Who are we?

The Health & 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 23 July 2019, 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?

There are 6 main items on the agenda

- Adults with Multiple Long Term Conditions
- Moving Forward Together in Partnership
- Health and Well Being Strategy 2019-30 Delivery Plan
- Better Care Fund
- Transition to New Children's Safeguarding Arrangements
- Commissioning of Sexual Health Services

Health & Wellbeing Board
23 July 2019
4.00pm
Council Chamber, Hove Town Hall

Who is invited:

B&HCC Members: Moonan (Chair), Appich (Deputy Chair), Shanks (Opposition Spokesperson), Bagaeen (Group Spokesperson) and Nield

CCG Members: Dr David Supple (Deputy Chair), Lola BanJoko, Malcolm Dennett Dr. Jim Graham and Ashley Scarff

Non-Voting Members: Graham Bartlett (Safeguarding Adults Board), Pennie Ford (NHS England), Pinaki Ghoshal (Statutory Director of Children's Services), Alistair Hill (Director of Public Health), David Liley (Healthwatch), Rob Persey (Statutory Director for Adult Care), Geoff Raw (CE - BHCC) and Chris Robson (Local Safeguarding Children Board)

Contact: **Penny Jennings**
Secretary to the Board
01273 291065
penny.jennings@brighton-hove.gov.uk

Date of Publication - Monday, 15 July 2019

This Agenda and all accompanying reports are printed on recycled paper

AGENDA

Formal matters of procedure

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

Page

1 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

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

2 MINUTES **7 - 20**

The Board will review the minutes of the last meeting held on the 19 March 2019, decide whether these are accurate and if so agree them (copy attached)

Contact: *Penny Jennings* *Tel: 01273 291065*

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 penny.jennings@brighton-hove.gov.uk

5 FORMAL MEMBER INVOLVEMENT

6 ADULTS WITH MULTIPLE LONG-TERM CONDITIONS - JOINT STRATEGIC NEEDS ASSESSMENT **21 - 38**

Joint report of Head Public Health Intelligence, consultant in Public Health and Brighton and Hove Clinical Commissioning Group (copy attached)

Contact: *Kate Gilchrist* *Tel: 01273 290457*
Ward Affected: *All Wards*

Health & Wellbeing

7 MOVING FORWARD TOGETHER IN PARTNERSHIP - PRESENTATION **To Follow**

Detail in respect of Presentation to follow.

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

8 BRIGHTON AND HOVE HEALTH AND WELLBEING STRATEGY 2019-30 DELIVERY PLAN **39 - 60**

Report of the Director of Public Health and Adult Social Care (copy attached)

Contact: *Alistair Hill* *Tel: 01273 296560*
Ward Affected: *All Wards*

9 BETTER CARE PLAN **To Follow**

Joint report of Rob Persey, Executive Director of Health and Social Care and Ashley Scarff, Director of Partnerships and Integration, CCG (to follow)

Contact: *Rob Persey* *Tel: 01273 295032*
Ward Affected: *All Wards*

10 TRANSITION TO NEW CHILDREN'S SAFEGUARDING ARRANGEMENTS **61 - 78**

Report of the Executive Director of Families, Children and Learning (copy attached)

Contact: Laura Perkins *Tel: 10273 296736*

Ward Affected: *All Wards*

11 COMMISSIONING OF SEXUAL HEALTH SERVICES **79 - 86**

Report of the Director of Public Health and Adult Social Care (copy attached)

Contact: *Stephen Nicholson* *Tel: 01273 296554*
Ward Affected: *All Wards*

WEBCASTING NOTICE

This meeting may be filmed for live or subsequent broadcast via the Council's website. At the start of the meeting the Chair will confirm if all or part of the meeting is being filmed. You should be aware that the Council is a Data Controller under the Data Protection Act 1998. Data collected during this web cast will be retained in accordance with the Council's published policy (Guidance for Employees' on the BHCC website).

Health & Wellbeing

Agendas and minutes are published on the council's website www.brighton-hove.gov.uk. Agendas are available to view five working days prior to the meeting date.
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 2910656 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.

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

An infrared system operates to enhance sound for anyone wearing using a receiver which are available for use during the meeting. If you require any further information or assistance, please contact the receptionist on arrival.

Fire / Emergency Evacuation Procedure

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

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

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

Health & Wellbeing

1. Procedural Business

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

(b) Declarations of Interest:

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

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

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

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

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

A list and description of the exempt categories is available from the Secretary to the Board.

HEALTH & WELLBEING BOARD	Agenda Item 2

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING BOARD

4.00pm 19 MARCH 2019

COUNCIL CHAMBER - BRIGHTON TOWN HALL

MINUTES

Present: Councillors Barford (Chair), Moonan (Deputy Chair), O'Quinn, Taylor (Opposition Spokesperson), Wealls and Page (Group Spokesperson); Brighton and Hove Clinical Commissioning Group (BHCCG): Dr David Supple (Deputy Chair), Lola BanJoko, Ashley Scarff, Malcolm Dennett and Dr Jim Graham

Also in attendance: Geoff Raw (Chief Executive), Rob Persey (Statutory Director-Adult Social Care), Pinaki Ghoshal (Statutory Director of Children's Services), Alistair Hill (Director of Public Health), Graham Bartlett (Brighton & Hove Safeguarding Adults Board), David Liley (Brighton & Hove Healthwatch) and Sandra O'Brien (Senior Solicitor)

PART ONE

47 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

47(b) Apologies

47.1 Apologies for absence were received from Wendy Carberry, Pennie Ford and Chris Robson.

47(c) Declaration of substitutes

47.2 Lola BanJoko, Deputy Managing Director Brighton & Hove CCG, was in attendance as a substitute for Wendy Carberry, Managing Director Brighton & Hove CCG.

48 MINUTES

48.1 **RESOLVED:** That the Minutes of the meeting held on the 29 of January 2019 be agreed as the correct record.

49 CHAIR'S COMMUNICATIONS

49.1 The Chair stated the following:

"**Better Care Fund clarification**

At the last Health & Wellbeing Board a query was raised about the large variance in community equipment spending and could the Board have clarification as to why this was.

The Community Equipment service budget was increased by 5% from 2017/18 to 2018/19 and the Council increased their permanent funding to replace the loss of £0.241m temporary funding in 2018/19. This is in recognition of the increasing demand and cost pressures within this service. I think the Board may remember the conversations we had here some time ago about was the original historic budget too low.

Due to additional funding received in the Autumn budget statement, there is now no expected variance on the Community Equipment service. A further detailed paper on the Better Care Fund will be coming to the June Board including the financial update and I have asked officers to ensure that this area is covered in the text not just in the financial tables.

NHS Long Term Plan

NHS Long Term Plan has been published. We are aware that over the next few months there will be a range of activities to assist with developing the delivery plan which I believe needs to project actions over the next 5 years for the local area and to which I anticipate there will be a close read across with Brighton and Hove's joint Health and Wellbeing Strategy which is being presented to this meeting for formal consideration.

Much of the information will be found on the CCG website as this this becomes available. https://www.brightonandhoveccg.nhs.uk/

Public Health funding

Councillor Yates as Leader of the Council recently signed a letter that went to senior cabinet ministers highlighting the issue of Public Health reduced funding and the impact on services such as cancer screening. The letter to Mr Hammond, Mr Hancock and Mr Brokenshire will be attached to the minutes (Appendix 1).

Carers

Between now and the next Board in June there is a range of activity covering Carers. I will touch on key elements now but this will be reported fully in the minutes of the meeting.

Young Carers Health Champions is a national programme run by NHS England, to encourage young carers aged between 16 and 24 years old, to have their say in how health services develop. The programme was established to support improved health literacy, promote health and wellbeing and develop the capacity of young carers to participate in planning and development of young carer friendly services. The Health Champions are recruited annually and we have three young carers from Brighton and Hove on the programme. The Commissioning Manager for Carers (joint BHCC/CCG post) will be meeting with them after their final residential this March, to discuss how they can be supported to improve the experience of young carers across the City. Rob Persey (Executive Director of Health and Adult Social Care) has also agreed to meeting with them to explore how their expertise can be best utilised within the development of our services.

National Carers Week 2019 is from the 10th June to 16th June – the theme this year is Getting Carers Connected in their Communities – the aim of Carers Week is to increase the awareness of carers, and to raise awareness with carers of the support available for them. Brighton and Hove's Carers Strategy has a commitment to building a stronger Carer Friendly

City, and Carers Week is a key vehicle to support this. We will be involved in a range of events and activities across the City, and are pleased to announce a new addition this year - the **Carers Festival**, to both raise awareness and to celebrate the vital (often unrecognised) contribution unpaid carers make to our City – the festival will both provide information for carers, and have a diverse range of entertainment and opportunities aimed at increasing the wellbeing of all carers (young, parent and adult carers), including 'taster' sessions from some of our local Carers Card offer providers. The timing of the event will enable young carers to attend after school, and we are hoping to foster an intergenerational approach by celebrating all carers. Additionally we will have specific activities aimed at engaging young carers, including potentially a performance from some of our local young carers.

The date for the **Carers Festival is 12th June 2019 between 2pm to 6pm at the Open Market** – more details will follow and will be widely publicised.

Update on Ardingly Court

At the last HWB the Board asked for further information about the changes in the development of Ardingly Court. I am grateful for the CCG for providing this update:

'During discussions the CCG has had with the Sussex Community Foundation Trust (SCFT) and Ardingly Court Surgery (ACS) practice partners, it became apparent that since the original proposal for the Palace Place development was discussed, the primary care landscape has changed. Available primary care capacity has increased with a number of neighbouring practices seeking to increase their registered patient list sizes, making it easier for residents to register and see a local GP, compounding ACS concerns that they may be unable to recruit enough patients for them to remain a financially sustainable practice in the new building.

Every effort is being made by the CCG to support GPs in the city so that they can provide services for local people, in the face of workforce pressures, and rises in demand for their services, that are being reported across the country. This includes financial and educational support to help them run their surgeries more effectively and efficiently to free up doctors to provide more care for patients.

A key area of CCG plans to improve health and social care across the city, is to make sure general practice is more sustainable, more resilient and works efficiently and effectively for many years ahead. This will include integrating some services, with other clinical specialists like pharmacists better supporting GPs, and helping GPs work more collaboratively together. There are also a number of specific schemes such as GP retention packages, as well as oversees recruitment, that the CCG is implementing as part of its workforce strategy.

The CCG is continuing to work closely with ACS to improve their premises and to support the development of plans for the practice team to continue to provide high quality care for their patients.'

Recommissioning sexual health services

As the Board is aware there was a report due to come concerning the recommissioning in sexual health services. This report has been delayed due to the potential changes in how these services are funded and commissioned which could impact on a longer terms contract. We are waiting for clarity about these matters and will update the Board as soon as possible with the outcomes and way forward.

Food and nutrition

The Board has highlighted access to food and nutrition as a concern. We have agreed the Brighton & Hove Food Partnership Food Strategy and also and several reports on nutrition for key groups in the city. A further deputation on the city becoming part of the Milan Urban Food Policy Pact will be going to Full Council. There is one area that is outstanding and that is access to food and cooking for homeless and vulnerably housed. We are waiting for the final work on Kendal Court and will report in the summer.

Arch Health

Arch Health Community Interest Company is the specialist GP surgery in Morley Street Brighton and provides GP and other services for our homeless and vulnerably housed residents.

Like all GP surgeries they have to be inspected by CQC. Their inspection took place in January 2019 and the inspection covered all the 5 areas of care: safe, effective, caring, responsive, and well led.

I am delighted to be able to report that Arch were rated as outstanding in all 5 areas. And I am sure that the Board would like to send our congratulations to all the team there."

49.2 Councillor Page asked for more information on the Update on Ardingly Court, whether the CCG could provide a more specific statement regarding the capacity for care in the city centre, and Recommissioning sexual health services, that the budget uncertainty was alarming.

49.3 Dr David Supple responded that the capacity was in a context of building space available, particularly for the Oxford Street Surgery.

49.4 Alistair Hill responded that the changes should not be of alarm because they were based on general landscape of service provision and not the level of funding. He stated that the national suggestions have come forward from the NHS Long Term Plan and the Secretary of State for Health and Social Care and the services to review the future of commissioning and stability of services.

49.5 The Chair stated that it was widely accepted Public Health had performed well by making good use of council funding and it was too early to comment on the future commissioning. She added that Alistair Hill would provide an update prior to the June HWB.

Appendix 1

Cancer Research UK
Angel Building
407 St John Street
London EC1V 4AD
United Kingdom
020 7242 0200
cruk.org

PUBLIC HEALTH INVESTMENT

As council leaders, we are writing to you on behalf of the millions of citizens that we represent, urging you to provide increased and sustainable funding for public health in the forthcoming spending review. This is vital if we are to work together to prevent ill health, reduce health inequalities and support a sustainable health and social care system. Community health engagement is also vital to the delivery of the NHS Long Term Plan as it is these interventions which will help keep people out of hospital and save the state money.

In 2018/19 and 2019/20 every local authority will have less to spend on public health than the year before. Councils are now responsible for delivering most public health services, but our ability to do so is increasingly compromised by ongoing public health grant reductions and the broader funding climate for local government.

Given that we know around four in ten cancers are preventable - largely through reducing avoidable risk factors, such as stopping smoking, keeping a healthy weight and cutting back on alcohol - reducing public health funding is a false economy. Smoking, obesity and alcohol account for 80,000, 30,000 and 7,000 early deaths each year respectively. Smoking remains the single biggest cause of preventable cancer in the world. Furthermore, smoking-related ill health costs our local authorities £760 million every year in social care costs. On average, for every £1 spent on smoking cessation, £10 is saved in future health costs.

Reducing investment in public health puts undue demand on local health services and our economy suffers too. Poor public health costs local businesses heavily through sick days and lost productivity. Unless we restore public health funding, our health and care system will remain locked in a 'treatment' approach, which is neither economically viable nor protects the health of our residents.

While we welcome the Government's recent commitment to preventing ill health through the NHS Long Term Plan, we know a sustainable NHS cannot be achieved if undermined by these local cuts. Public health must be seen as an essential component of a healthy society – it therefore deserves parity of funding and of esteem. That's why we are coming together and calling on you to deliver a sustainable funding solution, for the health, wealth and wellbeing of our communities

We look forward to hearing from you soon. [Undersigned council leaders]

50 CALL OVER

50.1 The following items on the agenda were reserved for discussion:

- Item 53: Reviewing the purpose and functioning of the Health and Wellbeing Board
- Item 54: Better Care Fund – Extension to Section 75 Agreement
- Item 56: Healthwatch Brighton & Hove Let's Get You Home – a report on the experiences of older people being discharged from the Royal Sussex County Hospital, Brighton from July-September 2018

50.2 The following items had not been reserved for discussion and that they were taken as received and the report's recommendations agreed:

- Item 55: Healthwatch Annual Report
- Item 57: Brighton & Hove Health and Wellbeing Strategy

51 FORMAL PUBLIC INVOLVEMENT

51(b) Written questions from members of the public

51.1 The Chair stated that three public questions had been received.

51.2 The Chair invited Mr. James Wood to ask the following question:

"Can the council confirm that 10 extra units for Housing First will be available from 1 April 2019?"

51.3 The Chair thanked James wood for his question and gave the following written response:

"I have accepted this question as part of the response at the last meeting was that we would be providing an update at this Board.

We support the commitment to expand Housing First by an additional 10 units.

We are currently working on sourcing these 10 units to deliver this scheme expansion.

There are a range of options available to us to meet this commitment which we are currently working through.

We would be happy to provide members with an update on progress at a future committee or via a separate briefing"

51.4 The Chair invited Mr. James Wood to ask his supplementary question.

51.5 Mr. James Wood stated that he was a part of Galvanise Brighton & Hove, a part of the European Campaign to end street homelessness, and that that there were many volunteers who were keen to take part in the effort. He asked if he could receive answers form the Board in plain English because what he had received was overly complicated.

51.6 The Chair responded that a formal letter could be arranged and a contact be provided for further communication on the subject.

51.7 The Chair invited Madeleine Dickens to ask the following question:

"Given the imminent merger of the HWB with the city CCG, and the proposed Integrated Care Partnership, are councillors aware of the acceleration of NHS privatisation being carried out by the CCG? The latest CCG Contracts Log reveals well over £100 million in private contracts including many £millions in payments to private hospitals. Does HWB agreement to the joint arrangements indicate acceptance of the fragmentation and dismantlement of the NHS which such levels of privatisation are bringing about?"

51.8 The Chair thanked Madeleine Dickens for her question and gave the following written response:

"The HWB, both as it is constituted now and however it may alter following the agreed review, is a Board that has a representative membership of those responsible for and stakeholders who have an interest in the health and wellbeing of our residents in Brighton and Hove and as such there is nor can there be an imminent merger as suggested. The Board does not recognise the fragmentation and dismantlement of the NHS that the questioner has stated and will continue to hold system leaders to account for NHS and system performance within national and local policy direction. We will continue to engage and consult with residents and other stakeholders as has been demonstrate with the Big Health & Care Conversation and more recently Our Health, Our Care"

51.9 The Chair invited Madeleine Dickens to ask her supplementary question.

51.10 Madeleine Dickens Stated that the written response she received had ignored privatisation as a factor in her question and she asked how £100 million of public money channeled in to private contracts would not have an impact on existing public services, whilst considering how that degree of privatisation was rapidly escalating. She stated she was disappointed in the Board's response and that these issues affected the whole City.

51.11 In response to the Chair commenting that the original question was centered on fragmentation, Ashley Scarff stated that he would be happy to provide a further written response however significant funding to external providers has and always would exist.

