Brighton & Hove City Council

Overview & Scrutiny

Title:	**Adult Social Care & Housing Overview & Scrutiny Committee**
Date:	**24 June 2010**
Time:	**4.00pm**
Venue	**Committee Room 1, Hove Town Hall**
Members:	**Councillors:** Meadows (Chairman), Wrighton (Deputy Chairman), Allen, Janio, Kemble, Older, Phillips, and Pidgeon
Contact:	**Kath Vlcek** **Scrutiny Support Officer** 290450 kath.vlcek@brighton-hove.gov.uk

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ADULT SOCIAL CARE & HOUSING OVERVIEW & SCRUTINY COMMITTEE

AGENDA

Part One **Page**

1. PROCEDURAL BUSINESS **1 - 2**

(a) Declaration of Substitutes – Where Councillors are unable to attend a meeting, a substitute Member from the same Political Group may attend, speak and vote in their place for that meeting.

(b) Declarations of Interest by all Members present of any personal interests in matters on the agenda, the nature of any interest and whether the Members regard the interest as prejudicial under the terms of the Code of Conduct.

(c) Declaration of Party Whip – to seek declarations of the existence and nature of any party whip in relation to any matter on the agenda as set out at Paragraph 8 of the Overview and Scrutiny Ways of Working.

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

NOTE: Any item appearing in Part 2 of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls.

2. MINUTES OF THE PREVIOUS MEETING **3 - 6**

Draft minutes of the meeting held on 4 March 2010 (copy attached).

3. CHAIRMAN'S COMMUNICATIONS

4. PUBLIC QUESTIONS

No public questions have been received.

5. LETTERS FROM COUNCILLORS

No letters have been received.

6. NOTICES OF MOTIONS REFERRED FROM COUNCIL

No Notices of Motion have been received.

The City Council actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public. Provision is also made on the agendas for public questions to committees and details of how questions can be raised can be found on the website and/or on agendas for the meetings.

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disc, or translated into any other language as requested.

For further details and general enquiries about this meeting contact Kath Vlcek, (290450, email kath.vlcek@brighton-hove.gov.uk) or email scrutiny@brighton-hove.gov.uk

Date of Publication - Wednesday, 16 June 2010

Agenda Item 1

To consider the following Procedural Business:

A. Declaration of Substitutes

Where a Member of the Committee is unable to attend a meeting for whatever reason, a substitute Member (who is not a Cabinet Member) may attend and speak and vote in their place for that meeting. Substitutes are not allowed on Scrutiny Select Committees or Scrutiny Panels.

The substitute Member shall be a Member of the Council drawn from the same political group as the Member who is unable to attend the meeting, and must not already be a Member of the Committee. The substitute Member must declare themselves as a substitute, and be minuted as such, at the beginning of the meeting or as soon as they arrive.

B. Declarations of Interest

(1) To seek declarations of any personal or personal & prejudicial interests under Part 2 of the Code of Conduct for Members in relation to matters on the Agenda. Members who do declare such interests are required to clearly describe the nature of the interest.

(2) A Member of the Overview and Scrutiny Commission, an Overview and Scrutiny Committee or a Select Committee has a prejudicial interest in any business at a meeting of that Committee where –

(a) that business relates to a decision made (whether implemented or not) or action taken by the Executive or another of the Council's committees, sub-committees, joint committees or joint sub-committees; and

(b) at the time the decision was made or action was taken the Member was

(i) a Member of the Executive or that committee, sub-committee, joint committee or joint sub-committee and

(ii) was present when the decision was made or action taken.

(3) If the interest is a prejudicial interest, the Code requires the Member concerned:

(a) to leave the room or chamber where the meeting takes place while the item in respect of which the declaration is made is under consideration. [There are three exceptions to this rule which are set out at paragraph (4) below].

(b) not to exercise executive functions in relation to that business and

(c) not to seek improperly to influence a decision about that business.

(4) The circumstances in which a Member who has declared a prejudicial interest is permitted to remain while the item in respect of which the interest has been declared is under consideration are:

(a) for the purpose of making representations, answering questions or giving evidence relating to the item, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise, BUT the Member must leave immediately after he/she has made the representations, answered the questions, or given the evidence;

(b) if the Member has obtained a dispensation from the Standards Committee; or

(c) if the Member is the Leader or a Cabinet Member and has been required to attend before an Overview and Scrutiny Committee or Sub-Committee to answer questions.

C. Declaration of Party Whip

To seek declarations of the existence and nature of any party whip in relation to any matter on the Agenda as set out at paragraph 8 of the Overview and Scrutiny Ways of Working.

D. Exclusion of Press and Public

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

NOTE: Any item appearing in Part 2 of the Agenda states in its heading the category under which the information disclosed in the report is confidential and therefore not available to the public.

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls.

BRIGHTON & HOVE CITY COUNCIL

ADULT SOCIAL CARE & HOUSING OVERVIEW & SCRUTINY COMMITTEE

4.00PM 4 MARCH 2010

COMMITTEE ROOM 1, HOVE TOWN HALL

MINUTES

Present: Councillors Meadows (Chairman); Wrighton (Deputy Chairman), Allen, Janio, Taylor, Wells and Smart

Co-opted Members:

PART ONE

42. PROCEDURAL BUSINESS

42A. Declarations of Substitutes

42.1 Councillor David Smart announced that he was attending as substitute for Councillor Dawn Barnett.

42B. Declarations of Interest

42.2 Councillor Keith Taylor declared a personal interest in Item 46(a).

42C. Declarations of Party Whip

42.3 There were none.

42D. Exclusion of Press and Public

42.4 In accordance with section 100A(4) of the Local Government Act 1972, it was considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in section 100I (1) of the said Act.

42.5 RESOLVED – That the press and public be not excluded from the meeting.

43. MINUTES OF THE PREVIOUS MEETING(S)

43.1 That the minutes of the meetings held on 07.01.10 and 21.01.10 be approved as a correct record.

44. CHAIRMAN'S COMMUNICATIONS

44.1 There were none.

45. PUBLIC QUESTIONS

45.1 There were none.

46. LETTERS FROM COUNCILLORS

46.1 Councillor Georgia Wrighton introduced a letter proposing holding a Scrutiny panel on autistic spectrum conditions (ASC).

46.2 Members debated this issue, agreeing to form a panel to look at adult ASC services, potentially including 'transitional' services supporting people moving from children's to adult services. Members also asked for a briefing note on this issue to be circulated to all members.

46.3 Councillor Keith Taylor introduced a letter from Councillor Ian Davey on lease-hold mediation services.

46.4 The Chair directed members to a recent response to similar queries from Nick Hibberd, Assistant Director, Housing Management. Committee members agreed that this response answered most of the queries raised in Councillor Davey's letter and that there was currently therefore no need for the matter to be taken further by the Committee.

46.5 **RESOLVED –** That: a) an ad hoc panel be formed to investigate issues relating to city services for adults with autistic spectrum conditions; b) that Councillor Davey be thanked for his letter regarding lease-hold mediation, but that no further action would be taken at this time.

47. NOTICES OF MOTIONS REFERRED FROM COUNCIL

47.1 There were none.

48. TRAINING SESSION: ADAPTATIONS CARE PATHWAYS

48.1 This Item was introduced by Guy Montague-Smith from Access Point and by Lesley D'Arcy-Garven from Community Solutions.

48.2 Members asked questions on issues including housing adaptations, social care needs assessments and client satisfaction with the service.

48.3 The Chair thanked Mr Montague-Smith and Ms D'Arcy-Garven for their contribution.

49. ANNUAL PERFORMANCE ASSESSMENT FOR ADULT SOCIAL CARE

49.1 This Item was introduced by Denise D'Souza, Acting Director of Adult Social Care (ASC). Ms D'Souza told members that ASC was expecting to be inspected by the Care Quality Commission (CQC) in the coming months, with the inspection anticipated to focus on safeguarding issues and the provision of Learning Disability services in relation to choice and control.

49.2 In answer to a question regarding the ASC assessment process, Ms D'Souza told the Committee that complying with all the demands of assessment could be onerous, but that the process provided valuable assurance for ASC, confirming that it is performing well in most areas and helping identify those areas where services might be improved.

49.3 In response to a query about voluntary sector involvement in ASC, Ms D'Souza offered to bring a report on this issue to a future meeting of ASCHOSC. It was agreed that this report should be added to the agenda for the September 2010 meeting.

49.4 The Chair asked the Acting Director of Adult Social Care to pass on the committee's thanks to all ASC staff for their hard work over the past year – as reflected in the generally very positive assessment.

49.5 **RESOLVED –** That the report be noted and ASC staff be commended for their performance.

50. PERSONALISATION

50.1 This Item was introduced by Denise D'Souza, Acting Director of Adult Social Care.

50.2 In response to a query as to the impact of grant funding ending this financial year, members were told that money provided via the Social Care Reform Grant had been used to 'pump-prime' various initiatives rather than as a funding source for ongoing expenditure, as it had always been recognised that this money would be available for only three years. The roll-out of the Re-ablement programme is expected to relieve pressure on the Community Care budget, as it will reduce people's reliance upon long-term care packages, reducing community care expenditure.

50.3 **RESOLVED –** That the report be noted and an update be received by the Committee in six month's time.

51. ADULT SOCIAL CARE GREEN PAPER/ FREE PERSONAL CARE FOR OLDER PEOPLE - UPDATE

51.1 This Item was introduced by Denise D'Souza, Acting Director, Adult Social Care.

51.2 **RESOLVED –** That the information provided by the Acting Director of Adult Social Care be noted.

