Total	**£ 654,000**	**£ 190,000**	**£ 844,000**

	Frailty / PHB	Recurrent	Non recurrent	Total
A	Integrated Service Delivery - Project Manager		£ 80,000	£ 80,000
A	Proj Admin (assume will be extended 6mth to end of FY)	£ -	£ 27,000	£ 27,000
A	PHB Project Manager - 1yr (NF)		£ 70,000	£ 70,000
	Total	**£ -**	**£ 177,000**	**£ 177,000**

A	Clinical Support to Pharmacists		£ 116,778	£ 116,778
A	Voluntary & Community Post for Better Care		£ 46,400	£ 46,400
	Project Support to developing premises for Homeless team		£ 10,000	£ 10,000

	Total All	**£ 1,081,000**	**£ 890,178**	**£ 1,971,178**

Payment for Performance

Nationally £1bn of the total Better Care Fund was tagged as being a payment for performance – the achievement of planned Non-Elective activity levels. For Brighton & Hove this is circa £5m.

There has been a lack of guidance or clarification of how this will work in practice, particularly given the overperformance against Non-Elective activity plans, being experienced nationally in the final quarter of 14/15.

Initial guidance suggested that the performance payment, rather than being available for the pooled fund would be allocated directly to the CCG to be spent outside of the pool to ensure that funds were available to cover the additional costs of the overperformance. This is less of an issue for Brighton & Hove in 15/16, as we have a risk sharing arrangement in place with the Trust. The Finance & Performance group is keeping this issue under review.

NHS England – South (South East)

GP Practice Closures

1. Background regarding GP practice closures

NHS England holds contracts with over 602 GP practices across the South East (covering the Kent and Medway and Surrey and Sussex areas).

A contract to provide GP services can come to an end (legally known as the contract terminating) for a number of reasons.

The reasons why a contract may end include the following (although this list is not exhaustive):

- **Automatic termination of the contact (for example if the contract was established as a time-limited contract and was due to end)**
- **Termination of the contract following notice given by the contractor (for example if a GP/GPs who hold the contract for services choose to retire)**
- **Termination of the contract by the commissioner (for example if a GP contractor repeatedly failed to deliver services to patients in accordance with the required standards then NHS England might have to end the contract).**

2. Timescales for the termination of a contract

The timescales within which a contract for GP services may end vary across the above three scenarios. For example a contract may have to come to an end immediately on the grounds of patient safety, or the contract may end after a period of notice is served (for example in the case of a retiring GP who holds the contract).

3. Process undertaken when a contract to provide services comes to an end

In any case where a contract for the provision of GP services is to end, NHS England's priority will always be to ensure that affected patients have ongoing access to good quality care from another provider.

In such cases, NHS England is faced with making an important commissioning decision regarding the future management of care for patients registered at the affected GP practice. In this respect there are only a limited number of options available to us. These are:

a) To commission a new contract to secure ongoing services to patients registered at the affected practice.

This would be in the form of an alternative provider medical services (APMS) contract for a fixed-term period. It is important to note that this option often requires NHS England to put in place an interim contract for the provision of services, so as to allow sufficient time for a full procurement exercise to be undertaken and in order to select a new provider for the longer term.

APMS contracts can be held by a range of different providers (including GPs, other healthcare providers, third sector organisations and others) and therefore meet the requirements of procurement law.

b) To support affected patients in re-registering with other existing GP practices.

This means that the existing list of patients from a GP practice would be dispersed and the practice closed. This option may be necessary if the practice is not considered to be viable and sustainable for any reason, or were the practice premises no longer available for an alternative provider to use.

4. Considerations taken into account in responding to the end of a GP services contract

In considering how to secure the future care of patients when a GP practice contract ends, NHS England would conduct an initial options appraisal in liaison with the relevant clinical commissioning group (CCG), neighbouring GP practices, and the Local Medical Committee (LMC). The purpose of this is to explore the range of options available for the future provision of care to patients. The elements to consider are:

- **Premises** – It is important to establish if the current premises are owned by the current contractor or are leased from a third party and whether they will continue to be available for use as a GP surgery after the existing contract ends. In addition we would wish to understand whether the premises are compliant with Care Quality Commission (CQC) standards and that they meet the requirements of relevant legislation (for example the Disability Discrimination Act).
- **Capacity within the local area** – we would wish to understand whether there was sufficient capacity amongst other existing local GP practices to register affected patients should the practice.
- **Patient choice and experience** – we would want to understand whether patients could continue to obtain the same range of services locally and whether they would need to travel an increased distance to their nearest practice. We would also need to consider whether there was sufficient choice within the surrounding area if the practice were to close
- **Sustainability** – we would need to make a judgment about whether the practice is sustainable, both clinically and financially.