51.12 The Chair invited Pat Kehoe to ask the following question on behalf of Ken Kirk:

"Trusts for our local health services are under immense financial stress, with record deficits. Primary care services are at breaking point. Demand for healthcare outstrips funding. The only way that "sustainability" can be achieved is by more cuts, limiting the service to Brighton and Hove; to suggest otherwise is deception. Is it not right that the HWB committee set up to represent the people be honest and admit that the pretence that's conveyed in STP plans, that a comprehensive health and social care system can be created by integrating them, isn't possible? Isn't it time that you are straight with us?"

51.13 The Chair thanked Pat Kehoe for her question and gave the following written response:

"The Board recognises the funding challenges of the NHS and indeed has received regular reports on progress being made where closer integration of strategy and working arrangements will support the health and care needs. These regular reports have stated the challenges we face and equally have outlined the opportunities for the city that will be assured through closer working. These have included critical reports, for example looking at GP numbers as well as looking at the financial concerns. I would refer you to the answer given to the previous question. This clearly shows that we have engaged and consulted with residents and will continue to do so"

51.14 The Chair invited Pat Kehoe to ask her supplementary question.

51.15 Pat Kehoe stated that the STP would result in a depleted Health and Social Care program ran by less qualified staff. She asked if a collaborative local approach would send a message to the Government to better fund services as this would be at the resident's best interest whom which the Board should foremost represent.

51.16 The Chair responded that the Board was absolutely in support of a partnership approach and their finances and resources were always aimed at delivering the best for the City. She stated that the local STP needed to change direction to align the national recommendations however the authority's sovereignty would be retained.

52 FORMAL MEMBER INVOLVEMENT

52(b) Written questions from members

52.1 The Chair invited Councillor Hill to ask her following question:

"Following the Scrap the Fee Notice of Motion passed at Full Council in February 2018, please can the CCG confirm that they contacted all GPs requesting that they voluntarily provide letters free of charge to victims of domestic abuse to support applications for legal aid?"

52.2 The Chair thanked Councillor Hill for her question and gave the following written response from the CCG:

"The CCG is not in a position to request that GPs voluntarily provide letters free of charge to victims of domestic abuse, to support applications for legal aid.

This is because the provision of such services is outside the General Medical Services contract, responsibility for which is delegated to CCGs from NHS England, and as such counts as non-NHS work.

More details on why GPs charge fees are available on the British Medical Association website: *https://www.bma.org.uk/advice/employment/fees/why-gps-charge-fees*

On review, I asked the CCG to provide some detailed information about the role of the CCG and also GPs in dealing with requests for letters as I am sure it is an area of some confusion for many people.

As noted above, the CCG can only ensure that GPs provide services that are within the General Medical Council contract. Providing such letters is not part of the contract and therefore the CCG cannot enforce or request GPs to do this.

GPs already deal with many requests for letters. These include a wide range of areas including:

- school places on grounds of medical need
- housing
- bus passes
- welfare benefit letters
- letters to employers

Each surgery can decide what they will or will not provide. Some have decided they will not provide such letters due to time.

If the Board wishes me to do so, I will write a letter to the CCG asking GPs to provide these letters. Whilst the CCG has stated that it will forward this letter to each GP practice, it cannot ask or enforce this itself as this falls outside of its powers"

52.3 In response to the Chair asking if there was agreement among the Board to write to the CCG, Dr David Supple stated that there would be no objection and he would be happy to meet people outside of this meeting to discuss matter further. He stated that this was a complex subject and highlighted the pressure on doctors who needed support on this issue; that they would not want to charge on genuine cases however only as a deterrent for the GP time exhausted on private employee letters thus put in to a position where monitoring was necessary.

52.4 Jim Graham stated that the Local Medical Committee's (LMC) response on this huge and emotive issue encompassed a great deal of thought and they should be involved to formulate a following response or continued discussion.

52.5 Dr David Supple stated that the LMC existed to represent GPs interests and whom many feel strongly on the issue of the provision of letters being in their right for refusal. He stated that the issue had parallels in other provisions whereby the additional resources taken from the service, in this case GP time, would be paid for by the Local Authority and not the NHS.

52.6 The Chair responded that the issue raised was in the specific context of domestic violence, however she did recognise the extensive workload of GPs and that everyone's interests were with the patient.

52.7 Councillor Taylor stated that this issue was brought to the Council, a sovereign body, by the residents of the City and that the motion was unanimous and cross-party and that ongoing work of the issue should report to this Board.

52.8 Councillor Page stated that the letter to the CCG should include that violence against women was serious societal and other bodies that supported those particular issues should be included.

53 REVIEWING THE PURPOSE AND FUNCTIONING OF THE HEALTH AND WELLBEING BOARD

53.1 The Statutory Director for Health and Adult Social Care introduced the report that provided a scoping document for the Policy Panel, a draft Terms of Reference for the Policy Panel with suggested membership for the Board and an outline timetable of meetings and their content.

53.1 In response to Councillor Wealls asking how the membership representation would be divisible in thirds, the Chair stated that they were looking to make the wording clear to ensure that the representation was based on elected councillors.

53.2 Councillor Moonan thanked the Statutory Director for Health and Adult Social Care for the report. She stated that the strategy needed to work and there was only a short period before the election which suggested an early May meeting would be advisable.

53.3 In response to Councillor Page, the Chair stated firstly that the Policy Panel membership would be balanced between councillors and the CCG and she secondly agreed that meetings should occur more than quarterly.

53.4 **RESOLVED:**

(1) That the Board agreed to decide on when the Policy Panel first meet;

(2) That the Terms of Reference (Appendix 1) be agreed.

54 BETTER CARE FUND - EXTENSION TO SECTION 75 AGREEMENT

54.1 The Statutory Director for Health and Adult Social Care introduced the report. He stated that the previous framework had served its function well and the future framework had been assured that it would be similarly consistent, if not the same.

54.2 Malcolm Dennett stated that the Section 75 Agreement had been amended, revised and approved last year and he, as a lay member for governance, must fulfil the due process of checking to make sure the agreement continued to be consistent and financially sound for its statutory purpose.

54.3 In response to the Statutory Director of Health and Adult Social Care stating that the wording in the recommendation was that the Board agree to a variation in the current contract without specially highlighting what this would be, the Chair stated that report should only return to the Board after delegated approval if there were significant changes to the agreement.

54.4 Councillor Taylor asked for clarification on the change that would be delegated away from the Board and why this agreement needed to be approved if the changes were so minimal.

54.5 In response to the Chair stating that the agreement was a one year extension in order to continue work until the final framework for the Better Care Fund (BCF), the Statutory Director

for Health and Adult Social Care responded that there was no great change anticipated and the disruption to the usual central guidance roll-out was because of Brexit.

54.6 Ashley Scarff stated that in absence of the Section 75 agreement they would lack the legal framework to continue and this approval simply provided a vehicle to move forward.

54.7 In response to Councillor Wealls asking if there were any meaningful financial changes, the Statutory Director for Health and Adult Social Care stated there had been no indication of this from central sources.

54.8 The Legal Advisor confirmed the previous guarantees in that the recommendations for authorisation were on the basis that there were no changes at present, however there was a mechanism which allowed the agreement to return to the Board if changes arose.

54.9 The Statutory Director for Health and Adult Social Care stated that there would be a BCF update at the June Board.

54.10 **RESOLVED:**

(1) That the Board noted the update in relation to the Better Care Fund Proposals for 2019/2020 as set out in paragraph 2.6 of the report;

(2) That the Board authorised the Executive Director Health and Adult Social Care and the Director of Partnership and Commissioning Integration to finalise and enter into a variation to the Section 75 Partnership Agreement for the commissioning of health and social care services from the Brighton & Hove Better Care Fund to cover the period 2019-2020.

55 HEALTHWATCH ANNUAL REPORT 2017/18

55.1 **RESOLVED:** That the Board note the Healthwatch Annual Report.

56 HEALTHWATCH BRIGHTON & HOVE LET'S GET YOU HOME - A REPORT ON THE EXPERIENCES OF OLDER PEOPLE BEING DISCHARGED FROM THE ROYAL SUSSEX COUNTY HOSPITAL, BRIGHTON FROM JULY-SEPTEMBER 2018

56.1 Michelle Kay, Healthwatch Brighton & Hove Project Coordinator, introduced the Brighton & Hove 'Let's Get You Home' Report which asked local older people about their experiences of getting advice and support when being discharged from hospital to home. Concerns raised in the report included the quality and consistency in care planning and the lack of coordination and personalization of care.

56.2 David Liley commented that the report highlighted the impracticalities of the discharge service and that patient expectations were not being met, which should be a KPI for commissioning. He added that there were also problems with third sector staff employment security and that they needed certainty to provide them with the opportunity to plan for future services.

56.3 The Statutory Director for Health and Adult Social Care responded that the Council and the CCG would have a single contract register line that would be completed in two weeks' time. He added that in the past it had been challenging for organisations to set up, however beyond 2020 there would be shared intelligence and that by Autumn 2019 there would be guidance for the NHS Long Term Plan and budgetary indicators which will then allow better notice given to smaller organisations if there funding continued.

56.4 Councillor Page stated that the report had high quality qualitative data, although the sample was small. He added that monitoring the issues raised in the report was essential and he agreed with the recommendation of referring the report to the Health Overview and Scrutiny (HOSC) to formally track the outcomes for patients.

56.5 Councillor Moonan thanked Healthwatch for highlighting the crucial areas for patient care and the system as a whole in the report and she stated that HOSC was the vehicle to continue scrutiny on the progress. She commended the huge effort that NHS colleagues had performed this Winter on these issues and asked how residents could be assured that this situation would not re-occur and how the issues be de-embedded from the system

56.6 The Statutory Director for Health and Adult Social Care responded that it was important remove blame from the solution to the issues and remember that this was not a seasonal occurrence, particularly as demand in Brighton and Hove was year-through. In the January Board's Chairs Communications it had been mentioned that they would be undertaking a hospital to home review, which was run by the Local Government Association and NHS England, which brought together the Hospital, the Council, the CCG and the Sussex Partnership Trusts. This review would be on the June Board's agenda and subject to feedback and actions on the findings.

56.7 In response to Councillor Moonan asking for assurance on the commitment from health colleagues to follow the recommendations of the report, Ashley Scarff thanked Healthwatch for its work and reiterated the backing from health colleagues to support the work to improve patient flow as this was key blockage system-wide

56.8 Councillor Taylor thanked Healthwatch for the report and supported the core principle of acting as a patient champion and collating real world experiences and invaluable knowledge of service users. He stated that the report indicated that rates of flow had improved but he added that providers must be careful not to sacrifice the quality of the service for speedy turnovers and he supported the recommendations to ensure actions were followed.

56.9 **RESOLVED:**

(1) That the Board agreed for the report to be noted;

(2) That the report be referred to the Health Overview and Scrutiny Committee to monitor how the recommendations were implemented and the outcomes/impact on to residents.

57 BRIGHTON & HOVE HEALTH AND WELLBEING STRATEGY

57.1 **RESOLVED:** That the 2019-2030 Brighton & Hove Wellbeing Strategy be approved.

58 PHARMACEUTICAL NEEDS ASSESSMENT CONSOLIDATION OF TWO PHARMACIES

58.1 **RESOLVED:** That the Board agreed that the following representation should be made to NHS England:

(a) That the proposed consolidation of two pharmacies (Pharma Supply Ltd trading as Blake's Pharmacy, 91 Blatchington Road, Hove, BN3 3YG with Trinity Pharmacy, 3 Goldstone Villas, Hove, BN3 3AT) does not create a gap in pharmaceutical services subject to receiving confirmation from Pharma Supply Ltd that the number of pharmacists available to provide services in the consolidated pharmacy, in comparison to the previous number across both sites, will be sufficient to prepare and provide prescriptions without causing untoward delays.

(b) The Board further noted that there is a reduction in hours due to lunchtime closure and asks whether this can be rectified by Trinity Pharmacy and whether the pharmacy can have a loop fitted for people with hearing impairments.

The meeting concluded at 5.30pm

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:	Adults with multiple long-term conditions JSNA (Joint Strategic Needs Assessment)
Date of Meeting:	23 July 2019
Report of:	Kate Gilchrist, Head of Public Health Intelligence Nicola Rosenberg, Consultant in Public Health Dr David Supple, Brighton and Hove CCG
Contact:	Kate Gilchrist Tel: 01273 290457
Email:	kate.gilchrist@brighton-hove.gov.uk
Wards Affected:	All

FOR GENERAL RELEASE

Executive Summary

Joint Strategic Needs Assessments (JSNAs) provide a comprehensive analysis of current and future needs of local people to inform commissioners and providers regarding how they can improve outcomes and reduce inequalities. The Health and Social Care Act 2012 (s196) requires the function of preparing a JSNA and a Joint Health and Wellbeing Strategy (JHWS) to be discharged by the Health and Wellbeing Board (HWB). From April 2013, local authorities and Clinical Commissioning Groups (CCGs) have equal and explicit obligations to prepare a JSNA and a JHWS. The JHWS is required to reflect local population health needs.

An in-depth needs assessment of adults with multiple long-term conditions was published in February 2019, as part of the JSNA programme. It provides a comprehensive analysis of current and future needs of local people, and provides the underpinning evidence of the need for integration of health and social care and recommendations for the commissioning and provision of services.

This paper provides an overview of the key findings from the needs assessment for noting by the Board and a summary of progress so far. This work fed into the JHWS that was approved by the HWB in March 2019.

Glossary of Terms

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

HWB – Health and Wellbeing Board
JSNA – Joint Strategic Needs Assessment
JHWS – Joint Health and Wellbeing Strategy
MLTCs – Multiple long-term conditions

1. Decisions, recommendations and any options

1.1 That the Board note the findings and recommendations of the needs assessment to improve the prevention of multiple long-term conditions and the care of those with multiple long-term conditions.

2. Relevant information

2.1 The Health and Social Care Act 2012 (s196) requires the function of preparing a JSNA and a Joint Health and Wellbeing Strategy (JHWS) to be discharged by the HWB. From April 2013, local authorities and CCGs have equal and explicit obligations to prepare a JSNA and a JHWS. The JHWS is required to reflect local population health needs.

2.2 JSNAs ensure relevant strategies, including the Joint Health & Wellbeing Strategy, are based upon high quality evidence. As well as an overarching summary, and the community insight data and mapping resource for the city, within the JSNA programme are in-depth needs assessments, such as the one presented here on adults with multiple long-term conditions. All these resources are available at: http://www.bhconnected.org.uk/content/local-intelligence

2.3 An in-depth needs assessment of adults with multiple (2 or more) long-term conditions was published in February 2019. It provides a comprehensive analysis of current and future needs of local people, and provides the underpinning evidence of the need for integration of health and social care and recommendations for the commissioning and provision of services.

2.4 In November 2017 the HWB approved that this needs assessment would be conducted as part of the JSNA programme. The needs assessment steering group was chaired by Dr Katie Stead, Brighton & Hove CCG, Primary Care Clinical lead and was made up of members from Brighton & Sussex University Hospital NHS Trust, Sussex Community NHS Foundation Trust, Sussex Partnership NHS Foundation Trust, Age UK, Healthwatch, Brighton & Hove CCG and Brighton & Hove City Council (BHCC) Health & Adult Social care Directorate.

2.5 The needs assessment included: literature reviews, in-depth analysis of local data from primary, secondary and adult social care; a survey of 160 professionals from across the NHS, social care and community and voluntary sector; a survey of 111 adults with MLTCs and 36 carers; in-depth analysis of GP patient survey data; semi-structured interviews with 19 health and social care professionals across the system and 8 community and voluntary sector representatives and collation of information on key services supporting adults with MLTCs.

2.6 Key findings from the report include:

- There are over 51,000 adults with two or more physical or mental health conditions in Brighton and hove
- 82% of emergency hospital admissions are adults with MLTCs.
- Although prevalence of MLTCs is age related there are more adults with 2 or more long-term conditions under 65 years (28,000) than over 65 (23,500)
- Obesity, substance misuse and being a current or ex-smoker are all significant risk factors for having MLTCs
- Prevalence of MLTCs is higher in the most deprived areas and there is an 8 fold difference in age groups 45-49 for those with more than 5 long-term conditions, between those in the least and most deprived areas
- Having a mental health condition increases as the number of physical health conditions increases and those under 65 are more likely to have a mental health condition than not
- Health and care professionals and people with MLTCs consider links between mental and physical health services to be the greatest challenge they face
- Emergency admissions costs for adults with 2 or more conditions are higher than for those considered moderate or severely frail

2.7 The needs assessment's recommendations fall within the following 6 themes, detailed within the executive summary

1. Scale up primary, secondary and tertiary prevention
2. Integrate mental and physical health
3. Focus on adults with multiple long-term conditions
4. Target specific conditions (dementia, end of life, bariatric care and learning disabilities), settings (housebound and care homes) and deprived areas
5. Improve integration and care coordination
6. Improve data and information sharing and systems

2.8 The report has been presented to the CCG's Commissioning Operations Meeting (4th Dec 2018), Brighton and Hove health and care integration event (5th Feb 2019), CCG's Governing Body (26th Feb 2019), Sussex Community NHS Foundation Trust Area Management Team (14th March 2019), Steering Group for an integration pilot happening in four GP practices within Hove (Primary care cluster 6) in addition to various CCG and BHCC management team meetings. This report has been welcomed and progress has been made to respond to the recommendations, including:

- Informing the CCG 19/20 business plan and MLTCs is one of the CCG's main priorities for this year.
- Informing the BHCC Health and Adult Social Care Directorate plan 19/20
- streamlining referral pathways for supporting the prevention of MLTCs e.g. to the BHCC Healthy Lifestyles team and the Ageing Well service (led by Impact Initiatives and commissioned by Public Health)
- developing a service to strengthen coordination and delivery of primary care services within care homes.
- piloting multi-disciplinary working between primary, secondary and community care in the NHS, adult social care, housing and community and voluntary sector, within primary care cluster 6.