52. CARE QUALITY COMMISSION: CONSULTATION ON ASSESSING QUALITY OF HEALTH AND SOCIAL CARE COMMISSIONERS AND PROVIDERS

52.1 Members considered a report concerning a national consultation exercise being organised by the Care Quality Commission (CQC) regarding how the CQC should go about assessing providers and commissioners of health and social care.

52.2 Councillors Anne Meadows and Keith Taylor agreed to meet with a conservative group member (Councillor Dawn Barnett to be invited to contribute) in order to agree a submission on behalf of the Committee.

52.3 **RESOLVED –** That a group of ASCHOSC members should be empowered to make a response to the CQC consultation on behalf of the Committee, providing that this group is able to reach unanimous agreement on the comments to be submitted.

53. ASCHOSC WORK PROGRAMME

53.1 **RESOLVED –** That the draft ASCHOSC Work Programme be adopted as the Committee Work Programme for 2010.

54. ITEMS TO GO FORWARD TO CABINET OR THE RELEVANT CABINET MEMBER MEETING

54.1 There were none.

55. ITEMS TO GO FORWARD TO COUNCIL

55.1 There were none.

The meeting concluded at 6pm

Signed Chair

Dated this day of

Adult Social Care & Housing Overview & Scrutiny Committee 24 June 2010

Briefing note: The Setting of Social Rents

1. Background

In the Housing Green Paper, *Quality and choice: A decent home for all* (DETR, 2000) the Government identified the problem of inconsistency of rents between similar properties in similar areas owned by social landlords of all types. The incoherence was seen as unfair and confusing for tenants, as well as an impediment to implementing a policy of choice based lettings and reforming housing benefit in favour of a local housing allowance (LHA). The existing pattern of rents reflected many factors, including when and where social housing had been built, changes in the subsidies given to social landlords, and the individual rent policies pursued by different landlords, as well as by Government.

It was in this context that the Government announced a new approach to the calculation of social rents in the December 2000 Housing Statement. Ministers' stated objectives in changing social rent setting are:

- that social rents should remain affordable in the long term
- that social rents should be fairer and less confusing for tenants
- that there should be a closer link between rents and the qualities which tenants value in their properties
- that unjustifiable differences in the rents set by local authorities and by registered social landlords should be removed

The new approach established a national formula for the setting of rents in the social housing sector. The initial formula has been amended slightly over the years reflecting the results of a three year review following it's implementation.

The national formula for calculating Local Authority or Housing Association rents is the same to ensure that there are no differences between rents in these sectors.

2. The Formula

The formula is based partly on the relative capital value of the property, partly on average manual earnings in the surrounding area and partly on the number of bedrooms.

The weekly rent is equal to:

70% of the national average rent
multiplied by the relative county earnings
multiplied by bedroom weight

plus

30% of the national average rent
multiplied by the relative property value

The use of local county earnings moderate the impact of property values on rent levels, which ensures that the rents calculated, reflect local incomes and therefore remain affordable.

By considering property size (bedroom weightings) a different rent is calculated for properties with different numbers of bedrooms.

3. An Example to Calculate Target Rent

4 bedroom property
Jan 1999 property value - £77,000

Information supplied by Government

National average rent - £54.62 Average Local Earnings - £281.50
Average National Earnings - £316.40 Bedroom Factor for 4 bed - 1.2
National Average Property Value - £49,750

Step 1 Calculate the Target rent for 2000/01

Weekly Target Rent

70% x (£54.62 x £281.50/£316.40 x 1.2) = £40.82
Plus
30% x (£54.62 x £77,000/£49,750) = £25.36

2000/01 Target Rent = 66.18

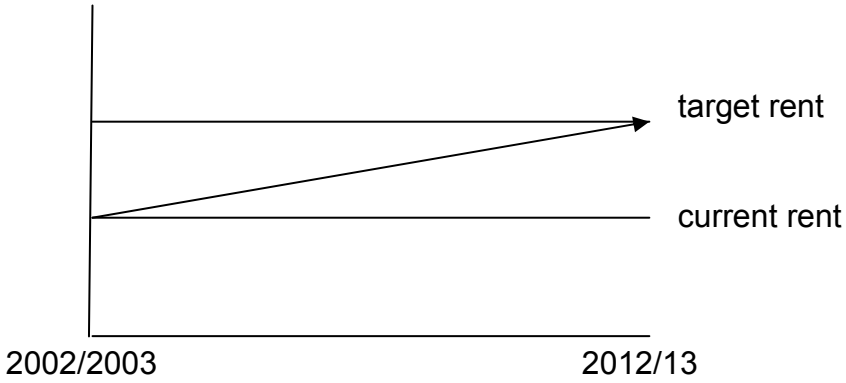
Step 2 Uprate to 2010/11 Target Rent

Multiply by 1.3671 to reflect inflation since 2000/01 (supplied by Government)

2010/11 Target rent = £90.47

4. Implementation

The new target rent will be implemented gradually over a period of years and the process by which current rents move towards the target rent is called rent restructuring or rent convergence. Some rents will be increasing and others decreasing gradually over the rent restructuring period. The Government has recently advised that the date for convergence, currently set at 2012/13 maybe changed annually. The graph below illustrates how this affects social landlords at a national level for increasing rents:



5. Restrictions (Constraints)

The Government has created safeguards to ensure that this is a fair system:

- Rent limits. Rents cannot increase by more than RPI plus ½% plus £2 in any one year.

- Rent caps (ceilings) were introduced to protect tenants in high property value areas. This ensures that properties with a high capital value (such as those in London) will not have an extremely high rent.

6. Service Charges

Housing landlords are able to make charges for additional services that may not be provided to every tenant. Normally these services relate to communal facilities such as cleaning of communal areas or communal aerials. The landlord has discretion on such charges but the service charge made must not recover more than the cost of the service provided. Such service charges are not included in tenant's target rents for rent restructuring purposes.

Local authorities have discretion on whether to implement service charges based on local circumstances. Increases in service charges are normally restricted to RPI plus ½%.

For further information please contact:

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16 June 2010

OVERVIEW AND SCRUTINY COMMITTEE	Agenda Item 8 Brighton & Hove City Council

Subject:		**Transfers of Care from Hospital**		
Date of Meeting:		**24 June 2010**		
Report of:		**The Director of Strategy and Governance**		
Contact Officer:	Name:	Kath Vlcek	Tel:	29-0450
	E-mail:	Kath.vlcek@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report presents information about transfers of care from hospital.

1.2 Information supplied by Adult Social Care and NHS Brighton & Hove is included as Appendix One to this report.

2. RECOMMENDATIONS:

2.1 That members:

(1) Consider and comment on this issue.

3. BACKGROUND INFORMATION

3.1 Please see Appendix One.

4. CONSULTATION

4.1 None was undertaken.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 See Appendix One

Legal Implications:

5.2 See Appendix One

Equalities Implications:

5.3 See Appendix One

Sustainability Implications:

5.4 See Appendix One

Crime & Disorder Implications:

5.5 See Appendix One

Risk and Opportunity Management Implications:

5.6 See Appendix One

Corporate / Citywide Implications:

5.7 See Appendix One

SUPPORTING DOCUMENTATION

Appendices:

1. **Transfers of Care from Hospital**

Documents in Members' Rooms:

None

Background Documents:

1. None

Report regarding Hospital discharges in Brighton & Hove

The purpose of this paper is to provide a briefing to the Adult Social Care and Housing Overview Scrutiny Committee on hospital discharges (including delayed transfers of care) and the actions being taken by the local health and social care economy to manage this process.

Background information

Admission to and discharge from any hospital is often a very stressful time for individuals, their families and friends. Most people, after treatment will return home and their usual way of life continues with very little or no help or assistance from state funded bodies. Some people however will need additional help to enable them to do so over and above their medical treatment. These needs cannot be met by one single organisation working alone. Effective hospital discharges can only be achieved when there is good joint working between the NHS, local authorities, housing organisations, primary care and the independent and voluntary sectors in the commissioning and delivery of services.

The local health and social care economy have been working together on this issue for some years to ensure that the discharge process is effective and efficient and there have been significant improvements over this time. These improvements have been both in the numbers of people being delayed and the length of time people remain in hospital e.g. most delays are usually for only a day or two.

In Brighton & Hove the partnerships established are based on the following premise:

- Acute hospitals should only be used for the those people who need acute hospital care, delivering services that cannot be provided as effectively elsewhere in the health service, or in parts of the social care or housing system
- The majority of people admitted to hospital fear the experience of hospitalisation and of losing their autonomy; they want to return to living their previous lives as soon as possible, with the support of family and friends
- There should be a presumption that every effort should be made to enable people to return to their lives as soon as possible and the NHS and City Council should help them do so.

- The provision of long term residential or nursing care for people coming out of hospital is the last option, other options need to be considered first.

NHS Brighton & Hove (NHSBH) and Brighton & Hove City Council, Adult Social Care & Health (ASC&H) jointly commission and fund arrangements to provide services for people who need support when leaving hospital, these include an Intermediate Care service (both a bed based and home care service); transitional beds and daily living equipment. These services are provided by South Downs NHS Trust, Brighton & Hove City Council Adult Social Care in house teams and Age Concern.

NHSBH also fund people through the Continuing Healthcare funding arrangements for people who need long term specialist health support, they are able to do this for people living at home or in residential or nursing homes. These arrangements include a clinical assessment of need and are not charged for when used. There are also arrangements for those people needing end of life care.

