Health &
Wellbeing

Who are we?

The Health and Wellbeing Board is the forum where representatives of the Council, NHS and Third Sector hold discussions and make decisions on the health and wellbeing of the people of Brighton & Hove. Meetings are open to the public and everyone is welcome.

Where and when is the Board meeting?

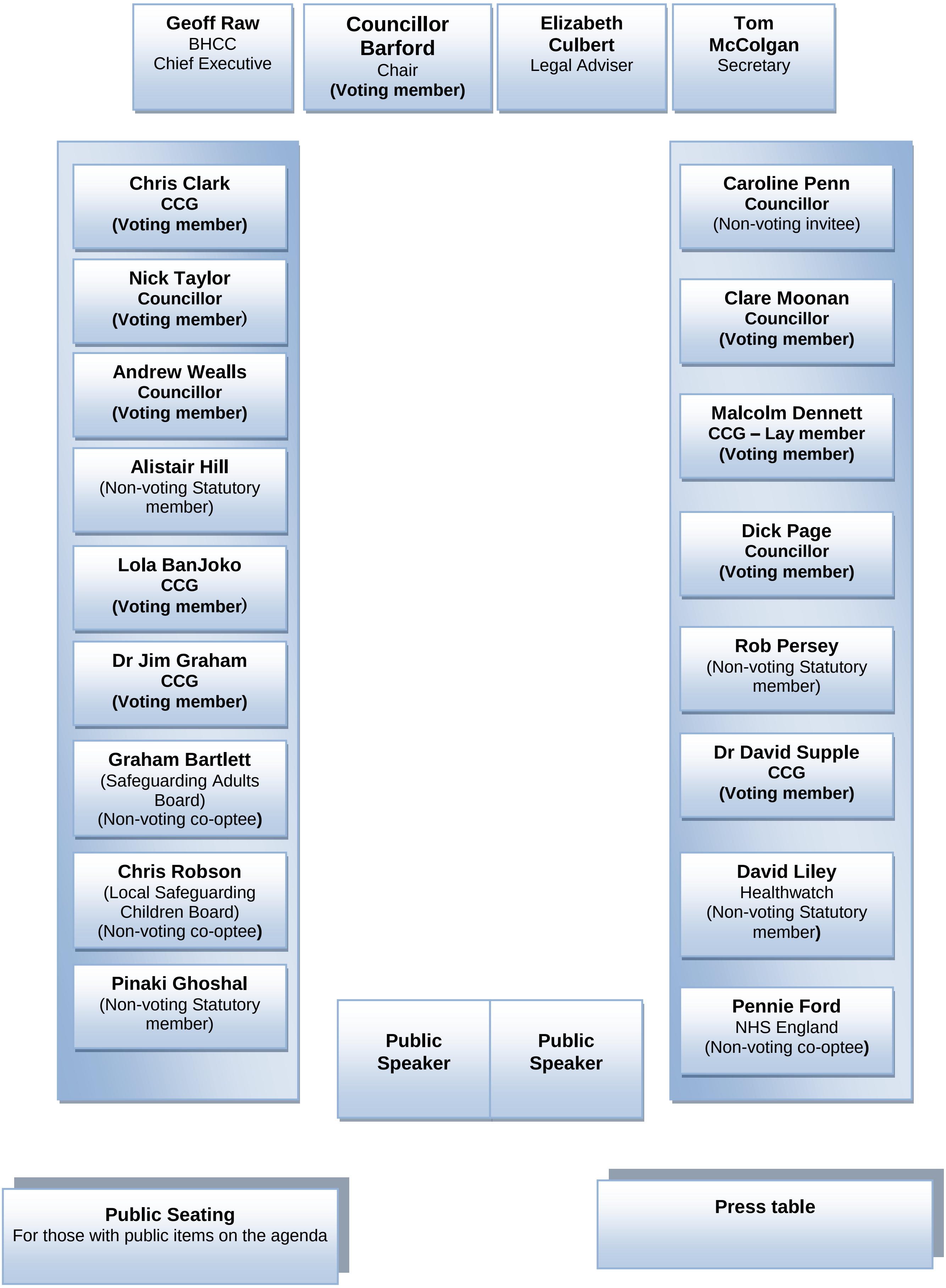
This next meeting will be held in the Council Chamber, Hove Town Hall on Tuesday 12 June 2018 starting at 4.00pm. It will last about two and a half hours.
There is limited public seating available for those who wish to observe the meeting. Board meetings are also available to view on the council's website.

What is being discussed?

The items on the agenda are:

- Better Care Plan
- Section 75 agreement review between Brighton and Hove City Council and Sussex Partnership Foundation Trust
- Approach to Commissioning and recommissioning of the Ageing Well Service, the Mental Health Support Service and an Integrated Advocacy Hub
- Integrated Commissioning Strategy

Health & Wellbeing Board



Geoff Raw
BHCC
Chief Executive

Councillor Barford
Chair
(Voting member)

Elizabeth Culbert
Legal Adviser

Tom McColgan
Secretary

Chris Clark
CCG
(Voting member)

Nick Taylor
Councillor
(Voting member)

Andrew Wealls
Councillor
(Voting member)

Alistair Hill
(Non-voting Statutory member)

Lola BanJoko
CCG
(Voting member)

Dr Jim Graham
CCG
(Voting member)

Graham Bartlett
(Safeguarding Adults Board)
(Non-voting co-optee)

Chris Robson
(Local Safeguarding Children Board)
(Non-voting co-optee)

Pinaki Ghoshal
(Non-voting Statutory member)

Caroline Penn
Councillor
(Non-voting invitee)

Clare Moonan
Councillor
(Voting member)

Malcolm Dennett
CCG – Lay member
(Voting member)

Dick Page
Councillor
(Voting member)

Rob Persey
(Non-voting Statutory member)

Dr David Supple
CCG
(Voting member)

David Liley
Healthwatch
(Non-voting Statutory member)

Pennie Ford
NHS England
(Non-voting co-optee)

Public Speaker

Public Speaker

Public Seating
For those with public items on the agenda

Press table

Health & Wellbeing Board

MeetingDate

4.00pm

Hove Town Hall, Council ChamberCouncil Chamber, Hove Town Hall

Who is invited:

Voting Members: Cllrs Karen Barford (Chair), Clare Moonan, Dick Page, Nick Taylor and Andrew Wealls; Dr David Supple, Chris Clark, Lola Banjoko, Malcolm Dennett, and Dr Jim Graham (Brighton & Hove Clinical Commissioning Group)

Non-Voting Members: Geoff Raw, Chief Executive; Rob Persey, Statutory Director of Adult Social Care; Pinaki Ghoshal, Statutory Director of Children's Services; Alistair Hill, Acting Director of Public Health; Cllr Caroline Penn (BHCC); Graham Bartlett (Brighton & Hove Safeguarding Adults Board); Chris Robson (Local Safeguarding Children Board) Pennie Ford (NHS England); and David Liley (Brighton & Hove Healthwatch).

Contact:
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Date of Publication - Monday, 4 June 2018

AGENDA

Formal matters of procedure

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

Page

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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 MINUTES **9 - 24**

The minutes of the last meeting held on 6 March 2018

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 FORMAL PUBLIC INVOLVEMENT

This is the part of the meeting when members of the public can formally ask questions of the Board or present a petition. These need to be notified to the Board in advance of the meeting Contact the Secretary to the Board at tom.mccolgan@brighton-hove.gov.uk

5 Formal Member Involvement

6 Effect of Social Care Budget Reduction Response **25 - 36**

Contact:	*Barbara Deacon*	*Tel: 01273 296805*
Ward Affected:	*All Wards*	

The main agenda

7 Better Care Plan **37 - 50**

Contact:	*Barbara Deacon*	*Tel: 01273 296805*
Ward Affected:	*All Wards*	

8 Section 75 Agreement review between Brighton & Hove City Council (BHCC) and Sussex Partnership Foundation Trust (SPFT) **51 - 58**

Contact: *Brian Doughty* *Tel: 01273 291904,*
Regan Delf *Tel: 01273 293504*
Ward Affected: *All Wards*

9 Approach to Commissioning **59 - 62**

Contact: *Andy Witham* *Tel: 01273 291498*

Ward Affected: *All Wards*

10 The Commissioning of Mental Health Support Services **63 - 70**
Contact *Linda Harrington* *Tel: 01273 238830*
Ward Affected: *All Wards*

11 Commissioning of an Integrated Advocacy Hub **71 - 144**

Contact: *Anne Richardson-Locke* *Tel: 01273 290379*

Ward Affected: *All Wards*

12 Commissioning a Brighton & Hove Ageing Well Service **145 - 186**
Contact *David Brindley* *Tel: 01273 291083*
Ward Affected: *All Wards*

13 Integrated Commissioning Strategy **187 - 190**

Contact: *Andy Witham* *Tel: 01273 291498*

Ward Affected: *All Wards*

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Electronic agendas can also be accessed through our meetings app available through www.moderngov.co.uk

For further details and general enquiries about this meeting contact Democratic Services, 01273 2905696 or email democratic.services@brighton-hove.gov.uk

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.

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- 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**.**

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.

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING BOARD

4.00pm 6 MARCH 2018

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Brighton & Hove City Council; Councillors Yates (Chair), Barford, Barnett, Page, and Taylor. Brighton & Hove Clinical Commissioning Group; Chris Clarke, Dr David Supple and Malcolm Dennett

Other Members present: Graham Bartlett, Safeguarding Adults Board; Pinaki Ghoshal, Statutory Director of Children's Services; Rob Persey, Statutory Director for Adult Care; Alistair Hill, Acting Director of Public Health; David Liley, Healthwatch

Also in attendance: Councillor Penn

Apologies: Chris Robson, Dr Sikdar, Wendy Carberry, Lola Banjoko

PART ONE

53 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

53 (a) Declarations of substitutes

53.1 There were no substitutes

53 (b) Declarations of Interest

53.2 Councillor Yates declared a Disclosable Pecuniary Interest in Items 58, 59 and 60 as he was employed by Western Sussex Hospitals Trust. Councillor Yates stated he had applied for and been granted dispensation by the Council's Monitoring Officer to permit him to Chair the Health and Wellbeing Board in its consideration of items relating to the NHS Sustainability and Transformation Partnership, and to speak and vote on those items, on the basis that the project to review health and social care service did not currently raise a direct or material conflict with his employment.

Councillor Barford declared a Disclosable Pecuniary Interest in Items 58, 59 and 60 as she was employed by St Peter and St James Hospice North Chailey. Councillor Barford stated that she had applied for and been granted dispensation by the Council's Monitoring Officer to permit her to attend and participate in the Health and Wellbeing Board in its consideration of items relating to the NHS Sustainability and Transformation Partnership, and to speak and vote on those items, on the basis that the project to review health and social care service did not currently raise a direct or material conflict with her employment.

53 (c) **Exclusion of press and public**

53.3 The Chair stated that as there were no Part Two items the press and public would not be excluded from the meeting.

54 MINUTES

54.1 **RESOLVED**: That the Minutes of the meeting held on 30 January 2018 be agreed and signed as a correct record.

55 CHAIR'S COMMUNICATIONS

55.1 The Chair gave the following communication:

Welcome to the meeting

There are a number of members of the public here, which is good to see. Clearly there are issues on today's agenda which people feel passionate about. Please do note that you are here as observers, not as participants in the meeting. The council has a number of ways for people to ask questions or present petitions to committee meetings. However, we cannot have the meeting disrupted by people shouting out from the public gallery, and I'm sure everyone here today will respect this.

Market Position Statement

The Market Position Statement (MPS) provides a useful tool for informing the market of future demand and the services that the Local Authority will commission and develop to meet that need.

The MPS also provides valuable information to support provider development and to ensure that organisations position themselves and their resources to meet future demand for services.

The Council published its first MPS in 2015 and as such it now needs to be refreshed to take into account the changing nature of demand and associated service development to support delivery.

A draft paper will be brought to the June meeting for consideration and comment with the final paper coming to the September meeting for approval. This will then fit with the budget cycle.

Migrant Needs Assessment

International Migrants in Brighton & Hove, a report which forms part of the city's JSNA programme, was endorsed by the Neighbourhoods, Inclusion, Communities and Equality Committee and published in January 2018. Both the full report and a summary of key points and recommendations are now available on the Brighton & Hove City

Council website - https://present.brighton-hove.gov.uk/ieListDocuments.aspx?CId=968&MId=8040&Ver=4

The report uses a broad definition of a 'migrant' as being any person who lives temporarily or permanently in a country where he or she was not born, looking at those whose intention is to stay in the UK for at least twelve months. So it examines the needs and assets of those who have come to the city to study, work or join family members as well as those who have been forced to migrate as refugees. The report has 42 recommendations, some of which relate to health and healthcare. Another group of recommendations relate to barriers to migrants accessing services generally.

The recommendations will be implemented through an action plan led by the Communities, Equality and Third Sector team. Many will focus on incorporating the findings of the report into existing structures and pieces of work rather than new initiatives.

Dr Manas Sikdar
Dr Sikdar will no longer be attending the Health & Wellbeing Board. This is due to changes in role within the CCG. Dr Sikdar has been a valued member of the Board. I am sure the Board would like me to send a letter of thanks.

Healthwatch
I am pleased to be able to announce that the Healthwatch contract has been extended by waiver. The current contract will therefore run until 2021.

56 FORMAL PUBLIC INVOLVEMENT

56.1 Petition

Ms Jackie Madders submitted the following petition (on behalf of Mr Kapp who was unable to attend). The petition was signed by 5 people.
We the undersigned petition Brighton & Hove Council to end the crisis in primary care by adopting a policy of medication to meditation, by mass-commissioning mindfulness courses that teach self-care, funded by the Better Care Fund, so that GPs can prescribe them instead of antidepressants to treat the epidemic of depression and addiction.

Background information to the petition:

1. *The root cause of the crisis is not shortage of money, but a toxic system where GPs and nurses don't want to work, because they can only over-prescribe drugs which generally do more harm than good.*
2. *Before 1980, when antidepressants started to be mass-marketed, mental disorders (called 'nervous breakdowns') were rare (less than 1 in 1,000) Now, 1 in 10 adults are on antidepressant medication, numbering 30,000 in the city of Brighton and Hove, and 6 million in England.*
3. *This proves Robert Whitaker right, who published 'Anatomy of an epidemic' in 2010, saying that the root cause is the medication given to treat it.*
4. *The Improving Access to Psychological Therapies (IAPT) programme was launched in 2006 to 'end the Prozac nation' but antidepressant prescribing has since more*

than doubled from 30 to 65 million monthly prescriptions annually, mostly against NICE guidelines, which say that talking therapy should be the first choice of treatment.

5. *Like street drugs, medication has harmful and addictive side effects, making patients go round in a revolving door, overwhelming primary care, and causing the crisis in A&E and GP surgeries, and burning out GPs (who now retire at an average age of 55) and nurses (for whom there are now more than 30,000 vacancies)*
6. *The solution is for the Council to mass commission the NICE recommended Mindfulness Based Cognitive Therapy (MBCT) 8 week course, so that GPs can prescribe them, instead of having to prescribe antidepressants, breaking their Hippocratic oath 'do no harm' and making them feel so guilty and ashamed that they burn out and have to take early retirement at an average age of 55.*
7. *The Better Care Fund (BCF) was enacted in 2013 to create Community Care Centres as mental A&Es to treat vulnerable patients, personified as Rachel, (65, depressed and in sheltered accommodation), and Dave, (40, alcoholic and homeless), for which the city has been allocated over £20m pa since 2015, which is enough to treat 20,000 Rachels and Daves annually.*
8. *However, in answer to a public question at the HWB on 13.6.17, no Community Care Centres have yet been created, and no Rachel or Dave has yet been treated, which is a scandal. For further details see paper 9.118, and other papers on section 9 of* http://www.reginaldkapp.org

56.2 The Chair gave the following response:

Thank you, and Mr Kapp, for the petition.

As you are aware from previous questions you have put to the Board, the CCG have already commissioned mindfulness services. The Better Care Fund has very strict criteria for what it can and cannot be used for. A report will be coming to the Board to update on the use of the fund and I hope you stay for this. As we have already submitted the Better Care Plan to NHSE, which has been accepted, we are not in a position to change it.

56.3 **RESOLVED:** The HWB agreed to note the petition.

56.4 **Deputation**

Dr Tredgold and Dr Aston presented the following deputation:

The Effect of Reductions to the Social Care Budget – A Survey of GPs
Is the present level of spending delivering the services people need? GPs in Brighton and Hove have told us that lack of Social Care may result in unnecessary hospital admissions and delay discharges. But how does this really affect patients and the GPs trying to car for them? Demand for Social Care is rising but the budget to meet it is failing. A survey of all Local Authorities undertaken by the Association of Adult Social Care Services (ADASS) (https://www.adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf) states the problems. The need for Social care is rising each year - as the numbers of the elderly and the disabled rise. The costs of Social Care are rising – due to the rise in the

National Living wage and Statutory Duties. Since 2010 Council budgets have been reduced each year. They are forced to make savings each year. (Brighton and Hove Policy Resources Committee agreed this February to make further savings in the Community Care budget (savings that they say mean reducing demand and diverting people from publicly funded services). Many councils were 'close to collapse' in 2016/17. They were saved by an improvement in the Better Care Fund and being able raise extra funds for Adult Social Care. But the ADASS report makes it clear that this additional funding only temporarily eased the problems. They are clear that the resources Social Care needs are not being met. Only 9 of the 138 Directors who responded to their survey (4%) felt fully confident of being able to deliver their statutory duties in 2018/19.

But the really important questions are: What does it actually mean to patients and GPs if they can't access Social Care? How often do the difficulties GPs have mentioned to us occur? To try and find out we sent a survey to 124 GPs in Brighton and Hove – 47 responded. All but one had experienced patients having problems because of difficulties with Social Care provision – over half had experienced these weekly, another third monthly. All but three had experienced patients being admitted to hospital unnecessarily because of limited Social Care resources – a fifth weekly, a half monthly. A large majority had experienced patients whose discharge had been delayed. For a quarter this had occurred weekly. A third were aware of Council plans to further reduce the Social Care budget in 2018-2020. A large majority thought that further reductions would severely worsen patients' health outcomes and safety. Eighteen GPs then gave their own comments and these give a clear picture of the difficulties they and their patients are having. GPs have experienced difficulty in getting a response to their requests and difficulty in getting adequate support. Their feeling of frustration is palpable – and, too, their feeling of shame that the system of which they feel a part should have failed their patients. The pressures on the NHS and Social Care are now so great that some GPs have said to us 'at what point should care professionals declare the system is no longer safe or sustainable and resign?' The patients are suffering and it is probably the most vulnerable who are suffering the most - the ones with the least voice to speak up. Some have been discharged without adequate social care; some have been unable to get care at home and have reluctantly been admitted to hospital. In the worst instance there was no care for a retired teacher with cancer who wanted to die at home. He had to be admitted. He died within 24 hours having spent most of that time on a trolley. As The Argus stated, 'this should be a wake-up call to us all'.

Social Care desperately needs more resources.

Signed by: Dr Jane Roderic-Evans, Dr Judith Aston, David Jones, Dr Anne Miners, Dr Yok Chang, Dr Richard DeSouza, Dr Tim Worthley.

56.5 The Executive Director Health & Adult Social Care noted that the ADASS survey was a national survey, and so wasn't directly referring to Brighton and Hove. The Director said that it was a challenging situation, and the Authority was working closely with health colleagues. Budgets for Adult Social Care had been cut nationally since 2010, with a 5% cut in Brighton and Hove, but there was growth with an additional £4.6m being put into the budget for 2018/19. All referrals to adult care are triaged and no one who is prioritised has to wait more than 13 days for an assessment. A report would come to the June meeting of the Board to address the issues raised in the deputation.

56.6 Councillor Page said that at the recent Budget Council meeting councillors were informed that over the last year there had been fewer requests for social care support, and yet demand was rising with an aging population who had complex needs. He asked if there were performance indicators to quantify the needs of the residents and how they access support. The Chair suggested that that could be addressed in the report which would come to the next meeting of the Board. The Executive Director Health & Adult Social Care agreed.

56.7 Councillor Barford suggested that some of the issues could be down to perception, as in Brighton & Hove the budget for social care had increased. The government needed to provide a sustainable funding model, as the Council had put over 40% of the General Revenue Fund into the adult social care budget which was not sustainable. Councillor Barford suggested that understandably social care support was sometimes confused with continuing health care which is funded by the CCG not the council, which is why further integration is important to ensure people get the best outcomes no matter who provided the funding.

56.8 Dr Supple said that as a GP it was hard to know what was funded by Social Care and what by Community Services, and it was important to establish who commissioned what service if solutions were to be found. Dr Supple referred to the example given in the deputation of the person with cancer and, whilst accepting he did not know the full details of the case, suggested the problems were to do with provision of community services rather than social care. Community Services were commissioned by the CCG.

56.9 The Chair said that when the Clinical Commissioning Groups were established one of the rationales behind it was to allow GPs to commission the services they felt were required. It was therefore ironic that GPs were coming to the Health & Wellbeing Board (HWB) to complain about services they had the power to commission but thinking they were delivered by Adult Social Care. He said it was a complex situation and the HWB was established to integrate the different services. Dr Tregold asked who was responsible for provision of the services and who GPs should complain to, and was advised it was the CCG.

56.10 **RESOLVED:** That the deputation be noted, and a report on the issues raised would come to the next meeting of the Board.

Public Question

56.11 Two Public Questions had been received.

(1) Amanda Bishop asked the following question:

In relation to the Big Care Conversation I note some respondents reported concerns around mental health waiting lists and risks to suicide. I note that Brighton & Hove have 50% higher suicide rates than the national average. But these are 2013/2015 reported figures. Do you think (or know) if this has increased, and what steps are you taking to ensure respondents concerns in this area are being prioritised, resulting in less suicides and better mental health care?

56.12 The Chair gave the following response:

Thank you for your question. The most recent information on suicide rates is for the period 2014-16. I have been given some data which will be reported in the minutes and also I have a printed copy of this response for you to take home today. The Brighton & Hove rate was 14.4 per 100,000 people compared with the England rate of 9.9/100,000. The suicide rates for 2013-15 were 15.2/100,000 and 10.1/100,000 respectively. Brighton & Hove has historically had a high rate of suicide. The gap between the national and local rates narrowed significantly between 2001-03 and 2010-12, when the local rate fell from 18.9 to 12.6/100,000, but this trend has levelled off over the past four years. The national rate has remained between 9.2 - 10.3/100,000 since 2001-03. The Five Year Forward View for Mental Health has set a target for all areas of a 10% reduction over the four years between 2017-18 and 2020-2. A local multi-agency suicide prevention steering group oversees the suicide prevention action plan. Priorities within the plan include;

- Analysing local information, including Coroner’s records and emergency services information.
- Continuing professional development for clinicians
- Reducing rates of self-harm
- Support for people in high risk groups
- Action at high frequency suicide locations

56.13 Ms Bishop asked the following supplementary question:

Why do emergency hostels in the city not have suicide prevention information or notices available to vulnerable residents, and will the Board commit to getting this resolved?

56.14 The Chair asked Mr A Hill (Acting Director of Public Health) to respond. Mr Hill said he didn’t know exactly what information was available in different locations, but thought that it would be appropriate for such information to be available in homeless services and so he would check to see what was provided.

56.15 Councillor Penn said that Public Health had a suicide prevention strategy, which they were looking to update. This was a very important issue, with suicide being the biggest killer for men under 45 years of age, and need to not only target the most vulnerable but the public in general. It was important for people to know how to support those at risk of suicide, and said that Grass Roots had produced an app on that issue, and encouraged people to download it to their phone. Councillor Penn noted that many public toilets had information about sexual health, and suggested it would be useful to have information on suicide and self-harm too.

56.16 Mr A Hill said the City did have a suicide prevention strategy, and the action plan was available on the Council’s website, and confirmed that an item on that would be brought to a future meeting of the Board.

56.17 Mr C Clarke agreed that information on suicide prevention should be available in public places. He said that the CCG would have a modest uplift from its national awards in what it could commission on mental health next year, and some of that would be spent on suicide prevention and mental health in children and young people. Many mental health support services would be re-procured in 2018/19, and the specifications on those services would come to the Board in June.

56.18 (2) Mr Daniel Harris asked the following question:

I’ve read the big health and care conversation report and note that homeless people were mentioned in this report just 8 times.

There were almost 2800 conversations, I also sadly note that this survey managed to get just 15 people either homeless or affected by homelessness to respond. More people affected by homelessness died in Brighton and Hove in 2017 than responded to this survey. We know homeless people use A&E services 5 times more than the average Brighton and Hove resident so what steps will the council take to rectify this social injustice and ensure the voices of those truly affected by homelessness are reflected in this report?

56.19 The Chair gave the following response:

Thank you for your question.

The Big Health & Care Conversation is being reported here later today and I do hope that you stay for that item or pick it up later on the website. The Big Health & Care Conversation is not finished, it is such be viewed as a brand of activity that we will use as needed. The Big Conversation represented a focused period of engagement; however, we continue to engage with service users, carers and the public routinely as part of our ongoing commissioning and service delivery, which includes targeted work to ensure that the voices of marginalised and vulnerable groups are sought and heard appropriately, and that feedback is used to shape and improve services. It is important to note that this is not the only engagement and service user feedback mechanism we use. Our work directly with homeless or insecurely housed people includes ways to systematically seek their views and feedback, and to ensure these are used to change and improve services. For example we have contracted a Patient Participation Group at the Arch. The Board is aware of the health and care needs of those who are not only homeless but are vulnerably house. The Board helped secure the specialist GP provision within the city when the Practice Group withdraw its contracts and the Morley Street service was at risk. At the last Board we also supported the work that is being done through the Housing First initiative and have secure additional resources to support this service. It is through these longer term contacts that we can help address these needs. For example, having fast track provision for those that were seeking housing, to health and care provision, which may be of secondary importance to those individuals at that time.

The report that is coming to the Board today was requested by the Board, as the first phase of activity comes to an end.

56.20 Mr Harris asked the following supplementary question:

GP services are being closed down, and there has been an increase in people requiring mental health support. Can the Board ensure that those people get the correct advice?

56.21 The Chair said that the HWB received a report at their last meeting regarding support available for those with mental health issues.

57 FORMAL MEMBER INVOLVEMENT

57.1 Councillor Taylor asked the following question:

Following studies from Public Health England in 2016 and the Annals of Medicine in 2017 vaping was recommended as a safer alternative to tobacco and in particular in supporting smoking cessation. Given news that there is some evidence that vaping itself may be carcinogenic there has been much public concern on their safety. Subsequent reports have shown that this new evidence is specifically referring to nicotine which is of course consumed by smoking. Can the Chair of the HWB reassure residents of this city that vaping is safe?

57.2 The Chair gave the following response:

It is very timely as Public Health England has recently (February 2018) updated its evidence review of e-cigarettes and heated tobacco products.

As regards the health risks of electronic cigarettes the 2018 report has reviewed the available evidence. It is still relatively early in terms of longer-term effects of electronic cigarettes. The report refers to an assessment of the published data on emissions from cigarettes and electronic cigarettes which calculated the lifetime cancer risks. It concluded that the cancer potencies of electronic cigarettes were largely under 0.5% of the risk of smoking. In 2015 an expert review from Public Health England stated that the best estimate was that electronic cigarettes are around 95% less harmful than smoking. In 2016 the Royal College of Physicians came to a similar conclusion.

As regards the safety of nicotine the 2018 report states that “While nicotine has effects on physiological systems that could theoretically lead to health harms the long-term use of nicotine as smokeless tobacco (snus) has not been found to increase the risk of serious health problems in adults, and use of nicotine replacement therapy by pregnant smokers has not been found to increase risk to the foetus. Adolescent nicotine use (separate from smoking) needs more research. The long-term impact of nicotine from e-cigarettes on lung tissue is not yet known and may be different from its impact systemically.” The report also states that no health risks of passive vaping to bystanders have been identified to date.

The advice to cigarette smokers is that it is better to stop smoking completely than to change to electronic cigarettes. Specialist help to stop smoking is available locally from pharmacies and GP surgeries. However, for smokers who are unable to quit, electronic cigarettes are considered a safer option.

57.3 Councillor Taylor asked the following supplementary question:

Aside from the availability of snus, in Norway for example less than 1% of under 25s are consuming tobacco related products. Are we therefore looking at the best international evidence to ensure tobacco and smoking cessation services are taking that into account.

57.4 The Chair asked Mr Hill to respond. Mr Hill confirmed that the most up to date data was being used.

58 MOVING TOWARDS INTEGRATION

58.1 The report was introduced by The Executive Director Health & Adult Social Care and Mr C Clark (Brighton & Hove Clinical Commissioning Group). The report outlined the work being undertaken to establish a golden thread for the vision for health and wellbeing in the city, proposing the process to prioritise objectives and set out how the shadow year of working arrangements between the Council and Clinical Commissioning Group would support improved integrated health and social care delivery. The report further confirmed the piloting of a policy panel with a proposal to focus on and refresh the Health & Wellbeing Strategy.

58.2 The Chair noted that there were a number of errors in the proposed recommendations. Point 1 should read paragraphs 2.3 - 2.6, point 2 should read paragraphs 2.7 - 2.10, and point 3 should read paragraphs 2.11 – 2.21.

58.3 The Chair said that during the shadow year it was important to try something which was going to be as successful, and to ensure that all parties understood the processes. It would be challenging to bring two large organisations together and needed everyone to work together.

58.4 Mr Dennett (CCG) said the CCG had commissioned a broader governance review for the purposes of the alliance of the CCG, and that that review picked up best practice elsewhere in the country of working with local authorities, and that should assist the dialogue on best practice in the future.

58.5 Councillor Page said that closer working would avoid duplication and hopefully provide a better service, but he was concerned that the integration was being done on the instruction of the government with the financial restrictions which came with it, and it was important to ensure that the needs of patients were still being met. He noted that there was no information of the costs of officer time for those involved in the reorganisation, and hoped that that would be taken into account. The CCG had recently cut funding to the low vision clinic, but some funding was subsequently provided by the local authority. There did not appear to be any working together in this case with a relatively small budget, so he hoped such problems would not occur in future. With regard to the Policy Panel he hoped that it would be open and inclusive to everyone.

58.6 Councillor Taylor said that the Conservative Group supported the integration, which made sense and would achieve better outcomes for the city.

58.7 The Chair referred to the panel, and proposed that all members of the Board be contacted to ask if they would be interested on sitting on it. He added that the panel would not be restricted to members of the Board.

58.8 Resolved:

That the Health & Wellbeing Board:

- Agreed the approach set out in paragraph 2.3 - 2.6 of the report to refresh the Health and Wellbeing Strategy using the JSNA to determine priorities
- Agreed the JSNA Forward Plan from April 2018 to March 2020, as set out in paragraph 2.7 – 2.10 of the report
- Supported the approach to developing a joint commissioning programme in the shadow year of integration including budget management and governance processes as set out in paragraph 2.11 - 2.21 of the report
- Noted the timelines to support the integration of health and social care as outlined in Appendix 1
- Agreed that the HWB establishes a pilot policy panel
- Agreed that using the prioritisation and scoping document, the pilot should focus on the Joint Health and Wellbeing Strategy for the city
- Agreed that the pilot panel should report the outcomes of the work to the HWB by September 2018
- Agreed that the pilot panel should also report back on the resources required to support a panel to enable a decision to be making on any future panels and the forward plan for such work

59 BETTER CARE PLAN

59.1 The report was introduced by The Executive Director Health & Adult Social Care and Mr C Clark (Brighton & Hove Clinical Commissioning Group). The report provided an update on the Better Care Plan for Brighton and Hove.

59.2 The Board were advised that there had been a change to the financial issues (paragraph 3.3 of the report), which should now read:

The Better Care fund is a section 75 pooled budget which totals £25.350m for 2017/18, including £5.093m Improved Better Care funding (iBCF). The CCG contributes £18.276m to the pooled budget and the Council contributes £7.074m including the iBCF. Any spend variance at outturn is subject to a 50:50 risk share as per the section 75 agreement. We are in the process of setting the 2018/19 budget however there are timing issues due to the differing budget timetables between the Council and the CCG. The financial performance of the Better Care fund is regularly reported to the joint Health & Adult Social Care Finance and Performance Board.

59.3 Councillor Penn referred to the stats, and asked they related just to those who were resident in the city. Mr Clark confirmed it was anyone who was currently registered with a GP in the city.

59.4 Councillor Taylor referred to the graph showing the ‘Delayed Transfer of Care – Total Delayed Bed Days’, and noted that there had been a substantial increase during 2016/17 and asked if there was confidence that there wouldn’t be any further unexpected demands in the future. Mr Clark said he was optimistic that steps had been taken to address transfer of care, and the expectation was that the numbers would fall.

59.5 Resolved:

1) That the Board note the progress and updates reported from the Better Care Fund Steering Group

2) That the Board review the draft BCF Dashboard metrics for discussion and assurance of the Better Care Plan.

60 BIG HEALTH & CARE CONVERSATION

60.1 The report was introduced by Ms J Lodge, Head of Engagement Central Sussex Commissioning Alliance. The report related to the ‘Big Health and Care Conversation’, which was a joint CCG and Adult Social Care engagement exercise held between July and December 2017, where over 2700 conversations were held about health and care issues which were important to the residents of the city.

60.2 The Board were advised the Equalities section (paragraph 3.3 of the report) had been amended to read:

The intention to engage with and reflect the views of a wide range of residents has been built into the ‘Conversation’ process from the start. The use and analysis of data and engagement will help ensure that funding is spent on healthcare that best meets the needs of the local population. Community researchers were recruited and trained specifically to increase opportunities for people from specific groups to engage. Barriers and concerns for people who share a protected characteristic are identified throughout this report and actions responding to them have been noted. These include targeted provision, accessible information, work with focused CVS groups and diversifying the workforce. If either the CCG or Council were going to make any significant / substantive changes the relevant party would have to decide if this required formal consultation. The Big Health & Care Conversation is not formal consultation in but engagement.

60.3 Mr Dennett noted that the Big Conversation had been commended by other CCGs as being very effective, and Ms Lodge and her team should be congratulated on the work undertaken.

60.4 Councillor Page said that whatever the cost of the exercise the feedback was that it was worth it.

60.5 Dr Supple agreed with Councillor Page and hoped that the information obtained was shared and would be a platform for discussions about the STP.