- initial phase of the establishment of the Sussex Integrated Dataset to enable better use of data and information to improve commissioning and service planning for improved prevention and patient care.
- Informing the future design of social prescribing in the city.

2.9 This needs assessment has fed into the development of the JHWS, informing actions required to improve healthy life expectancy, the approach to Living, Ageing and Dying well as well as informing the CCG's response to the NHS long-term plan.

3. Important considerations and implications

Legal:

3.1 The Health and Social Care Act 2012 (s196) requires the function of preparing a JSNA to be discharged by the Health and Wellbeing Board. Specifically, from April 2013, local authorities and Clinical Commissioning Groups have equal and explicit obligations to prepare a Joint Strategic Needs Assessment (JSNA) which provides a comprehensive analysis of current and future needs of local people to inform commissioning of services that will improve outcomes and reduce inequalities

Lawyer consulted: Nicole Mouton Date: 8/5/2019

Finance:

3.2 The resources required to support the production of the JSNA are funded from the general public health programme budget and are reflected within the service and financial plans for public health. The JSNA provides the needs assessment for the city which will help inform any future commissioning and delivery plans. The recommendations set out in the report have implications for commissioning and resource commitments for health and care services.

Finance Officer consulted: David Ellis Date: 8/5/19

Equalities:

3.3 The needs assessment considers the specific needs of groups with protected characteristics. The JSNA is a key data source to inform action to improve outcomes in all groups and meet the public sector equality duty (including by informing Equality Impact Assessments as required).

Equalities Officer consulted: Anna Spragg Date: 7/5/19

3.4 **Sustainability**:
The needs assessment highlights key areas where action can be taken to strengthen prevention, self-care and health and care services, to make better use of resources including medicines.

Supporting documents and information

Appendix1: Adults with multiple long-term conditions needs assessment executive summary below.

Appendix 2: Adults with multiple long-term conditions needs assessment Full report available at
http://www.bhconnected.org.uk/sites/bhconnected/files/B%26H%20MLTCs%20JSNA%202018%20full%20report%20FINAL.pdf

Adults with multiple long-term conditions in Brighton & Hove

Executive summary

November 2018

Part of the Joint Strategic Needs Assessment programme

NHS
Brighton and Hove
Clinical Commissioning Group

Brighton & Hove
City Council

The needs assessment

The number of people living with multiple long-term conditions is considered to be on the rise, in part because more people are living longer than ever before with accumulated health risks, but also due to unhealthy lifestyles and other factors. Multiple long-term conditions have been shown to be more predictive of hospital use than single specific conditions or age. People who have both mental and physical health conditions do worse than those who just have physical health problems and the likelihood of having a mental health condition increases as the number of physical conditions increase.

This needs assessment is conducted as part of the programme of Joint Strategic Needs Assessments overseen by Brighton & Hove Health & Wellbeing Board. The overall aim is to assess the health and wellbeing of adults with, and at risk of developing, multiple long-term conditions (MLTCs) in Brighton & Hove and to make recommendations for future commissioning and provision of integrated health and care services. Objectives are:

- To assess the size, impact and characteristics of the population with MLTCs - adults who have two or more long-term physical or mental health conditions
- To conduct an evidence review for prevention of developing MLTCs and for care, treatment and support for patients with MLTCs
- To assess how different parts of the local system respond to patients with MLTCs and their carers (this was done through interviews with professionals and online surveys with adults with MLTCs, their carers and professionals, local information from the National GP patient survey and information on local services)
- To make recommendations for the prevention of developing MLTCs and the care, treatment and support for patients with MLTCs and their carers.

Within this summary we provide a high-level overview of adults with multiple long-term conditions in the city, along with detailed recommendations under each of the following six calls to action:

1. Scale up primary, secondary & tertiary prevention across life course
2. Integrate mental and physical health
3. Focus on adults with multiple long-term conditions
4. Target specific conditions, settings and deprived areas
5. Improve integration and care coordination
6. Improve data and information sharing and systems

Our findings chime with those from the November 2018 Health Foundation report *Understanding the health care needs of people with multiple health conditions,* which states that the NHS needs to have a clear focus on people with multiple conditions. The Health Foundation report suggests six key steps to improve care for this group which are similar to our calls for action: supporting those with multiple conditions to live well; developing new models of NHS care for those with multiple conditions; resourcing the vital role of primary care; designing secondary care around those with multiple conditions; using data and sharing information to improve care for those with multiple conditions; and evaluating what works.

For further information please contact kate.gilchrist@brighton-hove.gov.uk or Nicola.rosenberg@brighton-hove.gov.uk

Adults with multiple long-term conditions in Brighton & Hove

There are over 51,000 adults aged 20 years or over in Brighton & Hove recorded as having multiple long-term conditions (two or more) as at March 2017 (22% of adults) (Table 1) and **around 8,000 with five or more conditions.**

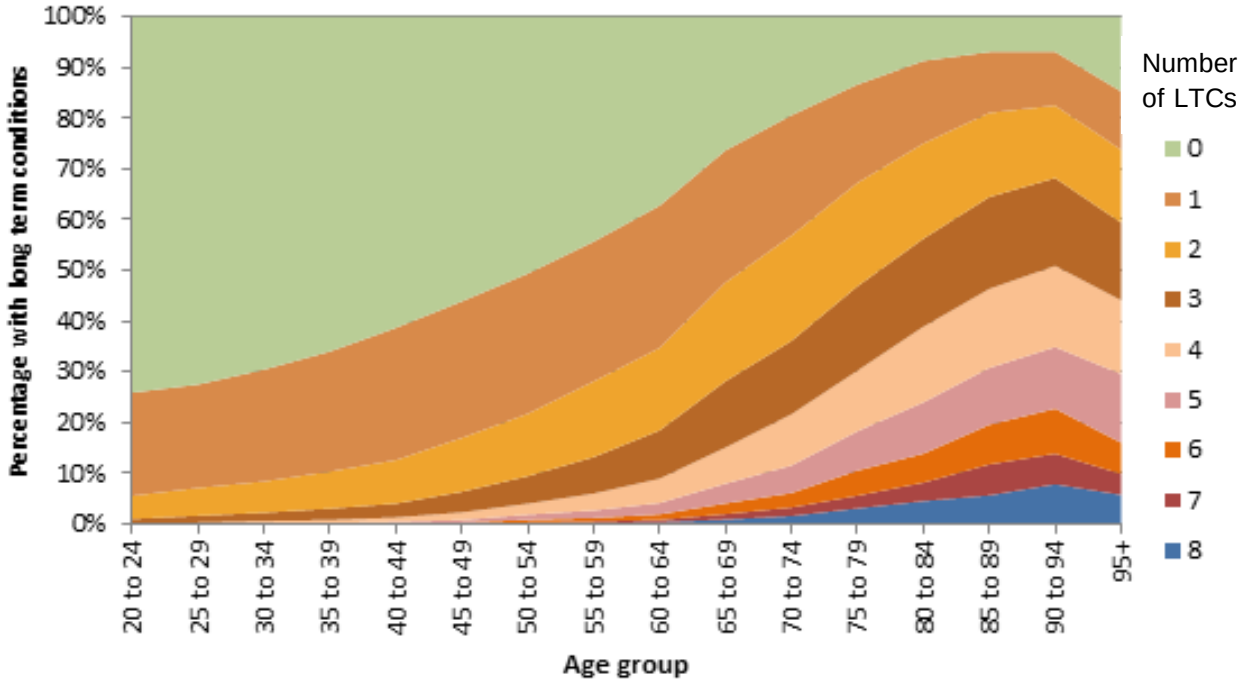
These figures are similar to estimates published by Public Health England, based upon a large scale study in Scotland and applied to our population (21% of people with multiple long-term conditions). We have significantly higher estimated prevalence than the South East for all age groups under 85 years, but because our population is younger our overall estimate is lower than the South East and England (both 23%).

Table 1: Prevalence of long-term health conditions in adults aged 20+, Brighton & Hove, March 2017

	Prevalence of health conditions	Number of adults (aged 20+)
No health conditions	54%	126,826
1 condition	24%	55,211
2 or more conditions	22%	51,379
5 or more conditions	3%	8,084
Physical and mental health co-morbidity	8%	19,060
All registered patients (20+)		**233,416**

The percentage of people living with long-term conditions increases with age (Figure 1). In 20-24 year olds 74% have no long-term conditions and up to the age of 50 years the majority of people in Brighton & Hove still have no long-term conditions. At 50-54 years, 22% have multiple long-term conditions, rising to 48% of those aged 65-69 years and 81% of those aged 85-89 years. However, those who reach 95 years or over have fewer conditions than those aged 80-94 years. This picture was similar for both males and females.

Figure 1: Percentage of people with specified number of long-term conditions, by age group, Brighton & Hove, March 2017



The average number of hospital inpatient admissions, A&E attendances, outpatient appointments, prescribed medications and GP practice contacts are highly related to the number of long-term conditions an individual has (Table 2).

Table 2: Average number of hospital admissions and attendances, GP practice contacts[1] and prescribed medications in the past year by number of long-term conditions

	Average outpatient appointments	Average emergency inpatient admissions	Average elective inpatient admissions	Average A&E attendances	Average GP practice contacts[1]	Average distinct prescribed medication count
<2 conditions	0.9	0.0	0.1	0.2	2.3	2.0
2+ long-term conditions	3.7	0.2	0.4	0.6	11.1	10.0
5+long-term conditions	6.6	0.7	0.7	1.3	19.2	18.2

The combinations of conditions adults with multiple long-term conditions have tend to vary by whether male or female in those aged under 65 years. In those aged 65 years or over, the same set of conditions appear to be most common whether male or female. We looked at how conditions cluster together, most clusters were age-related or due to common pathophysiological pathways (for example an association between obesity and diabetes), but **in younger adults there was a large cluster of adults with mental health and substance misuse (drugs or alcohol) issues.**

1. Scale up primary, secondary and tertiary prevention across the life course

Without upscaling prevention, the numbers of people with multiple long-term conditions in the city could increase by over 10,500 people to over 62,000 by 2030, with almost 2,900 more emergency admissions to hospital and £16.7million more in acute healthcare costs per year, based upon expected population growth and an increase in prevalence of 5%, similar to that within a national study.

If the prevalence of MLTCs increases by 5% by 2030:

There would be 62,003 adults with MLTCs (up from the current 51,379 adults in 2017) (10,624 more adults)

An increase in emergency admissions to an estimated 14,724 admissions a year (up from the current 11,850 total emergency admissions in 2017) (2,874 more admissions)

A resulting increase in acute healthcare costs (emergency, elective, outpatients and A&E) to an estimated cost of £84.6million a year (up from the current £67.9 million a year in 2017) (an increase of £16.7million)

[1] Note: GP contacts do not equate to appointments. They are an overestimate as include administrative changes to records, however are likely to reflect higher GP practice activity for patients with MLTCs)

We would need to see a decrease in prevalence of over 13% for there to be any reduction in the number of people with multiple long-term conditions in the city by 2030, because of our growing population.

Obesity, substance misuse and being a current or ex-smoker are all highly significant risk factors for having multiple long-term conditions. Of those adults who are recorded as obese, 56% have multiple long-term conditions compared with only 10% of adults who are not obese. Of those with recorded alcohol or substance misuse issues 43% have multiple conditions compared with 10% of those with no record of this. Of current or ex-smokers, 31% have multiple conditions compared with 17% of those who have never smoked.

In the interviews and surveys professionals and people with MLTCs say greater focus on prevention, including activities to keep people well, is needed. As well as increased resource and support for empowering people to self-manage their conditions. In the online survey, 40% of people with MLTCs say support for self-management is a challenge and professionals called for more time and resources, so that it was possible to look at needs holistically and help prevent the escalation of conditions.

Of those with MLTCs responding to the NHS England GP patient survey for Brighton & Hove, 21% felt socially isolated within the last year compared with 7% of those with 0-1 condition. Evidence from the voluntary and community sector highlighted prevention of social isolation and loneliness for key groups.

Recommendations for scaling up prevention

1. **Develop a one stop prevention referral pathway, including social prescribing,** for all health and social care services with services supported to actively refer. Social prescribing supports people to improve their health and wellbeing by connecting them to non-clinical community services. This needs to be considered in commissioning.
2. More capacity and training for staff to support **self-care and self-management** in primary, secondary, tertiary and social care. Self-management programmes and efforts must be tailored to the individual's culture and beliefs and clinical needs, and underpinned by a collaborative and communicative relationship with professionals. Care must be taken for self-management approaches to be appropriate and not over burdensome.
3. Social care to work more with those not meeting care thresholds to **support wellbeing.**
4. Multi-sector focus on addressing **social isolation and mental health and wellbeing,** including referrals to ageing well and other community and voluntary sector services to prevent social isolation by health and social care services.
5. Primary care to be supported to **identify people with, or at risk of, MLTCs**, opportunistically through routine care and proactively using electronic health records.
6. **Workplace wellbeing initiatives**, starting within the organisations providing care.
7. **Integrate primary prevention,** namely smoking prevention and stop smoking services, physical activity, weight management, substance misuse and alcohol across services. This can be through Making Every Contact Count to encourage all those who have contact with people to talk about their health and wellbeing and provide active signposting.
8. **Strengthen secondary and tertiary prevention,** in particular screening, early diagnosis, falls, cardiac, stroke and other rehabilitation
9. Adopt a more **person-centred approach**, tailoring support as appropriate and in a targeted way to adults with MLTCs.
10. **Continue to address polypharmacy and inappropriate prescribing** through proactive medication reviews and use of primary care records.

2. Integrate mental and physical health

Just over 19,000 adults in the city have both mental and physical health long-term conditions (8%). This increases to 35,000 (15%) if mild depression is included. The likelihood of having a mental health condition increases as the number of physical health conditions increases and is much greater in people living in more deprived areas.

The majority (63%) of adults with multiple long-term conditions under 65 have a recorded mental health condition and / or recorded substance misuse (alcohol or drugs misuse). However, in adults aged 65 or over, the majority (77%) do not.

In the surveys of professionals and adults with MLTCs, **links between mental & physical health services is the greatest challenge**. Respondents highlight increased needs of people with physical and mental health issues and that more joined up care is needed for those with mental illness for their physical conditions. Common themes from the professionals' interviews include:

- The complexity of services, care coordination, boundaries between care challenging
- A lack of a healthcare system for MLTCs
- A requirement for there to be more of a focus on mental health
- Training / education being needed to bridge the divide and focus more on mental health.

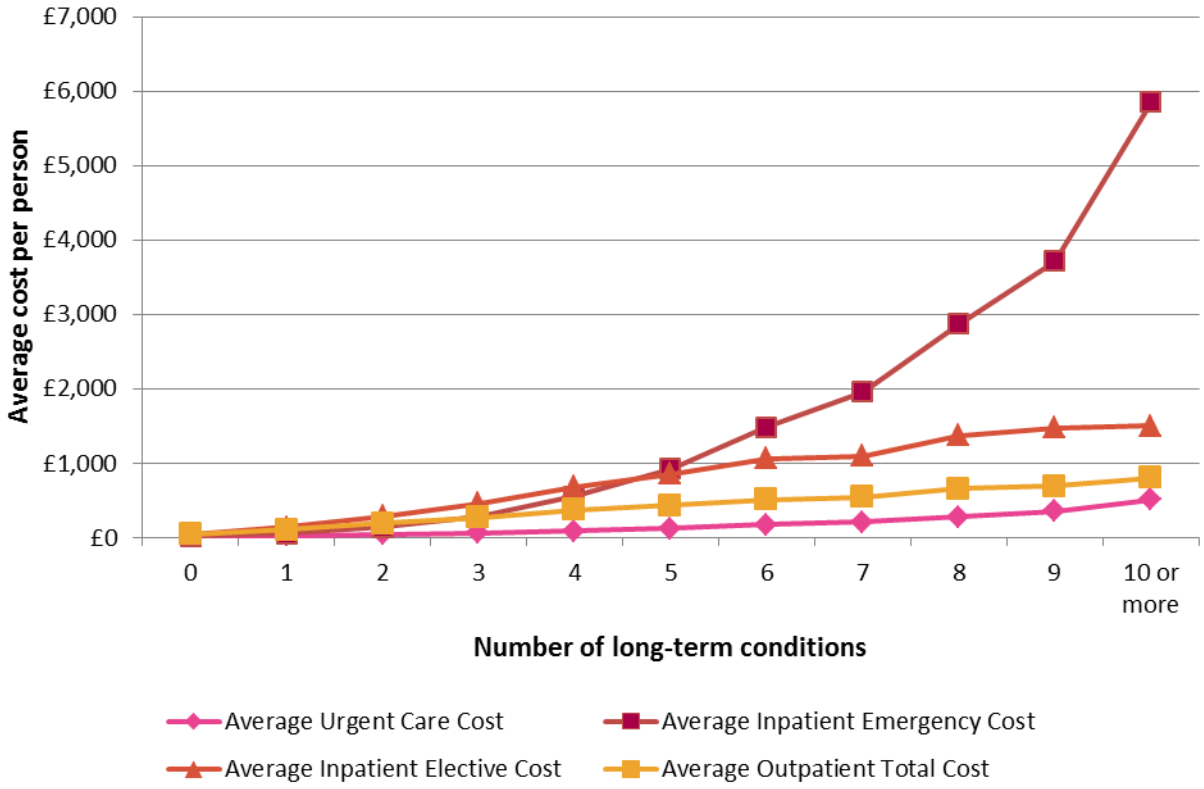
Recommendations for integrating mental and physical health

11. Increase and **strengthen training for the health and care workforce** in all sectors on mental health, to ensure that in all services mental health is prioritised alongside physical health. This is to specifically increase signposting and referrals to mental health (primary mental health care including increasing access to psychological therapies), wellbeing and healthy lifestyle services.
12. Inclusion of psychological / mental health initiatives **within disease management or rehabilitation programmes**. This is shown to be cost effective and results in reduced service use. Increase involvement of primary mental health and wellbeing services across health services.
13. Strengthen support across health and care services for addressing depression to enable people **to better self-manage conditions**. CBT-based interventions improve treatment adherence, psychosocial adjustment and coping skills. People with co-morbid mental health problems can gain most from self-management support programmes.
14. Health and social care services to be supported to strengthen work with the **community and voluntary sector** as they work at the intersection between individuals' mental, physical and social needs and provide support groups and peer-delivered plus other services preventing further exacerbations.
15. Develop a **check list for commissioning** of health and care services to ensure integration of mental and physical health.
16. Develop a more joined up approach to commissioning mental health / illness services **to avoid gaps in services** between primary and secondary mental health care.