ASC&H fund residential placements through the use of the Community Care budget for those people who are unable to live at home or where there is a need to provide care at home. A social care assessment (including a financial assessment) is made to determine the needs of each individual, and services are increasingly being provided through the use of Self Directed Support or Personalised budgets where people require financial support. Where people are 'self funders' and do not require financial support they are also entitled to an assessment of need and are able to access the service of their choice from a range of services and organisations.

Delayed transfer of care

The national definition of a delayed transfer of care is when a patient is ready for transfer from acute care, but is still occupying an acute bed. A patient is ready for transfer when

a. A clinical decision has been made that patient is ready for transfer **AND**

b. A multi-disciplinary team decision has been made that patient is ready for transfer **AND**

c. The patient is safe to discharge/transfer.

A multi-disciplinary team in this context includes nursing and other health and social care professionals, caring for that patient in an acute setting.

Non acute services also experience delayed transfers and whilst these are not monitored via national targets, they are monitored closely in Brighton and Hove and improvement plans are as relevant to these services as they are to the acute hospital trust.

The current delays in for Brighton & Hove residents equate to on average of 16 delayed discharges per week, this is for a variety of reasons including NHS and social care delays. It is has been recommended there should be a total of approximately 14 delays across BSUH on a weekly basis (8 for Brighton & Hove residents).

Why delayed transfers of care occur?

Patients become delayed for a number of reasons.

- It might be that they require further assessment before their discharge destination can be decided, there may be a lack of capacity in local care homes or community hospitals or they may need a specialist placement or have complex housing issues.
- Some delays are related to personal choice with the patient or their family/carer taking time to make a decision about a long-term placement.
- Sometimes there is a lack of planning when people are admitted to hospital.
- There are also more systemic issues with the discharge process that result in delayed transfers of care. These include delays in requesting assessments and referral to the various services whose input is required to help plan for and facilitate discharge. Some services also require their own assessment and do not fully utilise information in existing assessment. The result is that patients experience serial assessments and minimal 'joined up' working between services.

In comparing acute and non acute reasons for delays it is clear that patients delayed requiring some kind of long term placement or package of care are tending to move to non acute provision first. This is consistent with good discharge planning in that decisions about long term care should not be made in acute setting however patients are remaining in non acute care for extensive periods beyond the decision that they are fit for discharge.

Impact of delays

Delayed transfers of care are important as they have a direct and negative impact on the quality of care of individuals. Older people, for example, are at risk if kept in acute hospital once their medical needs have been met – they lose their independence, mobility, and social networks, and are at risk of falls and infection. For patients with confusion or dementia there are additional risks of losing capacity and of premature entry into a care home.

Delayed transfers of care also have a negative impact on the system as a whole with acute hospital bed days 'lost' to the system making the delivery of key national targets such as the 4 hour standard in A&E particularly challenging for BSUHT.

Monitoring hospital discharges

It is recognised that delayed transfers of care is not something that can be completely eradicated from the system, however the local health and social care economy is measured on delayed transfers of care by the Department of Health and has agreed some local indicators.

Delays are monitored in the following ways:

- The number of delayed transfers of care and reasons for delayed is agreed between social services, the PCT, BSUH and community providers on a weekly basis. This information is collated and used to inform a return (known locally as SITREP) which is submitted to the Department of Health. This information is a snapshot position only and shows the number of people delayed as of midnight on a Wednesday.
- Local organisations are now measured differently, the methodology for measuring individual organisations' performance varies in construction, time periods and data sources:
    - PCTs are measured on delay in acute and community beds as a rate per hundred thousand population.
    - Acute Trusts are measured on acute delays as a percentage of the number of acute admissions.
    - Adult Social Care are measured on delays as a rate per 100,000 population
    - Other organisations including third sector organisations are managed through contracts for service

Funding (Payment by Results and Reimbursement)

Acute trusts are currently recompensed for delayed transfers of care in two ways:

- Under Payment by results, the PCT pays an additional charge on a daily basis when the length of stay of an admission exceeds what is know as the 'trim point' for that particular condition. In the example of a bronchitis admission, a daily charge of £171 would be incurred by the PCT if the admission exceeded 17 days.
- Under the provisions of the Community Care (Delayed Discharges etc) Act 2003, acute hospitals are entitled to levy a daily charge of £100 on local authorities for patients whose discharge is delayed as a consequence of the local authority not putting in place the services the patient or their carer need for discharge to be safe**.** This process is otherwise known as reimbursement**.**

However this still means that a significant proportion of acute capacity is occupied by patients who no longer need acute care. Non acute providers are not entitled to the same recompense.

Actions to address delays

To improve hospital discharge across acute and community services to reduce length of stay and delayed transfers of care a group has been set up with representatives from across the local health and social care economy including commissioners and service providers (representatives from 3rd sector organisations providing care, NHS and the local authority). This group, the Hospital Discharge Operational Group aim to:

- Focus on addressing practical issues to reduce length of stay and delayed transfers of care in acute and community services
- Monitor performance against key performance indicators and national targets relevant to improving hospital discharge
- Determine priority work streams and establish appropriate operational groups to ensure delivery of these priorities
- Monitor the progress of priority work streams ensuring they are delivered within agreed timescales and deliver measurable outcomes
- Review patient case studies and identify opportunities to develop joint solutions to improve discharge planning processes
- Act as an information sharing forum and disseminate national best practice
- Escalate issues as appropriate to the Urgent Care Programme Board (a Board made up of representatives from the local health and social care economy who have responsibility for hospital discharge).

The underlying principles are that:

- Individual organisations take responsibility for managing their own capacity
- There should be tighter management of complex discharges from acute and community
- There should be consistently rigorous reporting of delayed transfers of care

Individual providers are expected to proactively manage their own capacity recognising the impact on the health system if capacity is reduced. They should:

- provide timely and regular briefings to the health system via the threshold meeting if capacity is reduced, for example, due to diarrhoea and vomiting or deep cleaning or staffing issues
- have a robust process in place with clear timeframes for proactively managing the situation so that capacity can be maximised as soon as possible – that this is shared with the local health economy so everybody has the same expectations
- be proactive in identifying immediate solutions to mitigate the loss of capacity with a timeframe clearly specified seek LHE advice and assistance where appropriate, for example, if capacity is reduced for a sustained period (>48 hours).

- Tighter management of complex discharges from acute and community services

There is a daily review of complex discharges at the 'threshold meeting' (conference call). The purpose of the threshold meeting is to:

- undertake a multi agency review of all patients on the complex discharge list (including those patients who are a delayed transfer of care)
- agree actions to expedite discharge
- hold organisations to account for delivering on agreed actions to expedite discharge.

The core membership of this group includes as a minimum a representative from each provider to include South Downs Health NHS Trust, Adult Social Care and BSUH. Where appropriate a member from Sussex Partnership Foundation NHS Trust is invited if there are people who have complex mental health needs. Representatives are sufficiently senior to assume the chair, be able to speak on behalf of their organisation as a whole and able to discuss issues at an individual patient level.

There is a proposal that this meeting should:

- extend to include Saturdays by the end of May and either Sunday or Bank Holiday Monday over a long weekend
- once a week extending the scope of the meeting to review community complex discharges

Underpinning this meeting is an escalation process for those patients who have exceeded their planned discharge date by 48 hours. This applies to patients on the complex discharge list with a confirmed discharge date and destination. Patients for escalation are identified at the daily threshold meeting along with the organisation with lead responsibility for expediting discharge. The lead organisation named senior manager is expected to explain the rationale for the delayed discharge and develop an alternative plan which facilitates discharge within 24 hours.

Each organisation has been tasked to set out an action plan for how they will support the above. There are also discussions regarding the current performance and a general agreement that this needs to improve if as a local health economy are to ensure safe and high quality care that is sustainable for our local population.

Conclusion

Ensuring that people are discharged from hospital in a timely fashion to the placed most suited to each individual remains a cornerstone of the Local Health Economies priorities and delayed transfers of care remain a significant issue for all partners.

The hospital discharge process relies on all agencies ensuring that they are 'playing their' part. Improvements have been made and it is anticipated that the actions currently being taken will mean the whole health and social care community can address the underlying issues and there is a firm commitment to work collectively to ensure a good discharge process and reduce the number of delayed transfers of care.

Wendy Young, Strategic Commissioner for Adults and Older People, NHS Brighton & Hove

Jane Simmons, Head of commissioning and partnerships, Adult Social Care and Health, Brighton & Hove City Council

ADULT SOCIAL CARE AND HOUSING OVERVIEW AND SCRUTINY COMMITTEE	**Agenda Item 9** Brighton & Hove City Council

Subject:		**Audit Commission Report on Health Inequalities**		
Date of Meeting:		**24 June 2010**		
Report of:		**The Director of Strategy and Governance**		
Contact Officer:	Name:	Giles Rossington	Tel:	29-1038
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Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 At its 29 September 2009 meeting, the Audit Committee considered an Audit Commission report on Health Inequalities in Brighton & Hove (the Audit Commission report is reprinted as **Appendix 1** to this report).

1.2 The Audit Committee decided to refer the Audit Commission report to the Health Overview & Scrutiny Committee (HOSC) in order for HOSC to monitor the implementation of the report recommendations. Although not explicitly stated in the Audit Committee minutes, it seems reasonable to assume that the matter was referred to HOSC because Audit Committee members felt that 'health inequalities' were a HOSC issue.