60.6 Councillor Penn said that it was a really good piece of work involving many people. She hoped that the feedback would be weighted in terms of priority, and that some issues were not overlooked. One area of importance was parents with depression or with mental health issues, a condition which impacted on their children, and hoped the provision of support for them would not be lost amongst the other issued raised in the Big Conversation.

60.7 Mr Liley said it was a pleasure to be involved in the project and noted that the work with young people was particularly impressive. The information obtained from the Big Conversation would prepare people for the challenges ahead.

60.8 The Chair said it was a fantastic piece of work, and it was important to think how the information obtained would inform how we worked in the future. He referred to the responses on the sustainability and transformation plans, and noted that they echoed the concerns which the Board had and only raised issues that weren't expected. He hoped that the information obtained would be acted on and not just placed on the shelf. Ms Lodge reassured the Board that the information obtained would be used. There were somethings which could be addressed straight away, and other things which would take longer, but all the data would be analysed and not put on the shelf.

60.9 The Chair noted that an analysis to review the progress made against the '*we have'* and '*we will'* areas, would be carried out in September 2018 and asked how that would be reported. Ms Lodge said she would be happy to bring a progress report to the Board.

60.10 The Chief Executive Brighton & Hove City Council said the Board would have to juggle the views of the general public, and what we find out from things like the Strategic Needs Assessment regarding things like government advice etc. when redesigning and funding services going forward. This document gives us a good reference point to refer back to, but not to lose sight of the other reference points which need to be considered.

60.11 Resolved:

That the Health and Wellbeing Board:

1) Notes the feedback and associated actions outlined in the report

2) Endorse the proposed approach for the Council and the CCG to refer to and reflect the findings in this report when they plan, commission and re tender services.

61 ADOLESCENT HEALTH OFFER

61.1 The report was introduced by Ms K Clarke (Children Young People and Public Health Schools Programme Commissioner), and Ms A Gianfrancesco (Head of Service BHCC, Adolescents, Children Families & Learning). The report provided an update, and sought endorsement, on the new Adolescent Health Offer, being developed to reduce the harm to young people caused by substance misuse and early sexual relationships.

61.2 The Executive Director Families, Children and Learning BHCC, said that some of the health outcomes for adolescents were the worst in the country, and the report outlined the new more integrated way of working to address that. Integrated working enabled agencies to work with each other to support adolescents. He gave the example of young people entering the criminal justice system, and said the city had had a high number, but groups had worked together to address issues such as exploitation, and now the number of children in criminal justice system, and those reoffending, was very low. It was hoped that working with multiple agencies would improve the health of young people in the city.

61.3 Mr G Bartlett thanked officers for the report. He referred to the transition of children to adulthood, and said that their vulnerability did not stop when they reached eighteen, and asked if there were plans to extend the integration into adult services. He was advised that there was, and staff worked closely with adult services. Young people who were likely to need continued support, were assigned an adult-worker to assist with the transition.

61.4 Councillor Taylor welcomed the report and said it was vital that there was more joined approach to this area of work. He noted that officers would be working with two secondary schools, Cardinal Newman and Patcham High School, to co-produce a whole school approach, and asked if it would go out to other secondary schools later. He was advised that from past experience it was preferable to work with just two schools to really work out the details, and then produce a single plan which could be then rolled out to other schools.

61.5 Councillor Taylor noted that the service would be launched in May/June which would be shortly before the school summer holidays, and asked if services would be provided over that period. He also noted that the report said that it was everyone’s responsibility to support young people and named groups such as the Police, NHS etc but did not make reference to parents. Officers said that the service wouldn’t just be delivering in schools but in other settings across the city, and so no one would miss out just because it was the school holidays. With regard to not referring to ‘parents’, it was confirmed that that was an oversight in the report, and added that support was also available to parents to enable them to assist their children.

61.6 Councillor Penn said that the city was quite drug tolerant, and so it might be necessary not to just support parents but also to challenge them. Allowing young people to smoke cannabis at home, for example, was not being a good parent. Officers said that tolerance was an issue, and it was important to educate parents on the risks of substance misuse.

61.7 Mr A Hill said that this would be a long term process and it was essential that worked started on social media before the summer. It would require a change of social behaviour within the city, and so there should be a long term strategic approach to address that. Officers said that there was a social media element within the plan, and websites had already been identified which would be used to publicise the messages on health.

61.8 The Chair said that integrating services could be challenging but usually worthwhile. He referred to tolerance in the city, and said whilst it was good to accept some things, it wasn’t good to tolerate behaviour which could impact on a young person’s health.

61.9 The Chair suggested that the report be referred to the Children Young People & Skills Committee for information.

61.10 Resolved:

(1) That the Health and Wellbeing Board endorse the city wide approach addressed in this paper to reducing the harm caused to young people by substance misuse (drugs, alcohol and tobacco) and early sexual relationships (teenage pregnancy and sexually transmitted infections).

(2) That the report be referred to the Children Young People & Skills Committee for information

62 PHARMACEUTICAL NEEDS ASSESSMENT: FINAL REPORT AND THE PROCESS FOR FUTURE SUPPLEMENTARY STATEMENTS

62.1 The report was introduced by Ms N Rosenberg (Consultant Public Health) and Ms B Hardcastle (Public Health Specialist). The report presented the 2018 Pharmaceutical Needs Assessment (PNA).

62.2 The Chair thanked officers for the report. He was concerned that when the next review PNA were due, things may be more challenging with additional pressure on pharmacists to deliver more extended services.

62.3 Mr A Hill congratulated officers on the work undertaken, and which showed that action had been taken on the recommendations from the last report and that the Board were listening to suggestions made.

62.4 The Chief Executive Brighton & Hove City Council asked what the relationship was between opportunities which public service providers might want to put with pharmacists, and the financial viability of them undertaking those opportunities. Officers said that if a service were financially viable pharmacists would bid for it.

62.5 Dr D Supple noted that many privately run pharmacists had closed so there were now more chain store pharmacies. He said that the LPC were concerned about passing work to pharmacists which was not paid, such as advising the public on medical issues. Councillor Page asked if there had been an increase in the public visiting their pharmacist rather than their local doctor or A&E. Officers said that it was part of the national contract for pharmacists to give advice to the public. The number of consultations made was not recorded, but the LPC would say there was increasing pressure on pharmacists to deliver that service.

62.6 Resolved:

1) That the Board approves publication of the 2018 Pharmaceutical Needs Assessment Report.

2) The HWB are asked to approve the process for supplementary statements delegating authority to the Director of Public Health working with the PNA Steering Group to identify and implement any future amendments to the PNA and to bring

back a full revised PNA to the HWB in April 2021. Before this any pharmacy closures will be reported to the HWB.

The meeting concluded at 6.55pm

Signed Chair

Dated this day of

Item 6

Although a formal committee of Brighton & Hove 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 Adults and Healthwatch.

Title:	Effect of Social Care Budget Reduction Response	
Date of Meeting:	12 June 2018	
Report of:	Rob Persey, Executive Director of Health and Adult Social Care Dr David Supple, Chair of Brighton & Hove CCG	
Contact:	Barbara Deacon	Tel: 01273 296805
Email:	barbara.deacon@brighton-hove.gov.uk	
Wards Affected:	All	

FOR GENERAL RELEASE

Executive Summary

This paper provides a detailed response to the deputation presented to the previous Health and Wellbeing Board on 6th March 2018 with regard to a Survey of GPs titled: The Effects of Reductions to the Social Care Budget. It is assumed for the purpose of this paper that the definition of social care in this context refers to adults aged over 18 with the primary cohort being the frail elderly.

The survey suggests and asks questions on the following:

- Demand for Social Care is rising but the budget to meet it is falling
- What is the impact to patients and GPs if they can't access Social Care?
- How frequent are the difficulties GPs refer to in the survey?
- Social Care needs more resources

This report provides factual context to the GP survey and presented under the four headings outlined above it challenges the conclusions of the GP survey, demonstrating that, whilst supporting the conclusion that additional resource would be welcome, it is incorrect to suggest both the indicated level of budget reduction in 2018/19 and infer the causal link to service delivery.

The report, prepared jointly by BHCC and the CCG is for information

1. Decisions, recommendations and any options

1.1 That the Health & Wellbeing Board note the contents of the report

2. Relevant information

2.1 The GP survey was sent out to 124 GPs in Brighton and Hove and 47 responses were received. The survey, when submitted to the previous Health and Wellbeing Board, was signed by eight signatories. Across the 37 GP practices in Brighton and Hove there are more than 160 GPs, either partners, salaried or locums. Therefore the survey results represent the views of approximately 29% of GPs across the city, and whilst valid to those respondents is not necessarily indicative of the views of the wider majority of general practice across the city

Demand for Social Care is rising but the budget to meet it is falling

2.2 The GP survey correctly states that, nationally, the need for Social Care is rising each year and equally it is correct that since 2010 Council budgets have reduced annually in line with the reductions in central government grant funding to local authorities. However, in clarifying the GP survey statement that further savings have been identified for 2018/19, in Adult Social Care over the past 6 years the reduction in budget has been circa 5% against a national grant reduction closer to 40% and in this financial year the facts are there will be a net increase in the overall budget for adult social care of approximately £6.5m (including allowance for inflation) since 2015/16. Indeed whilst BHCC net budget has reduced by 3% from 2015/16 to 2018/19 the percentage spend on adult social care as a proportion of the council overall budget has increased by 4%. This is in recognition of the priority given to supporting vulnerable adults with eligible adult social care needs (Appendix 1).

2.3 The table below demonstrates that whilst there has been required budget reductions across all council services Health and Adult Social Care has been protected recognising both the statutory nature of our services provided and one of the Council's agreed Corporate plan priorities being '**A good life** – ensuring a city for all ages, inclusive of everyone and protecting the most vulnerable'

2.4 It is important to recognise that savings identified against specific service areas must not be confused with budget reductions. As we work more closely with health colleagues to maximise the effective use of resources, which from a HASC perspective prioritises meeting our statutory responsibilities, maximising independence and choice and control, with an emphasis upon preventative services, we will review how current services are delivered and look for more effective and efficient ways to meet person centred outcomes.

2.5 With regard to delayed transfers of care the graph in appendix 2 shows that we have reduced the number of delayed bed days in the last year by 540 days (38.3% decrease since this time last year). The Board regularly receives detailed information within the Better Care Fund reports and one of these reports is coming to the Board today.

What is the impact to patients and GPs if they can't access Social Care?

2.6 To clarify the distinction between Adult Social Care and Continuing Health Care (CHC). CHC is defined nationally as a package of care funded by the NHS where an individual's care is fully funded by the NHS regardless of their wealth or savings. CHC may be available if the person's main requirement for care is down to health related problems. It can be received in hospital, a nursing home or at the individual's home. This is often described as 'fully funded care'. Eligibility for adult social care is based upon an assessment against a defined national framework and is chargeable on a scale dependent upon wealth and savings, further detail are available on the Council website. There are a number of clearly signposted routes into accessing Adult Social Care. With regard to primary care in the city, GPs are divided into six clusters and adult social care is delivered across 3 districts; east, central and west. These arrangements have been in place since May 2017 and work continues to further embed relationships between professional staff in the localities and clusters. However, this further embedding is from a position where relationships and pathways are in place already to ensure GPs are aware of the pathways into Adult Social Care and patients equally know or can be easily signposted into the Councils Access Service to be referred for assessment.

Social Care needs more resources

2.7 The survey of GPs concludes with the statement that social care needs more resources. This is more than a local issue and the current funding challenges facing Adult Social Care are subject to regular voicing on the national policy stage. Health and Wellbeing Board members will be aware that a Green paper on future adult social care funding is expected this summer and there has equally been acknowledgement of the need for additional funding of the system in the more immediate term. We continue to inform and provide evidence to support the need for additional funding through a number of routes but securing this is not within our direct control. However, the Council and CCG would wish to reassure members of the HWB that we do maximise the efficient spend of resources within our control for adult social care and, under any eventuality, should additional resources become available we have a strategic approach being developed to maximise the value of spend under our proposal for closer integration in Brighton and Hove.

3. Important considerations and implications

Legal:

3.1 There are no legal implications arising from this report which is to note.

Lawyer consulted: Elizabeth Culbert Date: 30.05.18

Finance:

3.2 The financial implications are outlined within the report.

3.3 The table in paragraph 2.4 reflects how the Adult Social Care Budget has been protected from overall council savings in the last 4 years. The Adult Social Care budget has had an overall net increase of 8% since 2015/16 whereas the Council's overall budget has reduced by 3%.

Finance Officer consulted: Sophie Warburton Date: 31/05/2018

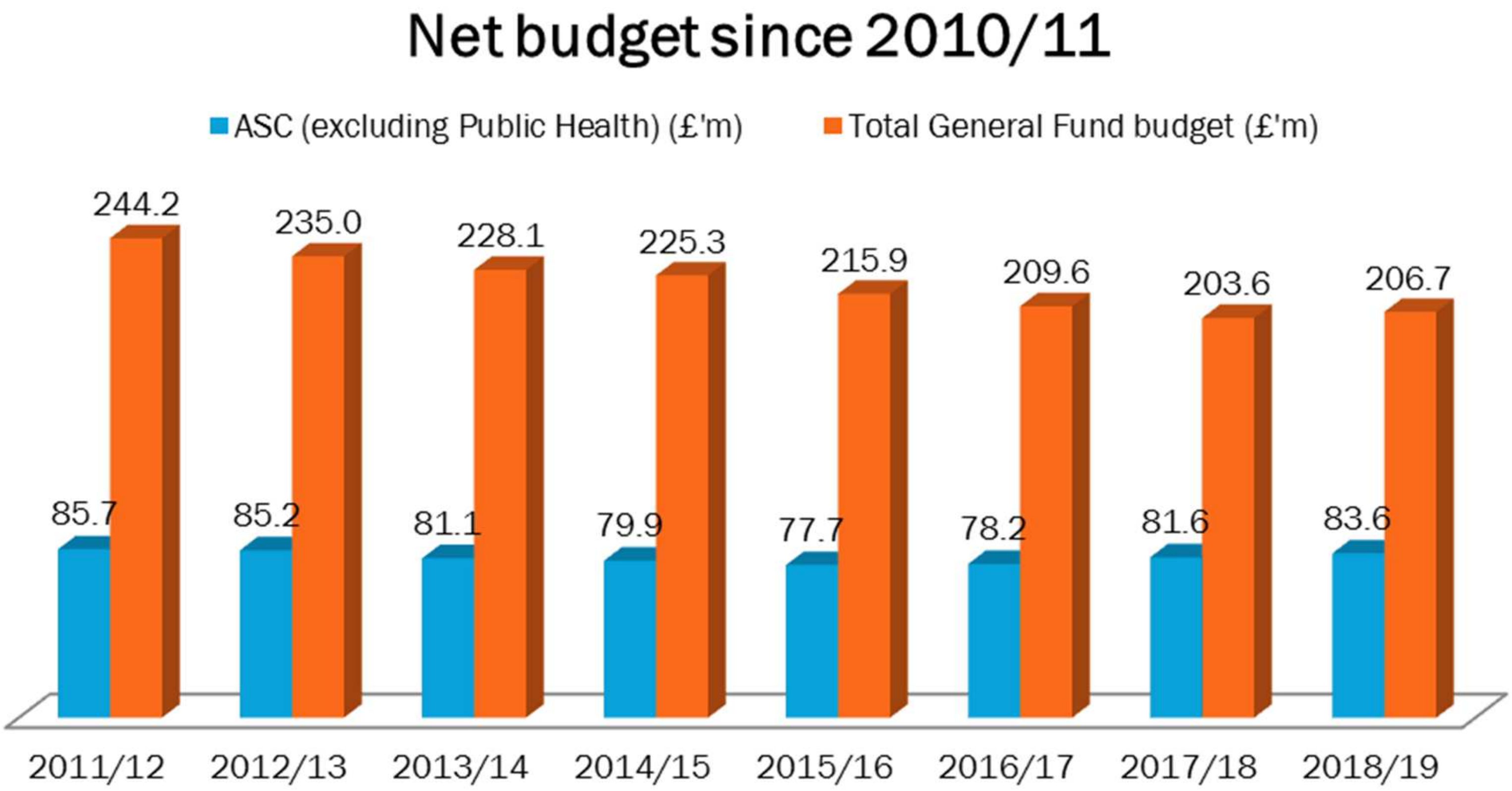
Equalities and Sustainability implications:

3.4 There are no further implications to note at this stage.

Equalities Officer consulted: Sarah Tighe-Ford Date: 31/05/2018

Supporting documents and information

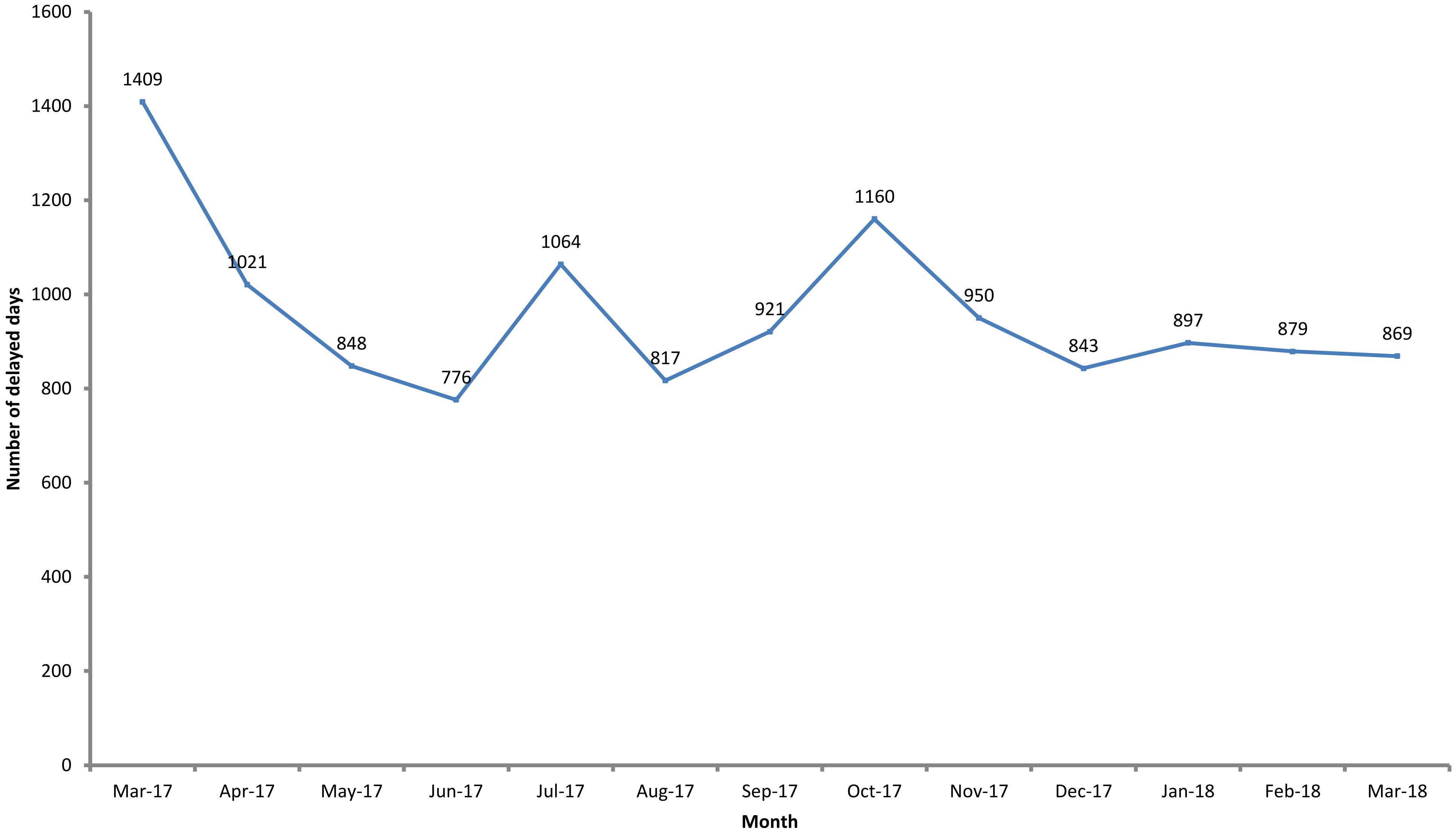
Appendix 1: Net Budget since 2010/11
Appendix 2: Total delayed days
Appendix 3: Data concerning Access Point referrals, interventions, progression and outcomes


Net budget since 2010/11
ASC (excluding Public Health) (£'m)
Total General Fund budget (£'m)
244.2
235.0
228.1
225.3
215.9
209.6
203.6
206.7
85.7
85.2
81.1
79.9
77.7
78.2
81.6
83.6
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19

Summary Details of ASC budget 2015-2019

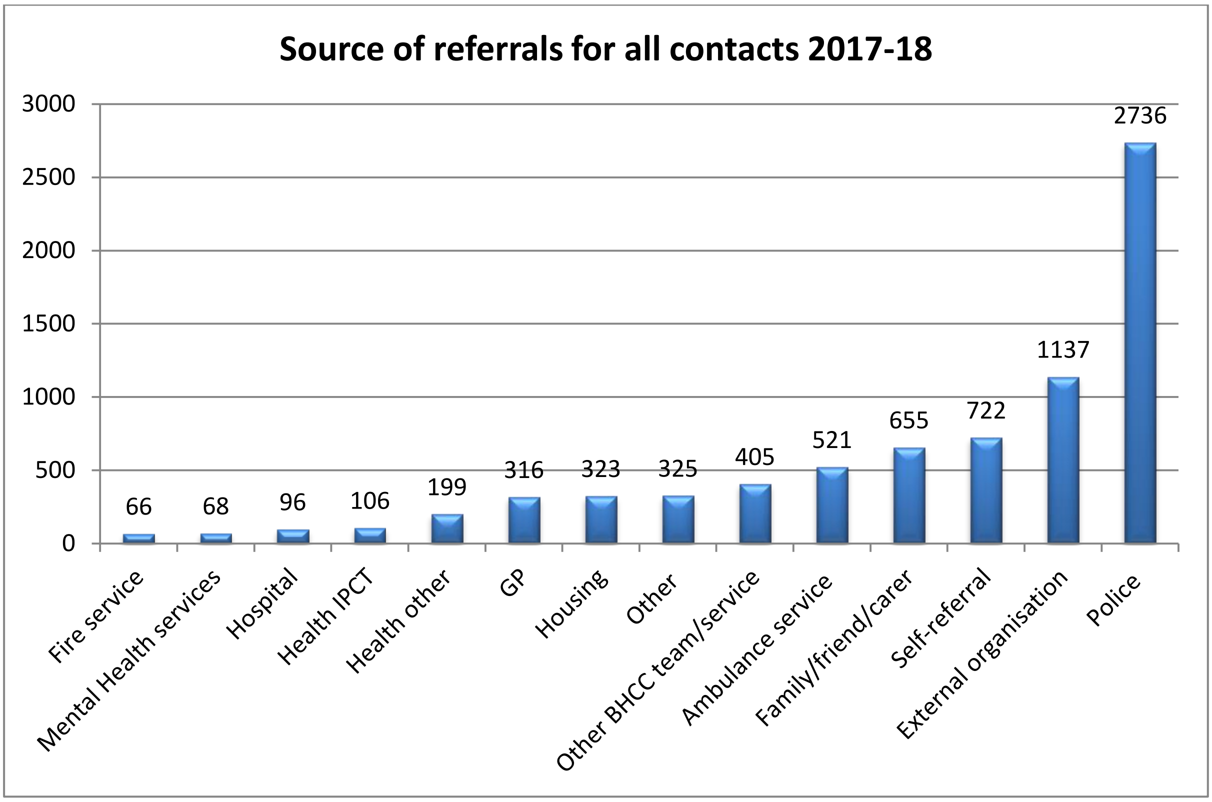
Financial Year	Overall Council savings £'m	Overall change in Adult Social Care budget £'m
2015/16	-£18.821	-£1.931
2016/17	-£19.248	-£0.984
2017/18	-£21.026	£1.140
2018/19	-£12.371	£6.338

APPENDIX 2: Total delayed days: BHCC



Appendix 3: Interventions at Access Point (including First Response) 2017-18

There were 7719 Contacts at Access Point in 2017-18 for 5007 individual people.



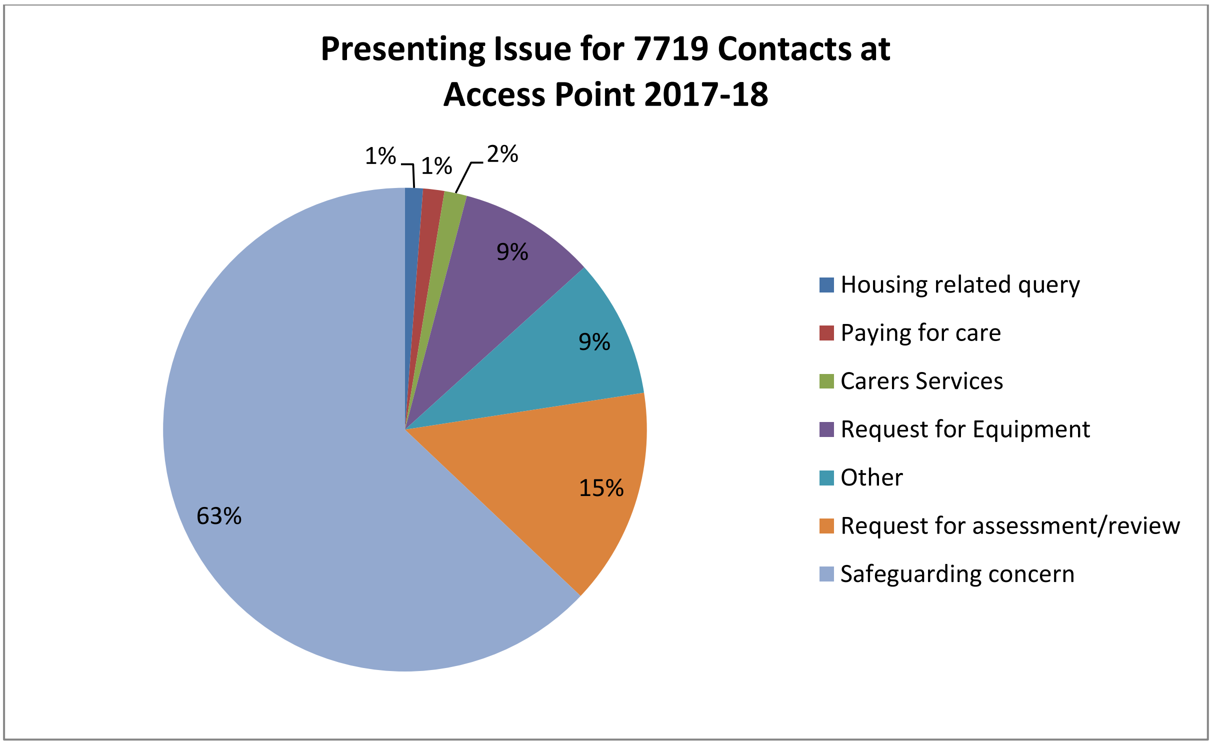
OUTCOME OF CONTACT	No.	%
Equipment Provided no further action	226	**3%**
Equipment provided and assessment needed	117	**1.5%**
Referred on for further assessment/review/Safeguarding	3080	**40%**
Resolved- Information and Advice/signposting/redirected	4295	**55.5%**

- Please note the numbers do not equate to individuals as people will present repeatedly throughout the year and often for different reasons.

- 50% of contacts were for individuals who did not present again- of these 63% were resolved through info/advice/signposting.

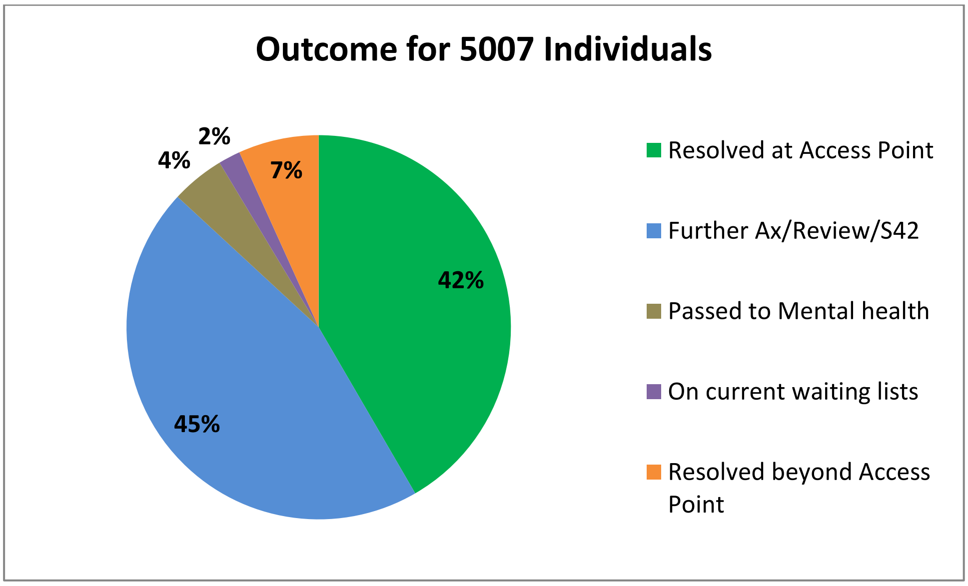
- 55.5% of all contacts have been resolved.

- The Police are responsible for almost 3000 of the contacts made.



Presenting Issue Numbers

Housing related query	92
Paying for care	110
Carers Services	116
Request for Equipment	708
Other	716
Request for assessment/review	1120
Safeguarding concern	4859



Although a formal committee of Brighton & Hove 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 Adults and Healthwatch.

Title:	**Better Care Plan – standing agenda item**
Date of Meeting:	**12 June 2018**
Report of:	**Chris Clark, Director of Commissioning Operations (Designate), Brighton & Hove CCG, Central Sussex and East Surrey Commissioning Alliance** **Rob Persey, Executive Director of Adult Social Care and Health**
Contact:	**Barbara Deacon** **Tel: 01273 296805**
Email:	c.clark6@nhs.net Rob.Persey@brighton-hove.gov.uk
Wards Affected:	**ALL**

Decisions, recommendations and any options

1.1 This report provides the Health and Wellbeing Board with a regular update on progress with the Brighton and Hove Better Care Fund Programme for 2018-19. It offers a general update on items managed through the BCF Steering Group since the last report, as well as the most recent Financial and Performance indicators agreed within the BCF Plan. The report is being presented to the Board for assurance and information, and does not make any recommendations requiring decision or approval by the Board.

2. Relevant information

2.1 Scope of the Report

This report contains three sections. The first section covers a general update from the BCF steering group meetings that have taken place since the last BCF update was reported to the Board. The notes from the last meeting are attached in **appendix 1**. The second section provides a brief update position on the financial position of the BCF programme. This is also reported to the Finance and Performance sub-committee of the Health and Social Care Integration Board, as well as CCG and Council management committee meetings. The end-of-year 2017-18 BCF Finance report is attached as supporting documentation in **appendix 2**. The third and final section is an update on the business intelligence programme within BCF, including an update on the performance measures agreed within the BCF plan. The BCF performance dashboard, which is still being developed, is attached in **appendix 3**.

2.2 Update from the BCF steering group

The following items are key updates from the BCF steering group since the last update report to the Board:

- The steering group recorded that the S.75 BCF Formal Agreement for 2018-19 has now been agreed and signed by the CCG Director of Commissioning and the Council Director of Health and Adult Social Care. This was an outstanding action from the Health and Wellbeing Board following approval of the 2018-19 BCF plan.

- The steering group noted the 2017-18 outturn position on the BCF budget. A small net overspend was noted and the steering group successfully agreed a distribution of this between the CCG and Local Authority under the terms laid out in the Section 75 Agreement. This is covered in more detail in the finance report in **section 2.3**.

- The steering group agreed to reallocate programme funds within the BCF to grow the investment in Home-First, to continue to build on the progress made in 2017-18 in reducing delayed transfers of care, and to commit to an invest-to-save scheme to prevent overspending on community equipment by increasing the opportunity to recover and recycle second-hand equipment.

- The steering group reviewed the progress from the business intelligence team in developing a KPI dashboard to report the performance of the BCF programme against the agreed measures in the plan. The report shows twelve-month trends in the nine key measurement areas, including delayed discharge bed days and emergency hospital readmissions within 30 days of discharge. The report format is still under development as the steering group would like the report to be accessible by the public as well as the Health and Wellbeing Board, and is being designed in such a way to be interpreted by people with visual impairment, by using larger font and not relying on colour-coding.

2.3 BCF Finance Report

At the time of reporting, the CCG and Finance teams are still preparing the financial reports for period 1 (April 2018). Therefore this report contains the most recent reporting period, which is month 12 and the 2017-18 year-end reported position. Key points of note are:

- The year end BCF position ended within 1% of the total budget of £25,519,684. The final yearly expenditure was £25,734,870, which resulted in an overspend of £215,186.

- CCG and LA finance teams agreed a joint resolution to this overspend in 1718 year end accounting, using the principles laid out in the section 75 agreement.

- New mitigations have been introduced in 2018-19 to reduce the risk of this budget continuing to overspend.

2.4 BCF Performance Report

The full BCF performance dashboard can be found in **appendix 3**. Key items of performance to note are:

- The Brighton and Hove Health and Social Care system continues to deliver a downward trend in delayed transfer of care bed days. Much of this can be attributed to investment programmes through the BCF. The system has committed to continuing to reduced delayed transfers of care from hospital.

- The overall number or emergency admissions to hospital have reduced from the same period last year, although the proportion of these that are readmissions within 30 days has increased very slightly and the average length of stay of emergency admissions has increased by around 1 day. These will be a main focus of the BCF programme in 2018-19.

- Overall attendances to A&E are significantly lower across the year than the previous period, although a high attendance in March 2018 resulted in a small increase from the same month the previous year.

- The proportion of patients going into re-ablement services and the proportion of patients with telecare in their support plans have both increased over the last 12 months.

3. Important considerations and implications

The CCG must report progress with the BCF programme to NHS England on a quarterly basis as part of a national assurance process. The BCF reporting cycle has been designed to align to the national reporting process, although the Health and Wellbeing Report contains more detailed local metrics and is refreshed on a bi-monthly basis.