3.Focus on adults with multiple long-term conditions

Hospital activity costs (in particular emergency admissions) increase exponentially as the number of long-term conditions an individual has increases (Figure 2). Whilst only 22% of adults have multiple long-term conditions, they account for 82% of all emergency admission costs in Brighton & Hove in the year prior to March 2017.

Figure 2: Average cost per person of various acute care in the last year, by number of conditions; Brighton & Hove, March 2017



In adults aged under 65, those with fewer (2-3) long-term conditions living in the most deprived quintile had the highest total costs in the past year. In adults aged 65 or over, those with greater numbers (5-6) of conditions had the highest total costs, with little difference by deprivation quintile.

Around three-quarters (73%) of prescribing costs were attributable to those with multiple long-term conditions (22% of adults), with 27% attributable to those with five or more conditions (3% of adults).

Among adults aged 65+ in the city, 11% are classed as moderately or severely frail (9% moderately frail and 2% severely frail), according to the electronic frailty index (eFI). Emergency hospital costs, in particular, in adults aged 65+ are driven by multiple long-term conditions: adults with moderate / severe frailty explain up to a third of costs, but focusing only on this group will have less impact than on focusing on those with multiple conditions as 95% of emergency admission costs could be attributed to the 62% of adults aged 65+ with multiple conditions.

Adults who are moderately or severely frail, but have lower numbers of long-term conditions (0.6% of adults) have emergency admissions costs of £0.5million in the last year. However, those who are **not** moderately or severely frail but have five or more long-term conditions (2.3% of adults) have emergency admissions costs of £8million per year (Table 3). It is this group which requires more intensive support and proactive management.

Table 3: Emergency admission costs in the past year by frailty and number of long-term conditions summary table, Brighton & Hove, March 2017

	Number of long-term conditions				
Frailty	0	1	2-4	5-7	8+
Fit / null (includes all adults under 65 years)	Very large numbers of people (96%, 223,935 people) with fewer conditions and less frail. Total emergency admissions costs of £15.3m			2.3% (5,254) who are not frail but who have 5+ LTCs. Require intensive support and proactive management. Total emergency admission costs of £8.0m	
Mild					
Moderate	Small number (0.6%, 1,397 people) of people who have fewer conditions but a high degree of frailty. Total emergency admissions costs of £0.5m			1.2% (2,830 people) who have 5+ LTCs and frail who require intensive support. Total emergency admission costs of £5.3m	
Severe					

If you only focus on older adults with moderate or severe frailty, you miss out on 62% of patients who are most at risk of high total costs or an emergency admission in the next year and 87% of those patients you do intervene with are not people who are most at risk of high costs or emergency admission.

The professionals interviewed said that it was difficult to have an impact with severely frail adults and thought it was better to target those who are less severely frail. They highlighted a gap in the care of younger patients with multiple long-term conditions and that there is currently no plan for how to respond to this. Evidence and data shows that targeting of the top 1% of frail people for intervention isn't cost effective and that Brighton & Hove has a significant population with multiple long-term conditions aged under 65 years.

Recommendations for focusing on adults with MLTCs

17. GP practices to be supported to **proactively identify those with MLTCs** who are not yet frail to prevent decline. A gap exists in the identification of the non-frail; however they too may be elderly, complex and often hospitalised. Proactive identification is also relevant for younger patients, particularly with mental health and substance misuse issues.
18. Frailty co-existing with MLTCs implies a significant level of vulnerability and therefore **proactive frailty services** in the community are needed.
19. **Support adults with MLTCs** to access support for prevention. For health and social care to be supported to prevent functional decline and frailty, maintaining a person's mobility. This can be through increased access to physiotherapy, other forms of appropriate exercise plus social interaction.
20. Many carers live with MLTCs, identifying **carers** is essential to increase access to support through the Carers Hub. Health professionals are in a unique position to validate carer's roles and encourage support seeking.

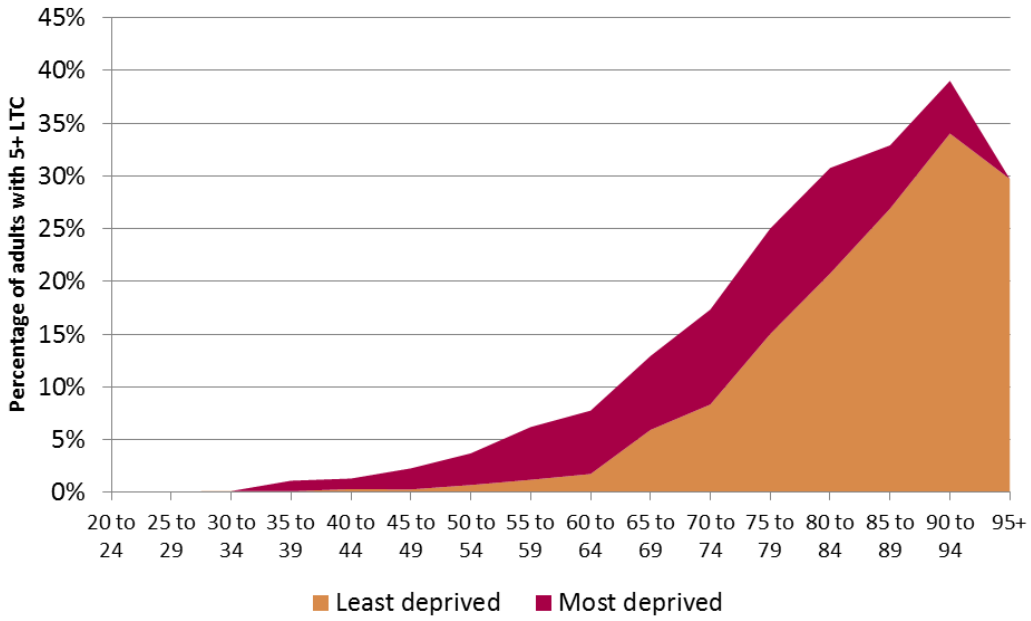
4.Target specific conditions, settings and deprived areas

The highest percentages of people with multiple long-term conditions (age-standardised) are concentrated around the more deprived Moulsecoomb and Bevendean and East Brighton wards and areas of North Portslade and Woodingdean.

Prevalence of multiple long-term conditions is greater in the most deprived areas of the city compared to the least deprived and this is most noticeable between the ages of 40-64 years, where prevalence is doubled.

Prevalence of five or more long-term conditions has an even more marked difference. **With people having 5+ conditions around 15 years earlier in the most deprived areas of the city** (Figure 3).

Figure 3: Proportion of adults with 5+ LTCs by age group in the most and least deprived quintiles, Brighton and Hove, March 2017



In terms of numbers, there are more adults with multiple long-term conditions in Brighton & Hove aged under 65 years (27,923) than there are aged 65 years or over (23,456). There are also more females (27,239) with multiple conditions than males (24,140).

In the interviews, professionals said that GPs have no easy to use, systematic way of identifying and flagging people at risk of, or with, MLTCs, although there are ways of identifying patients for medication reviews. Targeting of adults of MLTCs, as well as specific priority conditions and in key settings (as highlighted below), is needed.

Dementia is a very commonly specified condition for adults with multiple long-term conditions in receipt of social care, it is increasing in prevalence and there is a shortage of residential / nursing provision in the city for dementia. In 2017/18, 43% of delayed transfers of care related to people awaiting dementia placements. In the interviews, professionals identify those living with dementia as particularly vulnerable due to the complexity of care required.

From the professionals' interviews, there is a **lack of access to palliative / end of life care for people with MLTCs, as services tend to focus on people with cancer.** Interviews highlight opportunities to improve palliative / end of life care within nursing homes and for people with heart failure to be seen earlier by the palliative care teams. An example of good practice is provision of welfare / benefits advice to carers of those in the palliative care pathway.

Professionals, in the interviews, also highlighted the **needs of housebound patients, with more outreach and support required**. They report that services should work better together, with better coordination of multiple professionals visiting in a week and for there to be more preventative services made available including transport and with better outreach into people's homes and communities as well as into residential and nursing homes.

Care homes and nursing homes gaps in care result in increased pressure on the health and care system. Patients within care homes are often multimorbid with complex needs yet are poorly served by secondary care. Coupled with the increasing pressures on homes from dementia, end of life care and MLTCs, this setting is considered to be a priority for focus.

Similarly, a **lack of appropriate bariatric care** was highlighted, in relation to provision and mechanisms for supporting (e.g. beds and wheelchairs) those who are obese.

For **adults with learning disabilities** the multi-morbidity burden is greater, they have higher morbidity, earlier mortality and more unidentified health needs than the general population.

Recommendations for targeting specific conditions, settings & deprived areas

21. **Proportionate universalism** to be applied as part health and social care commissioning and in contracts with providers –so that universal services are provided but with greater resource within the most deprived areas to address increased prevalence of adults with MLTCs in those under 65.
22. GP practices to be supported to conduct **holistic annual reviews** and to facilitate better coordination across specialities.
23. Health and social care services to **enable trusted assessments** and **staff to share tasks** as appropriate, reducing duplication of effort and increasing support as required.
24. **Review access to community care and primary care services**, including transport, to ensure that care takes place in the most appropriate setting, to strengthen secondary prevention and reduce exacerbations.
25. **Early diagnosis of dementia** within primary care, and care and support for people living with **dementia** to focus more on improving quality of life, independence and patient and carer priorities as well as prevention of exacerbations of MLTCs.
26. **Ensure access to palliative / end of life care** for people with MLTCs without cancer. Provision of palliative care beds within care homes is needed to enable those with MLTCs to receive better end of life care in the community.
27. Primary, community care and nursing homes to carry out **better Advanced Care planning** as a means of extending personal autonomy in the event of lost capacity.
28. Commissioners to review provision of **bariatric care**, in relation to health and care provision and mechanisms (e.g. beds and wheelchairs) for supporting those who are obese.
29. Review and develop **nursing home nursing workforce** provision and training.
30. Review the **role of geriatricians** in residential and nursing homes and community services.
31. Review capacity of primary care to **support adults with learning disabilities.**

5. Improve integration and care coordination

Without integrated data systems, we have been unable to look at people's pathways through health and social care within this needs assessment. However, the majority of Adult Social Care clients with multiple long-term conditions (66%) are in receipt of physical support for personal care (frailty) and 14% have memory and cognition as their primary support reason (usually dementia).

There has been an increase in new long-term care placements for younger adults (aged 18-64), with the biggest increases seen in mental health and physical support placements. Social work services are reporting increasing complexity and acuity of cases. This is borne out by an increase in the proportion of nursing care placements as opposed to residential care placements; in 2015, 39% of older clients were in nursing care compared to 46% in 2018.

In both the professionals and individuals' surveys, 41% of respondents and 47% of carers, say **referrals between health services are a challenge,** 42% of professionals say **referrals between health and social care are a challenge**. Both surveys demonstrate how better integration and care coordination is needed to improve outcomes. Highlighting:

- Mental health affects a person's ability to communicate
- Good communication with people with MLTCs and between services is essential
- Primary Care care plans are not holistic enough and other organisations' care plans are not being shared systematically
- There is a lack of capacity in primary care to communicate clearly, or understand the behaviour of, vulnerable people such as those with learning disabilities
- Longer appointments are needed to allow time to address multiple / complex needs, for people to open up, or for those who have difficulty attending multiple short appointments (e.g. those with mobility issues)
- Long-term condition annual reviews, including mental health reviews, could be combined
- Health services set up to manage individual conditions, social care how people manage; the links between services are unclear to professionals, those with MLTCs or their carers
- Working in siloes, short-term, target-focused care is the norm; there is need of, and value in, a holistic approach that includes peoples' goals and values.

The interviews highlight significant challenges in **care coordination & multidisciplinary working**:

- Social workers felt other professionals weren't clear about their roles and they found health services difficult to navigate
- Secondary care is good at one condition in a multi-disciplinary way, but not good at managing people with MLTCs, with lots of clinicians involved, in a combined way. There is no forum for this, mainly email referrals or phone calls happening in a disjointed way
- The need for the co-location of health and social care professionals
- Development of a trusted assessor model so that professionals can share roles and responsibilities and avoid duplication of effort
- Primary care professionals feel social care is distant, under resourced, with high thresholds
- Developing relationships between primary care and community nurses; there is a lot of duplication in activity
- The need for access to specialist advice, including geriatricians
- More inclusion of the community & voluntary sector to support those with MLTCs & carers
- The value of shadowing of other services
- Development of more responsive and supportive services in general.

Recommendations for integration and better care coordination

32. Senior leaders of all health and care commissioning and provider organisations to commit to giving permission to staff to focus on multi-sector relationships with the specific aim of improving health and wellbeing outcomes for adults with MLTCs. Aspirational intent to work together is needed; **integration is not transactional, it is about relationships and trust.**
33. **A strong, appropriately skilled, multi-disciplinary team** is one of the most effective ways to deliver holistic, long-term care to those with MLTCs. Commissioners and providers to look

at ways of working together better across health and social care for all their conditions and the development of multidisciplinary **guidelines** for MLTCs.

34. Health and care providers to add **electronic decision support systems** within information systems to improve care for people with MLTCs.
35. **Continuity of care with GP practices is important, as well as quality interactions with professionals. Resource is required for longer appointments** with appropriate clinicians in primary care for those living with complexity or with five or more long-term conditions.
36. Community care services and GP practices to have better **access to specialist advice** from secondary care and mental health providers.
37. **Holistic personalised care planning** to be carried out by trusted, appropriate community care or social care professionals and embedded within GP practice systems. This improves people's capacity to manage their conditions and effects are greater when care planning is comprehensive, intensive and integrated into routine care.
38. **Improve care coordination,** particularly for older adults, which significantly improves outcomes. Successful care coordination has a holistic focus which supports people and carers. Commissioners to invest resources in **the role of the care coordinator**. Providers to ensure that professional support is provided to ensure the role is effective.
39. **Reduce unplanned hospital readmissions** through structured discharge planning and communication. This includes a system for secondary care to proactively identify and for primary and community care to review patients at high risk of readmission. For there to be a reconciled list of medicines on the GP record following discharge.
40. **Review and develop a directory of local health and care services** to better connect different parts of the system.

6.Improve data and information sharing and systems

This needs assessment would not have been possible without linked data from primary and secondary care. This data isn't now available and so it is not possible to look at pathways of care, or to monitor the prevalence and impact of multiple long-term conditions. **All professionals interviewed mentioned information sharing,** particularly difficulty in getting relevant information from other health professionals and not having shared IT systems that every health and social care professional can access relevant information. This is also a key challenge identified by those with MLTCs (17% say it works well) and carers (50% think it is a challenge).

Recommendations for better data systems and information sharing

41. Commissioners and providers to review **sharing of information** between health and social care professionals and to facilitate information sharing to improve individuals' care, appointments, care planning, coordination, prevention and self-management and ensure health and care professionals have access to relevant information in a timely manner.
42. **Invest in commissioning and provider data systems** across health and social care to **enable linkage of non-identifiable data and information to improve evidence based commissioning of services and to be able to evaluate programmes.**
43. **Invest in integrated data systems** across health and social care **to identify people with multiple long-term conditions** and prioritise them for proactive care.
44. **Better use of and recording of data** across health and social care (e.g. capturing appointments on GP practice systems). Training for professionals is required to improve data completeness and quality.
45. For data to be collected on **people's experiences** in order to augment routinely collected health and care data and for this to be provided alongside routine health and care data.

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:	Brighton & Hove Health and Wellbeing Strategy 2019-2030 Delivery Plan
Date of Meeting:	23 July 2019
Report of:	Director of Public Health, Health and Adult Social Care, BHCC Deputy Managing Director South, Brighton and Hove Clinical Commissioning Group
Contact:	Alistair Hill, Director of Public Health Tel: 01273 296560
Email:	alistair.hill@brighton-hove.gov.uk
Wards Affected:	All

FOR GENERAL RELEASE

Executive Summary

One of the key duties of the Health and Wellbeing Board is to prepare and publish a Joint Health and Wellbeing Strategy for meeting the needs identified in the Joint Strategic Needs Assessment (JSNA).

The new Brighton & Hove Health and Wellbeing Strategy 2019-30 was unanimously agreed by the Health and Wellbeing Board in March 2019. This is the overarching strategy for the Board that sets out how the organisations represented on the Board, along with partner organisations and communities, will improve the health and wellbeing of people in Brighton & Hove. The strategy vision is that everyone in Brighton & Hove will have the best opportunity to live a healthy, happy and fulfilling life.

This paper describes the process for developing a Health and Wellbeing Plan to

deliver the aspirations of the strategy and how Board members will provide system leadership to enable the delivery of the Plan and have oversight of its implementation.

Glossary of Terms

JNSA – Joint Strategic Needs Assessment

CCG – Clinical Commissioning Group

GPs – General Practitioners

NHS Long Term Plan – the new plan for the NHS to improve the quality of patient care and health outcomes. It sets out how the additional £20.5 billion budget settlement for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next 5 years.