1.3 However, whilst 'health inequalities' undoubtedly fall within HOSC's remit, it was clear from the Audit Commission report Action Plan that most of the report recommendations were not for implementation by health bodies. In fact, the bulk (seven out of nine) of the report's recommendations require implementation by officers of Housing Strategy (albeit sometimes working in conjunction with Public Health officers).

1.4 HOSC members therefore agreed to refer this matter to the Overview & Scrutiny Commission (OSC), asking the OSC to decide where this issue

might best be examined. The OSC has responsibility for "determining arrangements for dealing with a particular issue" where "matters fall within the remit of more than one Overview & Scrutiny Committee (Constitution Point 6: Paragraph 3.1b). The OSC considered this matter at its 27 April 2010 meeting and agreed to refer the matter to ASCHOSC, since most of the Audit Commission report recommendations involve the council's Housing Strategy department. An extract from the minutes of the OSC meeting is reprinted as **Appendix 2** to this report.

2. RECOMMENDATIONS:

2.1 That members:

(I) note the contents of the Audit Commission Health Inequalities report (**Appendix 1**);

(II) determine what additional action to take in regard to monitoring the implementation of the report Action Plan.

3. BACKGROUND INFORMATION

3.1 'Health Inequality' refers to the variable health outcomes across the population, with some groups of people typically suffering much worse health and earlier mortality than others.

3.2 Given the existence of a national framework of standardised NHS healthcare provision available to all UK citizens free at the point of contact, it is not generally considered that health inequalities significantly correlate with unequal access to healthcare or with major differences in the quality of NHS provision from place to place (although poorer communities may typically experience some access problems, particularly in terms of primary care services such as GP surgeries and dental practices).

3.3 Rather, health inequality is thought to correlate most strongly with social factors, such as worklessness, poor housing etc. Therefore, tackling health inequality requires effective partnership working between health bodies, local authorities and other agencies.

4. CONSULTATION

4.1 No formal consultation has been undertaken in preparing this paper.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are none for Overview & Scrutiny, as any monitoring work can be managed by the Overview & Scrutiny (O&S) team in the course of its day to day work.

Legal Implications:

5.2 The actions recommended at 2.1 above fall within the authorised functions of ASCHOSC. Part 6.1, paragraph 3.2(vii) of the council's constitution refers.

Equalities Implications:

5.3 Health Inequalities are clearly a core equalities issue, and as such are addressed within the main body of the audit Commission report.

Sustainability Implications:

5.4 None identified.

Crime & Disorder Implications:

5.5 None identified.

Risk and Opportunity Management Implications:

5.6 None identified.

Corporate / Citywide Implications:

5.7 Tackling health inequalities is a core priority of the Council ("Reduce Inequality by increasing opportunity"). It is also a significant driver for the Local Strategic Partnership and one of the key determinants of NHS Brighton & Hove's commissioning strategy.

SUPPORTING DOCUMENTATION

Appendices:

1. The Audit Commission Health Inequalities report;

2. Extract of relevant minutes from the 29.09.09 Audit Committee meeting.

Documents in Members' Rooms:

None

Background Documents:

None

Managing Health Inequalities

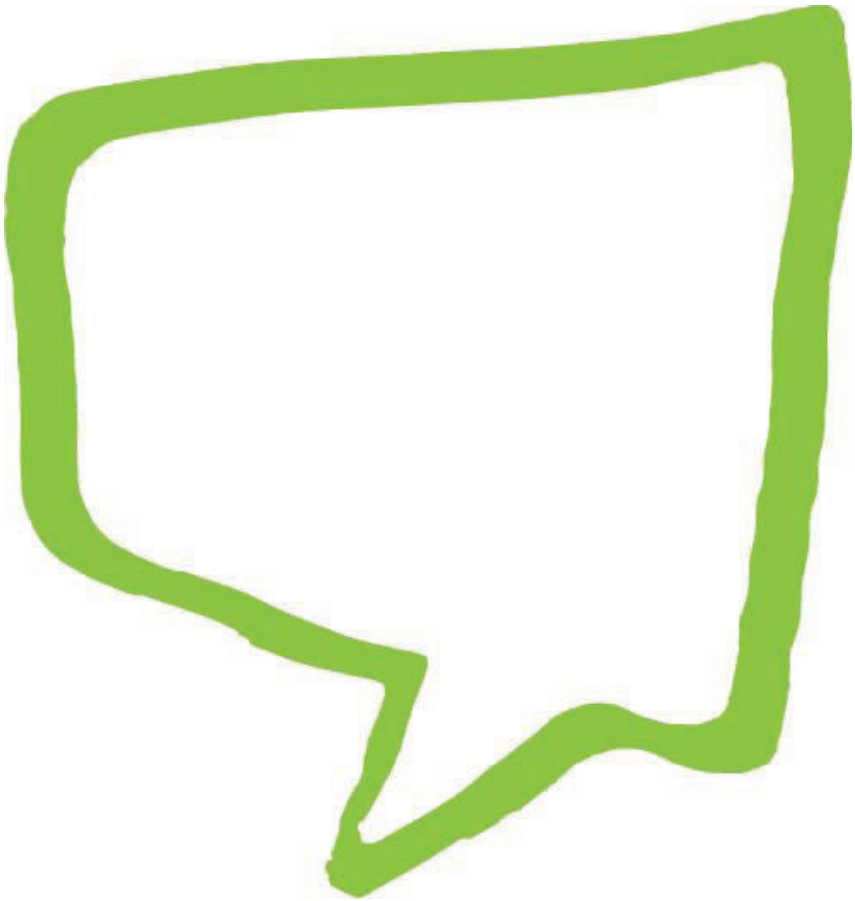
Phase 2

Brighton and Hove City Primary Care Trust

Brighton and Hove City Council

Audit 2008/09

September 2009



audit commission

Contents

Status of our reports

The Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission explains the respective responsibilities of auditors and of the audited body. Reports prepared by appointed auditors are addressed to non-executive directors/members or officers. They are prepared for the sole use of the audited body. Auditors accept no responsibility to:

- any director/member or officer in their individual capacity; or
- any third party.

Introduction

1 Health inequalities exist when some groups of the population suffer from significantly greater ill-health (morbidity) and earlier death (mortality) than the average and other groups of the population. There are significant levels of inequality globally, in some parts of the UK, and varying levels in all areas of the UK.

2 There is national and international recognition for the need to tackle health inequalities collaboratively. The 'Health is Global' (2008) five year national strategy demonstrates the links between economy, prosperity and health. It sets out actions to:

- 'improve the health of the UK and the world's population'; by
- 'combating global poverty and health inequalities'.

3 Tackling health inequalities is a formal requirement both of local authorities and Primary Care Trusts (PCTs). The reform agenda, as set out in the 'Commissioning framework for health and well being', emphasises the need for:

- 'joint strategic needs assessment by councils, PCTs and other relevant partners'; and
- 'sharing and using information more effectively'.

4 Tackling health inequalities absorbs huge amounts of public money in both local government and health sectors. Securing optimum value for money from these combined resources requires effective joint working among the public sector bodies in order to achieve public service agreement (PSA) targets.

5 Comprehensive Area Assessment (CAA) is a new assessment framework for councils and their partners to be implemented in 2009. Proposals describe an area-wide assessment by the inspectorates considering outcomes for people in an area and a forward look at prospects for sustainable improvement. This assessment will look at how well local public services are delivering better outcomes for local people in local priorities such as health. In managing partnership relationships, public bodies need to have regard to the risks to delivery. This includes identifying local needs and addressing them. The way in which health inequalities may be experienced by vulnerable groups will be a key part of this assessment in 2009.

Background

6 South East England is one of the healthiest regions in England with a comparatively well qualified workforce, low levels of unemployment and higher incomes. However, Brighton and Hove (B&H) presents a mixed picture when compared to England and the South East. For example:

- full-time workers in B&H gross weekly pay at £524.30 is greater than that of Great Britain (GB) at £479.20;
- more people are receiving job seekers allowance in B&H at 4.3 per cent compared to 3 per cent in the SE and 4.1 per cent in GB;[1]
- life expectancy in the SE was the second highest in England in 2007 at 77.7 years for men and 81.8 years for women;[2] and life expectancy in B&H is only slightly lower with only 17.5 per cent of local people reporting limiting long term illness.[3] However, this masks comparative inequalities in health outcomes between social groups and geographic areas.

Deprivation

7 To address inequalities the government has established a number of national regeneration programmes (NRP) that prioritise action in the most deprived areas where health inequalities are greatest. One of these is based in Brighton. B&H has some of the most deprived areas in England as measured by super output areas (SOAs) using the Index of Multiple Deprivation (IMD) and these are mostly in the East of Brighton.

Population

8 National Census information shows the people of B&H describe themselves as mostly white British (91.5 per cent), Christian (72.9 per cent) and with some of the lowest level of gypsy/travellers in England. Although we know there is a significant gay, lesbian and transgender (GLTG) population, there are no local statistics available for sexual orientation.

9 There are clear differences in the make up of the population of B&H that impact on health compared to other areas in the South East of England. For example B&H has:[4]

- the lowest proportion of 0 to 14 year olds (15.3 per cent); and
- the highest proportion of 15 to 49 year olds (54.9 per cent) who represent the bulk of the economically active population (workforce) and the large student population associated with local universities.

[1] Source: the Office of National Statistics (ONS) 2008 estimates
[2] Source: *South East Coast SHA Health Inequalities Strategy, 2007*
[3] Source: *Department of Health SHA Health Inequalities Baseline Audit, 2007*
[4] Source: the Office of National Statistics (ONS) most recent population data - 2004 mid year.