Legal:

3.1 The Section 75 Agreement that established the Better Care Fund for 2018-2019 sets out the requirement for a quarterly report on performance to the Health and Wellbeing Board. The Health and Wellbeing Board has responsibility under the s75 Agreement for ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

Lawyer consulted: Elizabeth Culbert Date: 28.5.18

Finance:

3.2 The Better Care fund is a section 75 pooled budget which totalled £25.520m for 2017/18, including £5.093m Improved Better Care funding (iBCF). The CCG contributed £18.276m to the pooled budget and the Council contributed £7.244m including the iBCF.

The outturn for 2017/18 was an overspend of £0.215m which was distributed as per the terms of the Section 75 agreement.

We are in the process of setting the 2018/19 budget and new mitigations will be introduced to reduce the risk of future overspending.

The financial performance of the Better Care fund is regularly reported to the joint Health & Adult Social Care Finance and Performance Board.

Finance Officer consulted: Sophie Warburton Date: 30/05/2018

Equalities:

3.3 Individual services and programmes relating to the Better Care Fund will be assessed for their equality impacts as part of their development and implementation.

Equalities Officer consulted: Sarah Tighe-Ford Date: 25 May 2018

Supporting documents and information

Appendix1: Notes and actions from the BCF Steering Group
Appendix 2: Month 12 2017-18 BCF Finance Schedule
Appendix 3: June BCF KPI Report

Appendix 1: BCF Steering Group Notes from Meeting
Date of Meeting: 8th May 2018, Hove Town Hall

Members Present

Chris Clark - Director of Commissioning Operations (Designate) Brighton and Hove CCG (Chair)
Andy Witham – Head of Adult Social Care Commissioning BHCC
Debra Crisp – Deputy CFO BHCCG
Cat Harwood-Smith – Head of Performance, Business Improvement and Modernisation BHCC
Grace Hanley – Assistant Director Health and Social Care BHCC

Apologies

Rob Persey – Director of Health and Adult Social Care BHCC
Jason Cheung – Information Analyst BH CCG
Ramona Booth – Deputy Director of Performance, Planning and Informatics BHCCG
Sophie Warburton – Financial Services Accountant BHCC

Item 1: Introductions, Apologies, Minutes and Actions, Conflicts of Interest (COI)

- The members gave introductions and apologies we noted
- The notes from the previous meeting were agreed and all actions noted as completed, including acknowledgement that the S75 agreement has now been signed by both parties.
- Members were invited to confirm that the COI register is up to date and if any new declarations needed to be made. None were noted.

Item 2: BCF Finance Report

- The steering group reviewed and approved the month 12 BCF finance report for 2017-18. A net overspend was recognised, and it was understood to be driven by and underspend of the disabled facilities grant and an overspend in the community equipment fund. The steering group noted from finance colleagues that a discussion had taken place which proposed a distribution of this overspend between the CCG and Local Authority, as per the principles set out in the section 75 agreement. The steering group agreed to this proposal.

Item 3: Investment Projects

- The Steering Group agreed to reallocate funds within the BCF to increase the investment into Home First to £650,000 to fund home care and discharge across all wards at RSCH.
- The Steering group agreed to commit to the invest-to-save scheme in community equipment to mitigate further overspending and expand the opportunity to recover and recycle second-hand equipment.

Item 4: BCF Performance

- The steering group review the BCF Dashboard that Business Inteligence colleagues had been developing and fed back on where formatting should change to make the report easier to read, and where further narrative was necessary to provide more detail explaining trends and variation from targets. The steering group approved the dashboard to be presented to the Finance and Performance Sub-committee of the Health and Social Care Integration Board.

Date of Next Meeting - TBC

Appendix 2: BCF Finance Report Month 12 2017-18

Better Care Fund Report for Month				**Mar-18**		
	Month			**Atual**		
Workstream	Budget £	Actual £	Variance £	Annual Budget £	Actual Outturn £	Variance £
Increasing System Capacity Workstream						
Additional Care Managers working across the City localities 7 days pw	117,732	117,732	0	117,732	117,758	26
3 Social Workers in IPCT's	103,228	103,228	0	103,228	103,250	22
Integrated Primary Care Teams (SPFT) Additional Mental Health nurses	100,574	100,574	0	100,574	100,574	1
Increasing capacity	1,026,430	1,026,430	0	1,026,430	1,026,430	0
Supporting the market	325,000	325,000	0	325,000	325,000	0
Total Increasing System Capacity Workstream	**1,672,964**	**1,672,964**	**0**	**1,672,964**	**1,673,012**	**49**
Integrated Discharge Planning Workstream						
Integrated Primary Care Teams (SCFT)	7,710,401	7,710,401	(0)	7,710,401	7,710,401	(1)
Incentivising care homes and homecare providers to respond 7 days pw	51,188	35,850	(15,338)	51,188	35,850	(15,338)
Hospital Discharge	3,058,350	3,058,350	0	3,058,350	3,058,350	0
Total Integrated Discharge Planning Workstream	**10,819,939**	**10,804,601**	**(15,338)**	**10,819,939**	**10,804,601**	**(15,338)**
Protecting Social Care Workstream						
Home First	435,379	435,382	3	435,379	435,382	3
Maintaining eligibility criteria	2,904,000	2,904,000	0	2,904,000	2,904,000	0
Additional social workers for Access Point	70,000	70,000	0	70,000	70,000	0
Protection for Social Care (Capital grants)	110,000	79,690	(30,310)	110,000	78,961	(31,039)
Disabled facilities grant (Capital grants)	1,703,174	1,175,429	(527,745)	1,703,174	1,213,229	(489,945)
Community Equipment (Capital grants)					470,000	470,000
Telecare and Telehealth (Capital grants)	100,000	150,614	50,614	100,000	150,614	50,614
Additional call handling resource for CareLink out of hours	35,000	35,000	0	35,000	35,000	0
Additional Telecare and Telehealth resource	200,000	200,000	0	200,000	200,000	0
Protection for Social Care	1,189,000	1,189,000	0	1,189,000	1,189,000	0
Supporting Social Care	442,000	442,000	0	442,000	442,000	0
Total Protecting Social Care Workstream	**7,188,553**	**6,681,115**	**(507,438)**	**7,188,553**	**7,188,186**	**(367)**
Supporting Recovery & Independence Workstream						
Community Equipment Service	2,334,000	2,609,714	275,714	2,334,000	2,609,714	275,714
Carers Reablement Project	17,500	20,000	2,500	17,500	20,000	2,500
Alzheimer's Society – Information, Advice and Support for Carers	25,000	25,000	0	25,000	25,000	0
Alzheimer's Society – Dementia Training for Carers	5,000	5,000	0	5,000	5,000	0
Sussex Community Trust – Carers Back Care Advisor	34,034	34,034	0	34,034	34,034	0
Amaze – Carers Card Development	10,000	10,000	0	10,000	10,000	0
Carers Centre – Adult Carers Support	104,000	104,000	0	104,000	104,000	0
Carers Centre – Young Carers Support	32,000	32,000	0	32,000	32,000	0
Crossroads – Carers Support Children and Adults	47,000	47,000	0	47,000	47,000	0
Carers Centre – End of Life Support	9,500	9,000	(500)	9,500	9,000	(500)
Amaze – Parent Carers Survey	1,000	0	(1,000)	1,000	0	(1,000)
Crossroads – Carers Health Appointments	37,500	37,500	0	37,500	37,500	0
Hospital Carers Support – IPCT Carers Support Service	27,000	27,000	0	27,000	27,000	0
Carers Support Service - Integrated Primary Care Team (ASC Staff)	93,175	93,175	0	93,175	93,175	0
Carers (other)	382,072	311,943	(70,129)	382,072	311,943	(70,129)
Carers Hub	350,675	354,675	4,000	350,675	354,675	4,000
Total Supporting Recovery & Independence Workstream	**3,509,456**	**3,720,041**	**210,585**	**3,509,456**	**3,720,041**	**210,585**
Person Centred Integrated Care Workstream						
Proactive Care (Primary Care)	1,207,000	1,175,205	(31,795)	1,207,000	1,175,205	(31,795)
Care Navigation Service	134,794	158,000	23,206	134,794	158,000	23,206
Befriending - Neighbourhood Care Scheme	170,625	190,000	19,375	170,625	190,000	19,375
Total Person Centred Integrated Care Workstream	**1,512,419**	**1,523,205**	**10,786**	**1,512,419**	**1,523,205**	**10,786**
Dementia Planning Workstream						
Dementia Plan	209,016	218,697	9,681	209,016	218,697	9,681
Total Dementia Planning Workstream	**209,016**	**218,697**	**9,681**	**209,016**	**218,697**	**9,681**
Homelessness Workstream						
Homeless Model	607,338	607,129	(209)	607,338	607,129	(209)
Total Homelessness Workstream	**607,338**	**607,129**	**(209)**	**607,338**	**607,129**	**(209)**
TOTAL	**25,519,685**	**25,227,751**	**(291,934)**	**25,519,684**	**25,734,870**	**215,186**

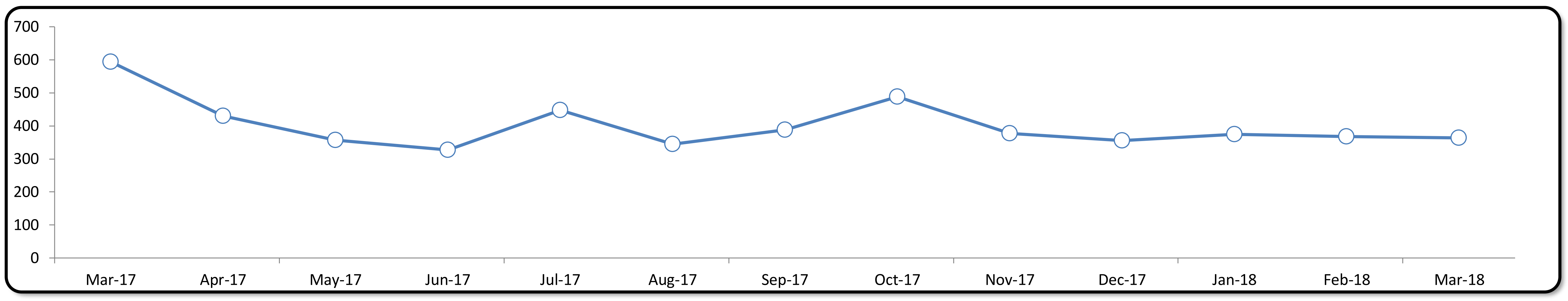
Appendix 3

Better Care Fund Performance Metrics

1. Performance figures reports are most recent data for each indicator
2. Latest performance is presented agaisnt the planned performance as an indciation of variance from target and a comparison is given to previous year
3. Regioonal or National benchmark data is provided where available, dependent on the indicator

Delayed Transfers of Care (DToC) beddays per 100,000 adult pop

Latest data available Mar-18	363	Vs same period last year Mar-17	593	Latest full quarter available Jan - Mar 18	1,105	Vs BCF plan Jan - Mar 18	817

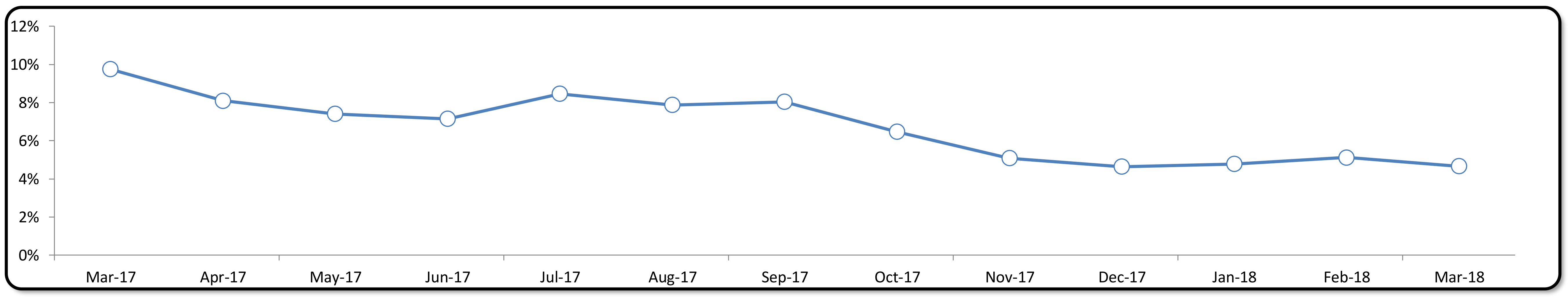


Source: NHS England Statistics

The number of Delayed Transfers of Care beddays per 100,000 Brighton and Hove population in Mar-18 has decreased against the same month last year, 363 in Mar-18 vs 593 in Mar-17. The total delayed days for Brighton and Hove during Mar-18 was 869. This demonstrates a significant improvement in delayed discharge performance in the Brighton and Hove System, returning performance to that which was seen 2 years ago. This is a response to the significant joint working accross health and social care which will continue to drive down delayed discharges in 2018-19. However the performance is still not quite meeting the quarterly target we would like to achive. Key causes of delays are time to assessment, discharge planning and identification of suitable capacity following discharge, these are foci of the BCF this year.

% of beds occupied by Delayed Transfers of Care (DToC) patient at Brighton & Sussex University Hospital

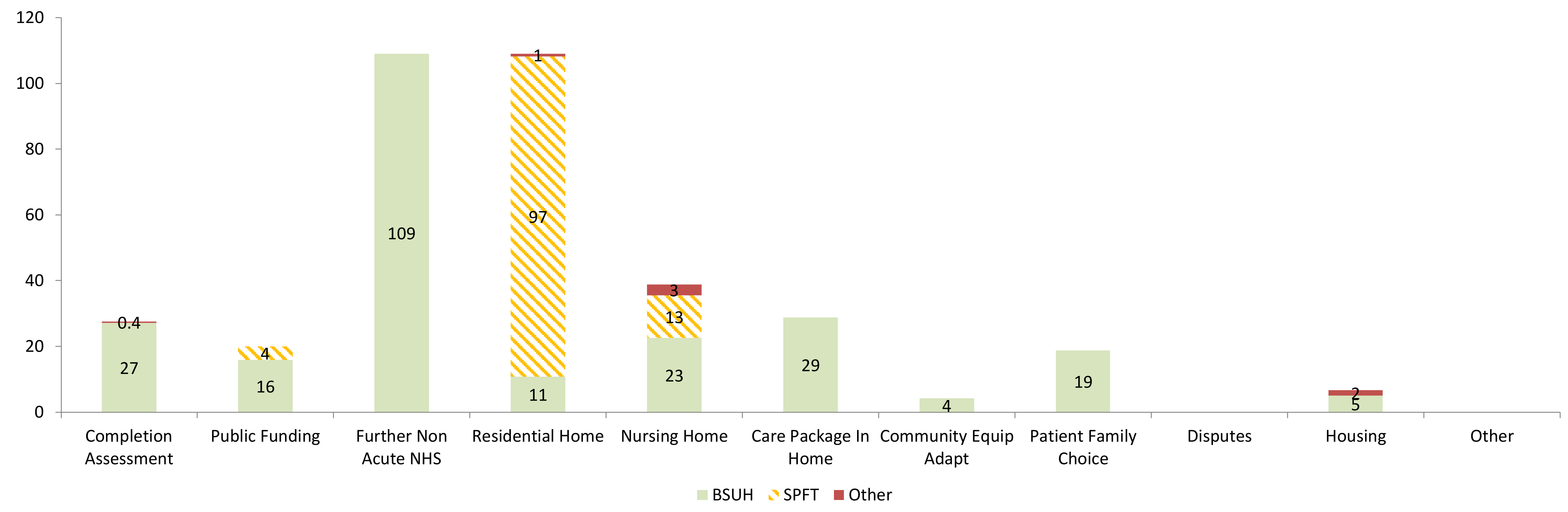
Latest data available Mar-18	4.7%	Vs same period last year Mar-17	9.7%	Other Adult Major Trauma Centres Mar-18	5.3%	National standard	3.5%



Source: NHS England Statistics

The number of beds occupied by a delayed transfers of care patient at Brighton and Sussex University Hospital in Mar-18 has decreased against the same month last year, 4.7% in Mar-18 vs 9.7% in Mar-17. This metric has a direct relationship with the number of delayed bed days per 100,000, thus the performance improvement is in line with that descrived above.

Total Brighton and Hove Unitary Authority area - Delays by reason per 100,000 - Mar 18

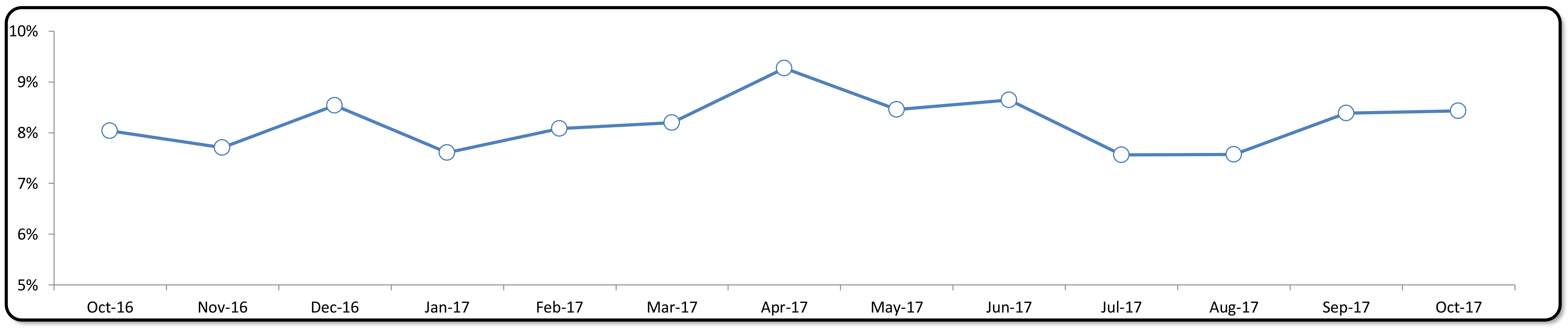


Source: NHS England Statistics

The top reason for delays for Brighton and Hove Unitary Authority area is Further Non Acute NHS and Residential Home with 30.0% of the delays each. 66.7% of the Brighton and Hove Unitary Authority area delays are from Brighton and Sussex University Hospital, 31.5% are from Sussex Partnership Foundation Trust and 1.7% from others providers.
The top reason for delays for England is care package in home with 21.7% of the delays and 19.0% for further non-acute NHS.

Emergency readmission rates (within 30 days) - All Ages

Latest data available Oct-17	8.4%	Vs same period last year Oct-16	8.0%	Latest full quarter available Jul - Sep 17	7.8%	Vs Jul - Sep 16 rates	8.3%

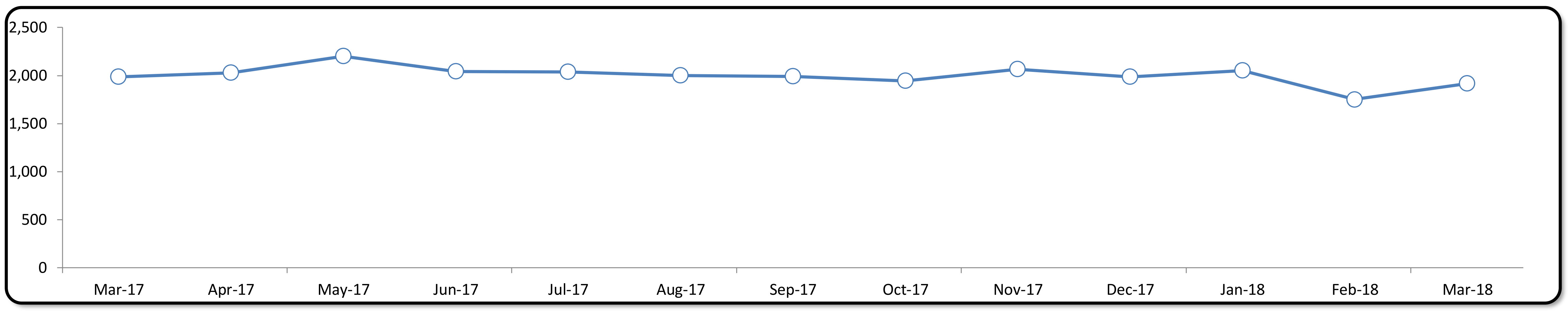


Source: Dr Foster

The percentage of emergency readmission rates (within 30 days) for Brighton and Hove CCG in Oct-17 has increased against the same month last year, 8.4% in Oct-17 vs 8.0% in Oct-16. The number of emergency readmissions was 455 In Oct-17, out of 5,399 emergency spells. This demonstrates a dissapointing lack of progress around re-admissions. This is also a focus for the BCF steering group through this investment in Home First and a care homes locally commissioned service with Primary care.

Total Non-Elective Spells (Specific Acute) - All Ages

Latest data available Jan - Mar 18	5,717	Vs same period last year Jan - Mar 17	6,136	Latest full quarter available Jan - Mar 18	5,717	Vs Annual planning (Jan - Mar 18)	5,818

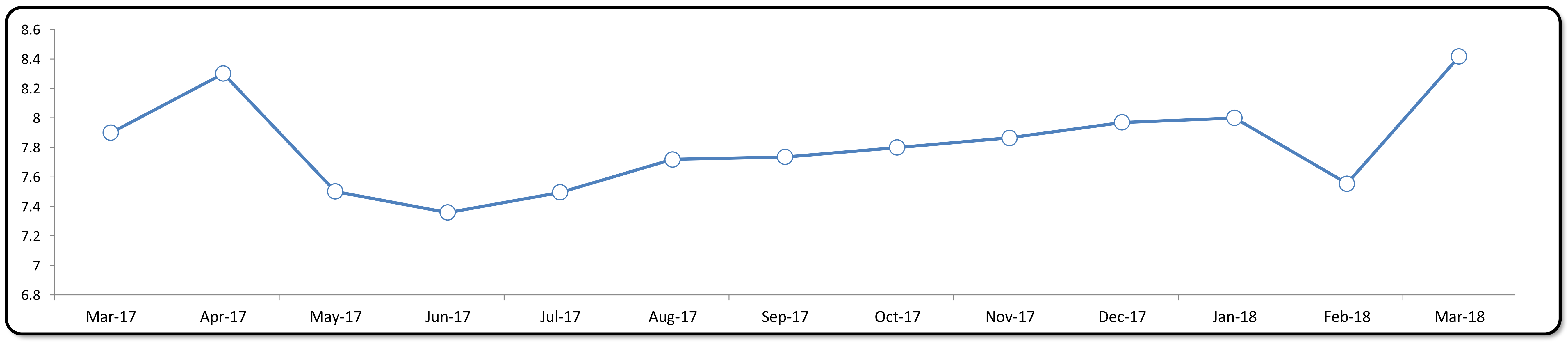


Source: SUS TnR / NHS England

The number of Non-elective spells for Brighton and Hove CCG in Jan - Mar 18 has decreased against the same months last year, 5,717 in Jan - Mar 18 vs 6,136 in Jan - Mar 17 (A decrease of -6.8%). The is a complex range of variables that contribute to the number of emergency admisions to hospital. These can include an improvement in the way the popluation is cared for in the community with primary and social care.

Emergency average length of stay for patients aged 65+ (days)

Latest data available Mar-18	8.4	Vs same period last year Mar-17	7.9	Latest full quarter Jan - Mar 18 Avg.	7.8	Vs Jan - Mar 17 Avg.	8.0

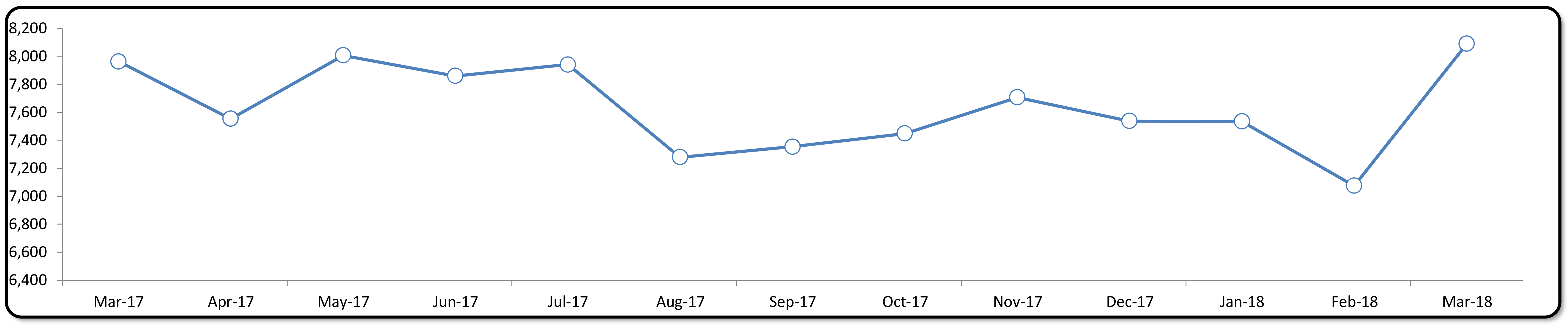


Source: SUS

The average emergency spells length of stay (days) for patients aged 65+ within Brighton and Hove CCG in Mar-18, has increased against the same month last year, 8.4 in Mar-18 vs 7.9 in Mar-17. Whilst the whole number of admissions has reduced, along with delayed discharges, the average length of stay is skewed upwards by a number of very long admission spells.

A&E attendances (type 1-2 only*) - All Ages

Latest available data Mar-18	8,090	Vs same period last year Mar-17	7,963	Latest full quarter Jan - Mar 18	22,698	Vs Jan - Mar 17	22,244



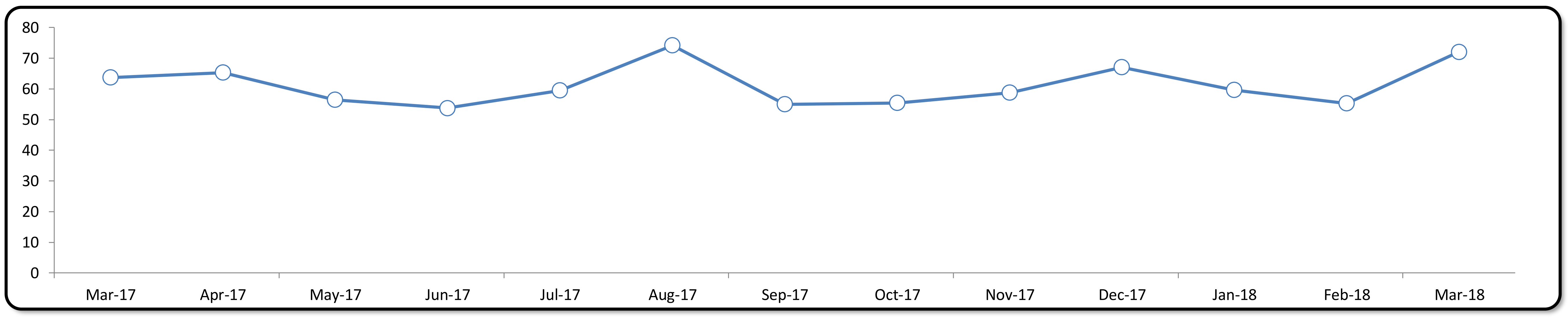
Source: SUS

The number of A&E attendances for Brighton and Hove CCG in Mar-18 has increased against the same month last year, 8,090 in Mar-18 vs 7,963 in Mar-17. This includedf the Easter Bank holiday, which occured in April last year. whilst March showed a higher number of attendances, this followed a longer trend of a reduction in the number of people attending A&E.

**Type 1 definition - consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients. Type 2 definition - A consultant led single specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients*

Super Stranded patients (21+ days length of stay) at Brighton and Sussex University Hospital (all ages)

Latest available data Mar-18	72	Vs same period last year Mar-17	64	Quarter to date Jan - Mar 18 Avg.	62	Vs Jan - Mar 17 Avg.	62

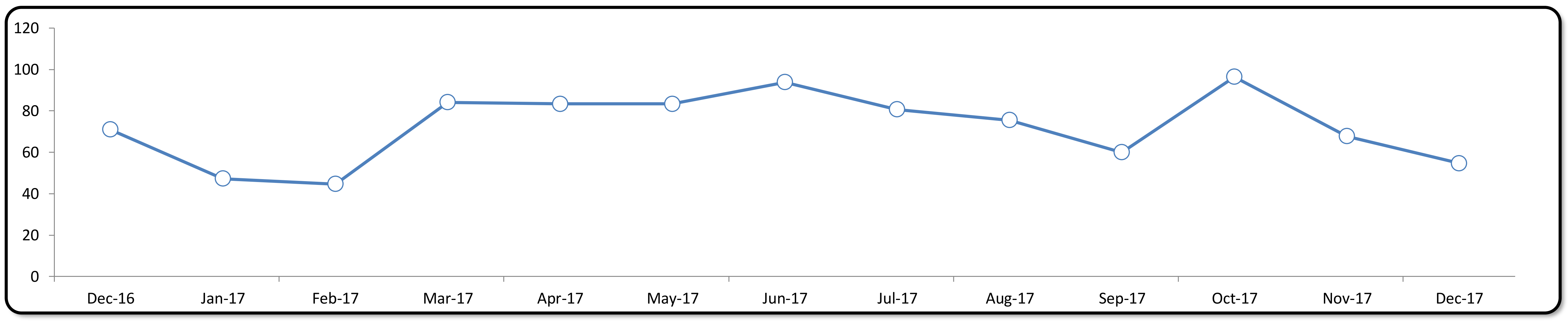


Source: BSUH Urgent Care pathway

The average number of super stranded patients (21+ days length of stay) at Brighton and Sussex University Hospital in Mar-18 has increased against the same month last year, 72 in Mar-18 vs 64 in Mar-17. This represents a small number of patients, however it is a poor patient experience for these individuals. This is an area of concern and a focus of partnership working between the hospital, CCG and Adult Social Care

New permanent admissions to nursing/residential care per 100,000

Latest available data Dec-17	55	Vs same period last year Dec-16	71	Quarter to date Oct - Dec 17	219	Vs plan	N/A



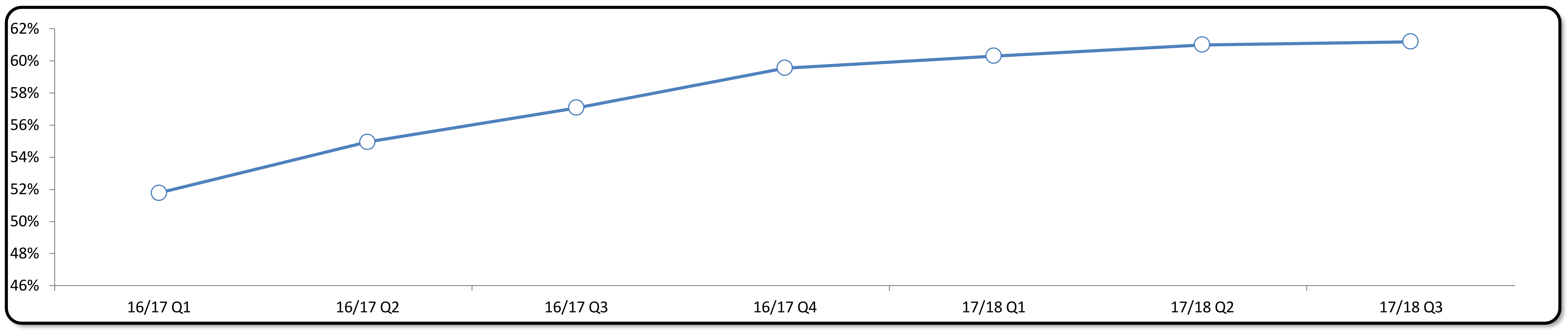
Source: Brighton and Hove LA

In the latest period Dec-17, the number of new permanent admissions to nursing/residential care per 100,000 has decreased against the same month last year, 55 in Dec-17 vs 71 in Dec-16.

The actual number of new permanent admissions to nursing/residential care in Dec-17 was 21.

% of support plans with telecare as a component

Latest available data Oct - Dec 17	61%
Vs same period last year Oct -Dec 16	57%
Quarter to date Oct - Dec 17	61%
Vs plan	60%

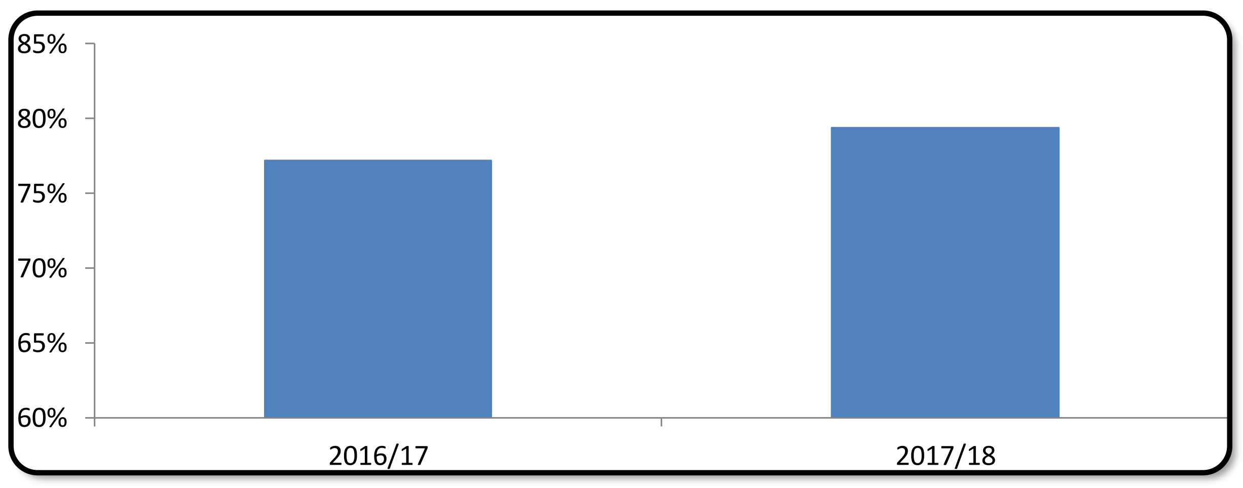


Source: Brighton and Hove LA

In the latest period 17/18 Q3, the % of support plans with telecare as a component has increased against the same quarter last year, 61.2% in 17/18 Q3 vs 57.1% 16/17 Q3.