On the basis of the options appraisal, NHS England will then consider what action needs to be taken in order to guarantee ongoing access to care for affected patients.

5. GP contracts that have come to an end in Brighton and Hove

During 2015 the contracts for services at two GP practices in Brighton and Hove have ended, with the circumstances being entirely different in each case. In both cases, NHS England had to respond to the different circumstances in order to make sure that patients could continue to access GP services

- ***Eaton Place Surgery***

This practice closed in February 2015 following the decision of the two GP partners to resign from their contract, thus terminating it. This practice had 4,091 patients registered with it as of 1 January 1 2015. The partners provided the regulatory 6 months notice period in informing NHS England of their decision to end their contract.

Following notification by the partners of their intention to resign from the contract NHS England undertook an options appraisal. This involved looking at the following:

- Availability of the surgery premises
- Capacity within the local area amongst other local GP practices
- Availability of patient choice

The options appraisal identified that there was sufficient capacity across other GP practices in the local area. It was also determined that there were no suitable premises available from which affected patients could be treated from following the end of the contract. Without surgery premises available it was not possible to issue a new APMS contract to another provider to deliver patient care.

The unavoidable decision was therefore taken to ask affected patients to register with other local GP practices in order to guarantee their ongoing access to GP services once the Eaton Place Surgery practice contract ended.

- ***Goodwood Court Surgery***

The situation which led to the closure of this GP practice was very different.

NHS England, NHS Brighton and Hove Clinical Commissioning Group (CCG) and the Care Quality Commission (CQC) shared concerns that the practice was failing to provide essential services to its patients.

The CQC subsequently undertook an unannounced inspection of the practice due to the collective concerns that had been raised. The practice was inspected by the CQC on Thursday 4 June, Monday 8 June and Tuesday 9 June.

The CQC's investigations confirmed the collective concerns that the practice was not providing an acceptable service to patients. The service was assessed as being so

inadequate as to potentially represent a risk to patients so great that unprecedented and urgent action should be taken.

As a result, the CQC determined that an urgent cancellation of the practice's CQC registration was necessary in order to protect the safety and welfare of patients. The CQC therefore applied to the local magistrates court to withdraw the practice's registration on 9 June and this was granted with instant effect. Without this CQC registration, the practice did not have the authorisation to deliver clinical care to its patients and therefore patients could no longer be treated at the Goodwood Court Medical Centre GP practice.

The action taken by the Care Quality Commission (CQC) did not affect the other services that are provided from the building at Goodwood Court Medical Centre, including Goodwood Court Dental Surgery and the podiatry service,

The CQC is the regulator for health and social care services and their action to withdraw the practice's CQC registration was independent of NHS England (although we shared their concern about the need to ensure patient safety).

Following the action taken by the CQC, NHS England was responsible for ensuring that patients had ongoing access to GP services.

It is important to note that this action by the CQC was the first of its kind nationally and NHS England and the CQC will therefore be sharing learning from this case to inform the management of any future issues in the best interests of patients. Due to significant issues and concerns about the practice's ability to deliver services to patients in line with the required standards and the fact that the practice was no longer able to provide clinical care to patients following the CQC action, NHS England determined that it was necessary to terminate the practice's contract to deliver services to patients. The practice's contract to provide services was subsequently terminated with effect from 17June 2015.

In order to secure suitable alternative arrangements for patient care as swiftly as possible, NHS England undertook an urgent mini-procurement exercise to identify a local GP practice that would be willing to hold a temporary contract until 31March 2016, so that affected patients could continue to access local GP services. Following this mini procurement exercise NHS England awarded a temporary contract to Charter Medical Centre on 19 June 2015..

As part of the mini-procurement process Charter had to provide assurance about how they would manage providing services to an additional 9,000 patients without this unduly impacting on patient care or the services provided to their current patients.