Key issues

10 Key issues currently affecting health outcomes in B&H include:

- high levels of non-decent housing in some parts of the city; as housing is the primary determinant impacting on health outcomes, we would expect housing to be the key focus of planning across B&H organisations;
- some of the highest suicide rates in England, which are persistently high despite intervention and linked to substance misuse; a cross-organisational planning initiative during 2008/09 worked to establish a Suicide Prevention Strategy;
- comparatively high levels of substance abuse – injectors; the Drug and Alcohol Action Team (DAAT) reported in 2005 that there were approximately 2,300 injecting users in the city, a higher rate than parts of inner London and the incidence of drug related deaths is amongst the highest in the country;[1]
- the high level of injecting drug users also means HIV infection is a key health issue in B&H;
- persistently higher rates of teenage pregnancy than the national average; and
- an increase in sexually transmitted disease.

11 Brighton and Hove's Director of Public Health who is appointed jointly by Brighton and Hove City Council ('the Council'), Brighton and Hove City Teaching PCT ('the PCT'), provides strong leadership on the public health agenda.

12 In 2004, Brighton and Hove was designated a 'Healthy City' by the World Health Organisation acknowledging strong commitment by the Council, PCT and partners to reduce health inequalities (HI). The Healthy City phase four programme currently focuses on urban planning and Health Impact Assessment (HIA).

13 The Local Strategic Partnership (LSP) has identified 'improving health and well-being' as one of its strategic priorities in its Sustainable Community Strategy 'Creating the City of Opportunities'. It has adopted a Health Inequalities Strategy and City Health Development and Action Plans to target cross sector action on the wider determinants of health.

14 Consultants commissioned by the Council and its partners to assist the Public Services Board (PSB) and LSP have reported on policy options for the future to reduce inequality and undertaken a detailed analysis mapping where inequality is most acute.

15 The Local Area Agreement 2008 to 2011 (LAA) for Brighton and Hove includes a number of relevant national and local indicators. Lead partners include the Council, the PCT, the Children and Young People's Trust, the Sussex Partnership Trust, Police and Fire authorities. These reflect the recognition that partnership working across the sectors is essential in tackling the wider determinants of health and inequality.

[1] Source: *Brighton and Hove City Council Corporate Assessment*, October 2006

16 The first phase of our review of Health Inequalities (HI) in Brighton and Hove was completed in May 2008. It found that the Council and the PCT have made good progress in establishing joint strategic arrangements to reduce HI. However, there is a high level of poor housing in Brighton and Hove and some health outcomes are persistently not improving and amongst the highest in England ie teenage pregnancy, drug and alcohol misuse, including smoking and suicide rates. People suffering poorer health outcomes are often also in housing need.

Audit approach

17 We agreed with the Council and the PCT that Phase 2 of our health inequalities work would evaluate the effectiveness of cross-organisational working on health inequalities. In order to probe this effectively, we focused on housing, the primary determinant of health.

18 The local Strategic Housing Partnership, led by the Council, is in the process of drafting and agreeing a new housing strategy for 2009 to 2013. Subsidiary strategies, including those for homelessness and Supporting People, are already in place. Further partnership working takes place at a sub-regional level in the Brighton and Hove East Sussex Together Partnership (BEST), set up to tackle housing conditions particularly for vulnerable people.

19 Our review focus has assessed the effectiveness of partnership working in:

- identifying and addressing need;
- consulting and engaging with local people;
- working together to allocate resources and secure good outcomes;
- sharing data for planning and monitoring;
- establishing means to measure outcomes and impact; and
- delivering on ambition.

20 We have carried out this work by:

- reviewing key strategies and supporting documents;
- interviewing officers from the Council and the PCT; and
- using a workshop at the Healthy Urban Planning Group (HUPG) to discuss our early findings with partner officers.

21 The presentation of findings and challenge questions which we used at HUPG in March 2009 is attached at Appendix 1.

Main conclusions

22 The partners in Brighton and Hove are working well together, demonstrating a strong commitment to tackling inequalities. However, against a backdrop of a multitude of different needs and a diverse range of targets, some of which have poorly defined success criteria, there is considerable work still to be done. For example, the partners led by the Council and the PCT need to prioritise objectives, agree areas of joint action and the use of health and housing resources so as to have the maximum impact in reducing health inequalities in the City.

Identifying and addressing need

23 The local strategic partnership has effectively gathered a good analysis of local needs to inform planning. The Local Area Agreement (LAA) for 2009 to 2011 effectively identifies local need. It makes clear links to other key documents that show inequalities between the most and least deprived people living in Brighton and Hove. In particular, it draws on the Reducing Inequalities Review, a thorough analysis of local issues which gives local partners a clear understanding of priority needs for disadvantaged people and places.

24 The draft housing strategy is clearly driven by the needs analysis. It is based on needs identified through the reducing inequalities review. Data was drawn together and presented on each of the themes in the strategy to identify local issues and to consult with stakeholders on headline goals and objectives. This means that the strategy aims to tackle important local issues.

25 Supporting strategies effectively identify needs and propose ways in which they should be addressed. They focus positively on local health inequalities. The homelessness strategy refers to the Reducing Inequalities Review and highlights key target groups. The first objective is to 'provide housing and support solutions that tackle homelessness and promote health and wellbeing of vulnerable adults'. This references other work driven by the single homeless strategy and the supporting people strategy. The priority actions in support of this objective identify actions which are clearly focused on the housing and support needs of vulnerable groups. For instance, they include actions to support people with mental health needs, to tackle delayed transfers of care and for people with learning disabilities.

26 However, some weaknesses were identified. Housing strategies do not define clear success criteria. The homelessness strategy, for instance, does not give a clear indication of the likely impact for vulnerable groups. The success of action for people with mental health needs is a reduction in homelessness due to mental ill health, without being specific and without linking to related impacts, such as reducing risk of suicide. It is therefore not clear how health inequalities will be reduced as a consequence.

Recommendation	
R1	Define success criteria in housing strategies more clearly and with a sharper focus on outcomes for vulnerable people. This is a high priority that should be completed in six months. This is a high priority that should be completed within six months.

Consultation and engagement

27 The housing strategy has been informed by consultation with local people. Each planning group had representatives from stakeholders and the local community champions. In addition, there was some action to reach target groups. Service users in hostels were trained to carry out consultation sessions with other users. This enables real life issues to be brought into the setting of strategy.

Working together

28 The awareness of the health inequalities agenda is well established in the City's partnerships. The LSP has emphasised the importance of Healthy City and this means a good impact in discussions at many levels. For instance, planning policy in the local development framework supports the way housing provision will address health inequalities, such as in setting minimum standards for development. All new homes in the City are required to be built to lifetime home standards so that they are adaptable to lifestyle changes such as the need for wheelchair access. This broad agenda creates the potential for impact across many services.

29 There is a range of fora which offer good opportunities for discussion of housing issues and health inequalities. At a high level, the Strategic Housing Partnership oversees this work and is chaired by the Leader of the Council. The partnership has not yet reviewed its objectives in light of the Health Impact Assessment findings and aims of the new Housing Strategy. The Healthy Urban Planning Group provides a good forum for discussion of detailed health issues that may emerge from proposed significant planning developments and a useful vehicle for highlighting the beneficial impacts that developments may have on reducing health inequalities. This has also been used to discuss housing strategy in its broader context. These fora are building awareness and understanding between partners of inequalities agenda.

30 Partnership working in developing housing strategy is good. For each element of the housing strategy, partnership development groups have been established with good representation from the PCT and the voluntary and community sectors. The Council is taking steps to maintain its involvement in implementation, for instance by allocating a monitoring and scrutiny role into the future. The involvement of many partners in its development offers the prospect of a good level of ownership in implementation.

31 However, the extent of the impact of this awareness and discussion on policy and practice is not yet fully developed. From our review, it is not clear how specific needs will be addressed in a shared way by partner organisations, nor how resources of separate organisations will be prioritised to address shared outcomes. Where we can judge some strengths in the housing strategy and its supporting plans, separation of function continues to drive action. For instance, there is little reference in the PCT's Strategic Commissioning Plan to the way in which action on housing needs can achieve health priorities. Although needs data has created an understanding that inequalities need to be addressed through a focus on people and place, there is no explicit response to this in the strategies we have reviewed. These indicators suggest that there is more to do to transfer a broad commitment into a robust method of sharing and prioritising resources and actions between partner organisations.

32 The sub-regional partnership, Brighton and East Sussex Together (BEST), is developing a broader focus to include health inequalities issues. The group has developed an approach to bidding for and sharing housing renewal resources. It is a positive example of partnership working in allocating the funding jointly. In addition, the partnership intends to use its new understanding around health inequalities to refocus its years 2 and 3 programme to achieve better health outcomes.

Recommendations	
R2	Ensure that the roles and responsibilities of key partnership groups with input to housing strategy are clearly set out and understood; in particular, review and revise the objectives of the Strategic Housing Partnership and BEST to reflect the broader focus on health inequalities issues. This is a high priority that should be completed within six months.
R3	Use partnership fora as a means to challenge further the way in which resources are allocated to address need, and challenge particularly how resources in health and local government can be focused to tackle needs. This is a high priority that should be completed within six months.

Sharing data

33 The LSP has high quality shared data. The reducing inequalities review, in two phases, established a clear analysis of deprivation and inequalities experienced in the City. It has been used since to inform planning. The public health annual report also presents strong analysis of data. The LSP has a partnership data group which agrees approaches to the use of data by partners. And the LSP has created a local intelligence service called Brighton and Hove Local Information Service (BHLIS) which presents a range of data in one place, accessible to partners and available for analysis. Data is therefore a key shared resource for partners locally.