1. Decisions, recommendations and any options

1.1 That the Board approves the establishment of the process to develop the Health and Wellbeing Plan.

2. Relevant information

2.1 Health and Wellbeing Boards have a duty to prepare a Joint Health and Wellbeing Strategy for meeting needs identified in the Joint Strategic Needs Assessment (JSNA).

2.2 The new Brighton & Hove Health and Wellbeing Strategy was approved by the Health and Wellbeing Board in March 2019. It is a high-level strategy that sets out the vision of the Board for improving health and wellbeing and reducing health inequalities in Brighton & Hove. The vision for the Board and its partners is that:

Everyone in Brighton & Hove will have the best opportunity to live a healthy, happy and fulfilling life.

2.3 The strategy describes eight principles that will guide the leadership of the Board and its partners in delivering the strategy:

- Partnership and collaboration
- Health is everyone's business
- Health and work
- Prevention and empowerment
- Reducing health inequalities
- The right care, in the right place, at the right time
- Engagement and involvement

- Keeping people safe.

2.4 The strategy sets an ambition that by 2030:

- People will live more years in good health (reversing the current falling trend in healthy life expectancy) and
- The gap in healthy life expectancy between people living in the most and least disadvantaged areas of the city will be reduced.

2.5 To achieve this requires action involving individuals, communities, and across the city. The key strategy outcomes for our population are starting well, living well, ageing well and dying well.

2.6 At the city level, Brighton & Hove will be a place which helps people to be healthy. Key areas of action identified within the strategy include inclusive economic growth; planning healthy places (including green and open spaces); prioritising active travel; improving air quality; supporting safe and warm housing; tackling homelessness; adopting a whole city approach to food and wellbeing; and making the best use of city assets such as libraries, community spaces and arts and culture to improve health and wellbeing. In addition, partners across the city will work with communities and residents to tackle the risks presented by substance misuse and excessive alcohol use.

2.7 Key areas of action have been identified for each life stage including:

Starting well: a focus on early years; promotion of healthy lifestyles and resilience; improving emotional health and wellbeing and improving mental health services; and providing high quality and joined up services around the family.

Living Well: information and advice to support people to eat well, move more, drink less and stop smoking; improving mental health & wellbeing and sexual health; and a focus on workplace health and supporting people, including people with disabilities, into work.

Ageing well: creating an age friendly and dementia friendly city (including the physical environment); reducing social isolation, loneliness and falls; and connecting people with their communities to help them live independently for longer.

Dying well: developing a city wide approach to improve health and wellbeing at the end of life; and supporting more people to die at home or in a place that they choose.

2.8 The next step will be to develop an overarching Health and Wellbeing Plan that will set out how these aspirations will be delivered. This will be integrated with the NHS Long Term Plan delivery plan that will be required by Autumn 2019.

2.9 The plan will include five workstreams:

- Starting Well
- Living Well
- Ageing Well
- Dying Well
- Citywide actions

2.10 The City Council and CCG (including GP clinical leads) will be jointly responsible for overseeing coordination and delivery as part of 'business as usual' rather than bolted on initiatives.

2.11 For each of the 'four wells', if an appropriate group exists, for example for Starting Well, this group will lead the process to develop the plan, otherwise a specific workstream will be established for this purpose. These will bring together relevant actions that are already underway and identify additional actions that are required to deliver the strategy. The plans will describe how local people will be engaged in the development of the workstreams.

2.12 These plans will be presented to the Health and Wellbeing Board for approval by January 2020. This timetable will enable the content to be consistent across the BHCC Corporate Plan, City Strategy and NHS plans.

2.13 A "virtual workstream" for City-wide actions will focus on making health and wellbeing everyone's business. This will address the wider determinants of health, for example housing, economy, transport, and environment. It will link with the work of City Council directorates and the Brighton & Hove Connected strategic partnerships so that health and wellbeing is integrated within the delivery of all the City's strategic plans.

2.14 The Health and Wellbeing Board will provide system leadership to enable the delivery of the Plan and have oversight of its implementation. It will do these by the following means:

- As system leaders, members of the Board will champion the priorities for joint action across the health and care system and with other local partners.
- All Board papers will be required to set out how they contribute to the delivery of the Strategy and its workstreams.
- The Board has a duty to review NHS commissioning strategies and plans to ensure that they support the delivery of the Strategy and the workstreams.
- The Board will review the progress in delivering the Health and Wellbeing Plan on an annual basis and will identify where they need to take further action as systems leaders to ensure that the Plan will be delivered.

2.15 Indicators to measure progress towards improving health and wellbeing outcomes and reducing health inequalities will be identified. These will be drawn from established national frameworks such as the Public Health

Outcomes Framework, Adult Social Care Outcomes Framework and NHS Outcomes Framework.

3. Important considerations and implications

Legal:

3.1 The Health and Wellbeing Board is required to publish a joint Health and Wellbeing Strategy pursuant to the Health and Social Care Act 2012 Section 193. In preparing the Strategy the Local Authority and the CCG must have regard to Guidance and involve local people and the local Healthwatch organisation.

Lawyer consulted: Nicole Mouton Date: 10/05/2019

Finance:

3.2 The Health and Wellbeing Strategy informs priorities, budget development and the Medium Term Financial strategy of the Council, Health and other partners. Resource requirements for the action plans within each workstream are identified through the budget planning process. This will require a joined up process for future budget setting in relation to all local public services ensuring that the Council and CCG have an open, transparent and integrated approach to agreeing the budget priorities. This will require both organisations to align their budget procedures whilst adhering to individual financial governance and regulations.

The financial risks for both organisations will be detailed within medium term financial planning and reported regularly through the appropriate governance structures.

Finance Officer consulted: Sophie Warburton Date: 09/05/2019

Equalities:

3.3 The strategy includes a strong focus on reducing heath inequalities. The strategy and its delivery is underpinned by the data within our Joint Strategic Needs Assessment which takes the life course approach identifying specific actions for children and young people; adults of working age and older people; and key areas for action that reflect specific equalities issues including inclusive growth and supporting disabled people and people with long term conditions into work. An Equalities Impact Assessment is not required for the strategy itself but should be completed for specific projects, programmes and commissioning and investment decisions taking forward the strategy.

Sustainability:

3.4 Sustainability is at the heart of the health and wellbeing and this is reflected in the inclusion of active travel, improved air quality and use of green and open spaces in the key areas of action.

Supporting documents and information

Appendix 1: Brighton & Hove Health and Wellbeing Strategy 2019-2030

Brighton & Hove Joint Health & Wellbeing Strategy

2019-2030

NHS
Brighton and Hove
Clinical Commissioning Group

Brighton & Hove
City Council

CONTENTS

This strategy sets out our vision for improving the health and wellbeing of local people and reducing health inequalities.

Everyone in Brighton & Hove will have the best opportunity to live a healthy, happy and fulfilling life

What is the purpose of the strategy?

This strategy sets out our vision for the health and wellbeing of people and communities in Brighton & Hove, together with the core principles which will guide local action to deliver the vision. It presents a shared view of where we are and of the challenges and opportunities that we face.

We want to make health and wellbeing everyone's business. Therefore local organisations and communities should use the strategy to develop actions that will contribute to improving health and wellbeing.

Who developed the strategy?

This is a refreshed strategy that builds on the Health & Wellbeing Strategy which was approved by the Health & Wellbeing Board in December 2015.

The strategy was developed by a policy panel that reported to the Brighton & Hove Health & Wellbeing Board. The panel included members nominated from the board plus representatives of Community Works (representing the community and voluntary sector), Brighton & Hove Chamber of Commerce and the Brighton & Hove Economic Partnership.

How were local people involved?

The views of local people and organisations have been instrumental in the development of this strategy. These were gathered through the following means:

- More than 2,000 people took part in the Brighton & Hove Big Health and Care Conversation in 2017, which aimed to find out more about what local people need to keep them healthy
- Engagement on the draft strategy was conducted from December 2018 to January 2019, culminating in an event attended by more than 100 people.

Our principles

Eight principles will guide the delivery of our strategy:

Partnership and collaboration	Individuals, communities and organisations across the city will work together to deliver our shared vision.
Health is everyone's business	Services and plans will reflect the contributions that factors such as education and learning, housing, employment, environment, leisure and culture, and transport make to improving health and wellbeing.
Health and work	Fulfilling work, including volunteering, contributes to good health and wellbeing – and local employers, communities and the economy will benefit from healthy workplaces and a healthy workforce.
Prevention and empowerment	Communities will be supported to develop networks and local solutions that lessen social isolation and improve wellbeing, and reduce the need for more specialist services. People will be encouraged and empowered to take responsibility for their health and wellbeing where they can. Early action will help people to live well for longer and to remain independent.
Reducing health inequalities	The physical and mental health of those with the poorest outcomes will improve the fastest. Services will be accessible to those who need them in all parts of the city, including people with learning and physical disabilities and those who are socially isolated.
The right care, in the right place, at the right time	Health and care services will provide high quality care, feel more joined up and will be delivered in the most appropriate place. Often, this will mean that more services are delivered in or close to people's homes.
Engagement and involvement	Local people of all ages will be active partners in the design, development and delivery of health and care services and supported to manage their health.
Keeping people safe	We want everyone to be safe from avoidable harm, taking particular care of our most vulnerable residents.

Our challenges

A growing population

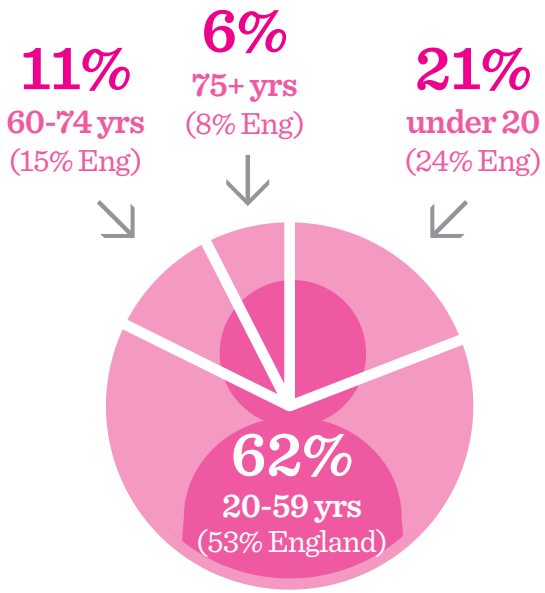
There are currently around 288,000 people living in the city. Our population profile is younger than England.

Our population is predicted to increase at a faster rate than the South East and England by 2030 (by 23,300 people or 8%).

By 2030, Brighton & Hove's age profile is predicted to get older. There will be 29% more people aged 75 or older (5,200 people) compared with 2017, including 400 more people aged 90 or over.

The number of children in Brighton & Hove will increase slightly. It is predicted there will be 800 more children (6%) aged 0-4, with more than half of the increase (500 people) happening by 2020. The number of 5-14 years old is expected to remain around the same (100 fewer children). There are projected to be 4,800 more young people (a 10% increase) aged 15-24 years by 2030.

288,155
residents (2017)

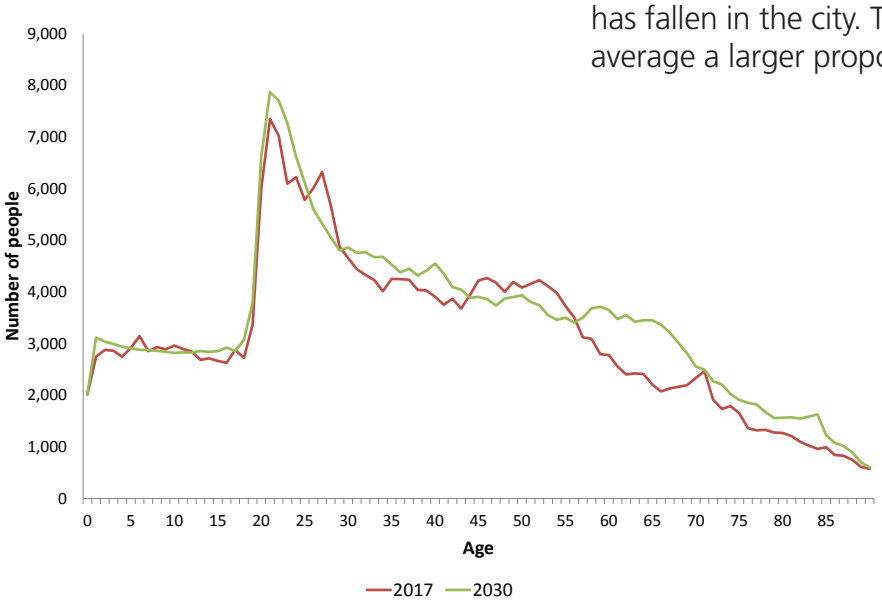


Health and wellbeing needs

Life expectancy in Brighton & Hove was 83.0 for women and 79.1 for men in 2015-17. It has increased over recent decades; however data suggests that this trend may have stalled in the last five years (nationally, life expectancy began to plateau in 2010).

Healthy life expectancy (a measure of how many years of life are lived in good health) has fallen in the city. This means that on average a larger proportion of life is now

Brighton & Hove population profile 2017 and 2030



spent in poor health, increasingly with multiple long-term health conditions. In Brighton & Hove women can expect to live 25% of their life in poor health (23% in England), while males in Brighton & Hove can expect 22% of their life to be lived in poor health (20% in England).

In addition, there are significant health inequalities across our population. For example, there is a gap in life expectancy of 10 years in men and six years in women between the most and least disadvantaged areas in the city. The gap in healthy life expectancy is greater still, highlighting that people living in our more disadvantaged communities spend more years living in poor health.

Local data highlights relatively good health and wellbeing in younger children. However, we have high rates of smoking, substance misuse and mental health needs in young people. In adults, some of our health outcomes, for example relating to mental health, are worse than average. For older people, there is a higher than average rate of falls.

Research suggests that most people would prefer to die at home and few wish to die in hospital. More than 9 out of 10 bereaved relatives believed that when their loved ones had died at home or in a hospice it was the right place for them (compared with 3 out of 4 in the case of hospitals).

Health and care services

Healthcare is often organised around individual health conditions and does not always meet the needs of those who have multiple long-term conditions.

Some people are being treated in hospital when they could receive better care provided by services in their own home or their neighbourhood.

Challenges for delivering local services include the capacity and resilience of GP practice services and recruitment to the health and care workforce.

In January 2019, the NHS Long Term Plan was published, which describes how:

- the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal setting
- the contribution the NHS makes to preventing ill health and reducing health inequalities will be strengthened
- NHS organisations and local authorities will work more closely together as part of Integrated Care Partnerships to deliver health and care services
- Local health services will come together into geographical networks (called Primary Care Networks) covering populations of 30,000 to 50,000 to provide better coordinated care closer to patients' homes.

The next steps in developing more joined-up services locally include:

- a local five year delivery plan for the NHS Long Term Plan will be published in Autumn 2019
- the role and membership of the Health & Wellbeing Board will be reviewed by Autumn 2019
- the NHS Clinical Commissioning Group and city council will develop a joint medium term financial strategy by 2020.

Our high level outcomes: starting, living, ageing and dying well

We want everyone in Brighton & Hove to have the best opportunity to live a healthy, happy and fulfilling life.

This strategy focuses on improving health and wellbeing outcomes for the city and across the key life stages of local residents: starting well, living well, ageing well and dying well.

Our ambition for Brighton & Hove in 2030 is that:

People will live more years in good health (reversing the current falling trend in healthy life expectancy).

The gap in healthy life expectancy between people living in the most and least disadvantaged areas of the city will be reduced.

Our city

Our health and wellbeing is influenced by social, economic and environmental factors:

102nd most deprived local authority (of 326) (2015)

64 rough sleepers (street count 2018)

5.8% of adult mortality is attributable to particulate air pollution (2017)

Those on the lowest 25% of earnings need **12 times their earnings** to afford the lowest 25% of house prices (2017)

11% (14,600 people) are estimated to be in fuel poverty (2016)

56 per 100,000 people are killed or seriously injured on the roads in the city (2015 to 2017)

4.8% (7,700 people) in the city are unemployed (2017).
Employment rates are lower for those with: **long-term health conditions; a learning disability;** and **people in contact with secondary mental health services** (2017/18)

4% of 16-64 year olds are out of work due to long-term sickness (October 2017 to September 2018)

39 per 100,000 people are admitted to hospital due to violent crime (including sexual assault) (2015/16 to 2017/18)

Starting well

We do well in many areas. Fewer mothers smoke, more breastfeed and more children are a healthy weight:

88% of mums breastfeeding by 48 hours (2016/17)

6% of mums smoking at delivery (2017/18)

16% of children live in poverty (2016)

73% 10-11 year olds are a healthy weight (2017/18), but 14,000 children are overweight/obese

73% of children achieving a good level of development at end of reception (2017/18)

The educational progress pupils make between primary and secondary school is in line with the England average (2017/18)

77 per 10,000 children and young people under 18 years are in care (September 2018)

Conceptions to under 18s fell from 48 per 1,000 15-17 yr old females (1998) to **19 per 1,000** (2017)

However, we have worse rates of smoking, drinking and drugs use, sexually transmitted infections (STIs) and poorer emotional wellbeing:

549 per 100,000 10-24 year olds admitted to hospital for self-harm (2017/18)

Most childhood vaccination rates, including MMR, are **below the 95% required for population protection**

The highest % of 15 year olds who smoke, have tried cannabis and the 3rd highest % drinking weekly in England (2015)

Young people aged 15-24 experience high rates of STIs, and are more likely to be reinfected within 12 months (2017)

Living well

77% of adults are physically active (2017/18)

14% of adults cycle to work at least once a week (2017)

606 per 100,000 people had alcohol related hospital admissions (2016/17)

18% of adults are current smokers (2017)

22% of adults aged 20+ have 2 or more long-term physical or mental health conditions, **8%** have mental and physical conditions, with a strong link with deprivation (2017)

10% of adults are on GP practice depression registers (2017/18)

We have the highest rates of new STI diagnosis and HIV prevalence outside of London (2017)

While life expectancy has been increasing, healthy life expectancy has fallen. People are therefore living longer in ill health.