The contract that NHS England have established with Charter Medical Centre will provide the practice with the additional resources that it needs to ensure a good quality service for both its new and existing patients.

In the immediate period following the closure of the Goodwood Court practice, Charter Medical Centre worked at pace to provide additional clinics to help support patients.

The practice has since been working to organise their services in the way they feel will best meet the needs of all their patients over the longer term.

As part of this the following actions have been undertaken by the practice to date:

- Charter Medical Centre has employed the majority of Goodwood Court staff, alongside employing additional clinical staff, to ensure the effective delivery of services to the increased number of patients.

- Additional clinics have been instigated, including extra surgeries outside of the core practice opening hours of Monday to Friday, 8.00 a.m. to 6.30 p.m.

- A dedicated reception area for Goodwood Court patients has been established.

We are grateful to Charter Medical Centre for their commitment to making sure that all patients who were registered at the Goodwood Court practice have ongoing access to local GP services. There has been significant input from Charter Medical Centre to enable this process to work. The majority of feedback from Goodwood Court patients to Charter Medical Centre staff has been good to date, but NHS England will continue to monitor the situation to make sure that patient needs are being met.

As confirmed above, the contract that NHS England has agreed with Charter Medical Centre is a temporary one which initially runs until March 2016. This will enable NHS England to keep these new arrangements for patient care under review, to make sure they are working to best effect, and to undertake a process of engagement with patients and stakeholders to help determine our longer-term commissioning arrangements

6. Communication

A contract termination is a complex event which requires action to make sure both patients and other local stakeholders are regularly updated about how the future patient care will be provided.

There are however some challenges in managing communications when a contract for GP services is to be terminated. For reasons of confidentiality, NHS England is unable to undertake talks with other local GP practices about this, prior to notice being served on the contract (either by the contractor or by NHS England). This therefore means that there is a restricted period of time during which NHS England can liaise with other local GP practices about what the impact of the contract ending may be on their surgeries.

NHS England does however work to make sure that there is regular communication with other local GP practices about any impact on their services, particularly if another local GP practice is having to close and will work to ensure the transfer of patients to other surgeries in a managed way.

NHS England - South (South East) has an evolving project plan that is used as part of the process for managing the termination of any GP contracts. This includes various elements to ensure the process is as effective as possible and we are continuing to develop this plan to take in to account any learning where previous contracts have come to an end.

1. Formal details of the paper

1.1. Children and young people's mental health and wellbeing Transformation Plan for Brighton and Hove

1.2 This paper can be seen by the general public.

1.3 21st July 2015

1.4 Author: Gill Brooks, Children and young people's mental health and wellbeing commissioner, Brighton and Hove CCG (gill.brooks1@nhs.net)

2. Summary

2.1 Improving the mental health and wellbeing of children and young people in Brighton and Hove is a Clinical Commissioning Group (CCG) and Brighton and Hove City Council (BHCC) Children's services priority. Whilst there are fantastic services in pockets across the City, they are working in isolation and in a fragmented way, not necessarily together as a whole system. The services are often reactive rather than proactive and not always able to respond to need.

2.2 The CCG, with Public Health is carrying out a Joint Strategic Needs Assessment on mental health and wellbeing including autism for 0-25 year olds, alongside a whole system review. The JSNA will be available in autumn 2015 and will inform future commissioning decisions.

2.3 The CCG, Children's Services and Public Health are also developing a Children's Strategy which will be presented at The Health and

Wellbeing Board in October 2015; mental health will be a key component of the strategy.

2.4 This strategic priority, to review and improve mental health and wellbeing services for children and young people, has been identified following user and stakeholder feedback within Brighton and Hove as well as national strategic drivers, access targets and recommendations.

2.5 Nationally, there is a great deal of focus on children's mental health services, recognising this is an area where improvements need to be made. Norman Lamb, Care Minister, led a taskforce of experts on Children's Mental Health services, calling for a whole child and family approach, improving interventions and recovery, working with the voluntary sector and digital systems to break down barriers to develop a whole system service.[1] The recommendations in *Future in Mind; promoting, protecting and improving our children and young people's mental health and wellbeing* also include:

a) A local Transformational Plan, and following completion will facilitate NHS England prioritising further investment in CCG areas that demonstrate robust action planning;
b) A Joint Strategic Needs Assessment; and
c) An annual `local offer` outlining what the needs of the population are and what the CCG and BHCC are commissioning to address those needs.