34 Data is not yet being used well to focus on outcomes. It is not clear from our review how strategies respond directly to specific data analysis, for instance by commissioning services to address specific needs identified and targeting services on deprived wards. Nor is it clear how well the shared data enables partners to agree targets and focus the use of separate resources. This might lead to the type of challenge where the partnership focuses extra investment in reducing teenage conceptions because of its potential to reduce demand for housing or other services. It is notable that BHLIS does not contain any of the LAA or other partnership targets. Therefore, though it offers a rich data source, it does not enable a focus on the desired or expected outcomes. Data is therefore confirming the current position rather than challenging future impact.

Recommendation

R4 Make shared data work harder by:

- making clear links to LAA targets and LSP planned outcomes; and
- using it to analyse the way in which resources are allocated for maximum impact.

This is a high priority that should be completed within six months.

Measuring outcomes

35 The proposed measures of success in housing strategies are inadequate. The proposed success measures tend to be:

- general rather than specific, eg reduction in homelessness;
- not clear about the health benefits of actions; and
- not clear about the impact on people.

The supporting people strategy, for instance, does not set specific and measurable indicators of success. The success criteria tend to focus on general reductions in homelessness, street drinking, delayed discharge, and many more - without being specific about what will be achieved. The integrated pathways of care are referenced - but the involvement of health services is not clear and beneficial health outcomes are not identified. For instance, in providing a range of actions to promote independent living for people with mental health needs and physical disabilities, the measures focus on reductions in homelessness and delayed discharge, without being clear of the health benefits to individual service users. In this respect, it is difficult to have a sense of priority and an understanding of impact on health inequalities.

36 The health impact assessment (HIA) of the housing strategy is a strong demonstration of the commitment to reducing health inequalities in addressing housing need. The HIA is an impressive attempt to cover all the factors that interact between housing and health and relates these to the various component parts of the draft housing strategy. The HIA contains many recommendations but these have not yet been developed as a prioritised SMART Action Plan whose implementation can be monitored by the partners.

37 Partners are innovative in the use of HIAs for proposed major local developments. The Council and its partners have commissioned health impact assessments of significant developments. The HIA for Brighton Marina is a very good example of a socio-environmental model of HIA and demonstrates that the PCT and the Council are offering a best practice initiative to developers in Brighton. However, the HIA does not contain an economic impact assessment of the development proposed, for instance in calculating the consequential financial impact of health changes resulting from development.

38 The extent of future use of HIAs by the partners is unclear. There is some doubt about the capacity and the capability of the PCT to continue to offer this service in the long term. The use of consultancy is costly without demonstrating specific benefits.

Recommendations	
R5	Review the success measures in the draft housing strategy and supporting strategies to ensure that they: • are SMART and clearly prioritised; • offer assessment of health impacts; and • show outcomes for people and how needs are addressed/reduced. This is a high priority that should be completed in six months.
R6	Use the HIA of the housing strategy to develop an action plan. This is a high priority that should be completed within six months.
R7	Have a clear policy on future use of HIAs, including the assessment of economic impact. This is a medium priority that should be completed within six months.

Delivering on ambition

39 Strategies are now in place, though it is too early to establish whether they are effective. Some actions are being delivered by partners, for instance in the GP practice provision for homeless people. However, more work is required to define the expected impact of key strategies and to establish methods of measurement. In our presentation to HUPG, we emphasised that to ensure delivery of ambitions, the challenge for partners may be encapsulated in the following questions.

- Is there an agreed set of priorities which will test your achievement over time in reducing health inequalities?
- Do your people understand these priorities?
- How will you measure success in addressing needs?
- By what means will you measure impact in the short term?
- How challenging are your targets?
- How do you plan to deal with the economic downturn?

Recommendation
R8 Consider holding a workshop for key partners to address the challenge questions relating to delivery of ambitions ie: • is there an agreed set of priorities which will test your achievement over time in reducing health inequalities; • do your people understand these priorities; • how will you measure success in addressing needs; • by what means will you measure impact in the short term; • how challenging are your targets; and • how do you plan to deal with the economic downturn? This is a medium priority that should be completed within six months.

Follow up of phase 1 recommendations

40 In phase 1 of our health inequalities work we made two recommendations.

41 The first recommendation has been completed. We recommended:

> **Ensure the City Council scrutiny committee receive regular health inequality reports to improve understanding of local health inequality issues and thereby support appropriate challenge.**

The PCT presented a report on health inequalities to the Health Overview and Scrutiny Committee last autumn. This was timed to coincide with the requirement to produce a Joint Strategic Needs Assessment and in accordance with World Class Commissioning requirements.

42 The second recommendation has been partially achieved. We recommended:

> **Include health inequality outcomes in performance reports to demonstrate progress against investment and to indicate if plans have produced effective health outcomes and value for money.**

The PCT has increased its performance monitoring in general using its Programme Office approach and close monitoring by its Delivery Board. Inequality targets such as reducing teenage pregnancy and smoking in particular have been subject to regular scrutiny. More work is required for the PCT to be able to demonstrate value for money from its investments in reducing health inequalities.

Recommendation
R9 Consider the best way in which to report the achievement of value for money from investments in reducing health inequalities. This is a high priority that should be completed within six months.

Way forward

43 We have made nine recommendations for improvement in this report. They are included in an Action Plan at Appendix 2. The Council and the PCT have responded to the recommendations. This response is shown at Appendix 3.

44 We will follow up on the Action Plan in the course of our future audit and assessment work with the organisations, and as part of our Area Assessment work.

Appendix 1 – Feedback presentation

Health inequalities – phase 2

Brighton & Hove CC/PCT Healthy Urban Planning Group

23rd March 2009

Marius Kynaston, Stephen Dowsett, Norma Christison
Performance Team, South East

audit commission

Agenda

- In Phase 1 of our work on HI we found:
  - The PCT and City Council have a history of working in partnership and have made good progress in establishing joint strategic arrangements to manage HI.
  - However, not all targets were SMART, and although Performance reporting at both the PCT and Council is improving some areas of weakness remain.
  - We are currently following up the recommendations from Phase1
- In Phase 2 we have evaluated the effectiveness of cross-organisational arrangements to address HI and deliver the outcomes agreed by partners, in particular in relation to housing especially for vulnerable people
- .This is a presentation of initial findings

… and some challenge questions

2 B&H HI Phase 2

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Strategy: identifying need

- High quality analysis of "Reducing Inequalities" provides sound basis for planning
- Housing strategy based on good needs data

Challenge:

- **Is there direct response to the data provided? E.g. in commissioning services to address specific need identified; targeting services on deprived SOA**
- **Do partners have shared priorities of need?**
- **Are resources invested to best effect?**
  E.g. does extra investment in reducing teenage conceptions potentially reduce housing demand?

3 B&H HI Phase 2

audit commission

Strategy: addressing need

- Draft Housing Strategy / Homelessness Strategy
  - Both tell the story really well of what is the need and how will we address it
  - But the expected outcomes and success criteria are not always clear

Challenge

- **Are partners confident that there is a golden thread within and between the organisations and their plans?**
- **Is there a shared understanding and prioritisation of outcomes?**
- **Is the intent to reduce health inequalities adequately reflected in the housing strategy?**
- **Does the PCT's Strategic Commissioning Plan have due regard to housing?**
- **Will the strategy drive actions by the partners?**

4 B&H HI Phase 2

audit commission

Strategy: consultation

Consultation on housing strategy

- Processes are good
- Good stakeholder involvement

Challenge

- **What examples are there of impact of consultation on policy and strategy?**

5 B&H HI Phase 2

Partnership working

- Developing shared agenda on housing role in addressing health inequalities
- Recognition that partners are on a journey: getting better at identifying shared issues

Challenge

- **HI agenda is known but not always clearly understood – could it be used more to challenge custom and practice?**

6 B&H HI Phase 2

Partnership working

- Good range of partnership forums
  - Healthy City Group and LSP at high level
  - Strategic housing partnership
  - Healthy urban planning group
  - Partnership groups on the housing strategy themes

Challenge:

- **Strategic Housing Partnership – responsibilities and objectives not clear**
- **BEST targeting of resources – too much emphasis on spending the money rather than targeting its impact?**
- **Are partners clear of their respective roles in delivery given that this is not always explicit in the plans?**

7 B&H HI Phase 2

audit commission

Data quality and information

- High quality shared data
  - Reducing inequalities – phase 1 and 2
  - PH annual reports
- Positive action taken to share data through the SCS and BHLIS

Challenge

- **How effectively is the data used to drive outcomes?**
- **In terms of health inequalities and housing what gaps exist in the data and how do you plan to address?**
- **BHLIS data is not linked to targets – a weakness?**

8 B&H HI Phase 2

audit commission

Health impact

- Health Impact Assessments
  - Positive about the commitment
  - HIA recommendations for Draft Housing Strategy need to be SMART if they are to have impact
  - HIAs lack health economics perspectives – absence of cost benefit analysis means its difficult to demonstrate VFM

Challenge

- **Why no health economics analysis – measuring impact and VFM of action for vulnerable groups and cost benefit analysis?**
  - **What Is the most valuable thing we are not doing?**
  - **What is the least valuable thing we are doing?**
- **Do you know what resources each partner is applying to specific health / housing initiatives in each locality aimed at reducing inequalities?**