This, alongside the rising retirement age, means increasing numbers of people of working age are living in ill health:

	Male	Female
Life expectancy (2015-17)	**79.1 years**	**83.0 years**
Healthy life expectancy (2015-17)	**62.2 years**	**65.3 years**

Ageing well

A relatively high proportion of older people live alone and a higher proportion of older people are income deprived:

58% of those surveyed receiving adult social care had good quality of life (2017/18)

Carers have a similar quality of life to the rest of England (2016/17)

The risk of loneliness for those 65+ in the city is in the top 20% in England (2011)

41% of people aged 65+ live alone (2011)

20.5% of older people are income deprived (2015)

104 in every 1,000 65+ year olds have age-related macular degeneration (preventable sight loss) (2017/18)

4.6% of 65+ year olds have a record of dementia (2018)

Flu immunisation uptake at **67.5%** in 65+ year olds (2017/18) is below the goal of 75%

2,465 per 100,000 people aged 65+ were admitted as an emergency to hospital due to a fall (2017/18)

749 per 100,000 people aged 65+ were admitted to permanent residential or nursing care homes (2017/18)

Dying well

Most people would like to die at home. In almost **half of all deaths (49%)**, people die in their usual residence (2017) This is a higher proportion than England and has increased from 40% in 2006

38% of deaths are in hospital

25% of deaths are in care homes

25% of deaths are at home

8% of deaths are in a hospice

Key - Based upon statistical significance

- **Better than England**
- **Not different to England**
- **Worse than England**
- **Difference cannot be calculated**
- **Higher than England**
- **Lower than England**

For more details on the health and wellbeing of people in Brighton & Hove please see our Joint Strategic Needs Assessment:

www.bhconnected.org.uk/content/local-intelligence

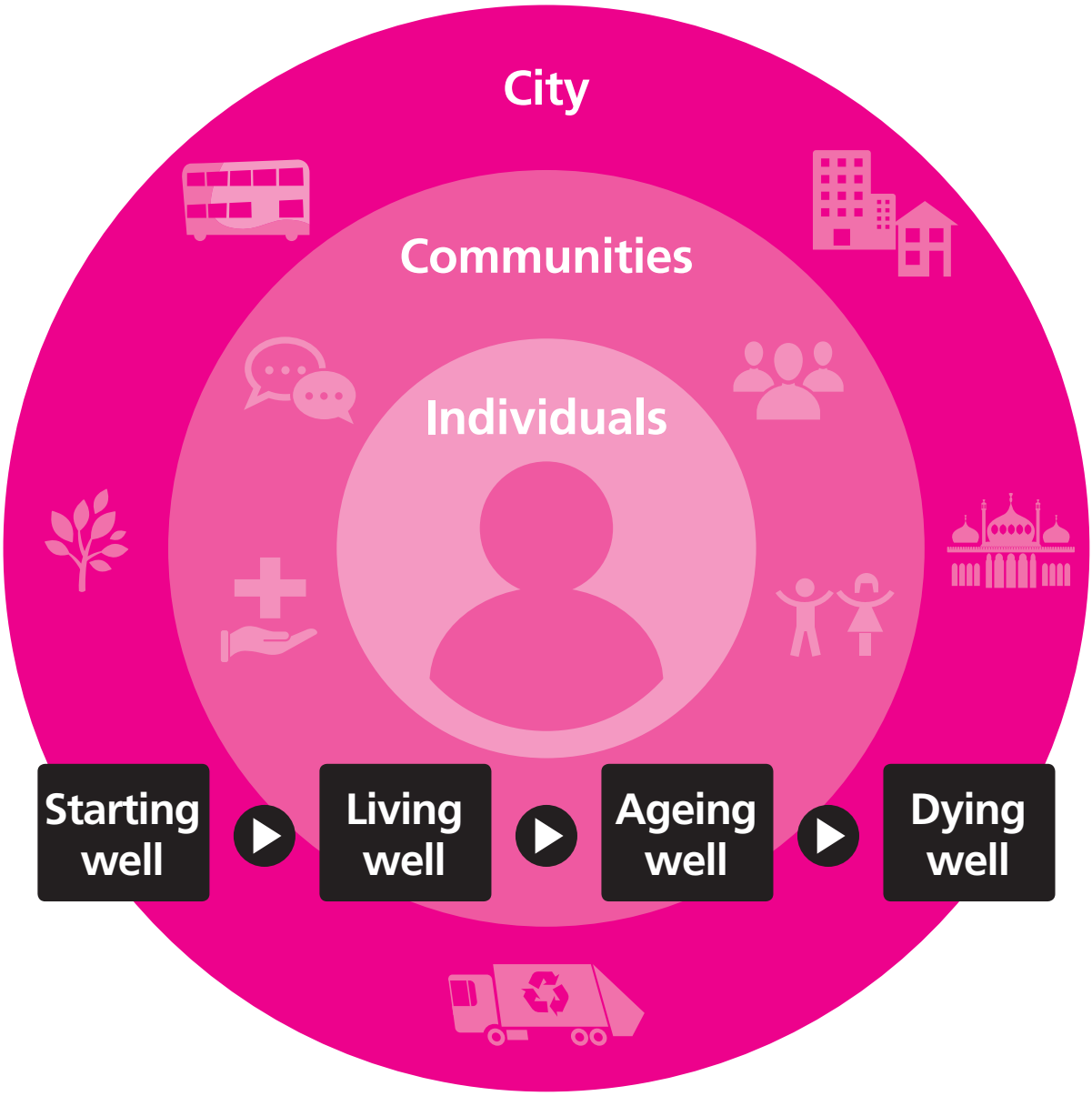
Key areas for action

Our approach to improving health and wellbeing

Social, economic and environmental factors have a major impact on our health and wellbeing.

Therefore, to achieve our vision we need Brighton & Hove to be a city where health and wellbeing is everyone's business.

Partners across the city all have a part to play in ensuring everyone in Brighton & Hove has the best opportunity to live a healthy, happy and fulfilling life. These partners include local communities, the council, NHS, the community and voluntary sector, universities, schools, police, the fire & rescue service and businesses.



Our city

Brighton & Hove will be a place which helps people to be healthy.

- The benefits of economic growth will be reinvested to support greater levels of inclusion. The gap between and within our communities will be narrowed.
- Planning of major developments and transport schemes will promote health and wellbeing.
- More people will travel actively, and walking and cycling will be prioritised, benefitting physical and mental health.
- Air quality will be improved.
- Residents will be supported to be safe, warm and well in their homes.
- The underlying causes of homelessness will be tackled.
- A whole city approach to food and wellbeing will be adopted, prioritising those with the poorest diets or least access to healthy food.
- Green & open spaces and sports & leisure facilities will be used effectively to improve wellbeing.
- Libraries and community spaces will be used to improve wellbeing.
- Arts and culture will benefit our health and wellbeing, including within local health and care services.
- People with caring responsibilities will be supported.
- Partners across the city will work with local residents to challenge the normalisation of substance misuse and excessive alcohol consumption and raise awareness of the detrimental impact they have on individuals and communities, so to reduce the associated harm, including physical and mental health problems and the exploitation of young or vulnerable people.

Starting well

The health and wellbeing of children and young people in Brighton & Hove will be improved.

- A focus on early years will maintain our good breastfeeding rates and improve the uptake of childhood immunisation.
- Healthy lifestyles and resilience will be promoted, including in school and other education settings, to reduce the risk of experiencing health problems in later life.
- Risks to good emotional health and wellbeing will be addressed, including parental substance misuse and domestic abuse, and mental health services will be easier to access.
- High quality and joined-up services will consider the whole family and, where appropriate, services will intervene early to provide support to prevent problems escalating.

Living well

The health and wellbeing of working age adults Brighton & Hove will be improved.

- Information, advice and support will be provided to help people to eat well, move more, drink less and stop smoking to reduce their risk of developing long-term health conditions. Local people and communities will be encouraged to make the most of these opportunities to improve their health and wellbeing.
- Mental health and wellbeing will be improved and easier access to responsive mental health services will be provided.
- Sexual health will be improved, including reducing new HIV infections.
- People will receive support to improve their wellbeing at work.
- People with disabilities and long-term conditions, and the long-term unemployed, will be supported into work.

Ageing well

Brighton & Hove will be a place where people can age well.

- The contribution that people of all ages make to Brighton & Hove will be nurtured and celebrated and we will be both an age friendly city and a dementia friendly city.
- The needs of our ageing population will be considered in the design of the physical environment and in planning new developments.
- People will be supported to reduce loneliness and social isolation and to reduce their risk of falls.
- More people will be helped to live independently in the community by services that connect them with their communities.

Dying well

The experiences of those at the end of their life, whatever their age, will be improved.

- A city wide approach will be developed to improve health and wellbeing at the end of life and to help communities to develop their own approaches to death, dying, loss and caring.
- More people will die at home or in the place that they choose.
- Support for families, carers and the bereaved will be enhanced.

Delivering the strategy

How will the strategy be delivered and monitored?

Some of the required action will be incorporated into work already underway while some will require the development of new plans.

The Health & Wellbeing Board will be responsible for monitoring the delivery and impact of the strategy and will agree a set of key indicators.

Other strategies that support health and wellbeing

This strategy provides a bridge between the plans produced by local health and care services and other plans that impact on health and wellbeing in Brighton & Hove. The content of this strategy will be reflected in the development and delivery of these plans.

For more information visit:
www.brighton-hove.gov.uk/health-wellbeing-strategy

6668 Brighton & Hove City Council Communications Team

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:	Transition to new children's safeguarding arrangements
Date of Meeting:	23rd July 2019
Report of:	Pinaki Ghoshal, Executive Director, Families, Children and Learning.
Contact:	Laura Perkins, LSCB Business Manager. Tel: 01273 296736
Email:	laura.perkins@brighton-hove.gov.uk
Wards Affected:	All

FOR GENERAL RELEASE

Executive Summary

This paper summarises proposed changes to children's safeguarding arrangements in line with new legislation under the Children and Social Work Act 2017 and subsequent revision to Working Together to Safeguard Children, 2018.

The report is submitted as a collaborative paper between the three statutory partners: Local Authority, CCG and Police and follows consultation with existing LSCB members. It seeks to set out the governance, strategic aims, scrutiny and structure that will satisfy statutory requirements, delivering the best possible safeguarding and promoting the welfare of children.

Significant timescales have been set out by the DfE. Details of new arrangements must be submitted to them for QA no later than 29th June 2019 and those arrangements should then be live no more than 3 months later.

Under the drive to increase awareness and ensure that safeguarding children is

'everyone's responsibility', this paper will impact on all residents and professionals in Brighton and Hove. There will be some important changes for professionals and existing partners who are involved in safeguarding, but of greatest significance is the impact this will have on our children and young people.
Glossary of Terms BHSCP – Brighton and Hove Safeguarding Children Partnership CCG – Clinical Commissioning Group LSCB – Local Safeguarding Children Board DfE - Department for Education QA – Quality Assure

1. Decisions, recommendations and any options

1. This paper is submitted to the Health and Wellbeing Board for comment and noting.

   Or

2. The Health and Wellbeing Board as asked to approve the New Safeguarding Arrangements and reporting structure.

2. Relevant information

This paper outlines changes to local children's safeguarding arrangements, as required by new legislation detailed in the Children and Social Work Act 2017 and subsequent changes to Working Together to Safeguard Children 2018.

Until the new legislation comes into effect the safeguarding arrangements are undertaken by the LSCB which provides the strategic and operational direction of safeguarding and continuous monitoring of performance in Brighton & Hove using a board structure with an independent chair.

The new primary responsibility for safeguarding children is now placed with three named 'safeguarding partners', Local Authority, CCG and police. The LSCB will cease to exist but there is an expectation that local partners will continue to contribute to safeguarding and may be named as 'relevant agencies' (list of proposed agencies are contained within the report). The new arrangements must include a provision for independent scrutiny (this is not the role of the Health and Wellbeing Board to undertake).

The paper explains the new structure that will take over from the existing arrangements with a strategic steering group, led by the safeguarding partners

overseeing delivery via an operational board and subject specific sub-groups. These groups will ensure strategy and policy are delivered in key areas.

The report sets out timescales for implementation and deals with the requirement for the new partnership to produce an annual report that will detail new arrangements and how effective the arrangements have been in practice.

3. Important considerations and implications

3.1 Legal:

Under the Children Act 2004, as amended by the Children and Social Work Act 2017, LSCBs, set up by local authorities, must be replaced. Under the new legislation, the three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups) must make arrangements to work together with relevant agencies (as they consider appropriate) to safeguard and protect the welfare of children in the area. The child death review partners (local authorities and clinical commissioning groups) must set up child death review arrangements.

The report details the proposals for arrangements for oversight of safeguarding children in the city per the requirements of the Children and Social Work Act (2017), The report details how the current LSCB will be replaced by the Brighton and Hove Safeguarding Children Partnership (BHSCP). The Partnership will need to provide a critical oversight function of the partners effectiveness in safeguarding the children of the city, and so meeting a range of statutory duties to promote the wellbeing of children- both as it relates to individual agencies and in terms of multi-agency working.

Under statutory guidance LSCBs must continue to carry out all of their statutory functions, including commissioning SCRs where the criteria are met, until the point at which safeguarding partner arrangements begin to operate in a local area. Safeguarding partners must publish their arrangements by 29 June 2019. Following publication of their arrangements, safeguarding partners have up to three months from the date of publication to implement the arrangements. The implementation date should be made clear in the published arrangements. Once the arrangements have been published and implemented, the LSCB for the local area will cease to exist.

The arrangements proposed meet the requirements of 'Working Together: transitional guidance' (2018)

Lawyer consulted: Natasha Watson *Date: 21.6.19*

Finance: Financial contributions are detailed in the report.

Sustainability: This is a joint paper that details changes across the current safeguarding partnership. There are no significant changes to commissioning anticipated at this time.

Health, social care, children's services and public health: Detailed in the paper

Supporting documents and information

Appendix1: Report for HWB on transition into new safeguarding arrangements.

Brighton & Hove Safeguarding Children Partnership

New Safeguarding Arrangements 2019

Brighton & Hove Safeguarding Children Partnership

Published Arrangements June 2019

This paper sets out the new local safeguarding arrangements as determined by the statutory safeguarding partners in accordance with the revised statutory guidance in "working together to safeguard children" (2018). They have been developed by the statutory safeguarding partners following productive engagement and consultation with all partners currently participating in Brighton & Hove LSCB.

These arrangements will be signed off through the appropriate governance process for Brighton and Hove City Council, the CCG and Sussex Police. These arrangements will be published by 29th June 2019 and will be implemented within three months of publication.

Geoff Raw,
Chief Executive,
Brighton and Hove City Council

Adam Doyle,
Chief Executive Officer,
Sussex and East Surrey Clinical Commissioning Groups

Giles York,
Chief Constable QPM,
Sussex Police

Contents

1. BHSCP Vision and Values

1.1 The Brighton and Hove Safeguarding Children Partnership has a vision that:

Children and young people in Brighton & Hove live a life free from fear, harm, abuse and exploitation, enabling every child in every part of the City to achieve their potential.

This is underpinned by our Core Values:

- A child centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.
- Safeguarding is everyone's responsibility: for services to be effective each citizen, practitioner and organisation should play their part.

2. Introduction

2.1 These arrangements are in line with 'Working Together to Safeguard Children (WTSC)' (2018) and are subject to approval by the Health & Wellbeing Board.

2.2 The partnership will be known as the Brighton & Hove Safeguarding Children Partnership (BHSCP) and will be coterminous with the Brighton and Hove Local Authority area with the exception of the work of the Child Death Overview Panel (CDOP) which will have a Pan-Sussex geographical footprint.

2.3 The three lead safeguarding partners are as follows:

- **Brighton and Hove City Council**
  Nominated officer: Executive Director, Families, Children and Learning (FCL)
- **Sussex Clinical Commissioning Groups**
  Nominated officer: Head of Safeguarding and Looked After Children
- **Sussex Police**
  Nominated officer: Detective Superintendent, Safeguarding Investigations Unit

2.4 The BHSCP will commission Independent Scrutiny (IS) for the partnership, whose role and function will be to provide external challenge to the business of the partnership, its meetings, subgroups and priorities.

2.5 The BHSCP draws on a positive environment of multi-agency working in Brighton and Hove. We are committed to partnership working between the three key partners, with all relevant agencies, with children and young people and with local communities. We aim to promote the welfare of all children and to ensure that children and young people are effectively safeguarded. We aim to achieve this by implementing WTSC (2018) effectively and imaginatively. We aim to work to support: universal safeguarding and protection of children and young people in public arenas, more safeguarding presence in social media, and more knowledge of safeguarding within organisations in the community.

2.6 The following principles have guided the work to develop the new arrangements:

- Striving to constantly improve and develop the quality of safeguarding across the city
- Development of an effective form of independent scrutiny
- Creative engagement with and seek the voice of young people
- Creative engagement with the wider community
- Ensuring that 'relevant agencies' continue to be involved in the activities of the partnership, for example, through membership and the work of the subgroups, participation in community engagement events, consultation on specific issues
- Development of Pan Sussex arrangements, as appropriate.