2.6 Each area will produce a Transformation Plan by September 2015. This paper outlines principles of the Brighton and Hove Transformation Plan.

2.7 The principles of the Brighton and Hove Transformation Plan are:

a) Involve children and young people;
b) Foster resilience across the system;
c) Prevent deterioration;
d) Engage children and young people in their care;
e) Reach out to where children and young people are;
f) Care for the most vulnerable groups;
g) Improve access;
h) Intervene early;
i) Best start in life;

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413393/Childrens_Mental_Health.pdf

j) Prepare for adulthood;
k) Build capacity across the system;
l) Collaborative and joint commissioning;
m) Physical and mental health issues are addressed equally; and
n) Ensure access to services in a crisis especially out of hours.

3. Decisions, recommendations and any options

This paper is presented to the Health and Wellbeing Board for information and noting, and to gain support for The Transformation Plan.

4. Relevant information

4.1 Background and context

4.1.1 Mental health issues generally begin before adulthood with half long-term mental health issues occurring by the age of 14 years[2]. Improving mental health in early life will have physical health benefits as well as increase life expectancy and quality of life, ability to socialise and sustain employment and/ or education[3]. Those young people who are not in education, employment or training (NEET) are more likely to suffer with mental health issues.[4] Significant focus on improving the mental health of young people will reap long-term benefits associated with personal as well as health and social costs.

4.1.2 Mental health problems, in particular depression, are the largest contributor to the global burden of disease among young people. In Europe, the estimate is almost one in ten 18-years-olds suffers from depression[5] and some risky behaviour that many young people engage in can contribute to health problems later in life.

4.1.3 UK data suggests that at any one time about 10% of all 5-16 year olds will be suffering from a clinically diagnosable mental health problem[6] .

[2] Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005 Jun;62(6):617-27
[3] http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf
[4] http://www.cypnow.co.uk/cyp/news/1152077/social-isolation-and-neet-status-raise-mental-health-risk-for-young-people
[5] Quality Criteria for Young People friendly health services, DH, 2011
[6] http://www.youngminds.org.uk/training_services/policy/mental_health_statistics

4.1.4 Locally we have specific needs around mental ill-health in Brighton and Hove. The population (0-19 year olds) of Brighton and Hove is 58,600 with an estimated 3,095 children (5-16 years) with a mental health disorder such as conduct disorders and 1,195 children (5-16 years) with emotional disorders[7]. With regards to self-harm we have seen an increase of 40% from 2010 until 2013, with increased levels of risk and severity in presentation. There are significantly higher rates of hospital admissions for self-harm for young people in Brighton & Hove. In 2012/13 there were 281, 0-24 year olds admitted to hospital for self-harm.[8]

4.2 *Future in Mind promoting, protecting and improving our children and young people's mental health and wellbeing*[9]

4.2.1 There needs to be a shift of balance in children and young people's mental health and wellbeing services from reactive, towards prevention, promoting mental health and wellbeing, and early intervention, where children and young people can thrive. The services should be based around family systems. To achieve this, there needs to be less fragmentation and more integration in a holistic way that takes account of the whole family experience and needs. These aims are reflected in the national strategy around healthcare[10] and in some new, proposed models of care.[11]

4.2.2 These desired outcomes echo those described in *Future in Mind* (full document can be found in 5.1), written as an open letter to children and young people as follows:

> "*…we want to help you acquire the resilience and skills you need when life throws up challenges. We want you to know what to do for yourself if you are troubled by emotions or problems with your mental health. That includes knowing when and how to ask for help and, when you do, to receive high quality care. We want services to be able to respond quickly, to*

[7] CAMHS Prevalence snapshot Brighton and Hove Public Health data 2012
[8] http://fingertips.phe.org.uk/search/self%20harm#gid//pat/6/ati/102/page/0/par/E12000008/are/E06000036
[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf
[10] http://origin.library.constantcontact.com/download/get/file/1102665899193-1598/five+year+forward+view.pdf
[11] http://www.ucl.ac.uk/ebpu/docs/publication_files/New_THRIVE

offer support and, where necessary, treatment that we know works, to help you stay or get back on track.[12]

4.2.3 The recommendations in *Future in Mind* also include:

a) A local Transformational Plan, and following completion will facilitate NHS England prioritising further investment in CCG areas that demonstrate robust action planning;
b) A Joint Strategic Needs Assessment; and
c) An annual `local offer` outlining what the needs of the population are and what the CCG and BHCC are commissioning to address those needs.