% older people at home 91 days after discharge from hospital into reablement/rehabilitation services

Latest available data Year 17/18	79.4%
Vs same period last year 16/17	77.2%
Vs plan	83%

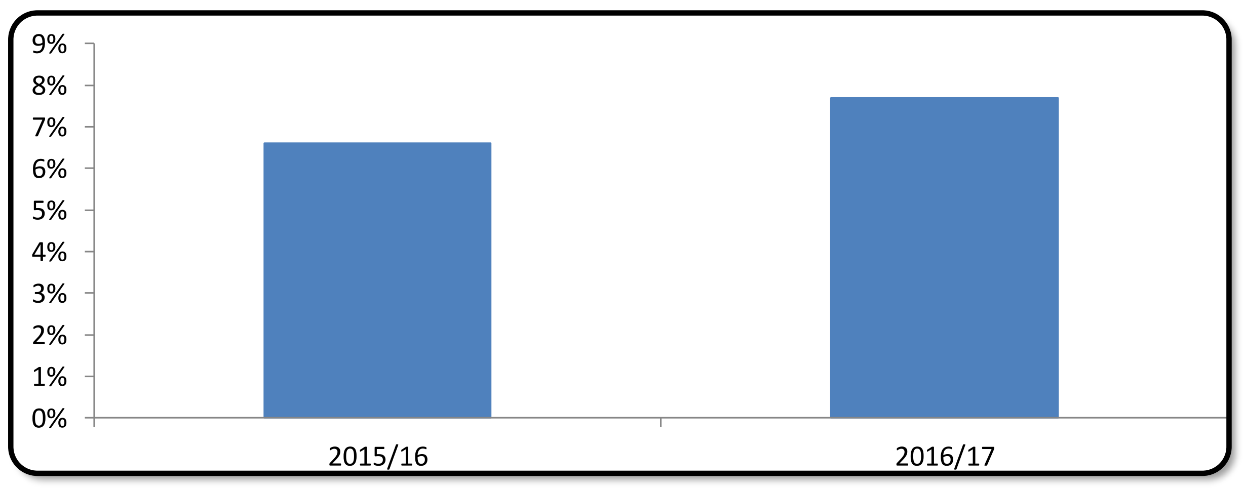


Source: Brighton and Hove LA

In the latest period 2016/17, the % older people at home 91 days after discharge from hospital into reablement/rehabilitation services has decreased against last year, 77.2% in 2016/17 vs 83.2% in 2015/16.
Performance needs to be viewed alongside Part 2 of the indicator % of overall older people discharged from hospital within the period who go into reablement services. Taken together these indicators reflect both effectiveness and coverage of the service.

% older people discharged from hospital who go into reablement services

Latest available data Year 17/18	7.7%
Vs same period last year 15/16	6.6%
Vs plan	7.8%



Source: Brighton and Hove LA

In the latest period 2016/17, the % older people discharged from hospital who go into reablement services has increased against last year, 7.7% in 2016/17 vs 6.6% in 2015/16.
2016/17 result is a high top quartile performance against comparators (Brighton and Hove ranked 1st out of 16 comparator authorities).

Although a formal committee of Brighton & Hove 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 Adults and Healthwatch.

Title:	**Section 75 Agreement review between Brighton & Hove City Council (BHCC) and Sussex Partnership Foundation Trust (SPFT)**
Date of Meeting:	**12 June 2018**
Report of:	**Rob Persey, Executive Director of Adult Social Care and Health**
Contact:	**Regan Delf** Assistant Director Health, SEN and Disability Services Regan.Delf@brighton-hove.gov.uk **Brian Doughty** Assistant Director Adult Social Care Brian.Doughty@brighton-hove.gcsx.gov.uk
Wards Affected:	**ALL**

Glossary:	**Section 75 :** Is a partnership agreement, legally provided by the NHS Act 2006, which allows budgets to be pooled between health and social care partners and enables resources and management structures to be integrated
Summary:	This report updates the Board on the operation of existing Section 75 (s75) arrangements between the Council and Sussex Partnership Foundation Trust (SPFT) in relation to integrated Mental Health and Learning Disability Services. The report seeks approval to delegate authority to the Executive Director, Health and Social Care to enter into updated s75 Agreements to govern the above services.

1. Decisions, recommendations and any options

1.1 That the Board notes the update in relation to the existing s75 arrangements between the Council and Sussex Partnership Foundation Trust (SPFT) in relation to integrated Mental Health and Learning Disability Services as set out in this report.

1.2 That the Board authorises the Executive Director Health and Adult Social Care, following consultation with the Council's Monitoring Officer, to finalise and enter into two new Section 75 Partnership Agreements for the provision of:

- Mental Health Services; and
- Specialist Health Related Learning Disability Services

for persons over the age of 18 for a period of three years, with the option to extend the agreements for a further two year period.

2. Relevant information

Authority to enter new Section 75 Agreements

2.1 The current Section 75 Agreement covers both Mental Health and Learning Disability services for persons over 18 years of age. It is proposed to split this into two separate agreements to enable a greater focus on the governance, staffing and performance arrangements for each of these service areas. This reflects the practical position that different managers are engaged in managing and delivering the services from the two organisations.

2.2 The Section 75 Agreements will continue to provide a governance framework for the integration and delivery of the mental health and learning disability services. The Agreements will include the following core components:-

- Information and descriptions of the services which are included within the Agreements, specifically stating the mental health services that are delegated by the Council to SPFT and the Learning Disability Services that are delegated by the Trust to the Council;
- Governance arrangements, including arrangements for reporting progress to the Health and Wellbeing Board;
- Arrangements for the management and development of seconded staff;
- Arrangements for managing risk across the partners to the agreements;
- Performance arrangements, including KPIs to enable the services to be effectively monitored;
- A standard range of terms and conditions covering issues such as dispute resolution and information sharing.

Learning Disability services

2.3 The Community Learning Disability Team has been successfully integrated for more than 10 years through a Section 75 agreement between the Council and Sussex Partnership Trust, with NHS staff seconded to the Council.

2.4 The key benefit of this arrangement is that Health and Social Care staff can deliver integrated care and assessment to people with learning disabilities, minimising duplication and ensuring health needs are addressed in social care packages. There are agreed service objectives for the Learning Disability Service shared by both the Council and the NHS Trust that underpin service delivery and the effective utilisation of expertise for the benefit of both service user and carer.

2.5 The Team have a stable and longstanding history of successful integrated working, which is reflected by the ‘good’ rating from the last inspection by the Care Quality Commission and the number of innovative projects that they cited within their Inspection Report (2017), all of which were integrated initiatives. There is a mutual respect for the health and social care roles and an appreciation of the value of an integrated model and partnership working.

Overview of funding contributions

2.6 Clinical Services will continue to be funded by the Trust in relation to Learning Disabilities, and clinical staff will remain employed by the Trust, although managed by the Council as part of an Integrated Service. These budgets are not currently pooled as part of the Agreement.

Client Group Learning Disabilities	Contributions from Brighton & Hove City Council for 2018/19 (£'000)	Contributions from Sussex Partnership Trust for 2018/19 (£'000)
Community Care Budget	31,879	
Staffing Teams	1,068	829

Overview of governance arrangements

2.7 At present the Community Learning Disability Team is managed by an Integrated team manager, directly employed by the B&HCC with joint accountability to SPFT for operations and financial management. There is a clinical lead post responsible for clinical governance of the service which is held by SPFT, the team is registered with the CQC as the regulator. Clinical staff, with the exception of psychiatry are seconded to B&HCC, and those Clinical staff who are seconded remain employed by the Trust but managed under the Section75 agreement with the Council.

Overview of performance arrangements

2.8 The clinical element of the Community Learning Disability Team reports into SPFT Care Delivery Service quality assurance processes (including performance and quality metrics, HR procedures, clinical audits, care pathways, demand and capacity and timescales to assessment and treatment).

2.9 There are regular meetings to discuss team performance with CCG and LA commissioners and subsequently the Transforming Care Partnership Board.

Mental Health Services

2.10 Formal integrated working arrangements have been in place through a Section 75 agreement between the Council and Sussex Partnership Foundation Trust for a significant period of time.

2.11 Adult Social Care staff members are deployed to work within secondary mental health care teams across Brighton and Hove. There are currently 67.69 WTE working in a variety of community teams, including the Assessment & Treatment Service, Specialist Older Adults Mental Health Service, Approved Mental Health Practitioners (AMHP team), Assertive Outreach Team, the Mental Health Homeless team and Crisis Intervention and Home Treatment Service. The Council also employs three hospital social workers who provide dedicated support to the wards at Mill View Hospital.

2.12 Brighton & Hove City Council retains responsibility for delivering itsstatutory functions directly to those individuals who require specialist Mental Health support from within the Service itself. The Council’s staff are part of a multi-disciplinary team, providing advice and support to health colleagues in relation to all aspects of social care.

2.13 Adult Social care staff hold caseloads within Mental Health Services, in the same way as medical staff, Nurses and Occupational Therapists.

2.14 Working in this integrated way ensures a streamlined approach to addressing the social care needs of people with severe and enduring mental illness.

2.15 Sussex Partnership NHS Foundation Trust was rated ‘good’ in January 2018 by the Care Quality Commission. The inspection reports make reference and recognise the positive impact of the Service being integrated with Social Care and the benefits this has to patient care.

Overview of funding contributions

Client Group	Contributions from Brighton & Hove CCG for 2018/19 (£'000)	Contributions from the Council for 2018/19 (£'000)
Community Care Budget	3,400	
Memory and Cognition Support (Community Care)		5,919
Mental Health Support (Community Care)		5,036
Staffing Teams		3,081

Overview of governance arrangements

2.16 A quarterly management meeting is held between key representatives of each organisation, this includes the Service Directors for the Trust and Assistant Director for Health & Adult Social Care, and representatives from the CCG.

2.17 The focus of these meetings is to discuss the operational performance in terms of statutory duties and staff, also governance, practice and finance arrangements.

2.18 Professional supervision is provided to the entire qualified workforce and is overseen by the Principal Social Worker for Adult Social Care.

2.19 There is a Quality & Assurance meeting held by the Trust on a quarterly basis in relation to Safeguarding activity. This is attended by the Head of Adult Safeguarding for Brighton and Hove City Council.

2.20 The Council holds a quarterly governance meeting covering the statutory duties in relation to the Deprivation of Liberty Safeguards and Mental Health Act. This is attended by the operational leads for the section 75 service.

Overview of performance arrangements

2.21 The Council retains responsibility for key performance indicators and targets aligned to the assessment teams, including the section 75 services. Activity is overseen by the performance team and reported through the quarterly management meetings.

2.22 The revised agreement will address the need for the Council's performance to form part of the overall performance reporting for Sussex Partnership Foundation Trust, and will be monitored as part of the monthly Clinical Standards Meeting and also the monthly Community Governance Meeting within all Community Mental Health Services.

3. Important considerations and implications

Legal:

3.1 The power to pool budgets between the Council and SPFT and to integrate services is set out in the NHS Act 2006 (the Act). The Act requires a formal Section 75 Agreement to be entered into by the Parties to enable the delegation of functions between the Parties, the pooling of budgets and/or service integration to take place. Regulations prescribe the format and minimum requirements for a Section 75 Agreement and these will need to be met in relation to the two Agreements proposed in the report.

The existing Section 75 Agreement was originally one Agreement, entered into in 2013 and extended by agreement in April 2017. In view of the need to enter into new Agreements, the Health and Wellbeing Board is the appropriate decision making body to approve the proposals and can delegate authority to the Executive Director Health and Adult Social Care and finalise and enter into the agreements, following consultation with the Council's Monitoring Officer.

Lawyer consulted: Elizabeth Culbert Date: 31 May 2018

Finance:

3.2 The Section 75 pooled budget for Mental Health Services is £17.436m in total for 2018/19 (£16.855m in 2017/18). This includes a contribution of £3.400m from Brighton & Hove CCG and £14.036m from Brighton & Hove City Council.

The Section 75 partnership arrangement for Mental Health contains a financial ‘risk share’ clause which has determined that the partners will share any overspend risk 50/50 up to a cap of £0.250m after which the commissioners (BHCC and the CCG) would be required to agree how to fund any additional overspend.

For Learning Disabilities, the funding contributions are £33.776m in total for 2018/19 which includes a £32.947m contribution from Brighton & Hove City Council and £0.829m from Sussex Partnership Foundation Trust. These budgets are not currently pooled as part of the agreement.

There is no associated financial ‘risk share’ clause in place for Learning Disabilities.

Finance Officer consulted: Sophie Warburton Date: 17/05/2018

Equalities:

3.2 Separating the agreements for these services allows for greater clarity over spend, provision and outcomes for people sharing these protected characteristics.

Equalities Officer Consulted: Sarah Tighe-Ford Date: 31 May 2018

Item 9

Although a formal committee of Brighton & Hove 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 Adults and Healthwatch.

Title: Approach to Commissioning

Date of Meeting: 12 June 2018

Report of: The Executive Director, Health and Adult Social Care

Contact: Andy Witham, Head of Adult Social Care Commissioning

Tel: 07825 358799

Email: andy.witham@brighton-hove.gov.uk

Wards Affected: All

FOR GENERAL RELEASE

Executive Summary

This report outlines the approach to the commissioning of the following services being presented to the Board on 12 June 2018.

1) Integrated Advocacy Services
2) Mental Health Community Services
3) Ageing Well Service

Glossary of Terms

BHCC - Brighton and Hove City Council
CCG - Clinical Commissioning Group

1. Decisions, recommendations and any options

1.1 That the Board notes the report.

2. Relevant information

2.1 With the intention of establishing fully integrated operational and commissioning arrangements from 2019 the Council and CCG Governing Body have approved proposals to support shadow arrangements from April 2018.

2.2 This paper sets out the approach to the joint commissioning of the three services listed above.

3. Commissioning Approach

3.1 The commissions as listed above will be run following an OJEU (Official Journal of the European Union) compliant process and in accordance with UK Procurement Regulations and the Council's own internal Contract Standing Orders.

3.2 The BHCC, procurement and legal teams are supporting the commissioning and procurement process and have been advising accordingly throughout.

3.3 The commissions are being delivered under the shadow year of integration as described above which has seen the Council and CCG further establish their approach to joint commissioning.

3.4 The reports listed have been through CCG and BHCC respective governance arrangements before being presented to the Board today (12 June 2018).

3.5 The commissioning proposals have been informed by evidence though a variety of, needs assessments, best practice guidance and extensive engagement activity.

3.6 This engagement activity has utilised both CCG, BHCC and Community support resources to ensure that providers, service users, professional and interested parties are engaged on both existing services and future models of delivery.

3.7 This engagement has helped shape and inform the lead provider models of delivery as described in the individual papers.

3.8 Each procurement process will use the MEAT (most economically advantageous tender) criteria which includes both a quality and price element which is used for evaluation purposes. The weighting used ensures that the process of evaluation will focus on the quality of the service rather than price being the overriding factor.

3.9 Social value requirements will be reviewed and included in line with the established Social Value Framework. These requirements will be incorporated into the specifications for each service along with appropriate weightings for tender evaluation purposes.

3.10 Community Works have been engaged to work with their members in the city to support with the commissioning activities and to ensure that the extensive range of skills, knowledge and experience is harnessed and best placed to support the models of delivery as described in the individual papers. This engagement needs to be managed in line with the public procurement principles of equal treatment and transparency.

3.11 The integrated approach to the contracting and contract management of these services is still in development but this will build upon the joint arrangements that currently exist where the Council contracts and contract manages these contracts on behalf of the CCG. This ensures that we reduce the burden on providers in terms of reporting and contract monitoring arrangements.

3. Important considerations and implications

Legal:

3.1 Legal implications are included in each individual report

As set out in the body of the report, the commissions referred to in the report will follow an OJEU (Official Journal of the European Union) compliant process in accordance with UK Procurement Regulations and the Council's own internal Contract Standing Orders. The legal implications of the individual schemes will be set out in the relevant report relating to that scheme.

Lawyer: Elizabeth Culbert Date: 28 May 2018

Finance:

3.2 Financial Implication are included in each individual report

Finance Officer consulted: Sophie Warburton Date: 30 May 2018

Equalities:

3.3 Proposals and procurement processes for each commission will assess equality impacts to ensure that negative impacts are mitigated and positive impacts maximised.

Equalities Officer consulted: Sarah Tighe-Ford Date: 25 May 2018

Item 10

Although a formal committee of Brighton & Hove 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 Adults and Healthwatch.

Title: **The Commissioning of Mental Health Support Services**

Date of Meeting: 12 June 2018

Report of: The Executive Director, Health & Adult Social Care

Contact: Linda Harrington Tel: 01273 238830

Email: linda.harrington@nhs.net

Wards Affected: All

FOR GENERAL RELEASE

Executive Summary

This report outlines the proposed joint Clinical Commissioning Group and Brighton and Hove City Council commissioning of non-clinical Mental Health Support services. It provides an overview of the new service model to be commissioned, the proposed delivery model for services and the proposed timescale for the commission.

The Mental Health Support Services are required to meet a broad range of mental health and wellbeing needs including:

- Services to promote wellbeing and prevent mental ill-health,
- Mental health and suicide awareness/first aid skills for frontline staff and volunteers,
- Support to those with common mental health issues (i.e. anxiety and depression), and more severe mental illness (e.g. psychosis), and
- Targeted support for those vulnerable or at risk of mental ill health including protected characteristic groups and those at risk of suicide.

The new service model of mental health support is informed by national and local strategy, initial findings of a Rapid Needs Assessment and Service User and Provider consultation events. The proposed new model is a Community

Connections model of support.

The aim of the model is to improve health and wellbeing outcomes through improved access and navigation to support, making it easier to find services and reducing any fragmentation in support pathways, providing early help and interventions to prevent issues of mental ill health and to extend pathways to community support ensuring smooth transitions between support services.

A wide range of support and activities will be included within the Community Connections model to meet the mental health support needs of the city.

To deliver this co-ordinated model of support commissioners will be seeking to contract with a single Lead Provider but with the expectation that service delivery will be achieved by a number of providers to ensure responsive service delivery, reach to protected characteristic groups and to maximise social value.

The Lead Provider delivery model is a change from current contracting where Brighton and Hove City Council and Clinical Commissioning Group hold a number of contracts (16) for mental health and wellbeing support.

Providers will be required to work differently and more collaboratively to deliver the new model of care.

In order to support potential bidders with developing this model, further market testing with providers will be undertaken during June-July 2018, prior to the release of tender in August 2018.

Glossary of Terms – see Appendix D

1. Decisions, recommendations and any options

1.1 The purpose of this report is to seek approval from the Health and Wellbeing Board for a joint Clinical Commissioning Group and Brighton and Hove City Council tender for non-clinical Mental Health Support Services. The proposal was taken to the Procurement Advisory Board on 30th April.

1.2 The Health & Wellbeing Board are requested to note the proposed model for future Mental Health Support services and the recommended delivery model for a lead provider to oversee service provision.

1.3 That the Board grants delegated authority to the Executive Director of Health & Adult Social Care to carry out the procurement and award of a contract for a Non Clinical Mental Health Support Service with a term of four years.

1.4 That the Board delegates authority to the Executive Director of Health & Adult Social Care to extend the contract at the end of the four year term for a further period of up to two years if it is deemed appropriate and subject to available budget.

2. Relevant information

Introduction

2.1 Mental health is defined by the World Health Organisation as "a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO 2003, *Mental Health a State of Wellbeing)*[1].

2.2 The impact of mental ill health is well evidenced and is associated with a number of significant health and care inequalities:

- Mental ill health is responsible for 23% of the total burden, compared to 16% for cancer and 16% for heart disease (WHO Global Burden of Disease Report)[2] .
- There is a 10-25 year life expectancy reduction in patients with severe mental disorders (*Reducing the Mortality Gap in People with Severe Mental Disorders: the Role of Lifestyle Psychosocial Interventions*)[3]. The vast majority of these deaths are due to chronic physical medical conditions such as cardiovascular, respiratory and infectious diseases, diabetes and hypertension.
- Suicide mortality rates among people with schizophrenia are 2 to 2.5 times higher than the general population *(Exploring the Increased Mortality Rate in Schizophrenia)*[4]

Local Demographics

2.3 Brighton and Hove has a high level of mental health need with local prevalence rates higher than the national average for both common mental health conditions (e.g. anxiety and depression) and severe mental illness (e.g. psychosis, bipolar) and a 2% increase in the prevalence of complex mental health conditions is expected by 2020-2025[5].

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[1] http://www.who.int/features/factfiles/mental_health/en/

[2] World Health Organization (2008). Global burden of disease report. WHO.

[3] https://www.frontiersin.org/research-topics/7252/reducing-the-mortality-gap-in-people-with-severe-mental-disorders-the-role-of-lifestyle-psychosocial

[4] https://www.platformqhealth.com/2018/01/25/exploring-increased-mortality-rate-schizophrenia/

[5] Taken from Public Health Rapid Needs Assessment 2018

2.4 The city also has a number of associated high risk factors including:

- The second highest rate of homelessness in the country (*Ministry of Housing, Communities and Local Government, Rough Sleeping Statistics Autumn 2017, England [Revised]*[6]
- Higher than average levels of self harm (PHE Fingertips Report, Self Harm)[7] and
- Currently the fifth highest rate for deaths by suicide (National Comparisons, Suicide, PHE Fingertips)[8]

Table 1: Local prevalence rates[9]

Depression & Anxiety prevalence GP Patient Survey 18+	18.3% compared with 13.7% (2016-17)[10]
Serious Mental Illness Prevalence as recorded by QOF on GP Practice Registers (all ages)	1.25% of our population compared with 0.92% in England (3,780 people, 2016-17)[11]

Commissioning Aims

2.5 Through the tender for non-clinical mental health support commissioners aim to secure a broad range of support contracted through a Lead provider model.

The vision for future mental health support services is for:-

"a strong collaborative and co-ordinated network of support which promotes mental health and wellbeing, builds resilience, supports recovery, empowering people to manage their health and wellbeing, and that connects and reconnects individuals with strong and effective community support".

Overview of service model

2.6 A Community Connections network model is proposed. The model has been informed by national and local strategy (Appendix A) the initial recommendations of a Public Health Rapid Needs Assessment and a wide range of stakeholder views (Appendix B)

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[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/682001/Rough_Sleeping_Autumn_2017_Statistical_Release_-_revised.pdf

[7] https://fingertips.phe.org.uk/search/self%20harm

[8] https://fingertips.phe.org.uk/topic/suicide-prevention/comparisons

[9] Source: Based on application of 17.2% CMHD profile tool estimated prevalence for 16-74 year olds to ONS 2012 Population Projections for 18 and over. Applying the higher Public Health England (PHE) CMHD tool prevalence of 17.2% for CMHD in Brighton & Hove

[10] https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#page/4/gid/1938132720/pat/46/par/E39000035/ati/153/are/E38000021/iid/90647/age/168/sex/4

[11] https://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/data#page/4/gid/8000030/pat/46/par/E39000035/ati/153/are/E38000021/iid/90581/age/1/sex/4

2.7 The Community Connections service will provide a broad range of non-clinical mental health and wellbeing support to meet local need from: raising awareness of mental health and promotion of mental health, early help and prevention, support to engage with treatment and during treatment and recovery services for those with more serious illness.

2.8 With a strong community presence and approach the Community Connections service will promote and champion mental health and wellbeing in the city, to reduce stigma and health and care inequalities.

2.9 The service will offer individuals choice through its range of support and interventions and through its pathways and connections to wider community and universal support services.

2.10 Pivotal within the mental health wellbeing and recovery pathways the Community Connections service will provide a clear point of access to non-clinical community mental health and wellbeing support for service users and referrers.

2.11 The service will work proactively and collaboratively with city partners including clinical services (GPs, primary and secondary mental health services) to develop integrated and comprehensive pathways to support. The support delivered will be non-clinical and will complement that provided by the clinical services.

Support will focus on helping individuals to manage life stressors, build confidence and resilience, develop self-management skills, and connect/ reconnect with strong and effective community support.

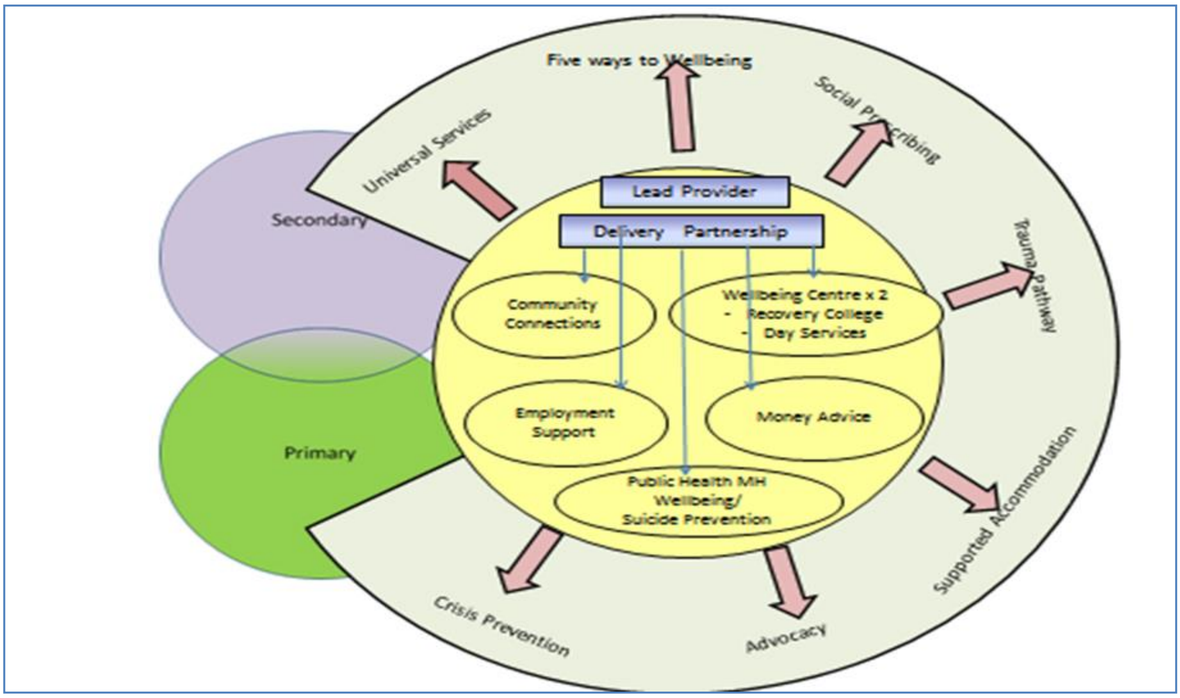
Targeted interventions will ensure reach to protected characteristic groups and those who are more vulnerable and at risk of mental ill-health. The service will also deliver targeted interventions to those who are known to be at more risk self-harm and/or suicide.

The provider will be required to ensure accessibility of services and will provide transport to support access where appropriate.

The new model will deliver a range of services and interventions *(see Appendix C Specified Services)* these will include*:*

- mental health awareness and promotion,
- suicide awareness and prevention interventions
- early help and prevention interventions,
- psychosocial and targeted support to vulnerable and high risk groups
- wellbeing centres including a specialist centre for those with complex needs,
- An Individual Placement Support model of Employment support and
- Money advice.

Diagram 1 – Community Connections Model



To deliver the Community Connections model commissioners will be seeking to contract with a single Lead Provider with the expectation that service delivery will include a number of providers to ensure responsive and appropriate service delivery and reach to protected characteristic groups.

Proposed timescales for the tender are shown in Table 2 below.

Table 2 Timescales for Tender

Task	Date
CCG Commissioning Operations Meeting approval for delivery model	20th March 2018
BHCC DMT approval for reprocurement	12th April 2018
Joint BHCC & CCG Procurement Advisory Board Meeting	30th April 2018
Joint BHCC & CCG Paper to Health and Wellbeing Being Board	12th June 2018
CCG Commissioning Operations Meeting approval of specification	19th June 2018
Issue Tender	15th August 2018
Tenders returned	14th October 2018
Evaluation/Moderation	16th October 2018 – 16th November 2018
Award of contracts	16th November 2018
Standstill Period	16th November 2018– 31st November 2018

Contract Mobilisation	16th November 2018–31st June 2019
Start of new contracts	1st July 2019

3. Important considerations and implications

3.1 Legal:

3.1 The council's contract standing orders require that authority to enter into a contract valued at £500,000 or more be obtained from the relevant committee which in this instance is Health & Wellbeing Board.

3.2 Schedule 3 of The Public Contracts Regulations 2015 will apply to the procurement of the new contract for mental health support services and the contract must be awarded in accordance with Section 7 of the Regulations. The council is required to advertise the contract by way of a PIN or contract notice published in the OJEU setting out the process by which it is intended to award the contract.

3.3 The tender process conducted must be at least sufficient to ensure compliance with the principles of transparency and equal treatment of economic operators bidding for the contract.

Lawyer consulted: Isabella Sidoli Date: 30/05/18

3.2 Finance:

The table below reflects the funding currently available for the Mental Health Support Services per annum:

CCG	BHCC (HASC)	Total
£1.699m	£0.409m	£2.108m

Of the £0.409m funding within Brighton & Hove City Council, £0.270m is within Public Health and £0.139m is within Health & Adult Social Care.

The CCG funding currently totals £1.699m per annum, across various contracts, but at this stage the CCG are unable to confirm this beyond 2018/19.

Tenders will be requested against an agreed service specification. Both BHCC & CCG are experiencing financial challenges and both organisations are subject to annual government financial settlements which can impact on the availability of funding. However it is anticipated that financial resources will be available to enable the commissioning of the service.

Finance Officer consulted: Sophie Warburton and Debra Crisp
Date: 30/05/2018

3.3 Equalities:

A full Equality Impact Assessment is being completed and this is to be informed by the Public Health Rapid Needs Assessment to ensure full consideration of any impact on protected characteristic groups, neighbourhoods and other equality issues with the recommission

Equalities officer consulted: Sarah Tighe-Ford Date: 25 May 2018

Supporting documents and information

Appendix A: Summary of relevant national and local strategy

Appendix B: Key Themes from Patient/Public and Provider Engagement Consultations 2017-2018

Appendix C: Service Overview

Appendix D: Glossary

Item 11

Although a formal committee of Brighton & Hove 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 Adults and Healthwatch.

Title: Commissioning of an Integrated Advocacy Hub

Date of Meeting: 12 June 2018

Report of: Executive Director, Health & Adult Social Care

Contact: Anne Richardson-Locke Tel: 01273 290379

Email: anne.richardson-locke@brighton-hove.gov.uk

Wards Affected: All

FOR GENERAL RELEASE

Executive Summary

Brighton & Hove City Council and Clinical Commissioning Group jointly fund eight different statutory and non-statutory advocacy services. Extensive engagement with people who use, refer and provide advocacy shows that whilst there is some excellent provision, the way that some of the services are organised by client group means that people who need advocacy are sometimes unsure where to go if they have multiple conditions and people need to be transferred between services if they need more than one type of advocacy.

The report recommends the procurement of an Integrated Advocacy Hub with a Lead Provider that will provide a central point of access to service users and referrers but still provide essential specialist provision to people who feel particularly excluded from mainstream services.

Glossary of Terms

BHCC	Brighton and Hove City Council
BHCCG	Brighton and Hove Clinical Commissioning Group
IMCA	Independent Mental Capacity Advocates
IMHA	Independent Mental Health Advocates

IHCA	Independent Health Complaints Advocacy
ICAA	Independent Care Act Advocacy (ICAA)
LGBT	Lesbian, gay, bisexual, trans

1. Decisions, recommendations and any options

1.1 That the Board grants delegated authority to the Executive Director of Health & Adult Social Care to carry out the procurement and award of a contract for an Integrated Advocacy Service with a term of four years.

1.2 That the Board delegates authority to the Executive Director of Health & Adult Social Care to extend the contract at the end of the four year term with the potential to extend the contract a further two years if it’s deemed appropriate and subject to budget being available.

2. Relevant information

2.1 Within this report the term advocacy is used to describe the support given to individuals to allow their voice to be heard and their wishes to be expressed in situations where they may be unable to do this fully by themselves. Advocates and advocacy providers work in partnership with the people they support and promote social inclusion and equality.

2.2 Advocacy is essential for people who due to a disability, health condition, communication difficulty, financial circumstances or social attitudes, find themselves in a position where their ability to exercise choice or represent their own interests is limited, or where processes are particularly complex to navigate, such as social care and health pathways or where there is a safeguarding issue. Advocates play an important role in feeding back to the Council and NHS how to improve services to make them more accessible to people.

2.3 BHCC and BHCCG jointly fund advocacy services. There are statutory duties for the following advocacy provision:

- Independent Mental Capacity Advocates (IMCA) under the Mental Capacity Act 2005
- Independent Mental Health Advocates (IMHA) under the Mental Health Act 2007
- Independent Health Complaints Advocacy (IHCA) under the Health & Social Care Act 2012
- Independent Care Act Advocacy (ICAA) under The Care Act 2014

2.4 There is no statutory duty to provide Community Advocacy but BHCC and BHCCG are committed to funding this provision as it plays an important role in supporting individuals, the health and care system and communities.

2.5 There are currently eight different types of advocacy provided by seven community and voluntary sector providers under 5 different contractual arrangements (see Appendix 1 for details). All contracts expire on 31st March 2019 and the majority of the services were commissioned via commissioning prospectus or competitive tender. The Care Act Advocacy and Trans Advocacy arrangements were developed in response to changes in legislation and according to an identified need. The IMCA service is commissioned as a joint contract with East and West Sussex.

2.6 In 2017/18 2,598 advocacy referrals were made compared to 2,419 in 2016/17 (7% increase). The IMCA service provided the most advocacy (25%) and the largest increase (65%) was in the demand for Trans Advocacy (177 to 292 new issues). People often present with more than 1 issue and advocacy can last for under an hour or in the case of parents with learning disabilities in care proceedings last for over a year. ICAA has had very little demand with only 88 people supported by an advocate during a social care process. This is less than 1% of the population who have received an assessment, review, care plan or safeguarding. Demand for IMHA and has remained stable at 418 whilst the demand for Community Mental Health advocacy dropped by 16%. The number of cases of LGBT mental health community advocacy, however, increased by 39%.