9 B&H HI Phase 2

audit commission

Measures of success

- Success measures in housing strategies are:
  - General and not specific, e.g. reduction in homelessness
  - Not clear about the health benefits of actions
  - Not clear about the impact on people

Challenge

- **How can you develop more SMART indicators?**
- **Mix of long and short term outputs and outcomes?**
- **Greater focus on health impacts for people?**
- **Do you know your priority outcomes?**
- **Given the quality of needs data, will you measure success in reducing need?**

10 B&H HI Phase 2

audit commission

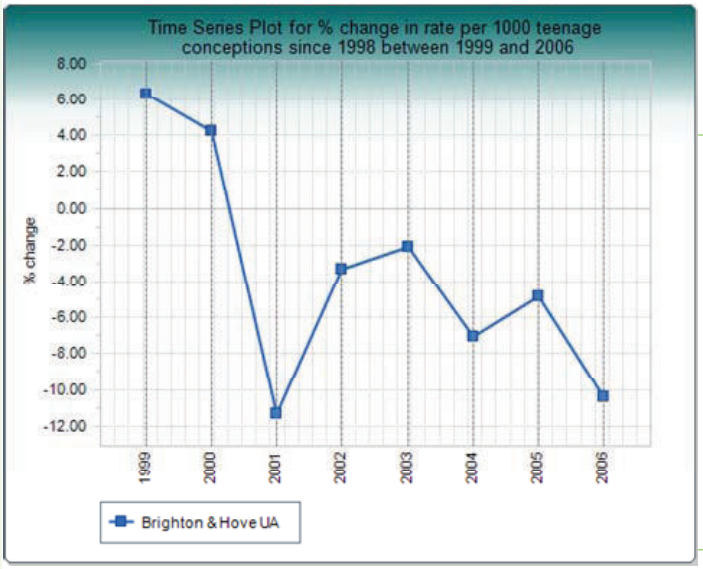
Achievement

Challenge

- Is there an agreed set of priorities which will test your achievement over time in reducing health inequalities?
- Do your people understand these priorities?
- How will you measure success in addressing needs?
- By what means will you measure impact in the short term?
- How challenging are your targets (some examples follow)?
- How do you plan to deal with the economic downturn?

11 B&H HI Phase 2

NI 112 – Teenage Conceptions



Target Reductions

- **2008 -28%**
- **2009 -36%**
- **2010 -45%**

12 B&H HI Phase 2

NI 141: Percentage of vulnerable people achieving independent living

- This indicator is being led by Brighton & Hove City Council & Strategic Housing Partnership.
- It measures the number of service users (i.e. people who are receiving a Supporting People Service) who have moved on from supported accommodation in a planned way, as a percentage of total service users who have left the service
- This indicator has been selected in 70 LAAs
- The LAA Baseline is 65% Subsequent targets are:
  - 2008/9 – 66%
  - 2009/10 – 67%
  - 2010/11 – 68%

13 B&H HI Phase 2

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Next steps

- NOW - opportunity to comment and respond on the challenge questions.
- We will take on your views in order to develop a draft report

14 B&H HI Phase 2

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Appendix 2 – Action plan

Recommendation	Priority	Link to evidence	Link to relevant standards	Positive outcome expected (savings, reduced risks, better value for money)	Consequences of failing to implement recommendation	Cost of recommendation (where significant)	Date reported to the Board/ Council	Officer responsible	Implement by when
R1 Define success criteria in housing strategies more clearly and with a sharper focus on outcomes for vulnerable people.	High	Housing strategies do not define clear success criteria. The homelessness strategy, for instance, does not give a clear indication of the likely impact for vulnerable groups.	UoR KLOE: 2.2	Better outcomes	Inability to monitor success	None	June 2009	Housing Strategy Manager	December 2009
R2 Ensure that the roles and responsibilities of key partnership groups with input to housing strategy are clearly set out and understood; in particular, review and revise the objectives of the Strategic Housing Partnership and BEST to reflect the broader focus on health inequalities issues. This is a high priority that should be completed within six months.	High	With respect to these bodies, there is little evidence of a partnership approach with health or of targeting resources on areas with the greatest health inequalities.	UoR KLOE: 2.3	Greater clarity of responsibilities in tackling joint goals.	Lost opportunity for partnership working	None	June 2009	Head of Strategy, Development and Private Sector Housing	December 2009

Appendix 2 – Action plan

Recommendation	Priority	Link to evidence	Link to relevant standards	Positive outcome expected (savings, reduced risks, better value for money)	Consequences of failing to implement recommendation	Cost of recommendation (where significant)	Date reported to the Board/ Council	Officer responsible	Implement by when
R3 Use partnership fora as a means to challenge further the way in which resources are allocated to address need, and challenge particularly how resources in health and local government can be focused to tackle needs.	High	It is not clear how specific needs will be addressed in a shared way by partner organisations, nor how resources of separate organisations will be prioritised to address shared outcomes.	UoR KLOE: 2.1	Potential for generating better vfm by applying joint resources to joint goals.	Piecemeal approach may mean goals are not so easily achieved.	None	June 2009	Head of Strategy, Development and Private Sector Housing	December 2009
R4 Make shared data work harder by: • making clear links to LAA targets and LSP planned outcomes; and • using it to analyse the way in which resources are allocated for maximum impact.	High	It is not clear how well the shared data enables partners to agree targets and focus the use of separate resources.	UoR KLOE: 2.2	Better targeting of resources with the potential for better vfm.	Lost opportunity to secure best vfm.	None	June 2009	Housing Strategy Manager/ Public Health Development Manager	December 2009

Recommendation	Priority	Link to evidence	Link to relevant standards	Positive outcome expected (savings, reduced risks, better value for money)	Consequences of failing to implement recommendation	Cost of recommendation (where significant)	Date reported to the Board/ Council	Officer responsible	Implement by when
R5 Review the success measures in the draft housing strategy and supporting strategies to ensure that they: • are SMART and clearly prioritised; • offer assessment of health impacts; and • show outcomes for people and how needs are addressed/reduced.	High	The proposed measures of success in housing strategies are inadequate being: general rather than specific, eg reduction in homelessness; not clear about the health benefits of actions; and, not clear about the impact on people.	UoR KLOE: 2.2	Better outcomes/vfm	Goals may not be met.	None	June 2009	Housing Strategy Manager	December 2009
R6 Use the HIA of the housing strategy to develop an action plan.	High	The HIA contains many recommendations but these have not yet been developed as a prioritised SMART Action Plan whose implementation can be monitored by the partners.	UoR KLOE: 2.2	Better outcomes/vfm	Goals may not be met	None	June 2009	Housing Strategy Manager/ Public Health Development Manager	December 2009

Appendix 2 – Action plan

Recommendation	Priority	Link to evidence	Link to relevant standards	Positive outcome expected (savings, reduced risks, better value for money)	Consequences of failing to implement recommendation	Cost of recommendation (where significant)	Date reported to the Board/ Council	Officer responsible	Implement by when
R7 Have a clear policy on future use of HIAs, including the assessment of economic impact.	Medium	The extent of future use of HIAs by the partners is unclear. There is some doubt about the capacity and the capability of the PCT to continue to offer this service in the long term.	UoR KLOE: 2.2	HIAs have the potential to provide supporting information for strategic investment decisions.	Decisions may be taken with incomplete information.	Some depending on the number and depth of HIAs undertaken in future years.	June 2009	Public Health Development Manager	December 2009
R8 Consider holding a workshop for key partners to address the challenge questions relating to delivery of ambitions ie: • is there an agreed set of priorities which will test your achievement over time in reducing health inequalities? • do your people understand these priorities? • how will you measure success in addressing needs? • by what means will you measure impact in the short term?	Medium	The partners are faced with challenging questions if they are to deliver their ambitions.	UoR KLOE: 3.3	Partners will become more knowledgeable about the delivery of each others' ambitions.	Missed opportunity to teat the realism of ambitions.	May involve some costs if third party engaged to facilitate the workshop.	June 2009	Housing Strategy Manager/ Public Health Development Manager	December 2009

Recommendation	Priority	Link to evidence	Link to relevant standards	Positive outcome expected (savings, reduced risks, better value for money)	Consequences of failing to implement recommendation	Cost of recommendation (where significant)	Date reported to the Board/ Council	Officer responsible	Implement by when
• how challenging are your targets? • how do you plan to deal with the economic downturn?									
R9 Consider the best way in which to report the achievement of value for money from investments in reducing health inequalities.	High	The PCT has increased its performance monitoring in general but more work is required for it to be able to demonstrate value for money from its investments in reducing health inequalities.	UoR KLOE: 2.1	Demonstration of vfm (or otherwise) will help inform future strategic decision making.	The absence of sound vfm information makes for less robust strategic investment decision making.	None	June 2009	Housing Strategy Manager/ Public Health Development Manager	December 2009

Appendix 3 – Partners' response to draft report

1 The response to the report was received on 21 August 2009, and a summary is included here, not including drafting points or factual amendments.

> **Thank you for your draft report and the time taken by your colleagues and yourself in reviewing our work to develop and embed the health and housing agenda in Brighton and Hove.**
>
> **We very much welcome your report and feel that you have identified and highlighted a wide range of positive practice that encapsulates the change in working practices, culture and outcomes we are hoping to achieve.**
>
> **In working towards linking health and housing we have been very much ahead of national guidance and good practice and it is very pleasing to note that we have made some significant steps in this direction. The issues and recommendations you have identified will help structure and shape our ongoing work and ultimately result in more effective outcomes for local people.**

2 The comments made on individual recommendations are shown below where they indicate the progress since our fieldwork and the approach to implementation. We have also noted where amendments have subsequently been made to the report text in response to the comments received.