4.3 The Transformation Plan

4.3.1 NHS England is now developing a major transformation programme to significantly re-shape the way services for children and young people are commissioned and delivered across all agencies over the next 5 years. This includes the development of robust local Transformation Plans that will be publically available.

4.3.2 The development of the local Transformation Plan is being led by the CCG involving the whole system, including children, young people and their families. It is essential that The Plan also has the support of the Health and Wellbeing Board.

4.3.3 The CCG is currently waiting on the guidance and template for the Plan and expects submission will be due in September 2015. At this time, therefore, the CCG would like to present the high level principles and aims of the Transformation Plan for the Health and Wellbeing Board support and agreement.

4.4 The principles of the Transformation Plan for Brighton and Hove

4.4.1 The Transformation Plan for Brighton and Hove is currently being developed and will be aligned with national guidance once published. The Plan is based on the recommendations contained in *The Future in Mind* document. The principles of the Plan are outlined overleaf.

[12] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413393/Childrens_Mental_Health.pdf. An open letter to children and young people

Principles of Brighton and Hove Transformation Plan for Children and Young People's Mental Health and Wellbeing Services

a) **Involve** children, young people, their parents and carers in any future design of services. Over the last four months, consultation has taken place with different children/ young people's groups as well as parents and carers, providing them with an opportunity to co-design future service models;

b) **Foster resilience** across the whole system by ensuring all involved with children and young people's care, are able to identify a child or young person in difficulty, can support them and know what to do if things escalate. For example providing a whole school approach to emotional wellbeing and de-stigmatise mental health, such as the pilot happening in 2 secondary schools from September 2015 (more details can be found in 5.2);

c) **Prevent** children and young people who feel anxious or stressed from deteriorating by working with our schools, youth service and general practice to ensure they can recognise the signs of mental health or deteriorating wellbeing, are equipped to support with the right level of training, and know what to do if they are no longer able to support with clear pathways;

d) **Engage** children and young people in their care by allowing them to set their own goals, review plans and progress. Following up where they are not attending or are not engaged with their treatment and support such as young men, black and ethnic minorities and those from deprived backgrounds. We can build on outreach teams already established in the City;

e) Ensure **vulnerable groups** can access the support they need, such as Looked After Children, neuro-behavioural issues, learning disability or victims of abuse. Recognise that this group has specific requirements to support their mental health and wellbeing and yet may be difficult to engage. The CCG has commissioned a therapeutic service for children who are victims of sexual assault and plan to develop a complex trauma pathway.

f) **Innovative communication and support** with children and young people by taking opportunities available in digital and social media. The City has already introduced online counselling and will continue to explore other innovations to provide information, support and intervention to our children and young people.

g) **Reaching out** to children and young people in a place they feel comfortable, providing the support and intervention where they are rather than in a clinical setting unless necessary. Adopt the principle that *no door is the wrong door*, and building on the foundations of outreach, drop-in and intensive home treatment services as well as recognising the privileged position our schools, colleges and other universal services are in to provide an immediate response, and provide a named point of contact.

h) **Improving access** to services with clear pathways, information and expected outcomes. Re-design the services so that services are more visible and accessible and reducing artificial barriers in the system such as the CAMHS tier approach[13]. Explore how services can be offered in locations other than clinical areas.

i) **Intervene early** by continuing to make links with the Early Help Hub and Stronger Families programme so that children and young people get to the right place, at the right time and receive the right support.

j) Provide the **best start in life**. There is a strong economic case for investing in services to support children from pre-birth and a young age, to prevent expensive longer term interventions in adulthood. The CCG would like to further develop the perinatal mental health service and work with Early Years services to develop an early model of support.

k) **Prepare for adulthood** by ensuring that children and young people transition well at different stages of their lives, especially at 18 years. Explore how a youth service can support young people at this potentially difficult time rather than automatically expecting them to be referred to adult mental health services.

l) **Build capacity across the system** to deliver evidence-based outcomes and focussed pathways. In Brighton and Hove we intend to develop a Children and Young People's Improving Access to Psychological Therapies Programme (IAPT). The focus will also be on developing a specialist Eating Disorder pathway. Training and development across the pathway, spread learning across sectors.