3. Governance

Pan-Sussex

3.1 In Brighton & Hove we start from a position where strong collaboration with West and East Sussex Safeguarding Partnerships is already happening, however, the safeguarding partners recognise the opportunity to further develop consistent policies throughout the safeguarding community. Any further collaboration, whilst welcomed, needs to be balanced against the acknowledged position that each local authority carries its own safeguarding risks.

3.2 Where appropriate the partnership will work with pan-Sussex partners to allow opportunity for innovation, improved practice, and creating better outcomes for our children and young people across a much wider area.

3.3 To drive forward the pan-Sussex arrangements there will be regular meetings at both business manager and strategic leadership level.

3.4 We will strive to ensure that there is 'consistency of language' pan-Sussex.

Pan-Sussex Strategic Leadership Group

3.5 The safeguarding partners from all three areas (West Sussex, East Sussex, and Brighton & Hove) will oversee Pan Sussex Strategic Governance through a Pan-Sussex Strategic Leadership Group; this will set a 'road map' for how to develop the partnership in the future.

Pan-Sussex Procedures Group

3.6 The pan-Sussex Procedures group currently oversees the Safeguarding & Child Protection Procedures website; this group will continue to meet on a quarterly basis.

Pan-Sussex Quality Assurance Framework (QAF)

3.7 We plan to develop a pan-Sussex Quality Assurance Framework (QAF), in relation to JTAI themes, which would create a consistent approach, better align quality assurance activity across the county, and reduce the potential for duplicated quality assurance efforts. A pan-Sussex QAF would also afford an opportunity to improve audit scheduling which could further support agency involvement from those agencies that span the county.

3.8 Each local authority area will also retain a local quality assurance sub-group (In Brighton & Hove this is the Monitoring and Evaluation group).

Brighton and Hove

Steering Group

3.9 There will be a Brighton & Hove Steering Group which will meet quarterly. This will be attended by:

- The nominated officers for the three lead safeguarding partners (Local Authority, CCG and Police)
- The independent scrutineer
- The designated professionals for the 3 agencies
- The chairs of the BHSCP subgroups
- A representative from the Community Safety Partnership
- A professional to represent schools and early years

3.10 People with expertise (including members of the Youth Reference Group) will be invited to attend the steering group if required to discuss specific issues.

3.11 This meeting will be chaired by the Independent Scrutineer.

3.12 Deputies of sufficient seniority will be allowed to attend the steering group provided the Chair has been notified in advance.

3.13 The meeting will be organised and supported by the Business Manager and the Senior Administration Officer.

3.14 The Steering group will be provided with data and intelligence in order to be fully appraised of the effectiveness of help, including early help, being provided to children and their families. This will include:

- Analysis of multi-agency statistics, performance measures and outcomes
- Scrutiny of reports
- Section 11 self-assessments and challenge events
- Practitioner and partnership challenge events
- Oversight of Child Safeguarding Practice Reviews (CSPRs)

3.15 This group will be responsible for the following:

- Developing & overseeing the overarching strategic aims of the BHSCP
- Setting safeguarding priorities for the BHSCP
- Financial planning and resourcing of the safeguarding arrangements
- Agreeing the Annual Report for publication
- Consideration of joint commissioning
- Oversight of safeguarding work completed by local partners through the Board
- Appointment of an independent scrutineer
- Consideration of opportunities for working in collaboration with other geographical areas to reduce cost and improve performance

4. Independent Scrutiny

4.1 The Independent Scrutineer will consider how effectively the arrangements are working for children and families as well as for practitioners, and how well the safeguarding partners are providing strong leadership. To achieve this, the Independent Scrutineer will attend the subgroups and speak to practitioners and service users to understand the effectiveness of partnership work.

4.2 The Independent Scrutineer will report to the steering group, providing details of strengths, weaknesses, and challenges.

4.3 The Independent Scrutineer will:

- Act as a constructive critical friend, providing critical challenge and appraisal of Brighton and Hove's multiagency safeguarding partnership arrangements in relation to children and young people
- Act independently of the three safeguarding partners
- Focus on the impact of the partnership arrangements and working rather than processes
- Promote reflection to drive continuous improvement
- Introduce the Annual Report
- Front 'Child Safeguarding Practice Review' publications, where needed, to demonstrate independent scrutiny

4.4 The Independent Scrutineer will scrutinise the decisions to undertake child Safeguarding Practice Reviews and provide challenge where s/he feels the decision is not correct. Where there is disagreement across the partnership in relation to commissioning of reviews the Independent Scrutineer will be the final decision maker.

4.5 The Independent Scrutineer role will be accountable to the partnerships and 3 Chief Officers. The employment and management will be through the Local Authority.

4.6 The partnership will continue to have lay member representation in the subgroups and board and lead member representation un the board, as this provides another level of scrutiny and challenge.

5. Annual Report

5.1 The steering group will produce an Annual Report which will be owned by the three Safeguarding Partners. This report will be available on the BHSCP website.

6. Business Delivery Model: Structure and Responsibilities

6.1 The work of the partnership will be driven by the BHSCP subgroups, which will be responsible for managing work streams and delivering against partnership strategies. The BHSCP will work in partnership with a list of 'relevant agencies', as defined by WTSC (2018), to ensure representation on the subgroups from wider partners.

6.2 The overall purpose of all subgroups is to:

- Drive forward and deliver the work of the Partnership
- Provide reports and information that will inform the strategies set by the Steering Group
- Report on progress to the Steering Group
- Keep the Steering Group appraised of emerging threats, patterns and gaps in safeguarding delivery
- Consider recommendations arising from local and national serious child safeguarding practice reviews.

6.3 The groups will require strong leadership and should be attended by individuals with decision-making status and who can contribute towards the end goals. The chairs of the subgroups will attend the steering group.

Case Review Group and Child Safeguarding Practice Reviews

6.4 The partnership will work to improve child protection and safeguarding practice through its review of practice, scrutiny and challenge functions, identifying areas of good practice, areas for improvement and in particular from the learning from local and national Child Safeguarding Practice Reviews. The reviews will be conducted in such a way to provide opportunities to explore why individuals and organisations operate in a particular way, making use of relevant research, case evidence, incorporating learning from national, regional and local reviews to inform findings and learning. The process will place the child at the centre, including them and their families (where possible) to understand their lived experience. Reviews will involve practitioners and managers in order to understand practice from their viewpoint.

6.5 Processes will be implemented to regularly monitor and follow-up actions from reviews/learning opportunities to ensure they make a real impact on improving outcomes for children and improvements are sustained.

6.6 The case review group will consider whether the partnership should undertake Child Safeguarding Practice Reviews (CSPR) or Learning Reviews, follow the progress of reviews underway, agree final reports, develop action plans and track actions.

6.7 All notifications, rapid reviews and practice reviews will be shared with the steering group and the Independent Scrutineer, so that they are fully aware of good practice, key incidents and developments.

6.8 We will review our Learning and Improvement framework to ensure that there is a mechanism to review good practice and disseminate any learning Pan Sussex.

Monitoring & Evaluation Group

6.9 The BHSCP will ensure data and intelligence is used to fully appraise the effectiveness of help, including early help, being provided to children and their families. The Monitoring & Evaluation group will hold the quality assurance function and provide the review and scrutiny.

6.10 This group's work currently includes:

- Analysis of multi-agency statistics, performance measures and outcomes
- Single and multi-agency audits
- JTAI audits and action plans

6.11 The group will undertake two multi-agency audits per year and present the Management Information Report to the steering group every six months.

6.12 This group will oversee and ensure that threshold documents are reviewed, as appropriate. The current documents are aligned to the new arrangements.

Exploitation Group

6.13 The Exploitation Group is a joint group with the Safeguarding Adults Board (SAB) and the Community Safety Partnership.

6.14 The Exploitation group reports to all three boards but the strategy is held by the Community Safety Partnership. It ensures the Violence, Vulnerability and Exploitation (VVE) strategy is operationalised via the action plan and addresses any multi-agency sticking points.

Learning & Development Group

6.15 The Learning & Development group will support the BHSCP Learning and Development Officer in commissioning, delivering, reviewing and evaluating the quality, scope and effectiveness of single-agency and multi-agency training to ensure all those coming into contact/working with children are competent and up to date with current legislation.

6.16 The Learning & Development group will work closely with other BHSCP groups, notably the Monitoring & Evaluation group and the Case Review group, so that output of one group informs the input to another.

6.17 Under the new arrangements this group will support the Business Manager with progressing the partnership's youth and community engagement work.

6.18 The group will ensure that learning from Pan-Sussex reviews is disseminated and incorporated into Brighton and Hove learning events.

Safeguarding Liaison Group (SLG)

6.19 The SLG is a forum for managers across the multi-agency partners to discuss practice, review local pathways, and consider cases where there are multi-agency practice concerns.

6.20 This group is not a statutory requirement, but the partners feel this is a valuable group that helps address multi-agency operational safeguarding issues.

7. Safeguarding Partnership Board

7.1 The Safeguarding Partnership Board will bring together wider partners from across the city to ensure the strategic direction as set by the steering group and subgroups is taken forward and operationalised in all organisations.

7.2 Proposed membership:

Brighton & Hove City Council	• Executive Director of Children's Services • Assistant Director Children's Services: Safeguarding & Care • Assistant Director Children's Services: Education & Inclusion • Head of Safeguarding • Head of Safer Communities • Tenancy Services Operation Manager, Housing • Education/Early Years Safeguarding Lead Officer • Lead Member, BHCC Children's Services • Managing Principal Lawyer
Public Health	• Director of Public Health • Public Health Strategic Commissioner Children's Services
Sussex Police	• Detective Superintendent, Public Protection • Detective Chief Inspector
National Probation Service	• Senior Operations Manager
Kent Surrey & Sussex Community Rehabilitation Company	• Senior Probation Officer
CAFCASS	• Service Manager
Domestic Violence Forum	• Chair, Brighton & Hove Domestic Violence Forum
Community & Voluntary Sector	• Three representatives, proving a good spectrum of representatives from across the CVS partnership, including sports groups.
Schools	• Primary School Representative • Secondary School Representative • Independent Schools Representative • College/FE Representation
NHS England (South East)	• Assistant Director for Safeguarding and Quality
Brighton & Hove Clinical Commissioning Group (CCG)	• Head of Safeguarding and Looked After Children • Named GP • Designated Doctor • Designated Nurse for Safeguarding Children
Brighton & Sussex University Hospitals (BSUH)	• Chief Nurse • Named Nurse • Named Doctor
Sussex Community Foundation Trust (SCFT)	• Named Doctor • Named Nurse • Head of Safeguarding • Lead Nurse for CSARC
Sussex Partnership Foundation Trust (SPFT)	• Lead Nurse • Named Nurse
East Sussex Fire & Rescue Service (ESFRS)	• Head of Community Safety • Inclusion and Partnership Manager
South East Coast Ambulance Service	• Executive Director • Safeguarding Practitioner

7.3 The purpose of the Board is to:

- Ensure good representation from organisations on subgroups
- Operationalise the strategic aims of the steering group
- Raise issues put forward by Steering Group
- Engage the wider safeguarding community

7.4 This group will meet quarterly and will be chaired the Independent Scrutineer.

8. Arrangements for Commissioning and Publishing Local Child Safeguarding Practice Reviews

8.1 BHSCP will work to improve local child protection and safeguarding practice through our practice, scrutiny and challenge functions.

8.2 Different subgroups will be responsible for leading on specific elements of CSPRs, for example commissioning and monitoring will be undertaken by the Case Review Group, and the Learning and Development Group will be responsible for identifying and responding to identified training needs as a result of the review findings.

8.3 We will incorporate learning from national, regional and local reviews.

8.4 The decision to undertake a CSPRs sits with the three safeguarding partners. The Chair of the sub-group makes recommendations that will be ratified or rejected by the partners. If an issue cannot be resolved, it will be referred to the independent scrutineer.

9. Youth Custody and Residential Homes

9.1 Brighton and Hove do not have any secure residential accommodation for children and young people or Youth Offender Institutions. Should this situation change in the future then the BHSCP will include scrutiny of the effectiveness of these or similar settings.

9.2 Brighton and Hove have three children's homes run by an independent provider. A representative of the provider will be invited to join the Safeguarding Partnership Board and we will ensure that their staff are kept updated with the work of the partnership through our newsletter and training events.

10. Liaison with Other Partnerships

10.1 The partnership is committed to multidisciplinary working in order to deliver effective outcomes and have a positive impact on the lives of children and young people. Strong collaborative relationships which are already established with the Safeguarding Adult Board and the Community Safety Partnership will continue. Joint working arrangements on specific themes (e.g. exploitation and trauma) will be maintained and progressed.

11. Child Death Overview Panel

11.1 The future arrangements of the Child Death Overview Panel are being progressed separately, led by the Child Death Review (CDR) Partners, namely the Local Authority and the CCG. It is acknowledged that there is a need to maintain the excellent links with CDOP, including early information exchange when children die.

12. Engagement

12.1 The BHSCP is committed to ensuring that we are consulting with the community and children and young people when developing our strategies. The partnership will achieve this by including:

Community, Voluntary sector and faith group Voice

12.2 We recognise that there are a lot of small voluntary, charity, social enterprise (VCSE) and faith groups within our city that we want to engage with.

12.3 Through offering one or two targeted community events a year we hope to engage voluntary, charity, social enterprise (VCSE) and faith groups in training, challenge and consultation.

12.4 The youth reference group (see below) would be involved in the planning of these events.

Youth Reference and Challenge Group

12.5 A crucial element to our new working arrangements is to ensure the voice of the child and families are considered when developing strategies and delivering safeguarding.

12.6 In Brighton and Hove the Local Authority has already developed a 'Youth Voice Forum' which works with young people identified by the community and voluntary sector to provide challenge and scrutiny on work and delivery of services provided by the local authority and council decision making. It is proposed that BHSCP work with this group, enabling them to provide challenge and the voice of young people to the partnership. Through additional joint work with the community and voluntary sector, there will be good access young people from across the city.

12.7 Sussex Police and Brighton & Hove CCG also have such arrangements in place, which the Partnership will seek to utilise.

13. Engaging with Partners within the Wider Safeguarding Arrangements

13.1 BHSCP will maintain an up-to-date website that will contain all relevant information. We will publish briefings and newsletters aimed at relevant professionals, children, young people and families. Signing up for the newsletter will be widely promoted through training, events and through community outreach.

13.2 BHSCP will host a learning event each year, in addition to the training programme, targeting smaller community groups. It will focus and deal with key safeguarding issues and/or emerging themes. It will provide an excellent opportunity to disseminate learning to a wider safeguarding community, learning from each other and support both statutory and non-statutory agencies in their safeguarding provision. The forward plan for the themes will be determined by the Steering Group.

14. Supporting the Partnership: The Role of BHSCP Staff

14.1 It is crucial that the safeguarding partnership has stable and robust support to both instigate and then develop the safeguarding work in the medium and long term. In order to ensure this the safeguarding partners have agreed the following:

Business Manager Role

14.2 The Business Manager will:

- Produce the Annual Report, Business Plan and strategies on behalf of the Partnership,
- Manage all case review activity, including liaison with the National Panel, on behalf of the Partnership,
- Set revised Terms of Reference for Partnership Sub-groups and manage the running of these,
- Vice-chair sub-groups,
- Provide business support to both the Partnership and the Independent Scrutineer,
- Recruit and support lay members,
- Manage the partnership staff, administration officer and the Learning and Development Officer,
- Be responsible for the BHSCP budget,
- Lead the community development work with faith/community groups, families and the youth group to ensure the voice of the child, families and the voice of the community are including and heard on all issues pertaining to the partnership.

Learning and Development Officer Role

14.3 The Learning and Development Officer will:

- Co-ordinate and provide the partnership safeguarding training,
- Working with Pan-Sussex partners, develop a Pan-Sussex training programme, as well as a local programme, identifying areas that may need to be addressed for local issues,
- Ensure learning from Child Safeguarding Practice Reviews and Learning Reviews across the Pan-Sussex area is disseminated (currently we only disseminate Brighton & Hove Reviews).

Senior Administration Officer Role

14.4 The Senior Administration Officer will:

- Provide support to the Partnership, Business Manager and Independent Scrutineer,
- Service all meetings, training events and conferences,
- Ensure the website and Twitter accounts are up to date, generate and upload news stories on behalf of the Partnership onto social media sites,
- Support the community engagement work and coordination of the community engagement activities.

Hosting the New Local Arrangements

14.5 The Local Authority will continue to host the post of Business Manager, Learning and Development Officer and Senior Administrator.

15. Finance

15.1 BHSCP will encourage equitable financial contributions from each of the partner organisations.

15.2 The partnership will seek funding from the wider partnership and explore the possibility of increasing income from training.