Table 1 Comments on recommendations

Received from Council and PCT August 2009

Recommendation	Comment
1	(para 26) We have taken this on board and improved the success criteria in the final drafts of the Housing Strategy, Older People's Housing Strategy and LGBT People's Housing Strategy which are being presented to Council and the Local Strategic Partnership for approval in the Autumn. Our previously published strategies relating to Supporting People and Homelessness etc are already accompanied by more detailed action plans that translate the success criteria into SMART actions that are subject to ongoing review. In respect of the lack of clear health outcomes - such as for example reducing suicide or mental illness this can only be stated as an aim as at a local level as it would be incredibly difficult to robustly measure reductions in suicide.

Recommendation	Comment
	We could look at mental health but that would involve surveys of residents before and after re-housing which would be tantamount to an experiment and not something that could be done routinely. Again the routine markers of mental health would not be able to be related to any housing intervention. One area we are exploring where we may be able to link housing interventions directly to health improvements is through our single homeless work, and in particular tackling alcohol and substance misuse. However, on the whole, our review of the evidence base highlighted the need for further research on the impact of housing interventions on health outcomes.
2	(para 29) The objectives of the Strategic Housing partnership are closely aligned to the Improving Housing and Affordability block of the Local Area Agreement and the citywide Housing Strategy. In addition the SHP has acted as the Project Board, overseeing the development of the strategy. (para 32) The BEST partnership recognises that good quality homes are important for the health and well-being of those living in them. The partnership is committed to improving the overall quality of the private sector housing stock in Brighton and Hove and East Sussex, to achieve our vision that every resident lives in a 'warm, safe and secure home'. To assist our private sector housing managers and partners in Health in achieving a better understanding of the links between health and housing, we are piloting the use of the Building Research Establishment toolkit which demonstrates the cost benefits of some specifically linked housing and health issues. The partnership in years 2 and 3 of the programme are targeting funding at improving health, by improving insulation and heating in homes to reduce excess winter deaths, removing hazards in the home which will reduce hospital admissions due to falls, allow people to stay in their own homes and facilitate hospital discharge by funding disabled adaptations. **We have amended recommendation 2 and paragraphs 29 and 32 in response to comments.**

Appendix 3 – Partners' response to draft report

Recommendation	Comment
3	(para 31) Across the Council and PCT it has been noted that there is now a need to develop a structure that will maximise the impact of JSNAs in driving improvements in local service and outcomes. As a result, a JSNA Steering Group is being set up that is being jointly chaired by senior officers of NHS Brighton and Hove and Brighton and Hove City Council. One of the key priorities of the group will be to produce a summary overview of the health and wellbeing needs of the city, including identified health inequalities and evidence of unmet need which will inform strategic commissioning and planning and particularly the PCT Strategic Commissioning Plan. Housing has been invited to become a founding member of the new JSNA Steering Group and the lack of comment on housing in the NHS Brighton and Hove Strategic Commissioning Plan has been noted and will be discussed within NHS Brighton and Hove. More effective partnerships are starting to be seen such as the JSNAs of Working Age Mental Health, Physical Disabilities and accompanying Commissioning Strategies. Additionally, joint work on the Local Area Agreement, 2020 Community Strategy Review and new Healthy City Strategy will help improve the joint and shared approach to tackling the city's issues. However, to be realistic, it will take more than six months to achieve this.
4	(para 34) The potential of BHLIS has been noted and the JSNA Steering Group is planning to explore the use of BHLIS to host and present health inequality data to complement the summary overview document of the health and wellbeing needs of the city. This work will in part be supported by a new Head of Public Health Research and Analysis has been appointed by NHS Brighton and Hove who will be working closely with their City Council counterpart. The need for common performance management software across the Local Strategic Partnership to manage the Local Area Agreement has been recognised and is in the process of implementation. BHLIS contains the background needs data for the partnership with the new Interplan carrying out the performance management function.
5	(para 35) As per our response to Recommendation 1.

Recommendation	Comment
6	(para 36) Two half-day workshops for Housing and Health staff were held at the end of July and beginning of August. These brought together Public Health and Housing staff to discuss and agree how the recommendations from the HIA of the new Housing Strategy will be taken forward. An Action Plan is being developed which will become part of the Housing Strategy which is currently going through its approval process. We have included a recommendation in the HIA around the possibility of commissioning a piece of work to conduct a health economics study.
7	(para 38) NHS Brighton and Hove and the Local Authority Planning Department are developing a strategy to take forward future HIA work. The strategy will outline a small set of options including integrating HIA into the scope of Environmental assessment where appropriate. NHS Brighton and Hove and the Local Authority Planning Department are drafting best practice guidance for developers and planners.
8	(para 40) As per our responses to Recommendation 1 and Recommendation 6. Across the Local Authority, Primary Care Trust and wider stakeholders the need to have an agreed set of priorities for the city aligned with clear targets for improving the health and wellbeing of local people has been already identified. To address this, the 2020 Community Strategy is being refreshed and work to develop a Health City Strategy has begun. The first draft of the refreshed Community Strategy has recently started its public consultation.
9	(para 43) As per our response to Recommendation 3.

Source: PCT/CC response to draft report

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Appendix 2

73. MANAGING HEALTH INEQUALITIES; REFERRAL FROM AUDIT COMMITTEE

73.1 The Commission considered the report relating to the referral from the Audit Committee on Managing Health Inequalities and the recommendation was agreed.

73.2 RESOLVED; That the report be referred to ASCHOSC for further consideration.

4 May 2010

Dear Anne

The Health Overview & Scrutiny Committee recently featured an item in which members and officers of the Brighton & Hove Local Involvement Network (LINk) updated HOSC members on the establishment of the LINk and the work it has now begun to do in terms of scrutinising city health and social care services.

The Chair of the LINk Steering Group told members that the LINk valued the formal relationship it had established with the HOSC (i.e. a LINk member sitting as a non-voting co-optee on the HOSC), and had hoped to establish a similar relationship with ASCHOSC in order to further the LINk's involvement with social care issues.

HOSC members were very supportive of this position, given the positive history of HOSC/LINk co-working, and resolved that I should write to you formally requesting that you consider LINk requests for a (non-voting) co-opted position on ASCHOSC.

Yours

Garry Peltzer Dunn
Chairman of Health Overview and Scrutiny

ASCHOSC Work Programme 2010

Issue	Date to be considered	Referred/Requested By?	Reason for Referral	Progress and Date	Notes
Assessment Care Pathways	04 March 2010	ASCHOSC	Training session on how people's care requirements are assessed	Noted	
Scrutiny request re: services for adults with autism	04 March 2010	Cllr Wrighton	Cllr letter requesting establishment of scrutiny panel	Agreed to set up ad hoc panel	
Care Quality Commission assessment of ASC services	04 March 2010	ASC	Update members on most recent assessment of BHCC ASC services	Noted – report requested on ASC and voluntary sector	
ASC Green paper	04 March 2010	ASCHOSC	Update on BHCC response to Green Paper on funding of care for older people	Noted	
Care Quality Commission consultation on assessing quality	04 March 2010	CQC	National consultation on how CQC should best assess the quality of health and social care commissioners/providers	Agreed to form group to feed in to consultation	

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Rent setting	24 June 2010	ASCHOSC	Training session on how social housing rents are set		
Transfers of Care	24 June 2010	ASCHOSC	Look at issue of delayed transfers from acute to community care – with view to setting up an ad hoc panel		HOSC is considering this health/ASC cross-over issue at a future meeting and will feed any concerns into ASCHOSC
Personalisation	24 June 2010	ASCHOSC	Not tabled at March meeting. Update to Committee.		
Dementia	24 June 2010	ASCHOSC	Report of Dementia Select Committee for information		

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Lease-Hold Issues	09 September 2010	ASCHOSC	Training session on important issues relating to lease-hold properties		
Autism Ad Hoc Panel	09 September 2010	Cllr Wrighton	Report of ad hoc panel on autism to be considered		
Voluntary Sector involvement in ASC	09 September 2010	Director of ASC	Report on how ASC works with voluntary sector		
Mental Health care in community – impact across city	09 September 2010	Cllr Meadows	Report on how the long term strategy to refocus MH care on community services impacts on city services (esp. ASC and Housing)		
CQC Inspection Report	09 September 2010	Director of ASC			

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Putting People First	24 June 2010	ASCHOSC	ASCHOSC Chair		
Personalisation	04 November 2010	ASCHOSC	Update on progress of personalisation initiative. Moved from September.		Geraldine Des Moulins to be invited to give a CVSF view.
ASC inspection report	04 November 2010	ASC	Report back on findings following CQC inspection of ASC		
New Repairs System	04 November 2010	ASCHOSC	Report on progress of new housing repairs system		
Decent Homes	04 November 2010	ASCHOSC	Progress report on reaching decent homes standard		
Issue	**Date to be considered**	**Referred By?**	**Reason for Referral**	**Progress and Date**	**Notes**
Budget Strategy	06 January 2011	ASCHOSC	To consider executive plans for ASC & Housing budget strategy 2011-12		Single issue meeting

Overview Workshops

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Housing CBRE Masterplan	Private Member's workshop to be arranged	Director	Policy development work. Opportunity for Members to comment upon the review of key estates, areas where new provision can be focused.		
Adult Social Care	Private Member's workshop to be arranged	Acting Director	Co-dependency between ASC & H.	Nov 2010	