[13] DH NSFC. Child and Adolescent Mental Health, 2010

m) **Collaborative and joint commissioning** with Children's Services and Public Health. Being clear about responsibilities, what the population needs are and how services are commissioned and monitored to support those needs. The JSNA will inform the need and the CCG, Children's Services and Public Health continue to work jointly on future commissioning and development of the Children's Strategy.

n) Ensuring that **physical health and mental health** issues are addressed equally when developing pathways for long term conditions such as medically unexplained symptoms.

o) Ensure when young people are in **crisis, especially out of hours,** that services are able to respond. Brighton and Hove's Crisis Care Concordat ensures that no-one under 18 years old will be detained in custody under Section 136 of the Mental Health Act[14]. All partners work together to ensure this doesn't happen. The CCG has also commissioned a mental health liaison team to be present in The Royal Alex Children's Hospital 7 days a week up to 8pm to support children and young people who attend A&E and also those who need to be admitted to acute hospital. This team should be in place by autumn 2015 but the CCG intends to scope the potential for expanding the hours the team is available.

4.4.2 The development of the Transformation Plan will involve the whole system and has a clear governance structure in place (see figure one overleaf).

4.4.3 The Transformation Plan will become embedded in the CCG commissioning and strategic intentions and mainstream planning and assurance processes.

[14] http://www.crisiscareconcordat.org.uk/inspiration/mental-health-act-1983-code-of-practice/

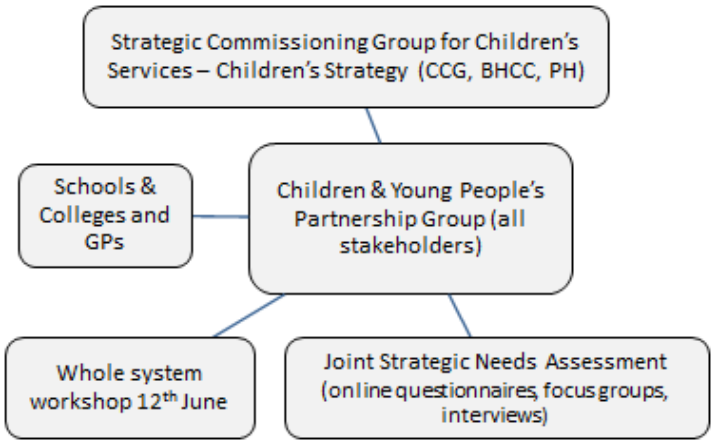


Figure One

4.5 Important considerations and implications

4.5.1 Legal

No legal implications at this time.

4.5.2 Finance

The Chancellor's autumn statement (December 2014) and Budget (March 2015) announcements of additional money to transform mental health services enable local areas to make good progress on these areas. It is unknown at this time how much money may be available to Brighton and Hove. Nationally money is available as follows:

a) Total £1.25 billion every year for the next 5 years (£15m for perinatal mental health and the rest for children and young people's mental health services); and
b) £30m each year for the next 5 years for eating disorder and self-harm services.

4.5.3 Equalities

An Equality Impact Assessment will be carried out as part of the development of the Transformation Plan.

4.5.4 Sustainability
A Sustainability Assessment will be completed as part the Transformation Plan.

4.5.5 Health, social care, children's services and public health
The CCG will work with Children's Services, Public Health and Children's Social Care as well as other stakeholders to develop the Transformation Plan.

5 Supporting documents and information

5.1 *Future in Mind; promoting, protecting and improving our children and young people's mental health and wellbeing* (March 2015) is a report following the national taskforce consultation on children and young people's mental health led by MP Norman Lamb. See below.

5.2 Brighton and Hove schools have stated that their pupils show an increase in mental health and wellbeing issues and they feel they need more specialist help to support them. In response Public Health and Children's Services, working in partnership, are proposing a new way of working; a whole school approach to mental health and wellbeing, by establishing a 12 month pilot in 2 schools. If the model is successful the aim would be to roll out to all schools across the City. The aim is to promote, protect and improve children and young people's emotional health and wellbeing, with immediate access to specialist mental health support as well as building resilience. The detailed proposal can be found below.