Advocacy Needs Assessment 2017

2.7 To help determine the current and future demand for advocacy services a Needs Assessment was carried out in 2017[1] (the Executive Summary is attached as Appendix 2) by Brighton & Hove City Council's Public Health department. The Needs Assessment carried out engagement with people who use, provide and refer into advocacy services and also draws on best practice nationally[2] in order to make recommendations for commissioners.

2.8 In summary the Needs Assessment identified that the majority of people were very positive about advocacy provision and its impact on their quality of life. People from the LGBT and learning disabled communities particularly value a specialist service whilst some other users didn't want to be categorised by client group and would like a 'one stop shop'. The lack of capacity, high thresholds and lack of awareness of advocacy were highlighted as barriers and people identified the need for a quick response to assess urgency & prevent crises.

2.9 The majority of referrers were satisfied with advocacy services but experienced greater difficulty in accessing Care Act Advocacy and were unsure where to refer clients with multiple needs. There are also hand offs between organisations where people need more than one type of advocacy.

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[1] The Adults Advocacy Needs Assessment 2017 is available at Brighton and Hove Connected

[2] Co-commissioning (Kent), Outcome based commissioning (Essex), The Advocacy Hub (Manchester)

2.10 The Needs Assessment recommended the commissioning of an integrated, responsive advocacy service, with a single point of access for referrals to provide a more streamlined and responsive service. Other recommendations include better promotion, co-location of advocates with referrers and a wider offer of advocacy that includes group, peer and self-advocacy. Not all protected characteristics were captured during the engagement so it was recommended that further engagement take place to ensure the views of all service users is captured.

Further engagement with people who use advocacy services

2.11 Consequently further engagement has taken place with people whose first language is not English, people with hearing impairments, older people, those on the autistic spectrum and parents with learning disabilities. A summary of the engagement and outcomes is included in Appendix 3. The general consensus is that people want continuity of advocates, a responsive accessible service and advocates who have excellent knowledge of local services and processes.

2.12 The older people who participated expressed the need for advocacy for specific issues rather than a dedicated service for older people whereas the deaf participants were very clear they want specific deaf advocacy rather than a BSL interpreter alongside an advocate. This was echoed by people whose 1st language is not English who would prefer a bilingual advocate to an interpreter and advocate. The autistic participants had clear examples of falling between the gaps in services and expressed a need for advocates who have expertise in autism and Asperger’s.

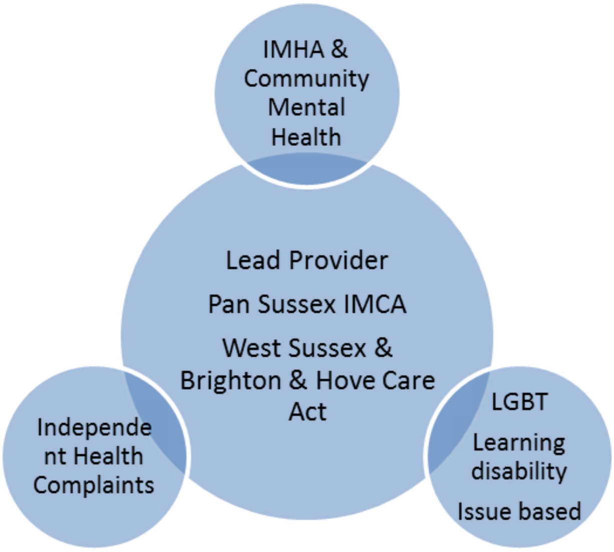
Engagement with advocacy providers

2.13 Engagement has also taken place with local, regional and national providers of advocacy and details are included in Appendix 4. Providers were asked for their perspective on the opportunities for pan Sussex work, providing a central point of access whilst retaining specialist provision, different models for delivery of services (single provider versus partnership models with a lead provider) and to consider whether advocates could provide more than one statutory role. The consensus was that a single point of access is required but the majority of providers, including those providing single advocacy services elsewhere in the country, said it is difficult for a single organisation to be able to provide the breadth of advocacy required across all the protected characteristics.

2.14 The IMCA service has been commissioned as a pan Sussex service for the last 10 years and provides economies of scale as well as continuity for people who are placed in care homes across the geographical area. Providers gave feedback that they could see the benefits of further pan Sussex commissioning as long as the different needs of each area are taken into account.

2.15 All of the above engagement has been considered carefully alongside the experiences of other areas in the country and best practice and the following model is recommended for the re-procurement:

Lead provider model



2.16 The proposal is that a Lead Provider directly provides IMCA across East Sussex, Brighton & Hove and West Sussex and ICAA for Brighton & Hove and West Sussex. The Lead Provider could either directly provide or sub-contract with specialist community advocacy organisations to provide IHCA, Specialist Community Advocacy and a combined IMHA and Community Mental Health Advocacy.

2.17 Spot purchase arrangements would also need to be in place for specialist providers of deaf, bilingual and autism advocacy. It is expected that a subcontracting / partnership arrangement would be the most effective model as it would retain the specialist knowledge held by specialist community providers. Discussions are also currently taking place with West Sussex regarding joint commissioning of some of the other advocacy provision but any pan Sussex arrangements would need to include separate geographical hubs to meet the unique needs of communities in the specific area.

2.18 A lead provider model will ensure an organisation takes the lead in taking referrals, triaging, providing and signposting where necessary. There will be reduced ‘hand offs’ between organisations and people that need advocacy and referrers will know where to go. Feedback from other local services that have a single point of contact show an increased ability to manage demand and identify gaps with better outcomes, increased social value and financial efficiency.

2.19 The advocacy services being procured are subject to the light touch regime and it is recommended that the service is advertised in the Official Journal of the European Union (‘OJEU’) and procured using a competitive tender process. The tender will be issued in mid-July, with tenders received back in the middle of September and evaluated in late September. Award would take place in mid-October with contract mobilisation from November to March with a start date of 1st April 2019.

2.20 The total funding for advocacy in Brighton & Hove is currently £648,367 per annum. A savings target of 5% is required for the community advocacy and IMHA (£20,810) but as there is some duplication in mental health and learning disability advocacy across the different contracts administrative savings are expected with the proposed model. In addition the CCG are removing £50,000 from community advocacy services and redirecting it to a Navigation role in the Mental Health Support Services. This leaves a total of £577,557 (56% BHCC and 44% CCG funding).

2.21 The specification will be outcome focused using the outcomes set out in Appendix 5 that have been developed nationally.[3] There will also be outputs that the provider(s) will be required to meet, with minimum targets set for each service group supported that include ringfenced activity of the statutory and non-statutory community advocacy provision to ensure that non statutory elements are protected as set out below:

Service group supported	**Number of people receiving advocacy in 2017/18**	**Minimum targets for individuals receiving advocacy under the B&H Advocacy Hub**
Independent Mental Capacity Advocates & Paid Representatives	656	700
Independent Care Act Advocacy	88	150
Independent Mental Health Advocacy & Community Mental Health Advocacy	418 338	420 300
Independent Health Complaints Advocacy	130	130
Learning Disability Advocacy	127	120
Older people & Physical disability	218	
Issue based advocacy		200
LGBT Community Mental Health Advocacy	266	250
Trans Advocacy	294	250
Total	**2,535**	**2,520**

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[3] https://www.ndti.org.uk/uploads/files/Advocacy_framework.pdf

3. Important considerations and implications

Legal:

3.1 The council's contract standing orders require that authority to enter into a contract valued at £500,000 or more be obtained from the relevant committee which in this instance is Health & Wellbeing Board.

3.2 Schedule 3 of The Public Contracts Regulations 2015 will apply to the procurement of the new contract for integrated advocacy services and the contract must be awarded in accordance with Section 7 of the Regulations. The council is required to advertise the contract by way of a PIN or contract notice published in the OJEU setting out the process by which it is intended to award the contract.

3.3 The tender process conducted must be at least sufficient to ensure compliance with the principles of transparency and equal treatment of economic operators bidding for the contract.

Lawyer consulted: Elizabeth Culbert Date: 30.05.18

Finance:

3.4 The current Advocacy provision is formed of multiple contracts that are joint funded by the Council, CCG and neighbouring local authorities.

The anticipated overall funding available for the Integrated Advocacy Hub is £0.578m of which the £0.324m is funded by the Council. The expected contribution from the CCG is £0.254m however this is still to be confirmed.

Included within the £0.578m is a savings target of 5% that is required for the community advocacy and IMHA contracts (£0.021m). The CCG has removed £50,000 from community advocacy services which has been included in the figures above.

The IMCA contract is a joint contract across 3 authorities and the funding is as follows: Brighton & Hove City Council £0.162m, East Sussex County Council £0.207m and West Sussex County Council £0.190m. The £0.162m provided by Brighton & Hove is included within the £0.324m overall funding provided by the Council.

Tenders will be requested against an agreed service specification. Both BHCC & CCG are experiencing financial challenges and both organisations are subject to annual government financial settlements which can impact on the availability of funding. However it is anticipated that financial resources will be available to enable the commissioning of the service.

Finance Officer consulted: Sophie Warburton Date: 31/05/2018

Equalities:

3.5 An Equalities Impact Assessment is attached as Appendix 6. In addition to the equalities strands included in the Advocacy Needs Assessment 2017 (Appendix 2) further engagement was also carried out with people that the Needs Assessment failed to engage with to ensure that all of the protected characteristics were considered. As mentioned in the body of the report and the summary of engagement (Appendix 3) the model is entirely influenced by users of advocacy and the purpose of the hub is to ensure that people have better access to services.

Equalities Officer consulted: Sarah Tighe-Ford Date: 25 May 2018

Sustainability:

3.6 The tender will include evidence of social value and bidders will be evaluated on their experience of working collaboratively to meet the needs of the population in as innovative, effective and efficient way as possible. The specification includes the need for the service to offer peer, group and self-advocacy to ensure that people can advocate for themselves and others where possible.

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

3.7 Health, social care and public health issues are already covered but advocacy for children and young people is not considered within this paper.

Supporting documents and information

Appendix1: List of advocacy services
Appendix 2: Advocacy Needs Assessment 2017 Executive Summary (full Needs Assessment available at Brighton and Hove Connected
Appendix 3: Summary of engagement and outcomes
Appendix 4: Report on advocacy provider engagement
Appendix 5: Outcomes framework
Appendix 6: Advocacy Hub Equalities Impact Assessment

Appendix 1: Current Advocacy Contracts Funded by BHCC & BHCCG

Provider		Service	Contractual arrangement
POhWER		Independent Mental Capacity Advocacy (IMCA) across Brighton & Hove, East Sussex and West Sussex	Contract
Mind in Brighton and Hove		Independent Mental Health Advocacy (IMHA) Community Advocacy for people with mental health needs	Funding Agreement
MindOut		Community Advocacy for LGBT people with mental health needs	
Brighton and Hove Advocacy Partnership		Independent Care Act Advocacy (ICAA) Specialist Community Advocacy for:	Funding Agreement with Lead Provider
	Mind in Brighton and Hove (Lead Provider)	People with mental health needs	
	Speak Out	People with learning disabilities and autism	
	Impetus	People with learning disabilities and autism and parents with learning disabilities in the child protection process	
	Age UK	Older People	
	Possability People	People with sensory and physical needs	
MindOut		Trans Advocacy	Letter of Agreement
Impetus		IHCA	Contract

Appendix 2: Adult Advocacy Needs Assessment 2017 Executive Summary

Adult Advocacy Needs Assessment 2017

Brighton & Hove City Council
Public Health Intelligence Team

September 2017

EXECUTIVE SUMMARY

Introduction

This needs assessment uses a combined epidemiological and corporate approach to identify the need for advocacy in Brighton & Hove. It has utilised a literature review; a review of data and both community and stakeholder engagement to inform the report.

The definition of Advocacy that we have used in this needs assessment is that used in the Advocacy Code of Practice[2]. Advocacy services in Brighton & Hove are provided by a wide variety of organisations across the City and are funded by multiple agencies. The scope of this needs assessment are the communities currently being provided for under the aegis of the existing contracts with Brighton and Hove City Council (BHCC) and Brighton & Hove NHS CCG based on the 2014 Commissioning Prospectus.

Strengths of the report include a comprehensive period of independent community engagement and a thorough and wide-reaching stakeholder engagement, with a good uptake of involvement from those referring into and providing advocacy services. It was therefore possible to produce a comprehensive view of the need for advocacy services within scope. However there is ambiguity around the meaning of the term advocacy and limits to accurately define populations who may have a need for advocacy services.

What does advocacy mean?

Advocacy is a broad concept and covers a range of different expertise. Individuals are able to advocate for themselves, family and friends can advocate on behalf of another person, health and social care professionals can sometimes advocate informally on behalf of their client and professional advocates are able to provide expert support when needed. Access to advocacy can be affected both by how health and social care professionals assess the advocacy needs of their clients and also referral processes into service, hence these have both been included within the scope of this needs assessment.

Certain forms of advocacy operate within a statutory framework guided by legislation drawn from the Mental Capacity Act, the Mental Health Act and the Care Act.

Within the City advocacy is currently delivered by specialist providers; by statutory provision as detailed above and also as a community service. Specialist community services commissioned at the time of writing include provision of advocacy for those with: mental ill-health (including specialist LGBTQ mental health service); sensory and/or physical disabilities; learning disabilities; language needs; those who are older people; vulnerable adults with autism; and people who are trans.

Evidence of best practice

Evidence from the research literature around advocacy identifies that support can come in many forms and that delivery is shaped by the type of advocacy needed. The sector is diverse and there is no ‘best’ form of delivery. All forms of advocacy should encourage self-advocacy. Evidence exists that access to advocacy by particular groups can be problematic and the use of referral systems that automatically enrol a client with advocacy services (sometimes referred to as an ‘opt-out’ rather than ‘opt-in’ access) was suggested as a way of addressing this. Key themes that emerge from the review of innovative services include the integration and co-ordination of services and aligned to this the use of partnership working and the flexibility of provision.

Using data to describe advocacy needs in Brighton & Hove

The data evidences the need for advocacy support for the existing communities of need for whom specialist provision is currently provided, however it is accepted that there may be other communities who may also have a need for advocacy support. Brighton & Hove is particularly characterised by the high number of individuals with mental health problems in the City. Though there are proportionately fewer older people living in the City when compared with England and the South East there are a higher proportion living alone.

These data do not identify the intersection of multiple factors that can affect an individual’s requirement for advocacy support. The provision of advocacy is also in part determined by social factors such as family and friends acting in an advocacy capacity.

Data from the Projecting Older People Population Information (POPPI) system and the Projecting Adult Needs and Service Information (PANSI) system predicts that the sizes of all populations they measure that are currently supported by advocacy services are likely to rise between 2014 and 2025.

It can be seen that the largest rises in numbers are expected in older people, adults with moderate or serious physical disability and those with hearing impairment. It can be seen that the largest percentage rise is expected in those adults with hearing loss (19.9%) and it is unclear how their needs are being met with regard to BSL interpreters. It is also unclear whether people with additional language needs are able to access some advocacy services.

Community research

Advocacy services in the city are not well-known about amongst people in need and the lack of a high profile seems to be the result of a combination of lack of understanding of the word (advocacy), a lack of awareness and proactive referring to advocacy services by core NHS and social care services (including GPs and Adult Social Care staff) and a lack of specific resources devoted to local promotion of these services.

The current use of advocacy services is amongst people with complex combinations of needs, including multiple conditions and disabilities, who are trying to live independently within the city, but are likely to be socially isolated. Service users report that much current use relates to navigating increasingly complex access routes into health and social care systems, increasingly complex processes for receiving disability and other benefits and diminishing housing choices that are affordable, safe and secure.

The potential need for advocacy is likely to be significantly greater than current usage suggests, given the low profile of these services locally within the health and social care system.

Most advocacy users consider advocacy to have had a significant impact on the quality of their life and to have prevented them from having crises or deepening need and are grateful for being able to access services within the city. Users are particularly positive about way that advocates work with them holistically, working alongside them to tackle their multiple issues and challenges over time, providing continuity of support in a welfare system that is increasingly fragmented and specialised. This is even though only some advocacy services support people struggling in the benefits system and there is little advocacy available to deal with housing problems. This research suggests that the impact of any reduction in advocacy for people like those interviewed in this research is likely to result in more crisis management and deepening need and therefore be felt in other parts of the local health and social care system.

Stakeholder engagement

The findings of the questionnaire consultation with those who refer into advocacy services indicates that participants felt that they assessed the advocacy needs of their clients and were able to refer clients into advocacy support without any difficulties in a timely manner. Issues identified included the complexity of service provision with each service having its own referral processes. Overall satisfaction with the provision was high.

Findings from the focus groups were affected by the role of the different teams. Teams with more specialist roles such as the Deprivation of Liberty Safeguards (DoLS) and Specialist Older Adults Mental Health Service (SOAMHS) teams had positive experiences of referral. However the more generic needs of clients supported by Adult Social Work teams in particular experienced greater difficulty in accessing advocacy support.   Participants from the Adult Social Care Service and to some extent the Learning Disability Service identified the multiple needs of their clients as presenting a gap between client need and current service provision as it was difficult to know which service to refer into with the effect that it deterred referrals. Other issues that negatively affected the uptake of services were the lack of a common access point and waiting times. Comments were also made about the need for advocates to be multi-skilled, probably reflecting the issue identified earlier in respect of the complexity of many client’s needs. There was also some concern about the professionalism of some advocacy support with respondents indicating incidents when they either felt there had been insufficient challenge to decisions or inappropriate challenges that touched on lobbying rather than representation. The need to raise awareness of local advocacy services was also mentioned as was the need for greater integration of service provision.

Providers who took part in the questionnaire indicated that they felt that a gap existed between those who would benefit from accessing support and those who actually made contact with the service. Lack of awareness of existing services was considered the key factor affecting this and this was again referenced when respondents were asked what they would like to see changed. Ambiguity as to understanding what advocacy meant was also cited as a factor. Increased capacity and funding were also cited as elements that the participants would like to see changed.

Findings from the Focus Groups supported the findings identified in the questionnaire for the need to raise awareness, improve promotion of services and the need to aid understanding of what advocacy was. Participants also felt that the more socially isolated a potential service user was, the less likely they were to be in contact with advocacy support. When asked what they would like to see changed providers who took part in the focus groups indicated that they would like to see more partnership working between services. It was also suggested that greater in-reach exist into referring services with for example social care teams having a member of staff with specialist expertise around advocacy: an Advocacy Champion. The value of having advocacy services delivered by services with local knowledge was also identified through the focus groups.

Lack of clarity around the meaning of the word advocacy was identified by service users as an obstacle to access for some clients, as was a perceived lack of awareness amongst staff who may refer to advocacy services. The most common responses from those who deliver services were made in respect of the need to raise awareness of advocacy services. This theme was also the most frequently mentioned at the Focus Groups with 14 participants suggesting the need to raise awareness and increase promotion of services. Examples of ways of doing this that were provided included the use of a directory, and greater outreach into the community. The stakeholder engagement expressed the need for professional high calibre staff with wide ranging knowledge who had the ability to actively listen to a client’s wishes. Participants also mentioned the lack of integration between services and that this made access difficult to navigate. It was also recognised that many who access Advocacy support have complex and specialist needs.

Recommendations

Findings from the preceding sections of the report have been synthesised and the following recommendations reached:

1. **Commissioners and providers to work to the definition of Advocacy used in the Advocacy Charter (and in this needs assessment)**

This definition is already used by the existing advocacy providers and by adopting the meaning already in operation this could aid consensus building and collaboration. It is important for commissioners and providers to identify what isn't advocacy and support this need in other ways e.g. social prescribing, community navigator, mental health support.

2. **Commissioners and providers to work to raise the awareness of advocacy and advocacy services through better promotion:**

a. Promote awareness of the advocacy services in Brighton & Hove with a clear description of the offer available to: service users; those referring into services; service providers and other Council services (for example by updating the BHCC advocacy webpage, inclusion in the MyLife website)

b. Develop and maintain an accessible directory of advocacy services available in Brighton & Hove

c. Consider the development of 'Advocacy Champions' within teams who refer people for advocacy

3. **Ensure that an effective and integrated advocacy service is offered in Brighton & Hove that is tailored to the specific needs of the City**

a. Commission an integrated service across the City with a single point of referral reflecting the potentially multiple needs of the user. Ensure that all providers work in partnership, for example by sharing training, information and experiences

b. Commission a responsive service, features of which would include: a common point of access with referrals being responded to within an agreed period; a duty system able to pick up calls/e-mails and respond within an agreed time threshold; referrals allocated across services to aid workflows and reduce waiting times

c. Agree a care pathway with commissioners, providers and referrers that specifies levels of service and expected timescales.

d. Consider co-location of advocates with referrers where appropriate

e. Commissioners and providers to ensure that people with interpreting needs (including British Sign Language) are able to access all advocacy services, and that demand in this group is monitored

f. Commission advocacy services with reference to the Social Care Institute for Health (SCIE) Care Act 2014: commissioning independent advocacy self – assessment tool. Consider co-commissioning and/or co-production of services with *providers and community members where appropriate*

4. **Ensure that advocacy services in Brighton & Hove can meet current and future demand**

a. Consider commissioning different types of advocacy e.g. could consider commissioning group advocacy or self-advocacy training courses, which anyone irrespective of their defined need could access

b. Provide feedback from advocacy services to relevant departments, for example workload requirements to assist with housing and benefits issues that could potentially be avoided if these services were more accessible

c. Further engagement work to be undertaken with older people and BME communities to better understand their needs for advocacy

d. Consider the development of an Advocacy Commissioners Network to aid integration and sharing of best practice between those who commission advocacy services across the City.

Appendix 3: Summary of engagement and outcomes **Advocacy User Engagement and Outcomes May 2017**

Source	**Feedback**	**Outcome**
Engagement for the Advocacy Needs Assessment 2017: 29 people included people with learning disabilities, autism, mental health needs and physical disabilities.	Continuity was highly valued amongst many respondents - so that they did not have to keep explaining their complex situations to new people	Add to service specification
	Important that advocates let them speak for themselves, not simply do things for them and allow them to keep as much control as possible (empowerment)	Add to outcomes
	Advocates must be skilled and knowledgeable, having knowledge of law changes and understanding systems	Add to service specification
	Advocates must be impartial or independent from statutory services/the council	Add to service specification
	Advocates must not judge the people they are advocating for	Add to service specification
	Peer advocacy was also valued for this feeling of being able to communicate about concerns and problems whilst knowing the space was ‘safe’	Add to service specification
	Threshold is set too high and people who found it difficult to communicate their needs were particularly at risk of not receiving services (those with autism, for example)	Further engagement work with autistic people New model
	Lack of awareness of advocacy as a service amongst those in need	Add to outcomes
	Lack of knowledge amongst health and social care workers about advocacy was also mentioned as a barrier	Add to outcomes
	Social Services were not sufficiently aware and knowledgeable about individuals in need being entitled to advocacy under the 2014 Care Act, resulting in individuals being bounced around between statutory and voluntary services unnecessarily, often at times when individuals were least able to cope.	Add to outcomes Further work by Council & CCG to promote advocacy
	The problem of the way local advocacy services are broken down into defined categories of need - it could be confusing for new potential users, trying to work out which service to go to first if the individual had a range of issues and needs	New model
	People also valued the specialist nature of some services – especially LGBT services	New model
	Gap identified in advocacy for housing-related problems for people with high and complex needs	Further work with the Council’s housing department

	Concern that advocacy for people with autism was insufficient	Further engagement work with autistic people New model
	People with multiple, long-term health conditions that did not have a mental health component, could fall between the criteria for the different advocacy services	New model
	Complicated for new users to navigate the different advocacy services offered within the city as they were currently organised and proposed a ‘one-stop-shop’ for advocacy	New model
	The advocate needs to understand complex systems well to be effective	Add to service specification
	LGBT-specific advocacy and Learning Disability-specific advocacy were requested	New model
	Little is known by GP’s about the value of advocacy and few referrals come from primary care	Add to service specification
	For new users a triage system or single helpline for people to call could be useful	Add to service specification
	More outreach by advocacy services to a cross-section of community groups to spread the word about what advocacy can achieve for people in need	Add to service specification
‘Tuesday Group’ deaf engagement 13/03/18	A deaf advocate is preferable to a hearing advocate and if possible provided by a deaf advocate outside of the local community.	Add to service specification
	Would like support with housing, benefits, as well as GP and hospital appointments.	Add to service specification
Engagement with older and deaf people 20/03/18 18 participants	Would like support with complaints, knowing rights, professional letters, navigating complex NHS services, attending health meetings, benefits, housing, legal issues	Add to service specification
	One to one support for deaf people and would prefer deaf person	New model Add to service specification
	Advocates need to have good knowledge of local services and expertise but also able to signpost to specialists	Add to outcomes
	Need good communication skills, clear language and good listening skills	Add to service specification
	Must help achieve outcomes set <u>by the person</u>	Add to service specification
	Need to be available when needed and at least Monday to Friday working hours and able to do home visits	Add to service specification
	Need to feel confident that data is confidential and that advocate can be trusted	Add to service specification
	Not aware of what services there are and how to contact services and what advocacy is	Add to outcomes

	Older people don’t feel valued or listened to and there is stigma and discrimination	Add to service specification
	Older people may not want to use a specialist older people’s service as they don’t need support due to their age but can be multiple issues and don’t want to be put in to a category	New model
	Need to be aware of ‘deaf culture’ and communication	Add to service specification
	Need to support people for whom English is a second language	Add to service specification
	Services need to be promoted through community centres, hubs, GP’s, navigators	Add to outcomes
	Written accessible information as well as online info	Add to service specification
	Buildings need to be accessible and home visits available	Add to service specification
	2 tiers of advocacy: 1 for lower and 1 for more complex needs	New model
	Need deaf awareness training and better dissemination to the deaf community	Add to service specification New model
	Triage available to prioritise needs	New model
	Advocates could be based at the hospital and within council teams	Add to service specification
Engagement with people with Aspergers Syndrome and high functioning Autism 23/04/2018 18 participants	Need consistency of the same advocate, particularly for people who find change difficult and find it hard to build relationships	Add to service specification
	Need to be aware that phone communication can be problematic and need to offer different types of communication, letters/email/planning	Add to service specification
	Need an advocate who has knowledge and preferably experience of working with people from the client group, especially understanding communication styles and not categorised with people with a learning disability	Add to service specification
	Need support with medical appointments; obtaining appointments, at the appointment, support for referrals, explaining medical conditions, support around diagnosis and navigating NHS services	Add to service specification
	Council Housing department need to understand the communication needs of people with autism and need support with tenancy issues – understanding that behaviours from neighbours can have a great impact on people with autism	Further work with the Council’s housing department
	Need to be knowledgable about health and social care services	Add to service specification
	Need time and understanding from GP about communication needs	Work with GPs and Practice Managers of GP surgerys/ CCG
	Need support with professional communication over the phone	Add to service specification

	Need expertise in working with autism and aspergers, training and understanding of the impact of their 'invisible disability'	Add to service specification
	Need to be person centred and active listening skills	Add to outcomes
	Need to know what services are available, how to contact services and what advocates are able to support with	Add to outcomes
	Lack of awareness of the needs of people with autism in services across the City	Outcomes and further work by BHCC/ CCG
	Online forms of advocacy as well as face to face including skype	Add to service specification
	Need central point of access to make accessing services easier	New model
Engagement event with people from the BAME Community 09/05/2018 8 participants	Need support with Housing; obtaining appropriate/ adapted housing and banding communication with landlord/ lady and ensuring fair treatment	Add to service specification
	Need support with medical/ health issues – difficulties to communicate with health professionals who ask a lot of questions and use jargon	Add to service specification
	Need advocates to help source and navigate services	Add to service specification
	Need to be able to contact the advocacy services in different ways inc. text, email and leaving messages in service users language	Add to service specification
	To be able to contact the advocacy services in different ways inc. text, email and leaving messages in service users language	Add to service specification
	Better promotion of what services are available especially bilingual advocacy and interpreting	Add to service specification
	Central point of access	New model
	Some people are able to advocate for themselves but need interpreting support	Add to service specification
	Good ongoing communication	Add to service specification
	Peer and group advocacy options as people share the same language and can share their experience and knowledge	Service specification
	Need to know how advocates can help/ support	Add to service specification

Appendix 4: Report on advocacy provider engagemen

Feedback from provider engagement for Adult Social Care Advocacy services re-commission

28th March 2018

1. Introduction

1.1 Brighton and Hove Adult Social Care Commissioners invited Providers to attend a pre-tender engagement event on the 28th March 2018 that was advertised on the contracts finder website (https://www.contractsfinder.service.gov.uk/Notice/452a61d0-ffec-4072-8f8a-14286644760d). Representatives from 13 advocacy providers attended the event and were a mixture of local, regional and national organisations (details of the organisations are included in Appendix A).

1.2 Providers were given a brief presentation of the local context and feedback from the Advocacy Needs Assessment 2017 (slides included in Appendix B).

1.3 Discussion groups then took place to look at opportunities for pan Sussex work, providing a central point of access whilst retaining specialist provision, different models for delivery of services including single provider and partnership models with a lead provider and considering whether advocates can provide more than one statutory role. They key points are summarised in this report together with the proposed model of delivery for advocacy services. Comments from the groups are included in Appendix C.

2. Question 1 *Can advocates provide more than one statutory role? Do some roles fit together better than others?*

2.1 Providers gave feedback that the benefits of advocates being able to provide multiple roles are the continuity for the person, it helps to build trust, avoids duplication and provides a more seamless and personalised service. Examples were given of autism people particularly benefitting from this approach, as it can be more difficult to cope being transferred between different advocates. There was also agreement in the challenges of this approach including the differing skills required for different advocacy roles, training and cost implications for services and concern that having multiple roles for advocates may impact on the quality of service including the loss of some specialist skills. Some providers were concerned that smaller organisations would not be able to deliver an advocacy service providing multiple roles due to the higher cost and larger teams that would be needed.

2.2 Considering specific advocacy roles that may fit together, there was consensus from the majority of Providers who attended the event that the Independent Mental Capacity Advocacy (IMCA) function fits well with Independent Care Act advocacy (ICAA). The benefits of this were considered to be providing continuity to the person and a more seamless and personalised approach to support. There was mixed feedback about the benefits of Independent Care Act Advocacy (ICAA) and specialist community advocacy sitting together. Similar benefits were considered in terms of providing continuity of support for a person who may access community advocacy and ICAA following on from this which may lead to a further need for community advocacy as things progress. However, it was also considered that the focus and time and resource allocation for community advocacy may be impacted if provided with ICAA, as it's a statutory function and would likely take priority.

2.3 As a result, a potential issue was identified of statutory advocacy functions being prioritised and better resourced by a service with advocates also providing community advocacy. It was suggested that ring fencing funding for community advocacy could help mitigate this risk otherwise this could adversely impact on the responsiveness of the service with regards community advocacy.

2.4 It was considered that the IMCA and Independent Mental Health advocacy were too disparate in their statutory function and the knowledge and skill base needed for an advocate to deliver both. It was suggested that the IMHA and community mental health advocacy could sit well together given the routes of access would likely be the same and the specialist knowledge and skills needed from advocates to support this client group.

2.5 There was some feedback that the IHCAS statutory function did not link with other advocacy roles other than in cases where advocacy for parents of children with learning disabilities progressing through the Court process as it was suggested that Health Complaints often run in parallel to this process.

2.6 It was highlighted that support for people with Learning Disabilities, Autism and hearing impairments can require more time and resource due to communication difficulties and the specialism that advocates need to support these people.

3. Question 2 *Central point of access – how do we provide a one stop shop without losing specialist provision?*

3.1 The importance of being clear about what a central point of access/ ‘one stop shop’ is in the service specification was highlighted in feedback.

3.2 There was some consensus about the benefits of a central point of access (CPA) including enabling a more responsive service when factors such as capacity of providers can be considered (absence, leave, waiting lists etc.) to promote a more responsive service. Providers also advised that this would prevent delays in identifying incorrect referrals e.g. a person requiring an IMCA rather than an ICAA, which we are aware is an ongoing issue. It was also fed back that the CPA needs an appropriate allocation of resources to function effectively.

3.3 Allowing for more than one route of access into the central point was highlighted as essential. The argument for this was put forward on the basis that often a person will already be in contact with a specialist community organisation, who commonly identifies the need for advocacy and can support the person to be referred into the central point of access. Providers also advised that a person is likely to make contact with a community organisation rather than the central point of access, this being especially true for people with specialist needs. Connected to this was the concern of losing some added value with specialist organisations providing advocacy in tandem with other services offered. There was also an overall apprehension about how peer and group advocacy would be supported if there is a central point of access.

3.4 The importance of the CPA not just being digitally accessible was discussed and drop-ins at community centres and hubs were recommended to enable equal access for people with specialist needs including people with hearing impairments. In addition, it was proposed that an interpreting service needs to be provided at the CPA and budgeted for.

3.5 Feedback highlighted the importance of trained and skilled advocates with knowledge of specialist community organisations in Brighton and Hove to be able to triage referrals and ensure signposting to community resources as appropriate. As well as some signposting, it was advised that the central point of access wold involve some information and advice and that this is a wider remit than the advocacy role so this needs to be considered.

4. Question 3 *Are there opportunities for more pan Sussex work?*

4.1 There was a general consensus from Providers that statutory advocacy duties could work well pan Sussex with some challenges highlighted that would need to be considered. It was proposed that pan Sussex statutory advocacy services could offer staff greater flexibility and potentially incorporate a wider specialist skill set of advocates given the larger geographical area covered. An example provided related to increasing access to advocates trained in BSL given the additional barriers people with hearing impairments face in accessing advocacy services. Other benefits suggested included reducing the potential for 'handoffs' between different areas and local authority boundaries which would offer a more cohesive and personalised service for people accessing statutory advocacy.

4.2 There was a consensus from providers that specialist service provision would be challenging to provide pan Sussex. The main issues raised were; that not all specialist and smaller organisations currently operate pan Sussex and those that don't may not be have the capacity and resources to do this which would exclude them from bidding for a pan Sussex service. Also that there is the challenge of different demographics, priorities and strategic approaches by Adult Social Care pan Sussex and the three local authorities this covers.

4.3 If specialist advocacy is to be provided pan Sussex, it was proposed that each locality would need its own specialist advocacy service that could meet the unique needs of people living in each area to ensure that people from groups with specialist needs would not be disadvantaged or unsupported in each area.