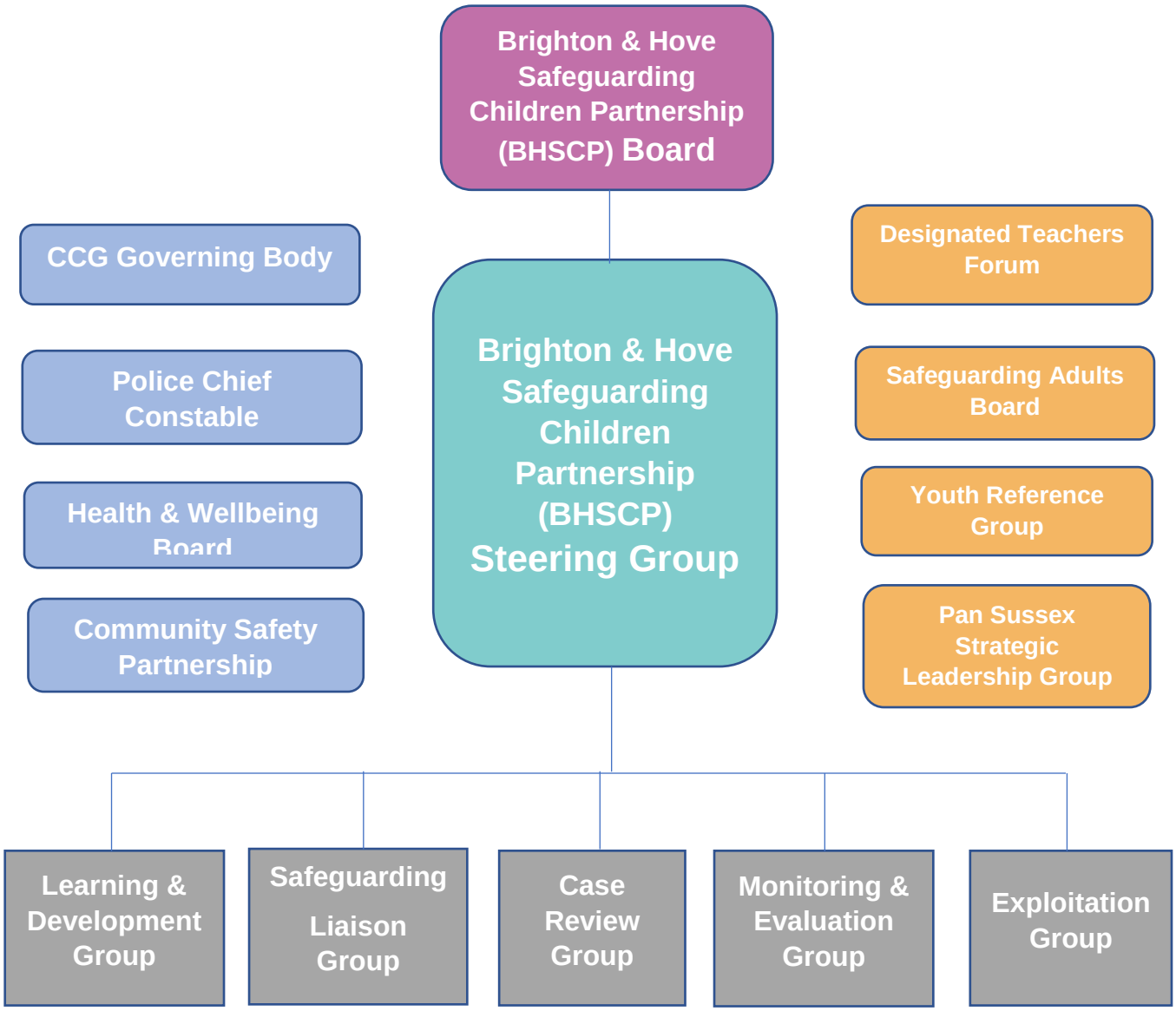
15.3 The partnership aims to put a mechanism in place for equal funding of Child Safeguarding Practice Reviews if they go over budget. A MOU will be developed.

16. Dispute Resolution

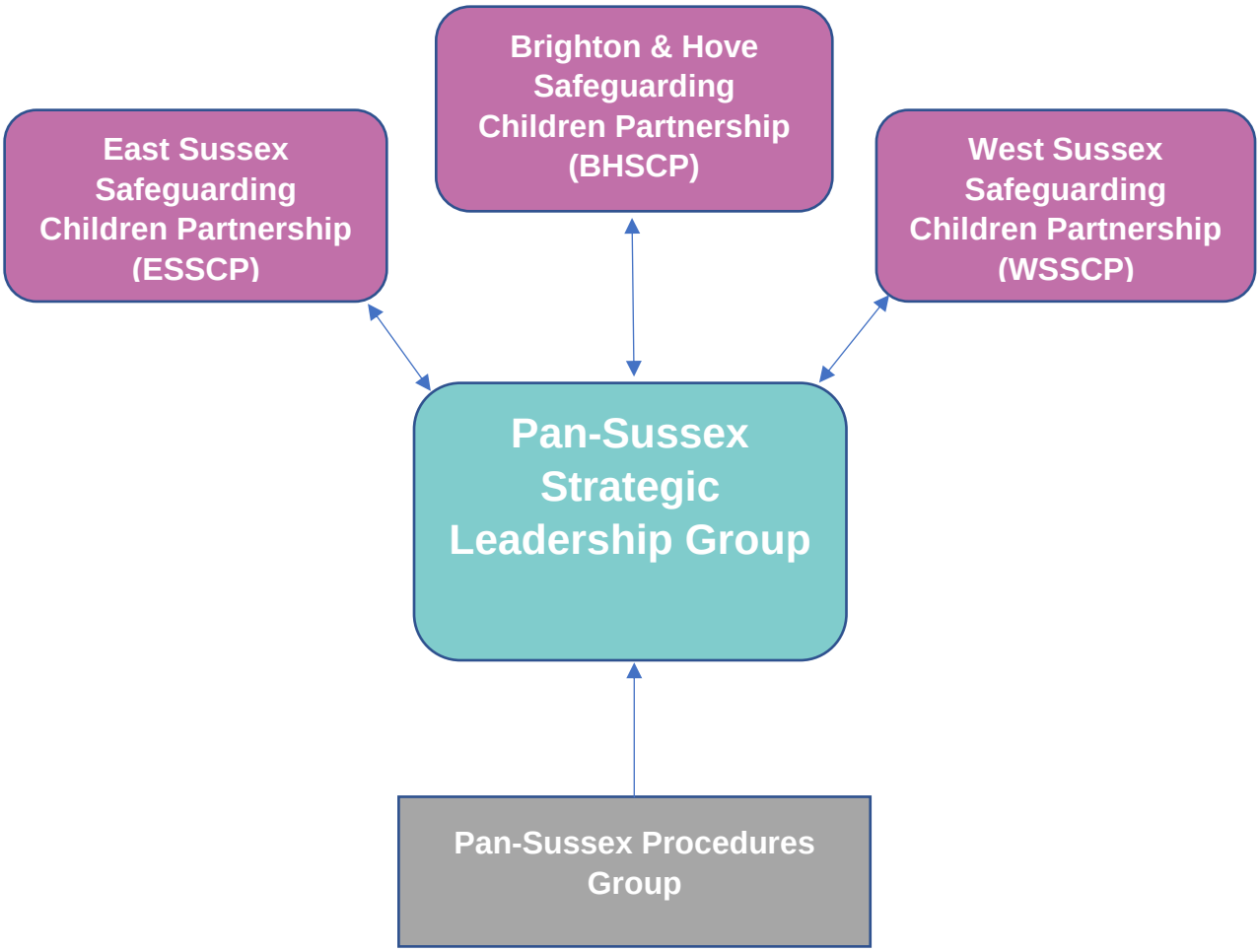
16.1 The BHSCP will use the dispute resolution procedure for professional conflict or disagreement that already exists in the Pan Sussex Safeguarding Procedures. Link here.

16.2 A conflict resolution protocol in regard to conflict between the three partner agencies will be developed. It is proposed that where there is conflict between the partners the independent scrutineer will be empowered to arbitrate to ensure decisions can be reached.

Appendix 1: Brighton & Hove Safeguarding Children Partnership Governance Flowchart



Appendix 2: Pan-Sussex Safeguarding Children Partnership Governance Flowchart



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 Sexual Health Services
Date of Meeting:	23rd July 2019
Report of:	Executive Director of Health and Adult Social Care
Contact:	Stephen Nicholson, x 6554 Lead Commissioner - HIV, Sexual Health and Substance Misuse
Email:	stephen.nicholson@brighton-hove.gov.uk
Contact	Judith Fisher, x 6974 Lawyer
Email	judith.fisher@brighton-hove.gov.uk
Wards Affected:	All

FOR GENERAL RELEASE

Executive Summary

This paper describes options for the arrangements for the future provision of sexual health services and seeks approval from the Health and Wellbeing Board for a two year extension of the current contract

Glossary of Terms

BHCC	*Brighton & Hove City Council*
HIV	*Human immunodeficiency virus*
JSNA	*Joint strategic needs assessment*
MSM	*Men who have sex with men*

PCR	*Public contract regulations 2015*
PreP	*Pre-exposure prophylaxis (HIV medication to prevent the sexual acquisition of the infection)*
SHAC	*sexual health and contraception (service)*
STI	*Sexually transmitted infection*
TUPE	Transfer of Undertakings (Protection of Employment) Regulations

1. Decisions, recommendations and any options

The purpose of this report is

1.1 To seek approval from the Health and Wellbeing Board to a two year extension of the current contract for the provision of statutory sexual health services required under the Health and Social Care Act 2012 and Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013.

1.2 For Health and Wellbeing Board to note the new requirements to adopt a co-commissioning model and to jointly develop a local sexual health plan.

2. Relevant information

Nature of the service requirement

2.1 Good sexual and reproductive health and wellbeing is an important contributor to our overall wellbeing. The quality of sexual and reproductive health and HIV services rely in part on effective commissioning[1].

2.2 There is a high burden of poor sexual health in Brighton and Hove with the 20th highest rate of new sexually transmitted infections (STIs) of 326 local authorities in England and the highest rates in South East region. Gay and other men who have sex with men (MSM), younger people, under 25 and those with a black ethnicity are at highest risk of STIs.

2.3 Brighton and Hove has the 7th highest prevalence of diagnosed HIV in England and the highest outside of London. In 2017 the prevalence was 8.5/1,000 aged 15-59 compared to 2.32/1,000 in England. The vast majority (83%) of people (91% of males) probably acquired the infection through sex between men. Eighty six per cent of people living with HIV in Brighton and

1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/640578/Sexual_health_reproductive_health_and_HIV_a_survey_of_commissioning.pdf

Hove are white but over half of women living with HIV locally are black African.

2.4 The under-18 conception rate in Brighton and Hove is 19.3/1,000 females aged 15-17 while in the South East region the rate is 13.9/1,000 and in England the rate is 17.8.8/1,000. Teenage conceptions have been on a long term downward trend.

2.5 More detail on the local picture of HIV and sexual health is available from the JSNA summaries: http://www.bhconnected.org.uk/content/needs-assessments

Statutory requirement

2.6 Local authorities assumed the responsibility for commissioning most sexual health services as part of the transfer of the public health function from the NHS to local authorities in 2013. Services are funded from the ring-fenced public health grant provided by central Government. The mandated function requires each local authority to secure the provision of open access sexual health services in its area including: preventing the spread of STIs (inc HIV); testing, treating and caring for people with STIs and partner notification; the provision of contraceptive services including advice on, and reasonable access to, a broad range of contraceptive substances and appliances and advice on preventing unintended pregnancy. Local authorities are not responsible for the provision of HIV treatment services as these are commissioned by NHS England. Brighton and Sussex University Hospitals Trust (BSUH) is the local provider of HIV outpatient and inpatient treatment services.

2.7 Prior to April 2015, services for STI testing, treatment and care and community contraception in Brighton and Hove were provided independently by separate NHS trusts in different locations. This meant that female patients often required multiple appointments at different services.

Current Contract and Services

2.8 Following approval from BHCC Policy and Resources Committee in March 2014, a lead provider contract was awarded (in accordance with the then current public contract regulations) to Brighton and Sussex University Hospitals NHS Trust (BSUH) for an integrated sexual health and contraception (SHAC) service. BSUH established a partnership agreement with the Sussex Community Foundation NHS Trust (SCFT) to provide some elements of the service. The contract was for three years from 1 April 2015 with an option to extend for an additional 2 years. The contract extension was subsequently agreed together with savings targets. As part of the savings plans the partnership agreement was dissolved in 2018 and the SCFT staff were transferred under TUPE into BSUH.

2.9 The contract value for 2019/20 is £3,035,000. This represents a 13% reduction in value from contract inception. These reductions have been made in response to year on year cuts to the public health budget by central Government. Following the reversal of sexual health budget cuts at budget council we are discussing options with the provider to ensure the best use of the resource. This will include ensuring access to PrEP and reducing waiting times.

2.10 The integrated SHAC service is currently delivered from three 'one stop shop' sites across the City with a mix of walk-in and booked appointments as well as the provision of on-line self-testing kits. SHAC also provides a chlamydia screening programme, condom distribution and sexual health promotion for young people (<25). The service is well regarded. Despite budget reductions positive and productive joint working between commissioners and the provider have ensured that quality has been maintained.

2.11 The provision of integrated sexual health services is supported by guidance from the relevant professional bodies including the Faculty of Sexual and Reproductive Health (FSRH), British Association of Sexual Health and HIV (BASHH), the British HIV Association (BHIVA), the Medical Foundation for AIDS and Sexual Health (Medfash), The Royal College of Obstetricians and Gynaecologists (RCOG) and NICE. National policy and guidance endorsing the approach is issued by the Department of Health and Public Health England (PHE).

2.12 The current contract will come to an end on 31st March 2020.

Future Contract and Services

2.13 Arrangements need to be made for the future provision of the service from the 1st April 2020. This can be achieved by extending the current contract or by awarding a new contract in accordance with the Public Contract Regulations (PCR) 2015.

2.14 There has been significant uncertainty regarding the longer term responsibilities for the commissioning of sexual health services. The NHS Long Term Plan, published in January 2019, announced that the Government was to review the future commissioning arrangements for sexual health with a view to extending the role of the NHS in this area. Subsequent statements by the Secretary of State for Health and Social Care confirmed that the Government was considering structural changes between the NHS and local authorities with regard to the commissioning responsibility for sexual health services.

2.15 The effect of the uncertainty has been to delay the development of local commissioning plans.

2.16 In June 2019, the Secretary of State for Health and Social Care announced the outcome of his review and confirmed that there would be no change in the commissioning responsibilities for sexual health services. There are however, additional requirements of local authorities in this regard.

2.17 Every local area is now required to adopt a co-commissioning model and to jointly develop a local sexual health plan with local and national NHS partners. No timescale for the delivery of these arrangements has been announced.

Available options

2.18 The options to extend or to procure have both been considered and the recommendation to H&WBB is that the current contract be extended for a period of 2 years for the reasons set out below.

Re-procure

2.19 In order to continue to ensure the most cost effective service and that best value continues to be achieved a tender issued to the market would need to be for the medium to longer term, probably for a minimum of 5 years with the option to extend for a further period of up to 2 years. In light of the current uncertainties it is considered that it would be pragmatic to delay re-procurement and avoid significant procurement costs at the present time and that a two year extension to the current contract would be the best way forward until plans are developed and a clearer picture of the commissioning landscape is available.

Directly Award a new contract

2.20 The PCR provides at Regulation 12(7) as follows

7 *Contracts which establish or implement co-operation between contracting authorities*
A contract concluded exclusively between two or more contracting authorities falls outside the scope of this Part where all of the following conditions are fulfilled: -
(a) the contract establishes or implements a co-operation between the participating contracting authorities with the aim of ensuring that public services they have to perform are provided with a view to achieving objectives they have in common.
(b) the implementation of that co-operation is governed solely by considerations relating to the public interest; and
(c) the participating contracting authorities perform on the open market less than 20% of the activities concerned by the co-operation."

2.21 Expert legal advice is that there is limited and contradictory case law on the application of PCR 12 and whilst there is merit in the argument it is ambitious to rely on it in order to justify a direct award in the circumstances where there

is a history of service delivery on a commercial basis. It is necessary to distinguish how the arrangement is other than a simple arrangement for one party to supply services to another pursuant to a commercial arrangement particularly where official guidance is very much based on the securing of service through a commissioning model

2.22 Other local authorities are currently examining the proper circumstances in which Regulation 12(7) may be applied and in this regard it may be prudent to await clearer authority when an alternative route is available in the shorter term to secure the services.

Extend current contract

2.23 The PCR 2015 permits contracts to be modified (which includes the ability to extend the term) in circumstances permitted in accordance with PCR Regulation 72. Regulation 72 (1)(e) permits contracts to be modified without a new procurement procedure where the modification, irrespective of value, is not substantial within the meaning given to the term substantial set out in Regulation 72(8). A substantial modification is one which renders the contract materially different to in character from the one initially concluded in that the changes would not have attracted additional candidates in the procurement process, or there is a change in the economic balance in favour of the contractor not initially provided for, or the scope of the contract is extended considerably or a new contractor is being appointed.

2.24 The proposed contract extension does not modify the contract substantially within the provisions of the Regulation.

2.25 Contract Standing Order 19 allows for modification of contract provided the finances are in place and the PCR are not breached. The CSO permits Executive Directors to authorise an extension but the value of these services (£3,035,000 per annum) is out-with the delegated authority of Executive Directors and Committee approval is therefore required.

2.26 Significant savings have been realised in the provision of these services. A procurement exercise at the present time when the future commissioning arrangements for the service is under review may not result in a tender which represents the best value as those involved in the provision of the services factor in potential risks arising by reason of the uncertain future.

2.27 In order to secure the continued good value of the service in the short term ensuring that the services are delivered efficiently and without disruption to the service users this report recommends that the Health and Wellbeing Board authorise the extension of the contract for the provision of integrated sexual health services for a period of two years at an annual cost not exceeding £3,035,000.

3. Important considerations and implications

Legal:
The legal implications are included in the body of the report

3.1

Lawyer consulted: J Fisher Date:22nd June 2019

Finance:

3.2 The overall Public Health Grant is £19.559m for 2019/20 which includes funding for Sexual Health services. Any re-provision of this service will need to be managed within the overall grant.

Finance officer consulted: Sophie Warburton Date 20th June 2019

Equalities:

Gay and other men who have sex with men (MSM), younger people, under 25 and those with a black African ethnicity are most at risk of sexual ill-health. Rates of new STIs are higher in more disadvantaged areas.

A full equalities impact assessment will be undertaken as part of the process to award a new substantive contract. This will ensure that the commissioning decisions are underpinned by a thorough assessment of the equality considerations and impact, using the most up to date and relevant data

3.3 Equalities officer consulted: Anna Spragg Date 21st June2019

Supporting documents and information

N/A