5. Question 4 *Single Provider v partnership with Lead provider model*

5.1 The general consensus was a preference for a lead provider model rather than a single provider doing everything. This includes feedback from organisations that have contracts to deliver advocacy within both models. It was acknowledged that a single provider may provide a more straightforward process and improve communication across the board and have budgetary and resource benefits. Also that single providers are still able to link in with specialist and community organisations and that this can be a reciprocally beneficial relationship where specialist organisations can benefit from the knowledge and experience of the single Provider.

5.2 However, there were several concerns about this model. The main concern was that this would exclude specialist community providers from the bidding of the contract and that people would not have the choice of advocacy provided by a specialist community organisation. This was considered as compounding access issues and quality of support for people with hearing impairments, autism, learning disabilities in particular. In addition, it was raised that specialist providers have the local knowledge of services and provide social and added value that would be lost if there was a single provider model.

5.3 Feedback about a partnership with a lead provider model was focused around the attributes needed from both with a focus on flexible working arrangements. The need for Lead Providers to be transparent, resilient, well resourced, able to absorb financial risk, good management and leadership were highlighted as important. Also the importance of due diligence in the tender process to ensure that the lead provider has a proven track record of working effectively with partnership arrangements and sub-contracting to specialist community organisations was highlighted.

5.4 Regarding partnership arrangements, the importance of flexibility across specialist community organisations was highlighted; both with regards to accepting referrals and working with other partners to avoid 'hand offs' between services or people being categorised by virtue of their primary need/ age. Also that a partnership arrangement with specialist community organisations ensures that people have choice and specialist support from organisations and prevents specialist knowledge and networks being lost including knowledge of local services and key professionals to contact with the Local Authority, CCG and NHS.

5.5 The preventative element to community advocacy was also highlighted as a consideration to retaining this in the re-commission, supporting people to avoid a crisis arising and the impact that this has on other part of Adult Social Care including the impact on assessment teams and funding.

5.6 Providers fed back that commissioners need to carefully consider the language in the service specification about the roles and responsibilities of the lead provider and specialist community organisations in a partnership.

6. *General feedback from feedback from group discussions for Commissioners to consider*

6.1 The need for assessment teams to promote advocacy services with clients and have a good understanding of advocacy services, referral processes and specialist community services was highlighted as important to the effectiveness of the advocacy service.

6.2 The importance of notifying providers of a pan Sussex model with lead provider and/or a partnership was highlighted as this will impact on which organisation could bid as lead provider and form partnerships. It was also stressed that Commissioners need to give providers sufficient time to discuss and explore partnership arrangements so that this is meaningful and that organisations values align.

6.3 One of the providers asked about advocacy for children and young people. The Youth Advocacy Project provide advocacy to young peope in Brighton and Hove www.bhyap.org.uk and there is a Council run service too.

7. Recommendation

Having considered the feedback from the Advocacy Needs Assessment 2017 and the engagement work to date with service users and providers, the following model is being recommended for the advocacy re-commission in April 2019.

The proposal is that a Lead Provider directly provide IMCA and ICAA across Brighton and Hove with specialist community advocacy organisations providing IHCA, Specialist Community Advocacy and a combined IMHA and Community Mental Health Advocacy. As engagement is still taking place with users of advocacy services the decision about which specialisms will be included within the Specialist Community Advocacy service(s) has not been made yet.

It is expected that a subcontracting arrangement would be the most effective model as it would retain the specialist knowledge held by community sector providers.

Discussions are currently taking place with East and West Sussex regarding the continuation of a pan Sussex IMCA arrangement.

Appendix A: List of provider organisations that attended the workshop

Royal Association for Deaf People

Possability People

Rethink Mental Illness

Impact Initiatives

Age UK Brighton & Hove

seAp

Speak Out

POhWER

Brighton & Hove Impetus

MIND Brighton and Hove

Voiceability

MindOut

Sussex Interpreting Services

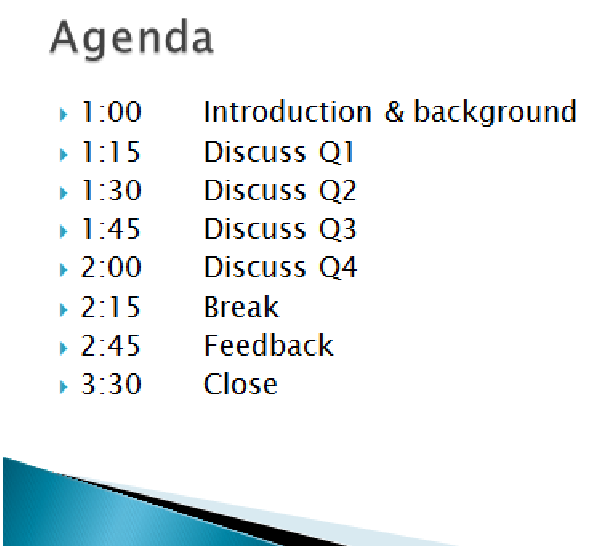
Appendix B: Presentation to Providers Engagement Workshop

Brighton & Hove City Council

NHS
Commissioning Alliance
Brighton and Hove CCG
Crawley CCG
High Weald Lewes Havens CCG
Horsham and Mid Sussex CCG

Provider Engagement Workshop
Advocacy Procurement
28th March 2018

Anne Richardson-Locke, Commissioning & Performance Manager
Natasha Gamble, Commissioning Support Officer
Steve Dillow, Procurement Category Specialist
John Reading, Community & Equalities Third Sector Manager
Amanda Waller, CCG Commissioning Project manager



Agenda

1:00	Introduction & background
1:15	Discuss Q1
1:30	Discuss Q2
1:45	Discuss Q3
2:00	Discuss Q4
2:15	Break
2:45	Feedback
3:30	Close

Current provision

8 different types of advocacy provided by 7 community and voluntary sector providers (total £648k):

- Independent Mental Capacity Advocacy (IMCA)
- Independent Mental Health Advocacy (IMHA)
- Independent Care Act Advocacy (ICAA)
- Independent Health Complaints Advocacy (IHCAS)
- Community Mental Health Advocacy
- Specialist Community Advocacy (OP, MH, LD, PD)
- LGBT Community Advocacy
- Trans Advocacy

All contracts expire on 31st March 2019

Advocacy Needs Assessment

Advocacy user feedback:

- People were very positive about advocacy services, their advocates & the impact on their quality of life
- Continuity of advocate is important to people
- LGBT users particularly value a specialist service whilst some other users don't want to be categorised by client group
- Lack of capacity, high thresholds and lack of awareness were highlighted as barriers to accessing advocacy
- Need for a quick response to assess urgency & prevent crises

Advocacy Needs Assessment

Referrer feedback:

- Majority of referrers very or fairly satisfied with advocacy services
- Like other areas very low numbers of Care Act referrals & referrers experienced greater difficulty in accessing Care Act Advocacy
- Referrers unsure where to refer when clients have multiple needs
- Hand offs between organisations where people need more than 1 type of advocacy

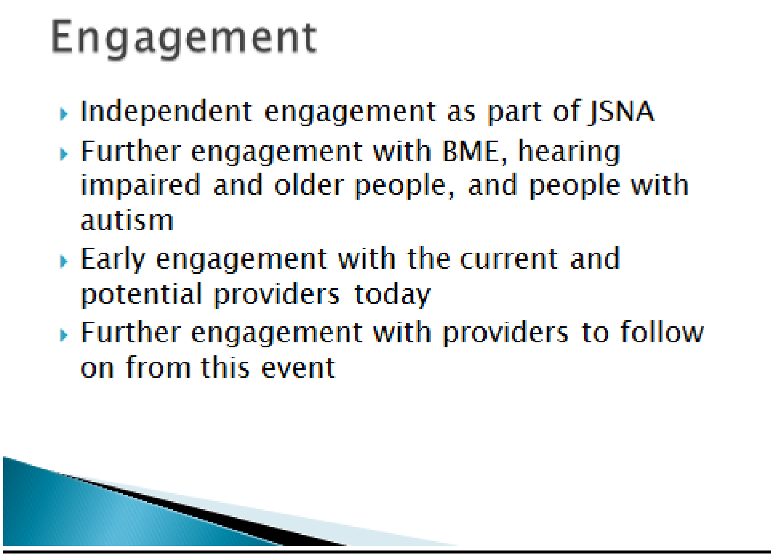
Advocacy Needs Assessment

Recommendations:

- Raise awareness of advocacy and advocacy services through better promotion with a clear description of the offer available to: users, referrers and other services
- Clear care pathway that specifies levels of service and expected timescales
- Single point of access and duty system
- Consider co-location of advocates with referrers (works well with IMHA at Millview)
- Commission different types of advocacy to include group, peer and self-advocacy

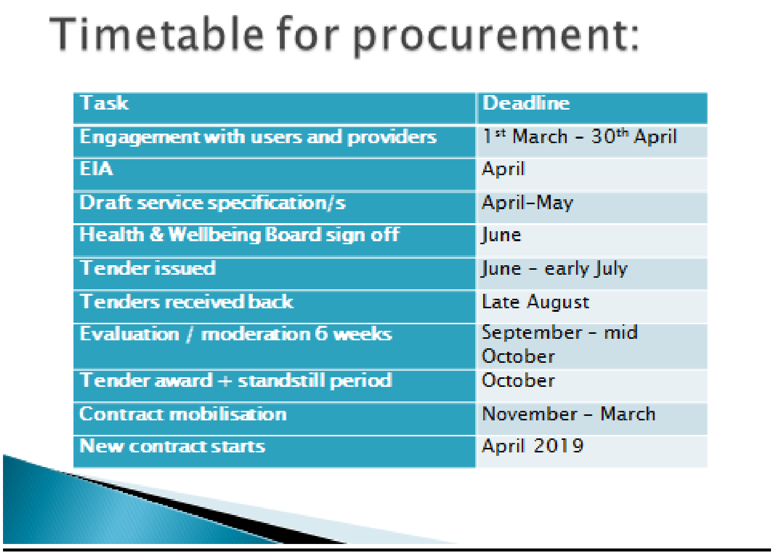
Drivers

- Increase in demand predicted – but less money
- Good practice :
  - Single point of contact to triage and prioritise referrals
  - Single provider or partnership with a lead
  - Innovative and flexible provision making best use of technology
  - Network of providers working collaboratively not in competition



Engagement

- Independent engagement as part of JSNA
- Further engagement with BME, hearing impaired and older people, and people with autism
- Early engagement with the current and potential providers today
- Further engagement with providers to follow on from this event



Timetable for procurement:

Task	Deadline
Engagement with users and providers	1st March – 30th April
EIA	April
Draft service specification/s	April-May
Health & Wellbeing Board sign off	June
Tender issued	June – early July
Tenders received back	Late August
Evaluation / moderation 6 weeks	September – mid October
Tender award + standstill period	October
Contract mobilisation	November – March
New contract starts	April 2019

Areas for discussion with market

- Q1. Can advocates provide more than 1 statutory role? Do some roles fit together better than others?
- Q2. Central point of access – how do we provide a one stop shop without losing specialist provision?
- Q3. Are there opportunities for more pan-Sussex work?
- Q4. Single provider v partnership with lead provider?

Appendix C: Feedback from workshop groups

Q1. Can advocates provider more than one statutory role? Do some roles fit together better than others?

Care Act and IMCA roles appear to sit together well and provide continuity for the person

IMCA and IMHA considered too disparate and conflict of interest concern raised

IMHA and community MH advocacy could sit together given routes of access but some feedback that IMHA needs different skill set

IHCAS difficult to link to other roles

Advocacy for people with LD and health complaints works well together as these roles often run in parallel

Provides continuity for the person, builds trust, avoids duplication and provides a more seamless and personalised service. Exampled given of people with autism particularly disliking being transferred to different advocates

A potential issue was raised in terms of some roles being prioritised over others e.g. the IMCA role have a time limit on allocation and higher volume of referrals and concern that if advocates are providing more than one roles, others would be lower priority and therefore less responsive

Community advocacy may get lost amongst statutory roles; suggestion of ring fencing funding for community advocacy

Community advocacy to be included with statutory to help continuity of support eg. A person receives community advocacy, required ICAA and following a crisis may then need community advocacy

Some feedback that community advocacy needs to be separate from Care Act

Potential issue with advocacy for people with LD/ Autism taking longer due to communication difficulties and the specialism advocates need to support these groups

Differing skills required for different advocacy roles could be an issue, training can be expensive. Will advocates be paid more? Example of Voiceability who had training to act as IMCA/ ICAA and IMHA. Smaller providers concerned they won’t be able to provide this.

Will having multiple roles for advocates impact on quality of service and less specialised skills within a role?

Look at Essex model of commissioning advocacy

Difficulties in recruitment of advocates

Higher cost and bigger teams needed – smaller organisations can’t afford/do this

Q2. Central point of access – how do we provide a one stop shop without losing specialist provision?

Allow for more than one route of access;

- through specialist organisations who may already be working with the person and can identify a need for advocacy that the person may not and make referrals on behalf of clients
- not just online; phone, drop in at community centres/ hubs
- accessing advocacy via specialist organisation can provide social value with some people going on to volunteer with the organisation

A local based single point of access for each authority if services are pan-Sussex enables knowledge of and signposting to local services/ community assets where needed

Central point of access needs trained and skilled advocates to provide effective triage. Example of Kent model given with a contact centre and triage by trained advocates

The role for advocates on CPA is wider than advocacy role; also signposting and advice?

CPA can provide a more responsive service when factors such as capacity of providers can be considered inc. absence/ leave/ waiting lists. Also prevent delays by identifying incorrect referrals eg. The person requires an IMCA rather that an ICAA.

An interpreting service needs to be provided at CPA and budgeted for to provide equal access to all.

Specialist need can mean that these people are excluded as can’t use phone/ digital e.g. deaf community wouldn’t be able to access a central point of contact

Be clear about what a central point of access means in the Service Specification

Clear expectations from Commissioning and Procurement set out in service specification about how partnership should work and what role/ responsibilities the Lead Provider has

Test partnership model and ask for evidence as part of evaluation

It needs appropriate allocation of resources for the Provider that operates the central point of access. Managing this is challenging

Partnership benefits from having a lead provider and ‘single point of contact’

‘No wrong door’

People often access advocacy via community services/ specialist organsiations

Peer support groups/ advocacy?

Support groups can influence service provision

If client has specialist needs, then specialist providers need to work together to determine how best to support the person

Advocates in central point of access need to have local knowledge of specialist services

Examples of this in operation in others Las;

Northampton – Total Voice

Suffolk – Voiceability with 5 specialists in partnership, upskilled the local providers

Q3. Are there opportunities for more pan-Sussex work?

Consensus that statutory duties/ advocacy could work well pan-Sussex

Many organisations operating locally in Brighton and Hove could offer a Service pan Sussex but not all specialist organisations do

Concerns that social/ added value will be impacted and local knowledge of specialist local services/ community assets lost

Pan Sussex with some local provision considered a good model e.g. the Lead Provider operating Pan Sussex with specialist partnership in each locality (ESCC, WSCC and BHCC). This will also tackle issues with difference in demographics and environment

Pan Sussex provision could work with links into local organisations

Pan Sussex service could prevent some local/ smaller Providers being able to bid for the contract

Pan Sussex could offer staff greater flexibility and potentially wider specialist skills of advocates given the larger geographical area covered e.g. those trained in BSL

Wider geographical coverage will mean more funding and sustainability of smaller specialist providers

Reduces potential handovers

Cultural challenge of differences between areas/ LAs

Q4. Single Provider v partnership with Lead provider model?

Organisations that have both models appear to prefer partnership with lead provider model as it's a more effective way of delivering specialist support and providing more choice for people.

Lead Provider needs to be transparent, resilient, well resourced, financially viable and able to absorb potential financial risk, good management and leadership

Lead Provider can offer support to specialist orgs in the partnership to deliver and they can learn from each other

There would need to be flexibility for people with multiple needs across the partnership to provide the most responsive and personalise service – not categorising people where avoidable

Partnership with lead provider prevents specialist knowledge and networks being lost including knowledge of 'go to' people for various issues within the LA/ CCG/ Housing

Minority groups have difficulty accessing advocacy services and it's likely they would access an advocate via the specialist service they are familiar with/ already engaged with.

Benefit of partnership with lead provider giving people the benefit of somewhere in the community they can go

Group/ collective advocacy may be difficult to deliver by a single provider

A single provider can work with local more specialist organisation in the area to make use of their knowledge and expertise

People don't want to be 'handed off' between services or 'pigeon-holed' according to their primary need/ age etc but other feedback was that the risk of hand off is a false expectation of the partnership model

Single Provider can make communication with stakeholders/ commissioners easier as single point of contact and may have budgetary and resource benefits

Consideration needs to be made to what the community and people using the service would prefer

Commissioners to carefully consider language in service specification re lead provider and partnership and do due diligence with lead providers about track record of working/ engaging with specialist providers and that they have the resources, can absorb risk, well managed and well led and resilient.

Be careful that the lead provider subcontracts well with smaller providers – be fair!

Important of trust across all providers

Specialist providers have the local knowledge of what's available and provide social and added value

__General feedback;__

Idea of 'opt out' approach to advocacy but could create capacity issues

Social workers to promote advocacy and always consider advocate for assessments

Social care teams/ referrers to understand the advocacy service and processes

Pan Sussex models will impact on which organisations could bid as lead provider and form partnerships so needs to be decided on ASAP

Providers need sufficient time to discuss/ explore partnership so that this is meaningful and values etc align

Need to retain community advocacy – preventative element

People like to be offered a specialist advocate

Concern that specialist providers won't all be able to provide service pan Sussex

Importance of collating data re referral demand in order to get required resources/ funding

Appendix 5: Outcomes framework

Commissioners have used the Advocacy Outcomes Framework developed by the National Development Team for Inclusion (NDTi) and then developed 6 local outcomes to be measured and reported on. The Framework was developed nationally and there is helpful guidance and a tool for providers to use to help measure the outcomes (Advocacy Outcomes Toolkit, NDTi, July 2016).

1. Outcomes that result in changes for individuals: 1.1 Individuals are supported to access information to support decision making, make their own decisions, challenge decisions, appeal, complain and raise concerns. 1.2 Individuals have improved quality of life, increased choice and control, improved health or treatment, are protected from abuse or neglect and able to challenge discriminatory practice. 1.3 Individuals are more independent, have increased confidence, increased access to communities and networks, increased knowledge and feel more able to use health and care processes and services.	**2. Outcomes that change the health and care system:** 2.1 Trends and themes identified by the Advocacy Provider have led to improvements in the way that services are delivered and individuals' experiences of them.
3. Changes to communities: 3.1 Community organisations, groups and individuals are more aware of advocacy services and advocacy users are more aware of and more connected to their communities and networks.	**4. Outcomes that change the way the advocacy service is run:** 4.1 The Advocacy Service is more accessible to excluded groups (BAME, D/deaf, people with autism), advocacy users feel confident that the advocate understands their issues and that they have a voice in decision making and service developments.

Brighton & Hove
City Council

NHS
Brighton and Hove
Clinical Commissioning Group

Equality Impact and Outcome Assessment (EIA) Template - 2018

EIAs make services better for everyone and support value for money by getting services right first time.

EIAs enable us to consider all the information about a service, policy or strategy from an equalities perspective and then action plan to get the best outcomes for staff and service-users[1].They analyse how all our work as a council might impact differently on different groups[2]. They help us make good decisions and evidence how we have reached these decisions[3].

See end notes for full guidance. Either hover the mouse over the end note link (eg: Age[13]) or use the hyperlinks (‘Ctrl’ key and left click).

For further support or advice please contact:

- **BHCC: Communities, Equality and Third Sector Team on ext 2301**
- **CCG: Engagement and Equalities team (Jane Lodge/Meg Lewis)**

1. Equality Impact and Outcomes Assessment (EIA) Template

First, consider whether you need to complete an EIA, or if there is another way to evidence assessment of impacts, or that an EIA is not needed[4].

Title of EIA[5]	Commissioning of an Advocacy Hub	**ID No.[6]**	
Team/Department[7]	Health and Adult Social Care		
Focus of EIA[8]	Adult Social Care and the CCG jointly commission 8 different statutory and non-statutory advocacy services. All of the contracts expire on 31st March 2019 and new provision will be recommissioned. A Needs Assessment was carried out in 2017 to help define the populations who need advocacy and the type of advocacy support they need. Current and potential future demand for statutory and non-statutory advocacy was also explored as well as gaps in provision. This was the first stage in the ‘commissioning cycle’ and the Needs Assessment identified that the majority of people were very positive about advocacy provision and its impact on their quality of life. People from the LGBT and learning disabled communities particularly value a specialist service whilst		

some other users didn’t want to be categorised by client group and would like a ‘one stop shop’. The lack of capacity, high thresholds and lack of awareness of advocacy were highlighted as barriers and people identified the need for a quick response to assess urgency & prevent crises. The majority of referrers were satisfied with advocacy services but experienced greater difficulty in accessing Care Act Advocacy and were unsure where to refer clients with multiple needs. There are also hand offs between organisations where people need more than 1 type of advocacy.

The Needs Assessment recommended the commissioning of an integrated, responsive advocacy service, with a single point of access for referrals to provide a more streamlined and responsive service. Other recommendations include better promotion, co-location of advocates with referrers and a wider offer of advocacy that includes group, peer and self-advocacy. Not all protected characteristics were captured during the engagement so it was recommended that further engagement take place to ensure the views of all service users is captured.

Further engagement has taken place and has been summarised below and engagement has also taken place with providers of advocacy services. The recommendation is that an integrated Advocacy Hub is commissioned. The Hub will have a lead provider directly providing Independent Mental Capacity Advocacy across East Sussex, Brighton & Hove and West Sussex and Independent Care Act Advocacy for Brighton & Hove and West Sussex. The Lead Provider will either directly provide or sub-contract with specialist community advocacy organisations to provide Independent Health Complaints Advocacy, Specialist Community Advocacy and a combined Independent Mental Health Advocacy and Community Mental Health Advocacy. Spot purchase arrangements would need to be in place for specialist providers of deaf, bilingual and autism advocacy.

Discussions are also currently taking place with West Sussex regarding joint commissioning of some of the other advocacy provision but as there are different needs across the different geographical areas separate hubs would be developed in each area.

The purpose of this EIA is to summarise the findings of the engagement work and show how this has contributed to the recommended model and to also provide evidence of the impact the model will have on the protected characteristics.

Throughout the EIA the following acronyms are used:

IMCA	Independent Mental Capacity Advocacy
IMHA	Independent Mental Health Advocacy
IHCA	Independent Health Complaints Advocacy
ICAA	Independent Care Act Advocacy

2. Update on previous EIA and outcomes of previous actions[9]

What actions did you plan last time? (List them from the previous EIA)	**What improved as a result?** What outcomes have these actions achieved?	**What further actions do you need to take?** (add these to the Action plan below)
No previous EIA		

3. Review of information, equality analysis and potential actions

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
Age[14]	Needs Assessment 2017: • Brighton & Hove has a relatively large proportion of older people living alone and potentially isolated who are more dependent upon public services. 500 (41%) people aged 65 years and over live alone in Brighton & Hove compared to 31% nationally. • 17.2%.increase predicted in population aged 65 years and over in Brighton & Hove between 2014 and 2025 with an even greater proportion of those elderly with additional health needs, for example 19% increase in older people with a serious visual	The Needs Assessment was not able to capture the views of older people who use advocacy and it was therefore one of the recommendations that further engagement take place and consequently engagement took place with a group of older people who told us the following: • Older people don't feel valued and listened to • They would like support with complaints, knowing their rights, professional letters,	There may be a negative impact on some older people who access advocacy via a specialist older people's organisation. For people who do not want to be badged as 'older' the removal of a specific older people's advocacy service will have a positive impact as the Advocacy Hub will be open to all ages and provide advocacy for the issues that people tell us they need support with.	The Advocacy Hub to engage with and seek feedback from older people who need or have used the service and ensure that older people have a voice in decision making and service developments. The Advocacy Hub to have close links with organisations that provide information and advice to older people and assessment teams.

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	impairment, dementia or severe depression. • In 201718 88 people accessed a specific older peoples' advocacy service with 12 of these people requiring Care Act advocacy. • Older people may require advocacy services if they are unable to have their voice or wishes heard. This is likely to be due to an additional factor, for example mental ill- health or a physical disability.	navigating complex NHS services, attending health meetings, benefits & housing • Advocates must have good knowledge of local services & expertise, good communication and listening skills • Older people don't necessarily want to use a specialist older peoples' service as they don't need support due to their age but can be multiple issues and don't want to be put in a category. • Triage needs to be available to prioritise needs	Older people will have access to a wider range of advocacy provision and consistency of advocate. .	
Disability [15]	Needs Assesssment 2017: • There is a large projected increase in the number of people with physical disabilities in Brighton & Hove (15%) and 19.9% increase in	13 people with physical & sensory gave feedback on the local advocacy services to feed into the Needs Assessment (18 people described themselves as having a	The removal of a specific physical disability advocacy service will have a positive impact on people with multiple needs as the advocacy hub will offer specialist	The Advocacy Hub to engage with and seek feedback from people with physical disabilities who need or have used the service and ensure that disabled people have

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	people with moderate, severe or profound hearing impairments. • JSNA: It is estimated that in Brighton & Hove in 2015 there were 3,777 people aged 18-64 with a serious physical disability, 125 people aged 18-64 with serious visual impairment and 3,383 aged 65 and over with a moderate or serious visual impairment; 6,086 people aged 18-64 with a moderate or severe hearing impairment and 50 people aged 18-64 with a profound hearing impairment (deaf); 16,069 people aged 65 or over with a moderate to severe hearing impairment and 462 aged 65 or over with a profound hearing impairment (deaf). • In 2017/18 146 people received advocacy, 142 via the specialist physical disability community service and 4 people with physical disabilities received Care Act Advocacy. • 20% of people receiving support from non-physical disability advocacy services also reported having a physical disability. • As advocacy services are provided	disability). People told us that they need advocacy to support them with: • disability benefits issues, particularly benefits re-assessments • housing issues • help to manage processes around multiple health conditions • navigating NHS services. People want advocates to have good knowledge of complex benefits systems and found it confusing the way that the local advocacy services are broken down by client group as they may have multiple conditions. People with <u>hearing impairments</u> told us that: • A deaf advocate is preferable to a hearing advocate and if	issue based advocacy and if people have multiple needs that include a physical disability they will receive the consistency of an advocate rather than be transferred between services. There may be a negative impact on people who have accessed advocacy via a specialist disability organisation. The provision of deaf advocates for BSL users will have a positive impact on the deaf community as it will remove the need for an advocate and a BSL interpreter.	a voice in decision making and service developments. The Advocacy Hub to have excellent understanding and awareness of the physical and sensory disabilities that effect people and the benefits system and close links with organisations that provide advice and information to disabled people.

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	for deaf people, we would expect the requirement for British Sign Language interpreters. However data was not available of the number of deaf people who received advocacy support and how many were also supported by a BSL interpreter.	possible provided by a deaf advocate outside of the local community and • One to one support is important. • Advocates need to be aware of 'deaf culture' and communication • They would like support with housing, benefits, as well as GP and hospital appointments. • Need deaf awareness training and better dissemination of info to the deaf community •		
Mental Health	Needs Assessment 2017: • JSNA: an estimated 39,798 people aged 18-74 years in Brighton and Hove have common mental health disorders (17%). • Local prevalence continues to be generally higher than England as well as rates of hospital admissions and detentions under the Mental Health Act.	13 people involved in the Needs Assessment engagement had a mental health condition and were dealing with this alongside other conditions. They expressed the need for advocates to: • receive support from local Mental Health services	The Advocacy Hub will have combined IMCA and ICAA provision that will have a positive impact on people who move between having 'substantial difficulty' in engaging in Adult Social Care processes and 'lacking capacity' as they will no longer have to	The Advocacy Hub to continue to provide a co-located IMHA service at Millview Hospital and to make links with the potential new provider(s) of the community mental health services.

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	• PANSI: predicts that the number of people with mental health problems in Brighton & Hove will rise by 3.7% between 2017 and 2025. • Demand for Independent Mental Capacity Advocates (IMCA) and Paid Representatives for people who lack capacity has increased by 24% in 2016/17 and 26% in 2017/18 with 2027 closed cases in 2017/18 across Brighton & Hove, East & West Sussex. • 418 people received Independent Mental Health Advocacy (IMHA) in 2017/18 (an increase of 2%). • 403 people received specialist community mental health advocacy – a reduction of 16% on the previous year. • 30 people with mental health issues received Independent Care Act Advocacy – an increase of 43% on the previous year.	• explain the eligibility criteria for receiving mental health support • help them retain a sense of control over the services offered to them	move between different services and will receive consistency of advocate. Similarly if someone receiving an IMHA service is no longer receiving mental health treatment but still continues to need some community advocacy there will be continuity of provision through the same service.	
Learning disability	Needs Assessment 2017 • HSCIC: In 2014/15 825 people with learning disabilities were receiving long term support from Brighton & Hove City Council, of these, 725	7 people with learning disabilities / difficulties in total took part in the engagement for the Needs Assessment and there was a focus group with 4	The provision of specialist learning disability provision will have a positive impact on people with learning disabilities as they will	The Advocacy Hub to ensure a range of communication methods with people with learning disabilities and to promote learning

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	were aged 18-64 (88%). • Approximately between 145 and 242 adults with a learning disability receiving long term support from the council also have an Autistic Spectrum Condition. • Projection of numbers of people in the City with a learning disability predict that the numbers will increase from 4716 in 2015 to 4991 in 2025, a rise of 5.8%. • In 2017/18 127 people with learning disabilities received community advocacy – a reduction of 27% on the previous year and 42 received Care Act Advocacy – an increase of 56% In 2017/8 18 parents with learning disabilities received advocacy to support them to navigate the child protection processes. Add numbers from other provider when received	people and this includes 1 person who had accessed support from an advocate to help with care proceedings. The knowledge of specialist learning disability organisations were highly valued by people with learning disabilities. They described not being able to explain their needs because of their learning disabilities and being treated badly by people in society. Advocacy providers gave feedback that advocacy for people with LD/ Autism can take longer due to communication difficulties and specialist service is required. Further engagement is taking place with parents with learning disabilities on 7th June – to be added.	have the assurance that they can access a safe space where people understand their communication needs. If people do not want to be associated with the learning disability service the single point of access means that there will be choice of provision and they could access the issue based advocacy service.	disabilities awareness across other services. The Advocacy Hub to work closely with referrers in Health and Adult Social Care and Families, Children & Learning. The Advocacy Hub to provide time limited advocacy for child care proceedings but not to duplicate the work of a legal advocate.

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
		Feedback from referrers into advocacy for parents with learning disabilities in care proceedings is as follows: • The specialist support is valued but referrers questioned the need for advocacy alongside legal advocacy • Advocacy for parents should be led by what the person wants • Advocates should not be providing support work		
Autistic Spectrum	Needs Assessment 2017: • PANSI: Estimated that in 2014 there were 1941 adults with an Autistic Spectrum Disorder in Brighton & Hove, and it is estimated that this will rise by 7.8% to 2093 in 2025. • Data from the 2 advocacy organisations that support people with learning disabilities and / or autism does not distinguish autistic	There was concern expressed during the Needs Assessment that advocacy for people with autism was insufficient. Autism was described as a form of invisible disability, alongside mental health issues, with challenges for accessing services and being perceived as not being in need. 1	The provision of specialist autism advocacy will have a positive impact on autistic people and those with Asperger’s.	The Advocacy Hub to promote autism awareness across all services. The Advocacy Hub to offer a range of methods of communication.

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	people from people with a learning disability and many people with Aspergers Syndrome or High Functioning Autism do not have a learning disability and may therefore not seek support from one of those organisations and instead access an autism specialist service. • The Needs Assessment recommended further engagement with autistic people to ascertain their views and ensure fair access.	participant said they would never have got through NHS system to get a diagnosis of autism without the support of specialist advocates Further engagement took place with 18 people with Asperger’s / high functioning autism and they told us: • Consistency of the same advocate is important, particularly for people who find change difficult and find it hard to build relationships • An advocate should be knowledgeable and preferably experienced with working with people from the client group, especially understanding communication styles and not categorising people with those with a learning disability		

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
		• Support is needed with phone communication, appointments, support with getting a diagnosis and complex processes.		
Gender reassignment[16]	Needs Assessment 2017: JSNA: estimates are that there are at least 2,760 trans adults living in Brighton & Hove. The true figure is probably greater than this and it is likely that the number of trans people living in Brighton & Hove will rise as the City is seen as a trans-friendly and inclusive city which attracts people who have had negative experiences elsewhere. The Brighton & Hove Trans Needs Assessment 2015 reported that trans people are less likely to report that they are in good health and more likely to report that they have a limiting long-term illness or disability. As a result of the Trans Needs Assessment the specific Trans Advocacy service was commissioned. The Trans Advocacy service received 292 new referrals in 2017/18, an	Feedback from the Trans Advocacy service has been overwhelmingly positive with 100% of users recommending the service. Issues people are supported with include transphobia, problems with medical practitioners, housing, benefits, debt, suicide, substance misuse and issues at work. The engagement for the Advocacy Needs Assessment identified that for people using specialist LGBT or Trans advocacy services, it is important that they can access services without having to worry about the service provider being judgemental about their LGBT identity:	The Advocacy Hub will include specialist Trans advocacy provision that will have a positive impact on the trans community as it will offer a safe non-judgement space.	The Advocacy Hub to promote trans awareness across all services.

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	increase of 65% from the previous year. Trans people will also access the other statutory and non-statutory specialist community advocacy services. Data from 2017/18 shows that trans people accessed the physical disability service (7%) and the IMHA service (3%).	Peer advocacy was also valued for this feeling of being able to communicate about concerns and problems whilst knowing the space was ‘safe’. Safety was a significant factor for Trans people using health and social care services, dealing with GPs in particular.		
Pregnancy and maternity[17]	No specific data has been collected on this group.			
Race/ethnicity[18] Including migrants, refugees and asylum seekers	Needs Assessment 2017: At the time of the 2011 Census in Brighton & Hove: • 11% of households had at least one person for whom English was not their first language. • There were almost 6,000 households in the city where no-one has English as a main language, and this percentage (4.9%) is higher than both the South East and England (3.1% and 4.4%).	There was little participation in the engagement for the Needs Assessment from the local Black and minority ethnic community groups that are most well-known in the city. An engagement event was held with 8 participants from the BAME community	The Advocacy Hub will ensure access to interpreters and provide access to bilingual advocates that will have a positive impact on the BAME community.	The Advocacy Hub to ensure access to interpreters is available within all of the service provision and raise awareness of the importance of interpreting and translation amongst other services to prevent the need for advocacy. The Advocacy Hub to monitor access by BAME

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	• The three most commonly spoken languages after English were Arabic, Polish and Spanish. All of the advocacy services have targets for reaching the BAME population and the majority have exceeded these targets indicating that excluded groups are accessing advocacy: • IMHA – 31% • LGBT mental health community advocacy – 19% • Physical disability – 23% • Learning disability – 8% • Older people – 11% People may however have a need for advocacy services which are made more complex by an additional need for language support. From December 2014 for 3 years Brighton & Hove Clinical Commissioning Group and the Council funded a Bilingual Advocacy Project for those with both advocacy and language needs. Bilingual advocates supported vulnerable and isolated service users who also have a	and they told us that they need: • Support with housing, medical / health issues, sourcing and navigating services • Someone who can advocate and interpret rather than 2 people • Peer and group advocacy options to support each other • Central point of access, clear info and a range of communication methods eg text, email, messages in languages Engagement with Black, Asian and Minority Ethnic (BAME) communities who use our advocacy service has also been sought via Survey Monkey – to be added.		community and engage with BAME organisations.

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	language need and supported 62 people in 2016/17. In addition the advocacy services have access to interpreters via their own service or where it is a statutory service the referrer should organise an interpreter. The Needs Assessment reviewed activity under the Bilingual Advocacy Project that may have alternatively been provided for by community specialist advocacy providers. In 2016/17 13% (10/77) of those receiving support were over the age of 65; 32% (46/77) had a disability; 1% was trans (1/77); 1% were LGB (1/77). There appears to have been little use of interpreters in the specialist community advocacy services and the number of interpreters used for IMHA and IMCA was not available. The Needs Assessment identified that this may indicate a gap in service provision of more specialist community advocacy support (outside of the Bilingual Advocacy project), to users with an additional language need.			

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
Religion or belief[19]	Data from the monitoring of the current advocacy providers shows that the majority of users identify as Christian or prefer not to say / no religion. There are a very small number of people who identify as Muslim, Buddhist or Jewish.	There is some evidence of advocates supporting people in care homes to have more access to opportunities to practice their religion that has been effective.	One of the outcomes for the provider(s) of the Advocacy Hub is to improve access for people to communities and networks and this will include religion and belief.	The Advocacy Hub to make links with a broad range of community organisations and groups to make them aware of advocacy services. .
Sex/Gender[20]	The majority of the advocacy services have a slightly higher proportion of females to males using the service (54-58% female to 42-45% male) with the exceptions of the LGBT service that supported 22% females, 41% males and 12 other and the service that supports parents with learning disabilities supported 84% females, 8% males and 8% prefer not to say.			
Sexual orientation[21]	Needs Assessment 2017: JSNA: There is no definitive research into the number of lesbian, gay, bisexual (LGB) people who live in the city and is 11% to 15% of the population aged 16 years or more and is similar to two recent representative surveys conducted across Brighton & Hove (Health Counts and City Tracker), where 11% of respondents identified themselves as lesbian, gay,	Within the Needs Assessment an important theme, especially for LGBT people using specialist LGBT or Trans advocacy services, was the lack of judgement they experienced from advocates. Several users of these advocacy services expressed how important it was that they	The Advocacy Hub will include specialist LGB advocacy provision that will have a positive impact on the LGB community as it will offer a safe space. Alternatively if people don't want the association with an LGB service they can access	The Advocacy Hub to promote LGBT awareness across all services.

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	bisexual, unsure or other sexual orientation. Lesbian, gay and bisexual (LGB) people are at higher risk than heterosexual people of bullying, abuse, discrimination and exclusion. LGB people are also at greater risk of mental disorder, substance misuse and dependence, self-harm and suicidal behaviour/ideation than heterosexual people. Socially isolated LGB people and those on a low income are more susceptible than others. In view of the above factors, the need for mental health advocacy may well be higher in LGB people than the general population and is provided as a service distinct from the specialist community service. However, people who are LGB also access the other specialist community services and in 2017/18 the percentage of LGB users were: • IMHA – 14% • Community mental health advocacy – 19% • Physical disability advocacy – 20% • Learning disability – 10%	could access services without having to worry about the service provider being judgemental about their LGBT identity: There was appreciation of the fact that such specialist services are available in the city and this wasn't common in other places people had lived in. Whilst some individuals felt compartmentalised by the separation of services by 'client group', as many also valued the specialist nature of some services – especially LGBT services.	other provision through the central point of access.	

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	• Older people – 2% In 2017/18 266 individuals in Brighton & Hove received advocacy from the specialist LGB community mental health (39% increase on the previous year).			
Marriage and civil partnership[22]	No specific data has been collected on this group			
Community Cohesion[23]	People who need advocacy services are more likely to feel isolated from their own or other communities.	People who use advocacy services report issues with neighbour disputes, bullying and harassment and discrimination in many areas of life. People report feeling very isolated and alone.	The Advocacy Hub will play an important role in ensuring that individuals are more independent, have increased confidence, increased access to communities and networks, increased knowledge and feel more able to use health and care processes and services. An integrated service .	Advocates can only link people in to services that exist already so it is crucial that the Advocacy Hub provides feedback to services about where the gaps in service are and how they can improve access to help prevent the need for advocacy.
Other relevant groups[24]	If any of the following groups have difficulty accessing support because of the reasons outlined above they would be able to access advocacy services: Carers, people experiencing domestic	There has been no specific engagement with these groups of people but within the Advocacy Needs Assessment 2017;	The Advocacy Hub will have a positive impact on people who are vulnerable but don't necessarily fit neatly	The Advocacy Hub to make links with organisations that support other vulnerable groups.

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
	and/or sexual violence, substance misuse, homeless people & ex-armed forces personnel	6 people had substance misuse issues, 2 had been homeless and 1 person had experienced domestic violence.	within the current model of client group provision.	
Cumulative impact[25]	The Needs Assessment identified issues that cut across all client groups and advocacy providers. Further analysis of the equalities monitoring of the advocacy services shows that there are high levels of multiple need within services.	Needs Assessment 2017: Many interviewees were, or had been, involved in disability benefits re-assessment (including Disability Living Allowance, now called Personal Independence Payments) and had needed an advocate to support them to get through this assessment process. Most found the benefits system incomprehensible and described their experiences of being challenged about the legitimacy of their claims for benefits as ‘fright Housing was a dominant need that sat behind several of the other problems and difficulties individuals were	The Advocacy Hub will have a stronger voice in highlighting the changes that services could implement to make them more accessible to people.	The Advocacy Hub to give feedback to commissioners on improvements that could be made to the way that services are delivered to improve individuals’ experiences of them.

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
		experiencing. People are struggling with either Private Rented Sector landlords or the Council's housing services and systems. In addition people at every engagement event highlighted the complex health processes and pathways and difficulties accessing and understanding GP's.		

Assessment of overall impacts and any further recommendations[26]

There may be a small number of older people and people with physical disabilities who are impacted by the recommended removal of specialist older people's and physical disability advocacy services. The decision, has however been influenced by feedback from advocacy users and referrers who find the current configuration impacts negatively on these groups. Older people don't necessarily want to be badged as 'older' and want support with specific issues or due to a mental health impairment and the demand is currently less than expected. Physical disabilities cuts across all of the services with 20% of the non-physical disability specialist services reporting that their users also have a disability. Referrers report not knowing where to refer when someone has multiple conditions so a single point of access with issue based advocacy for any type of advocacy will help to alleviate this. Also people with hearing impairments do not feel represented by a physical disability organisation and have asked for specific deaf advocacy.

An Advocacy Hub with a lead provider has also been recommended as the best solution as there will be a reduction in funding from April 2019. The total funding for advocacy in Brighton & Hove is currently £648,367 but will reduce to a maximum of £577,557 (a reduction of

Protected characteristics groups from the Equality Act 2010	**What do you know[10]?** Summary of data about your service-users and/or staff	**What do people tell you[11]?** Summary of service-user and/or staff feedback	**What does this mean[12]?** Impacts identified from data and feedback (actual and potential)	**What can you do[13]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
£70,810). The CCG are removing £50,000 from community advocacy services and redirecting it to a Navigation role in the Mental Health Support Services and as there is currently some duplication in mental health and learning disability community advocacy across the different contracts, administrative and management savings are expected with the proposed lead provider model (£20,810). By working in partnership with East and West Sussex there will be further economies of scale that will enable extra capacity to cope with the predicted increase in demand. The feedback from the engagement with people who provide, refer to and use advocacy services will be used to develop the service specification for the new service.				

4. List detailed data and/or community feedback that informed your EIA

Title (of data, research or engagement)	**Date**	**Gaps in data**	**Actions to fill these gaps: who else do you need to engage with?** (add these to the Action Plan below, with a timeframe)
Adults Advocacy Needs Assessment 2017 Engagement carried out with users of advocacy services who: • Have learning disabilities • Have mental health issues • Have physical and sensory disabilities • Are lesbian, gay, bisexual or trans • Have substance misuse issues	**September 2017**	Older people Black, Asian and Minority Ethnic (BAME) communities Autistic people People with hearing impairments Parents with learning disabilities	Further engagement carried out – listed below.

Engagement events were facilitated by the Commissioning & Performance Team Focus groups took place with: • Older people • Black, Asian and Minority Ethnic (BAME) communities • Autistic people • People with hearing impairments • Parents with learning disabilities	**April – June 2018**		

5. Prioritised Action Plan[27]

Impact identified and group(s) affected	**Action planned**	**Expected outcome**	**Measure of success**	**Timeframe**
NB: These actions must now be transferred to service or business plans and monitored to ensure they achieve the outcomes identified.				
Older people no longer have access to a specialist older people's service.	**The new service will be for all adults including over 65+**	**Older people continue to receive issue based advocacy**	**The total number of older people receiving advocacy increases and their outcomes are met.**	**By 31st March 2020**
People with physical disabilities no longer have access to a specialist physical disabilities service.	**The new service will be for all adults including those with physical disabilities and multiple health conditions.** **The new service will provide specific deaf advocacy.**	**Disabled people continue to receive issue based advocacy.** **Deaf people receive more appropriate advocacy provision.**	**The number of people with physical disabilities using the Advocacy Hub report easier access to the service and outcomes are met.** **The number of people with hearing and visual impairments receiving advocacy provision increases and their**	**By 31st March 2020**

			outcomes are met.	
Reduction in funding for advocacy of £70,810 will have an impact on the community advocacy as it is not a statutory function.	**The lead provider model will ensure greater economies of scale and less duplication of services.** **Community advocacy numbers will be ringfenced to ensure it is still a priority.**	**Community advocacy still available to service users.**	**The target for the number of people supported with community advocacy is met and people report that their outcomes are met.**	**By 31st March 2020**

EIA sign-off: (for the EIA to be final an email must sent from the relevant people agreeing it or this section must be signed)

Staff member completing Equality Impact Assessment: Anne Richardson-Locke **Date:** 29.05.18

Directorate Management Team rep or Head of Service/Commissioning: Andy Witham **Date:**

CCG or BHCC Equality lead: Sarah Tighe-Ford **Date:**

Guidance end-notes

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[1] The following principles, drawn from case law, explain what we must do to fulfil our duties under the Equality Act:

- **Knowledge:** everyone working for the council must be aware of our equality duties and apply them appropriately in their work.
- **Timeliness:** the duty applies at the time of considering policy options and/or before a final decision is taken – not afterwards.
- **Real Consideration:** the duty must be an integral and rigorous part of your decision-making and influence the process.
- **Sufficient Information:** you must assess what information you have and what is needed to give proper consideration.
- **No delegation:** the council is responsible for ensuring that any contracted services which provide services on our behalf can comply with the duty, are required in contracts to comply with it, and do comply in practice. It is a duty that cannot be delegated.
- **Review:** the equality duty is a continuing duty. It applies when a policy is developed/agreed, and when it is implemented/reviewed.
- **Proper Record Keeping:** to show that we have fulfilled our duties we must keep records of the process and the impacts identified.

NB: Filling out this EIA in itself does not meet the requirements of the equality duty. All the requirements above must be fulfilled or the EIA (and any decision based on it) may be open to challenge. Properly used, an EIA can be a tool to help us comply with our equality duty and as a record that to demonstrate that we have done so.

[2] **Our duties in the Equality Act 2010**
As a public sector organisation, we have a legal duty (under the Equality Act 2010) to show that we have identified and considered the impact and potential impact of our activities on all people with ‘protected characteristics’ (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation, and marriage and civil partnership).

This applies to policies, services (including commissioned services), and our employees. The level of detail of this consideration will depend on what you are assessing, who it might affect, those groups’ vulnerability, and how serious any potential impacts might be. We use this EIA template to complete this process and evidence our consideration.

The following are the duties in the Act. You must give ‘due regard’ (pay conscious attention) to the need to:

- **avoid, reduce or minimise negative impact** (if you identify unlawful discrimination, including victimisation and harassment, you must stop the action and take advice immediately).
- **promote equality of opportunity**. This means the need to:
  - Remove or minimise disadvantages suffered by equality groups
  - Take steps to meet the needs of equality groups
  - Encourage equality groups to participate in public life or any other activity where participation is disproportionately low
  - Consider if there is a need to treat disabled people differently, including more favourable treatment where necessary
- **foster good relations between people who share a protected characteristic and those who do not**. This means:
  - Tackle prejudice
  - Promote understanding

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[3] EIAs are always proportionate to:

- The size of the service or scope of the policy/strategy
- The resources involved
- The numbers of people affected
- The size of the likely impact
- The vulnerability of the people affected

The greater the potential adverse impact of the proposed policy on a protected group (e.g. disabled people), the more vulnerable the group in the context being considered, the more thorough and demanding the process required by the Act will be.

[4] **When to complete an EIA**:

- When planning or developing a new service, policy or strategy
- When reviewing an existing service, policy or strategy
- When ending or substantially changing a service, policy or strategy
- When there is an important change in the service, policy or strategy, or in the city (eg: a change in population), or at a national level (eg: a change of legislation)

Assessment of equality impact can be evidenced as part of the process of reviewing or needs assessment or strategy development or consultation or planning. It does not have to be on this template, but must be documented. Wherever possible, build the EIA into your usual planning/review processes.

Do you need to complete an EIA? Consider:

- Is the policy, decision or service likely to be relevant to any people because of their protected characteristics?
- How many people is it likely to affect?
- How significant are its impacts?
- Does it relate to an area where there are known inequalities?
- How vulnerable are the people (potentially) affected?

If there are potential impacts on people but you decide not to complete an EIA it is usually sensible to document why.

[5] **Title of EIA:** This should clearly explain what service / policy / strategy / change you are assessing

[6] **ID no:** The unique reference for this EIA. If in doubt contact your CCG or BHCC equality lead (see page 1)

[7] **Team/Department:** Main team responsible for the policy, practice, service or function being assessed

[8] **Focus of EIA:** A member of the public should have a good understanding of the policy or service and any proposals after reading this section. Please use plain English and write any acronyms in full first time - eg: ‘Equality Impact Assessment (EIA)’

This section should explain what you are assessing:

- What are the main aims or purpose of the policy, practice, service or function?
- Who implements, carries out or delivers the policy, practice, service or function? Please state where this is more than one person/team/body and where other organisations deliver under procurement or partnership arrangements.
- How does it fit with other services?
- Who is affected by the policy, practice, service or function, or by how it is delivered? Who are the external and internal service-users, groups, or communities?
- What outcomes do you want to achieve, why and for whom? Eg: what do you want to provide, what changes or improvements, and what should the benefits be?
- What do existing or previous inspections of the policy, practice, service or function tell you?
- What is the reason for the proposal or change (financial, service, legal etc)? The Act requires us to make these clear.

[9] **Previous actions:** If there is no previous EIA or this assessment if of a new service, then simply write ‘not applicable’.

[10] **Data:** Make sure you have enough data to inform your EIA.

- What data relevant to the impact on protected groups of the policy/decision/service is available?[10]
- What further evidence is needed and how can you get it? (Eg: further research or engagement with the affected groups).
- What do you already know about needs, access and outcomes? Focus on each of the protected characteristics in turn. Eg: who uses the service? Who doesn’t and why? Are there differences in outcomes? Why?
- Have there been any important demographic changes or trends locally? What might they mean for the service or function?
- Does data/monitoring show that any policies or practices create particular problems or difficulties for any groups?
- Do any equality objectives already exist? What is current performance like against them?
- Is the service having a positive or negative effect on particular people in the community, or particular groups or communities?
- Use local sources of data (eg: JSNA: http://www.bhconnected.org.uk/content/needs-assessments and Community Insight: http://brighton-hove.communityinsight.org/#) and national ones where they are relevant.

[11] **Engagement:** You must engage appropriately with those likely to be affected to fulfil the equality duty.

- What do people tell you about the services?
- Are there patterns or differences in what people from different groups tell you?
- What information or data will you need from communities?
- How should people be consulted? Consider:
  (a) consult when proposals are still at a formative stage;
  (b) explain what is proposed and why, to allow intelligent consideration and response;
  (c) allow enough time for consultation;
  (d) make sure what people tell you is properly considered in the final decision.

- Try to consult in ways that ensure all perspectives can be considered.
- Identify any gaps in who has been consulted and identify ways to address this.

[12] Your EIA must get to grips fully and properly with actual and potential impacts.

- The equality duty does not stop decisions or changes, but means we must conscientiously and deliberately confront the anticipated impacts on people.
- Be realistic: don’t exaggerate speculative risks and negative impacts.
- Be detailed and specific so decision-makers have a concrete sense of potential effects. Instead of “the policy is likely to disadvantage older women”, say how many or what percentage are likely to be affected, how, and to what extent.
- Questions to ask when assessing impacts depend on the context. Examples:
    - Are one or more protected groups affected differently and/or disadvantaged? How, and to what extent?
    - Is there evidence of higher/lower uptake among different groups? Which, and to what extent?
    - If there are likely to be different impacts on different groups, is that consistent with the overall objective?
    - If there is negative differential impact, how can you minimise that while taking into account your overall aims
    - Do the effects amount to unlawful discrimination? If so the plan must be modified.
    - Does the proposal advance equality of opportunity and/or foster good relations? If not, could it?

[13] Consider all three aims of the Act: removing barriers, and also identifying positive actions we can take.

- Where you have identified impacts you must state what actions will be taken to remove, reduce or avoid any negative impacts and maximise any positive impacts or advance equality of opportunity.
- Be specific and detailed and explain how far these actions are expected to improve the negative impacts.
- If mitigating measures are contemplated, explain clearly what the measures are, and the extent to which they can be expected to reduce / remove the adverse effects identified.
- An EIA which has attempted to airbrush the facts is an EIA that is vulnerable to challenge.

[14] **Age**: People of all ages

[15] **Disability**: A person is disabled if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. The definition includes: sensory impairments, impairments with fluctuating or recurring effects, progressive, organ specific, developmental, learning difficulties, mental health conditions and mental illnesses, produced by injury to the body or brain. Persons with cancer, multiple sclerosis or HIV infection are all now deemed to be disabled persons from the point of diagnosis.

[16] **Gender Reassignment:** In the Act a transgender person is someone who proposes to, starts or has completed a process to change his or her gender. A person does not need to be under medical supervision to be protected

[17] **Pregnancy and Maternity:** Protection is during pregnancy and any statutory maternity leave to which the woman is entitled.

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[18] **Race/Ethnicity:** This includes ethnic or national origins, colour or nationality, and includes refugees and migrants, and Gypsies and Travellers. Refugees and migrants means people whose intention is to stay in the UK for at least twelve months (excluding visitors, short term students or tourists). This definition includes asylum seekers; voluntary and involuntary migrants; people who are undocumented; and the children of migrants, even if they were born in the UK.

[19] **Religion and Belief:** Religion includes any religion with a clear structure and belief system. Belief means any religious or philosophical belief. The Act also covers lack of religion or belief.

[20] **Sex/Gender:** Both men and women are covered under the Act.

[21] **Sexual Orientation:** The Act protects bisexual, gay, heterosexual and lesbian people

[22] **Marriage and Civil Partnership:** Only in relation to due regard to the need to eliminate discrimination.

[23] **Community Cohesion:** What must happen in all communities to enable different groups of people to get on well together.

[24] **Other relevant groups:** eg: Carers, people experiencing domestic and/or sexual violence, substance misusers, homeless people, looked after children, ex-armed forces personnel, people on the Autistic spectrum etc

[25] **Cumulative Impact:** This is an impact that appears when you consider services or activities together. A change or activity in one area may create an impact somewhere else

[26] **Assessment of overall impacts and any further recommendations**

- Make a frank and realistic assessment of the overall extent to which the negative impacts can be reduced or avoided by the mitigating measures. Explain what positive impacts will result from the actions and how you can make the most of these.
- Countervailing considerations: These may include the reasons behind the formulation of the policy, the benefits it is expected to deliver, budget reductions, the need to avert a graver crisis by introducing a policy now and not later, and so on. The weight of these factors <u>in favour of</u> implementing the policy must then be measured <u>against</u> the weight of any evidence as to the potential negative equality impacts of the policy.
- Are there any further recommendations? Is further engagement needed? Is more research or monitoring needed? Does there need to be a change in the proposal itself?

[27] **Action Planning:** The Equality Duty is an ongoing duty: policies must be kept under review, continuing to give ‘due regard’ to the duty. If an assessment of a broad proposal leads to more specific proposals, then further equality assessment and consultation are needed.

Item 12

Although a formal committee of Brighton & Hove 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 Adults and Healthwatch.

Title:	**Commissioning a Brighton & Hove Ageing Well Service**	
Date of Meeting:	12 June 2018	
Report of:	Executive Director, Health & Adult Social Care	
Contact:	David Brindley	Tel: 01273 291083
Email:	David.brindley@Brighton-hove.gov.uk	
Wards Affected:	All	

FOR GENERAL RELEASE

Executive Summary

The aim of this paper is to set out a proposal for the commissioning of a citywide ‘Ageing Well Service’, and, to seek approval from the Health & Wellbeing Board to go to tender for the new service in September 2018.

The Ageing Well Service will focus on: reducing social isolation and loneliness, promoting good health and wellbeing, preventing ill health, and enabling people to remain independent for as long as possible.

The service will be citywide and open to anyone aged 50+ but will target those older people who are identified as being most at risk of a decline in their independence and wellbeing.

This service has the potential to deliver an innovative model of preventative delivery for ageing well in Brighton & Hove, and offer a best practice model for joint health & social care commissioning, whilst also delivering efficiency savings.

Glossary of Terms
BHCC – Brighton & Hove City Council
CCG – Brighton & Hove Clinical Commissioning Group
ASC – Adult Social Care
PH – Public Health
HASC – Health & Social Care
AWS – Ageing Well Service
NICE – National Institute for Health and Care Excellence

1. Decisions, recommendations and any options

1.1 That the Board grants delegated authority to the Executive Director of Health & Adult Social Care to carry out the procurement and award of a contract for a Brighton & Hove Ageing Well Service with a term of four years.

1.2 That the Board delegates authority to the Executive Director of Health & Adult Social Care to extend the contract at the end of the four year term for a further period of up to two years if it is deemed appropriate and subject to available budget.

2. Relevant information

2.1 Context:

2.2 By 2030 there will be an estimated 103,000 people aged 50+ years living in Brighton & Hove – an increase of 24%

2.3 The numbers of people in the city aged 65+ will increase by 30%

2.4 Brighton & Hove has a relatively large proportion of older people living alone, and, in income deprivation

2.5 Health related quality of life is poorer for older people in the city than in any of our neighbouring authorities, and out of 67 district and unitary authorities in the South-East Brighton & Hove is ranked 9th worst

2.6 Growing old is not the same as growing infirm and people can take some control over their ageing

2.7 Primary prevention is cost-effective and can prevent or delay first entry into the Health and Social Care System

2.8 Current services:

2.9 Since April 2014 health promotion and wellbeing activities for older people have been commissioned in locality hub areas across the city. Using a commissioning prospectus, partnerships of local organisations were commissioned to work together in locality areas or hubs to provide a mix of community based activities and interests, befriending services, and building based group and 1:1 activities. There are eight provider organisations working across three hub areas; East, West and Central.

2.10 Overall the programme has delivered well but there remain areas of the city where provision is relatively inaccessible and support fragmented.

2.11 Initial contracts were entered into for three years but waivers have been granted allowing the contracts to be extended to 31 March 2019. The programme has always been jointly funded by the Council and the CCG, although the proportions have changed over time and the overall programme budget has reduced.

2.12 Running alongside the above are three other contracted services which address the health & wellbeing of older people and which will be assimilated into the new proposed service. These are for:

- Befriending
- Information and advice
- Community Transport

2.13 There are eleven provider organisations affected by this proposal (*appendix 1)* and all current contracts will end on March 31st 2019

2.14 The providers have all been fully engaged and informed of this process and have had 1:1 meetings with the commissioner during Feb/March this year to discuss the proposal and to confirm that their contract will end on the above date (appendix 2).

3.1 Proposal:

3.2 We are now proposing a new model, and will tender for an integrated 'Ageing Well Service' for Brighton & Hove to start delivery on 1 April 2019.

3.3 The AWS will focus on the following outcomes: reducing social isolation and loneliness, promoting good health and wellbeing, preventing ill health, and enabling people to remain independent for as long as possible.

3.4 The service will be open to anyone aged 50+ but will target those older people who are identified as being most at risk of a decline in their independence and wellbeing.

3.5 The service will deliver innovative primary prevention to support people to age well in Brighton & Hove, and, offer a best practice model for joint health & social care commissioning, whilst also delivering efficiency savings. The recommission will bring together a large number of separately funded contracts and allow for more effective commissioning and contract management.

4.1 The new service will:

4.2 Be delivered by a partnership (of providers) with a lead provider, all working under a single contract, to deliver an integrated service of primary prevention to people aged 50+.

4.3 Be delivered citywide with a focus on:

- areas of the city with a greater concentration of older people living alone
- areas with higher levels of deprivation
- Responding to the diverse demographics of our older population e.g. LGBT and BAME older people

4.4 Have a single point of contact (SPOC) which is accessible to both professionals and members of the public. The SPOC will offer signposting, information and guidance on the range of activities available and support to access them, including transport provision.

4.5 Reduce pressure on health and social care services by working upstream to:

- Keep people well and independent and prevent or delay first entry into the health & social care system, and,
- Prevent or delay decline in those people already in receipt of services.

4.6 Offer a range of evidence based activities - recommended by NICE https://www.nice.org.uk/guidance/ng32 - which will support the health & wellbeing outcomes. This includes the provision of group and one-to-one activities such as:

- Singing programmes
- Arts and crafts and other creative activities.

- Tailored, community-based physical activity programmes including strength and balance to reduce the risk of falling

- Intergenerational activities involving; for example, older people helping with reading in schools or young people providing older people with support to use new technologies.

- Multicomponent activities. For example, lunch with the opportunity to socialise and learn a new craft or skill in a community venue.

- Citywide volunteer befriending

- Programmes to help people develop and maintain friendships. For example, peer mentoring programmes, and programmes to learn about how to make and sustain friendships

4.7 Build community capacity for prevention and early intervention, utilising the substantial assets of older people in our city through engagement and co-production of activities, and provision of regular volunteering opportunities within the service.

4.8 Work alongside new models of care being developed around primary care and community support

4.9 Tackle the broad determinants of health in later life by demonstrating clear links, and access, to support for bereavement, financial insecurity, and housing tenure.

4.10 Proactively identify vulnerable older people and take positive action, linking with primary, secondary, and social care to ensure the service links into local pathways of support.

4.11 Act as a catalyst to community participation; bringing people into the service and then linking them up with, or back into, their wider communities.

4.12 Offer a clearly accessible information and advice service to older people, their families, and carers, which will support them to remain independent and well

4.13 Have an overarching branding for all activities whilst allowing individual providers to maintain their identity

4.14 Provide transport solutions to enable greater access to community activities.

4.15 Build on the best practice delivered by the existing providers, and address specific areas where they have not worked so well e.g. engaging BAME older people

5.1 Financial and other implications:

5.2 The value of the new contract will be £598,000 per year over a six year period, which represents a saving of £110,000 per year compared to existing funding.

5.3 The funding will come from BHCC public health (£398k) and the CCG (£200k)

5.4 Commissioners believe this proposal can offer a high level of social value and this is reflected in 25% of the ‘quality’ scoring being for social value.

5.5 in order to offer stability both to the service provider(s) and recipients we would like the contract duration to be six years (4 years + 2 years).

5.6 The provisional timetable for the procurement process is as follows:

Task	**Deadline**
Tender issued	3rd September
Tenders received back	October 26th
Evaluation / moderation	29th October – 14th November
Clarification / legal checking	15th November – 11th December
Contract award	12th December
Contract mobilisation	January - March
Contract start	April 2019

6. Important considerations and implications

Legal:

6.1 The council's Contract Standing Orders require that authority to enter into a contract valued at £500,000 or more be obtained from the relevant committee which in this case is the Health & Wellbeing Board.

6.2 This contract falls within Schedule 3 of the Public Contracts Regulations 2015 and is therefore classed as Light Touch. The value of the contract exceeds the threshold above which Light Touch Contracts are required to be advertised in the Official Journal of the European Union (OJEU). Therefore a Prior Information Notice or a Contract Notice must published in the OJEU setting out the process by which it is intended to award the contract.

6.3 The tender process must be conducted transparently and fairly to ensure equal treatment of those bidding for the contract.

6.4 To comply with Contract Standing Orders any contract awarded must be in the form approved by the Head of Law and executed as a deed under the common seal of the council

Lawyer consulted: Judith Fisher Date: 17 May 2018

Finance:

6.5 The proposal for the Brighton and Hove Ageing Well Service means that the new contract value will be £0.598m per year. This is made up of 398k public health and 200k from the CCG.

Tenders will be requested against an agreed service specification. Both BHCC & CCG are experiencing financial challenges and both organisations are subject to annual government financial settlements which can impact on the availability of funding. However it is anticipated that financial resources will be available to enable the commissioning of the service.

Finance Officer consulted: Sophie Warburton and Debra Crisp
Date: 30/05/2018

Equalities:

6.6 An EIA will follow this report and its findings will inform the recommissioning process, ensuring that weaknesses in previous provision (eg: engagement with BME older people, as highlighted in section 3.20 above) are addressed and that services appropriately identify and address the needs of older people who share one or more protected characteristics.

Supporting documents and information

Appendix1: List of current providers affected by this proposal

Provider	**Service**	**Lead Commissioner**
Somerset Day Centre	Locality Based Activities	BHCC
Volunteering Matters - Lifelines	Community Activities	BHCC
Trust for Developing Communities	Community Activities	BHCC
LGBT Switchboard	Community Activities	BHCC
Impact Initiatives	Locality Based Activities	BHCC
Hangleton & Knoll project	Locality Based Activities	BHCC
Impetus	Neighbourhood Care Scheme	BHCC
Possability People	Citywide Connect	BHCC
'Time to Talk Befriending'	Befriending Service	CCG
Age UK	Information & Advice	BHCC
Community Transport Ltd	Easylink shopping service and group hire of Minibuses	BHCC

Appendix 2: DRAFT Provider engagement report

Feedback report of the Ageing Well Service provider market engagement event - 14th May 2018

Introduction

Brighton and Hove public health and CCG Commissioners invited providers to attend a pre- tender engagement event on the 14th May 2018. Representatives from 27 providers (33 people) attended the event and were a mixture of local, regional and national organisations (details of the organisations are included in Appendix A).

Providers were given a presentation on the local context and the proposal to commission a new Ageing Well Service. This was supplemented by a presentation on the procurement process (all slides included in Appendix B).

Table top discussion groups then took place to discuss any issues and questions arising from the presentation. The commissioners also set the tables three questions to guide and trigger the discussions (Appendix C). The key questions and points raised are summarised in this report.

One attendee e-mailed a further set of questions following the event and gave permission for responses to be shared with all attendees. These questions and responses are included below:

Bidding process:

- Will a pre-qualification questionnaire (PQQ) be used as part of the procurement process?
    - **We will use the standard selection questionnaire (SSQ) which replaced the pre-qualification questionnaire (PQQ)**
- Can only the lead provider submit instead of all the subcontractors having to submit an SSQ?
    - **Only the lead provider has to submit via in-tend. There will be an SSQ document as part of the tender docs that the lead will need to share with their subcontractors and then upload all completed forms**
- The proposed timescale from tender going out to being returned is too tight – can this be reconsidered as four weeks is not long enough?
    - **This has been amended and the tender will now go out from September 3rd until October 26th**
- What is your proposed contract model for the Lead contractor/Provider?
    - **We will only contract with a lead provider**
- The presumption has been that your model will be Lead Provider/Contractor will receive all contract monies as opposed to the commissioner paying each service line by line within a lead contractor model. Can you confirm if this is an accurate reflection?
    - **Yes this is accurate**
- Will services not already commissioned be able to place/ or be part of any bids?
    - **Yes**
- Can more than one partnership bid?
    - **Yes**
- Will B&HCC/CCG bring partnerships together?
    - **No**
- What does Service Mobilisation mean?

    - **This is the time allocated following a procurement exercise before commencement of the service delivery**

Delivery:

- What are the minimum services that have to be delivered in terms of outcomes, people, hours, breadth of provision?
    - **This information will form part of the specification and will be in the tender documents**
- What is the commissioner’s matrix in terms of service, hours and outcomes and what proportion of contract allocation do you envisage applied to each service line within the matrix?
    - **This information will form part of the specification and will be in the tender documents**
- Can you provide clarification over how many people are expected to come through the door?
    - **This information will form part of the specification and will be in the tender documents**
- Which areas/groups will the delivery focus on?
    - **areas of the city with a greater concentration of older people living alone**
    - **areas with higher levels of deprivation**
    - **Responding to the diverse demographics of our older population e.g. LGBT and BAME older people**
- What % of delivery is targeted and how much is generic?
    - **This information will form part of the specification and will be in the tender documents**
- Will there be defined resource allocation from the commissioners to each element of the partnership delivery? this would start to identify how resource should be prioritised as we move forward in developing our local offers and help us with the on ground prioritisation
    - **In response to feedback commissioners are considering options for resource allocation to different elements of delivery. This may be ring fenced elements of the budget or a suggested proportion of delivery for some elements. This information will form part of the specification and will be in the tender documents**
- Will the Older People’s festival funding will be included?
    - **We will be asking the service to run an annual older people’s festival to coincide with International Older Peoples day**

Contract/service specification:

- Question about the move from grants to a contract – Has thought been made as to what the total capital might be? The query centred on cash flow implications for organisations (e.g. will money be in advance/how will the contract model impact on organisations?)
    - **The intention is to pay the lead provider monthly in arrears. This information will form part of the draft terms and conditions, and will be in the tender documents**

- Will the contract be divisible by service line and therefore if one sub contracted element fails there is scope for an improvement and escalation model, within the partnership and ultimately back to commissioners allowing them to recall/re-tender that service line element **OR** is your proposal that the Lead Provider will be fully accountable and liable in terms of full

contractual liability and risk. The former enables protective measures for commissioner, the collective of providers and the Lead Provider whereas the latter is significantly more risk for the Lead Provider but also leaves sub –contractors open to penalty charging by the Lead Provider – at a large scale this model became an element of the Carillion failure so there is a public accountability duty to have clarity around this notwithstanding this contract is smaller than Carillion's programmes.
    - **It will be the responsibility of the lead provider to set up contracts with sub-contracted partners**
- What is the proposed working capital cycle associated with this contract? This will impact the required cash flow of Lead provider and sub-contractors. Will it be the same working capital cycle for the full annual allocation or will it alter by service within the contract?
    - **The intention is to pay the lead provider monthly in arrears. This information will form part of the draft terms and conditions, and will be in the tender documents**
- Given the "new" service includes an over-all funding reduction, is your expectation of a proportionate % cut by existing service line or an entirely new model? And within this do commissioners have specific views around value and funding allocation/cut for all/any specific element e.g. transport, befriending, I&A, building based services?
    - **We are commissioning for a new model. We are considering how we might allocate specific funding or % of delivery to some elements of the programme based on provider feedback and this information will be in the specification and tender documents**
- What will be the termination terms for Lead Provider/Contractor and sub-contractors and will there be a penalty attached for early termination?
    - **This information will form part of the draft terms and conditions, and will be in the tender documents**
- What is the proposed indemnification elements of the contract for the Lead provider, particularly against loss
    - **This information will form part of the draft terms and conditions, and will be in the tender documents**

Transport:

- There is a need for greater clarity around exactly what is needed and what exists
- Who has transport already and how it is used?
- How is transport coordinated?
- Will there be a set ringed fenced amount for transport? Bidders would like an indication of how much of the model should be focused on transport
- Clarity required over what transport requirements are (e.g. level of community transport?) Concerns that this is a large area to take on, therefore it might be helpful for BHCC to understand what they need first?
    - **It is clear in local feedback from both providers and from older people that transport (lack of and/or difficulty accessing) is the most significant barrier to older people being able to access health and wellbeing opportunities in their communities. We will be looking for innovative solutions from bidders and are considering whether to set a ring fenced amount of the budget for this purpose or set a 'rough guide' as to what proportion of delivery should be focussed on transport. This information will be in the specification and tender documents**

Comments on a Single Point of Contact (SPOC):

- Need to be transparent and open and look at nuts and bolts of process – a ‘no wrong doors approach’ & something that reduces barriers
- Discussion over low tech – should be straightforward for service users – ensure there is low tech option, but doesn’t have to be limited to only low tech
- Age range considerations with regards to tech & contract
- all partners involved
- Co-production
- Clarity around provision
- Matrix of provision
- Support to navigate the whole
- A single front door has to speak to breadth of diversity in the city
- It cannot inhibit the trusted relationships that already exist
- We can’t lose the trusted doors that exist
- Barriers to access is a big issue – the move to digital platforms has been a problem
- The SPOC should NOT be a website
- Affordability of access is an issue
- SPOC is not necessarily about structures – attitude /consistency / support: brand without losing identities
- We need to recognise how older people want to make connections / access
- If you aren’t going to put an indicative number on who comes through the single front door how are you going to assess value for money?
    - **Your feedback and comments on the SPOC are valued and will all be considered during development of the specification. We will be looking to the experience of bidders to suggest innovative solutions**

General questions and comments:

- What will be the level of input required for clients that are being “picked up” because no longer being assessed as in need via care act assessment?
    - **We do not expect the new service to carry out care act assessments. Any older person or their carer who may have care and support needs should contact Access Point, the contact centre for Adult Social Care, to ask for an assessment.**
- It is a very uncertain environment - hard to know what will happen with physical assets e.g. parks

For information: The Ageing Well Service proposal will go to the Health and Wellbeing Board on the 12th June 2018 for approval to go to tender.

Appendix A: Full list of provider organisations that attended the workshop

1. Possability People
2. Impact Initiatives
3. Age UK Brighton & Hove
4. Brighton & Hove Impetus
5. Volunteering Matters
6. Hangleton and Knoll Project
7. Somerset centre
8. LGBT Switchboard
9. Cranstoun
10. Albion in the Community
11. Brighton and Hove Food Partnership
12. Connect Health
13. T7 Technology
14. East Sussex Association Blind
15. Hilton Nursing Partners
16. Open Strings Music
17. Creative Future
18. Community Works
19. Trust for Developing Communities
20. Everyone Health
21. Brighton Housing Trust
22. Healthwatch
23. Time to Talk Befriending
24. Elder Abuse
25. British Red Cross
26. Arts Unwritten
27. Solutions 4 Health

Appendix B: Presentation to Providers Engagement Workshop

Appendix C: Table top discussion questions

NHS
Commissioning Alliance
Brighton and Hove CCG
Crawley CCG
High Weald Lewes Havens CCG
Horsham and Mid Sussex CCG

An Ageing Well Service for Brighton & Hove

David Brindley

Jane Lodge

Rachel Maddison

Brighton & Hove
City Council

Agenda

- 10.10 Introduction
- 10:15 **Brighton & Hove Ageing Well Service proposal** – presentation from commissioners
- 10.45 Procurement
- 11.00 Break
- 11.10 Table top discussions
- 11.40 Feedback
- 12.00 Close

Brighton & Hove City Council

Context 1

- The 65 years and over population is expected to increase from approx. 38,396 in 2018 to 50,100 people by 2030
- The highest proportion of older people aged 65 years and over in the city are living in Rottingdean Coastal (24%), Woodingdean (21%), and Patcham (19%)
- The lowest proportions are in St Peters and North Laine (6%), Hanover and Elm Grove (6%), Brunswick and Adelaide (8%), and Regency (8%)
- The highest proportion of pensioners living alone are found in Rottingdean Coastal and H &K wards (16%) and Queens Park (15%)
- Rottingdean Coastal (27.9%), Withdean (24%) and Hove Park (23.3%) have the highest proportion of carers aged 65 and over

Brighton & Hove
City Council

Context 2

- In 2015 20.3% of older people were living in income deprivation which is higher than both England and the South East
- The highest proportions of older people living in poverty are in Queens Park, East Brighton, and Brunswick and Adelaide - the lowest in Hove Park, Withdean, and Rottingdean Coastal
- In 2017 there were 9,835 people aged 65 and over with a limiting long term illness whose day to day activities were limited a little; this number is projected to increase by 3,000 by 2030
- Health related quality of life is poorer for older people in the city than in any of our neighboring authorities
- Growing old is not the same as growing infirm and people can take some control over their ageing

Current provision

- Since 2014 eight local organisations have been working together in locality areas; providing a mix of community and home based activities & interests, and building based day services for older people
- An additional programme was commissioned alongside to support and develop locality based working & engage wider partners

We also have…..

- Information & Advice
- Befriending partnership
- Community transport

All contracts expire on March 31st 2019

We are proposing a new model of delivery, and will tender for an integrated ’Ageing Well Service’

The service will:

- Offer health promotion & wellbeing support
- Be delivered citywide proportionate to need
- Focus on reducing social isolation and loneliness, promoting good health and wellbeing, preventing ill health, and enabling people to remain independent for as long as possible.
- Be open to anyone aged 50+ but will target older people identified as being most at risk of a decline in their independence and wellbeing
- Act as a catalyst to community participation
- Maximise existing community assets including use of green and outdoor spaces

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Ageing Well Service

The service will:

- Be delivered by a partnership with a lead provider/contractor working under a single contract
- Have one front door for a consistent offer across the city
- Provide transport provision **&** outreach activity
- Provide information & advice
- Provide routine identification of vulnerable older people – falls, fuel poverty, malnutrition & carers
- Build strong links with primary, secondary, and social care linking with the above
- Support action on the broader determinants of health
- Build community capacity

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The Ageing Well Service

The service will offer:

- Opportunities for genuine co-production
- Arts and cultural activities
- Tailored physical activity programmes - including strength and balance to reduce the risk of falling
- Intergenerational activities
- Multicomponent activities - such as lunch with the opportunity to socialise and learn a new craft or skill
- An all ages (adult) befriending service
- Peer mentoring
- Volunteering opportunities

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Drivers

- There is less funding available – the public health ring fenced grant is £0.5m less in 19/20
- Public health issues are ‘wicked’ issues – they cannot easily be solved by one organisation or partner alone
- Current provision is sometimes fragmented creating gaps in provision – aiming for a more integrated and ‘joined up’ service
- Local evidence that prime contract/provider model is proving to be effective
- A partnership under one contract can create economies of scale

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Evidence

- Joint Strategic Needs Assessment http://www.bhconnected.org.uk/content/needs-assessments
- Equality Impact Assessment – being refreshed
- National Institute of Health and Care Excellence https://www.nice.org.uk/guidance/ng32

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Engagement

- Independent engagement as part of JSNA
- Early engagement with the current providers
- Engagement with current and potential providers today
- BHCC & CCG Integration Board
- BHCC Procurement Advisory Board
- Brighton & Hove Caring Together
- Public Health England South East Network

Brighton & Hove City Council

Procurement timetable

Task	Length	Date(s)
Health & Wellbeing Board	n/a	12/06/18
Tender out	1 month	04/09/18
Tender back	n/a	03/10/18
Evaluation (individual)	2 weeks	18/10/18
Moderation and clarification	1 month	21/11/18
Contract award and standstill period	2 weeks	November - December
Mobilisation	3 months	January - March
Contract start	n/a	01/04/19

Brighton & Hove City Council

Budget

- In order to offer stability both to service provider(s) and service recipients we would like the contract duration to be six years (4 years + 2 years)
- The maximum value of the new contract therefore will be £3,580,000 over a six year period (£598k pa)
- The quality/cost split for scoring will be 80/20
- Commissioners believe this proposal can offer a high level of social value and this is reflected in 25% of the 'quality' scoring being for social value

Table top discussion

Q1. Single point of contact– how do we provide a one stop shop without losing specialist provision & identity?

Q2.

Q4. Single provider v partnership with lead provider?

Table top discussion

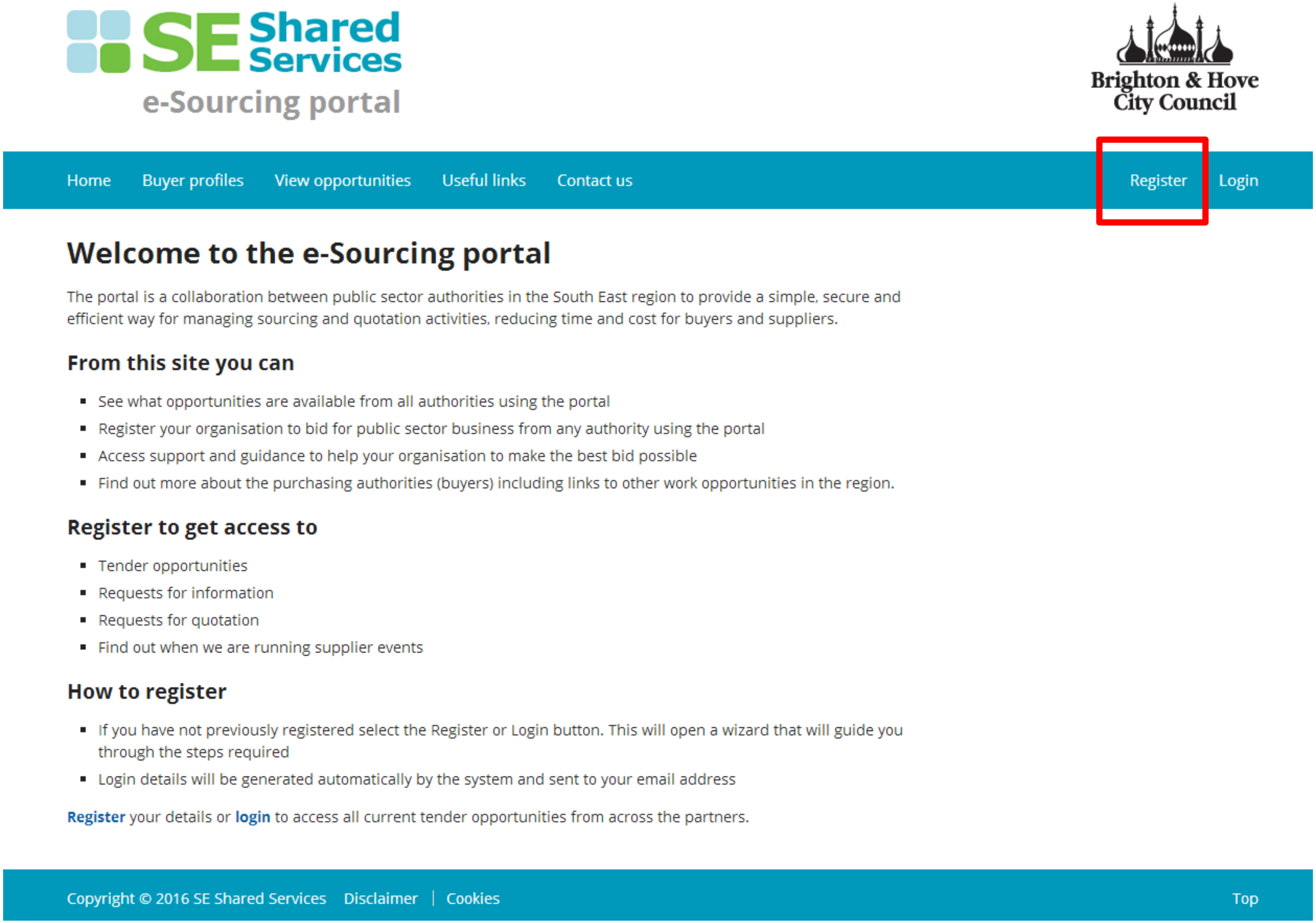
Widowed older homeowners living alone with long-term health conditions	**Unmarried, middle-agers, with long-term health conditions**
Older widowed homeowners who live alone and have long-term health conditions were particularly likely to report feeling lonely more frequently. On further examination, people in this group were predominantly: • female • not in paid work and economically inactive; given their age likely to be retired • better-off financially than the sample average; • as well as being homeowners, 62% of this group live in the 50% least deprived areas	At even greater risk of feeling lonely more often were unmarried middle-agers also with long-term health conditions. Further examination of this group showed that they tended to be: • less likely to be in paid work • more likely to be unemployed or economically inactive • much more likely to report a long-term illness or disability described as "limiting" • worse off financially than the sample average; 69% of this group live in the 50% most deprived areas

Procurement

- The application process will be online
- Register as soon as possible on the South east Shared Service Procurement Portal

https://www.sesharedservices.org.uk/esourcing

South East Shared Services



Welcome to the e-Sourcing portal

The portal is a collaboration between public sector authorities in the South East region to provide a simple, secure and efficient way for managing sourcing and quotation activities, reducing time and cost for buyers and suppliers.

From this site you can

- See what opportunities are available from all authorities using the portal
- Register your organisation to bid for public sector business from any authority using the portal
- Access support and guidance to help your organisation to make the best bid possible
- Find out more about the purchasing authorities (buyers) including links to other work opportunities in the region.

Register to get access to

- Tender opportunities
- Requests for information
- Requests for quotation
- Find out when we are running supplier events

How to register

- If you have not previously registered select the Register or Login button. This will open a wizard that will guide you through the steps required
- Login details will be generated automatically by the system and sent to your email address

Register your details or **login** to access all current tender opportunities from across the partners.

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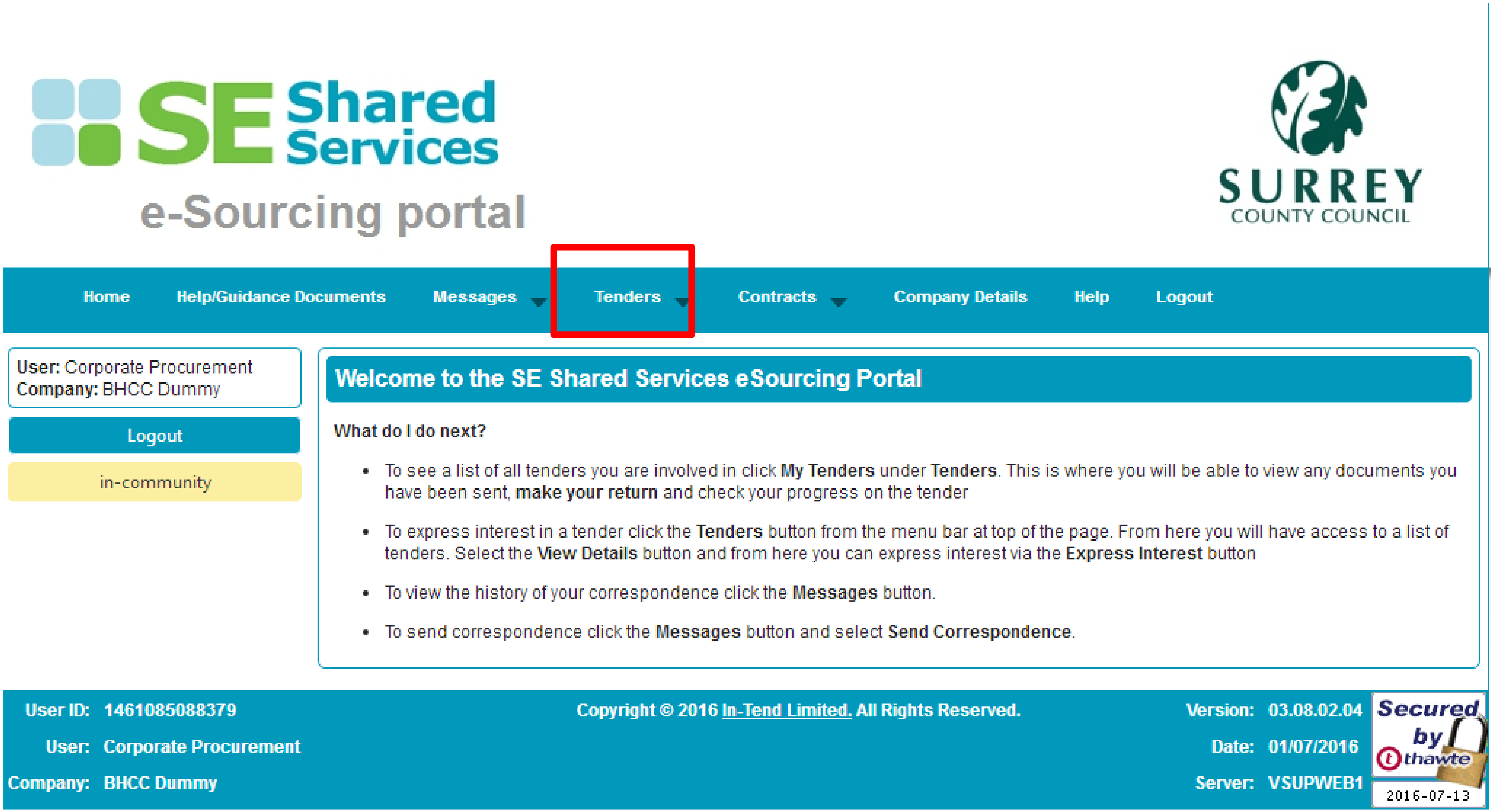
South East Shared Services



User: Corporate Procurement
Company: BHCC Dummy

Welcome to the SE Shared Services eSourcing Portal

What do I do next?

- To see a list of all tenders you are involved in click **My Tenders** under **Tenders**. This is where you will be able to view any documents you have been sent, **make your return** and check your progress on the tender
- To express interest in a tender click the **Tenders** button from the menu bar at top of the page. From here you will have access to a list of tenders. Select the **View Details** button and from here you can express interest via the **Express Interest** button
- To view the history of your correspondence click the **Messages** button.
- To send correspondence click the **Messages** button and select **Send Correspondence**.

User ID: 1461085088379
User: Corporate Procurement
Company: BHCC Dummy

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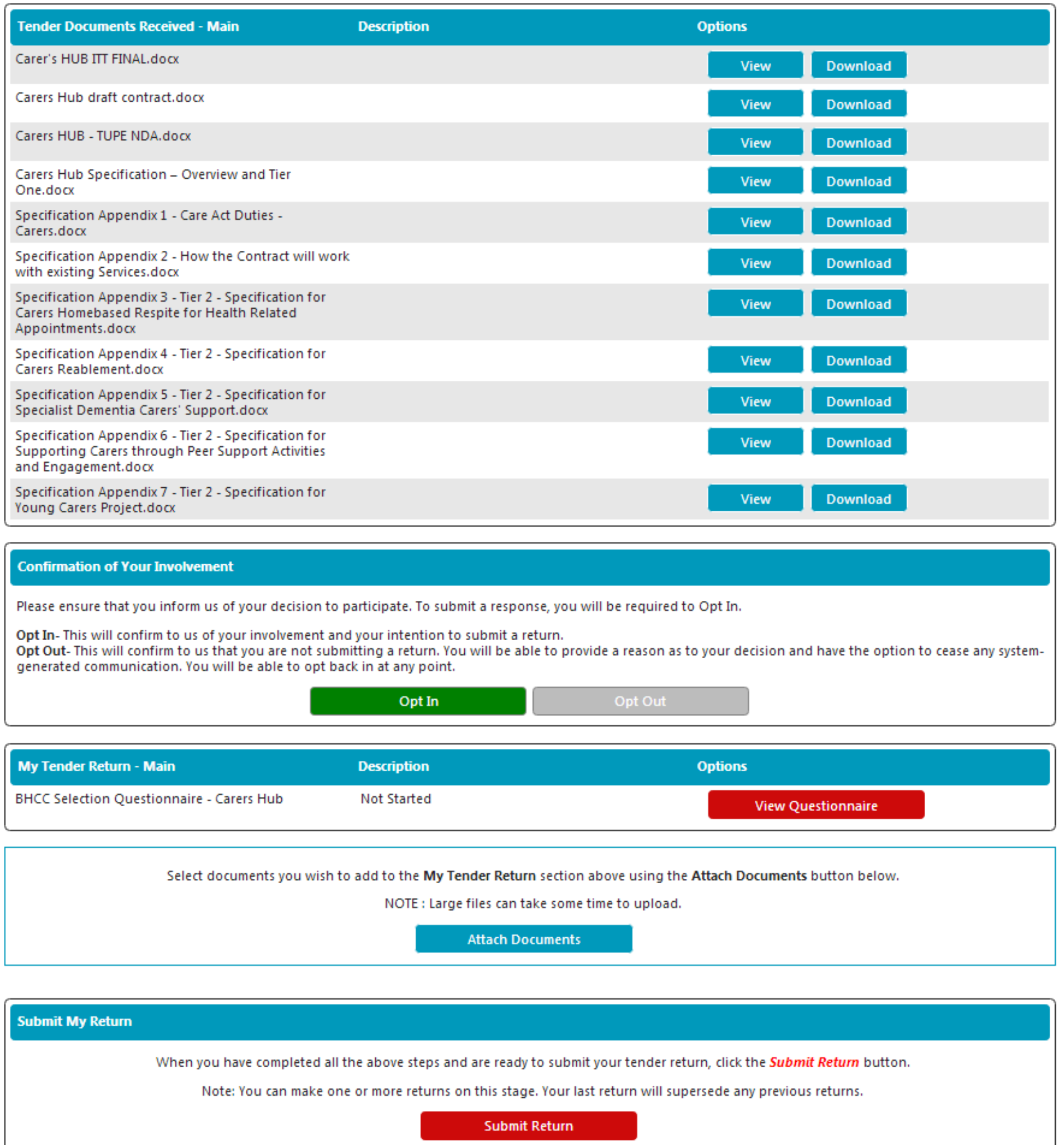
Version: 03.08.02.04
Date: 01/07/2016
Server: VSUPWEB1



Tender Documents Received - Main	Description	Options
Carer's HUB ITT FINAL.docx		View Download
Carers Hub draft contract.docx		View Download
Carers HUB - TUPE NDA.docx		View Download
Carers Hub Specification – Overview and Tier One.docx		View Download
Specification Appendix 1 - Care Act Duties - Carers.docx		View Download
Specification Appendix 2 - How the Contract will work with existing Services.docx		View Download
Specification Appendix 3 - Tier 2 - Specification for Carers Homebased Respite for Health Related Appointments.docx		View Download
Specification Appendix 4 - Tier 2 - Specification for Carers Reablement.docx		View Download
Specification Appendix 5 - Tier 2 - Specification for Specialist Dementia Carers' Support.docx		View Download
Specification Appendix 6 - Tier 2 - Specification for Supporting Carers through Peer Support Activities and Engagement.docx		View Download
Specification Appendix 7 - Tier 2 - Specification for Young Carers Project.docx		View Download

Confirmation of Your Involvement

Please ensure that you inform us of your decision to participate. To submit a response, you will be required to Opt In.

Opt In- This will confirm to us of your involvement and your intention to submit a return.
Opt Out- This will confirm to us that you are not submitting a return. You will be able to provide a reason as to your decision and have the option to cease any system-generated communication. You will be able to opt back in at any point.

My Tender Return - Main	Description	Options
BHCC Selection Questionnaire - Carers Hub	Not Started	View Questionnaire

Select documents you wish to add to the **My Tender Return** section above using the **Attach Documents** button below.

NOTE : Large files can take some time to upload.

Submit My Return

When you have completed all the above steps and are ready to submit your tender return, click the ***Submit Return*** button.

Note: You can make one or more returns on this stage. Your last return will supersede any previous returns.

Once you have expressed an interest and Opted in, you will see this ←

You will need to complete the questionnaire and uploaded a completed copy of the ITT

Remember to request TUPE by filling out the NDA!

Click 'Submit Return' when ready. You can re-submit if you want to make changes

The Scoring Process

- Applications will be scored on Quality
- A panel will individually evaluate your bids first
- Then the panel will meet with procurement, and moderate the scores
- The preferred bidder will be selected and notified, and any unsuccessful bidders will be notified and given feedback.
- There will be a 10 day standstill period
- The contract will be formed and forwarded onto the winning supplier by our legal department

TUPE

Transfer of Undertakings (Protection of Employment)

What is TUPE?

TUPE applies to employees of businesses in the UK.

The employees’ jobs usually transfer over to the new company and their employment terms and conditions transfer

Service provision change

This is when:

- a contract ends and is given to a new contractor
- Only the employees who can be clearly identified as providing the service being transferred are protected

How it applies to Ageing Well

- You will need to fill out the Non-Disclosure Agreement
- Please send a signed copy to us via SE Shared Services
- You will then be sent the TUPE data – this is a spreadsheet containing all the employees currently employed and working on this service and the details of their employment

How it applies to Ageing Well

Bidders’ pricing models must include the costs associated with the TUPE transfer of the employees.

Bidders will be expected to deal with the incumbent Contractor(s) on all TUPE issues that may arise.

The staff will transfer under TUPE on the transfer of the service. The new service provider will be responsible for, including meeting the costs of, any subsequent redundancies that may occur as a consequence of the transfer.

Any other questions?

Table top discussions

Question 1 A **s**ingle point of contact– how do we provide a ‘one stop shop’ without partners losing specialist provision & identity?

Question 2 Transport has been consistently identified as the greatest barrier to participation – what do you think the challenges will be of integrating transport provision into the new service? And what are the solutions?

Question 3 What are the challenges for a single service working and engaging with both the two groups below?

Widowed older homeowners living alone with long-term health conditions	**Unmarried, middle-agers, with long-term health conditions**
Older widowed homeowners who live alone and have long-term health conditions were particularly likely to report feeling lonely more frequently. On further examination, people in this group were predominantly: • female • not in paid work and economically inactive; given their age likely to be retired • better-off financially than the sample average; • as well as being homeowners, 62% of this group live in the 50% least deprived areas	At even greater risk of feeling lonely more often were unmarried middle-agers also with long-term health conditions. Further examination of this group showed that they tended to be: • less likely to be in paid work • more likely to be unemployed or economically inactive • much more likely to report a long-term illness or disability described as “limiting” • worse off financially than the sample average; 69% of this group live in the 50% most deprived areas

ONS 2018: What are the combined characteristics of the most lonely people?

Item 13

Although a formal committee of Brighton & Hove 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 Adults and Healthwatch.

Title: Integrated Commissioning Strategy

Date of Meeting: 08 May 2018

Report of: The Executive Director, Health and Adult Social Care

Contact: Andy Witham

Email: andy.witham@brighton-hove.gov.uk

Wards Affected: All

FOR GENERAL RELEASE

Executive Summary

Health and social care services commissioned by and delivered on behalf of BHCC and the CCG should not only meet statutory requirements but also be of good quality and provide value for money in meeting the needs of service user/ patient. This requirement is enshrined in the Care Act where a duty is placed upon the local council to support and sustain a provider market that offers both range and choice to local service users.

The city’s first Market Position Statement (MPS), prepared in 2014, has provided a useful tool for informing the market of future demand and the services that the Local Authority will commission and develop to meet that need. However, service developments, and our progress toward the closer integration of health and social care require that the existing MPS needs to be refreshed and updated.

The review of the MPS provides an opportunity to develop a wider commissioning strategy which as well as being used to inform and promote market development can also be used to underpin the development and work of the integrated commissioning team as discussed in the Moving Towards Integration paper presented to the Board in March 2018.

Glossary of Terms
MPS – Market Positioning Statement

1. Decisions, recommendations and any options

1.1 That the Board requests officers produce a report that sets out the principles and approach (as set out within the Policy Framework) for the development of a commissioning strategy linked to the development of the integrated commissioning function to be presented to the Health and Wellbeing Board in autumn 2018.

The report will aim to:

- Define the scope and purpose of the new strategy including individual services
- Identify key stakeholders including internal and external providers, residents and other interested parties
- Review and analyse current commissioning practice identifying strengths, weaknesses and areas for improvement
- Investigate best practice in commissioning and make recommendations for adoption
- Identify and understand key providers markets
- Review and analyse the use and role of technology

2. Relevant information

2.1 The Care Act (2014) introduced new duties for local authorities to facilitate and shape the market emphasising that local authorities have a responsibility for promoting the wellbeing of the whole local population, not just those whose care and support they currently fund. Although the local authority may still act as a purchaser of care and support, its overarching responsibility is to ensure there is a diverse, sustainable, and good quality care and support market operating in its area. There needs to be sufficient care and support available to enable choice for all those who need care and support, including carers.

2.2 It is important to recognise that the MPS published in 2015 was not intended to be the end point but was the start of a conversation with both providers already delivering services or those looking to enter the local market or diversify their current range of supply.

2.3 These ongoing conversations regarding market development are managed by the commissioning team and are part of our ongoing dialogue, through well-established provider forums, contract management meetings or via our work in developing markets as part of our current commissioning activity.

2.4 Much of the content of the existing MPS remains current and it is recognised that the development of an integrated commissioning function provides an opportunity to review the MPS and explore how this can be incorporated into a broader commissioning strategy.

2.5 The Oxford Brookes Institute of Public Care describes a commissioning strategy or plan as follows:

“A formal statement of plans for securing, specifying and monitoring services to meet people’s needs at a strategic level.” It applies to services provided by the local authority, NHS, other public agencies and the private and voluntary sectors.”

2.6 The Commissioning Strategy could aim to do the following:

2.6.1 Sets out the 4-5 year approach to the commissioning / decommissioning and development of services and how this will be carried out at a strategic level linked to the Health and Wellbeing strategy.

2.6.2 Explains the process of commissioning linked to the commissioning cycle and the roles that of both internal and external stakeholders in the commissioning process

2.6.2 Provides a strategy that brings together relevant analytical data and relevant information into a document that presents both internal and external partners, providers, residents and interested stakeholders with information that will both inform and provide strategic direction in terms of future demand and commissioning / development of services.

2.6.3 Identifies the needs and preferences of different service user groups in the market, *e.g.* older people, learning disability, mental health *etc.* and covers funded and privately funded users of care. Indicates the necessary changes, characteristics and innovation to service design and delivery the local authority would like to see in the market to meet the needs and preferences of the whole population.

2.6.4 Provide clarity to the provider market and interested parties on what future demand is likely to look like in the city and the type of Health and Social Care provision the Local Authority and CCG will need to commission to meet this and where commissioning activity will reduce.

2.6.5 Give information on the national and local developments that will have a significant impact on social care over the next 3 years.

2.6.6 Support organisations to adapt and grow their businesses to support the future demands and ensure that they are best placed respond in a timely way.

3. Important considerations and implications

3.1 Legal:

There no legal implications.

Lawyer consulted: Elizabeth Culbert Date: 28 May 2018

3.2 Finance:

The Commissioning Strategy will detail the demand and services required across the city including the commissioning intentions for the Council and Brighton & Hove CCG. This will then inform future budget strategies.

Finance Officer consulted: Sophie Warburton Date: 30 May 2018

3.3 Equalities

The Commissioning Strategy supports the Councils priorities in relation to tackling inequalities, creating a more sustainable city and ensures we have the right services to meet the population demographics. To enable each stage in the process of developing a new commissioning strategy will include assessment of impacts on people who share a protected characteristic. This will include: ensuring stakeholders are representative of diverse people and groups; reviewing equalities outcomes and opportunities in existing commissions; and ensuring diversity of provision and equality of access and outcomes in all commissioning processes.

Equalities Officer consulted: Sarah Tighe-Ford Date: 25 May 2018

Supporting documents and information

Appendix1: Market Positioning Statement 2014 available from: http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/FINAL%20MARCH%20ASC%20Commissioning%20Statement%20Report.pdf