Who are we?

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

Where and when is the Board meeting?

This next meeting will be held in the Council Chamber of Hove Town Hall on Tuesday March 24th 2015, starting at 4pm. It will last about two and a half hours.

There is public seating and observers can take part in an informal question and answer session with the Board prior to the formal meeting, starting at 3.30pm and they can leave when they wish.

What is being discussed?

There are 6 main items on the agenda

- Reducing Late Diagnosed HIV Infection
- Joint Health and Wellbeing Strategy
- Developing Enhanced Health & Wellbeing GP Services
- Pharmaceutical Needs Assessment
- Better Care Section 75 Pooled Budget
- Exploring Options for the Future of Community Short Term Services Rehabilitation Beds

What decisions are being made?

- The Board will consider the Notice of Motion and consider the report requesting members to note and support the approaches being taken to reduce late diagnosed HIV infection.
- The Board will receive a verbal update on the Health & Wellbeing Strategy
- The Board will be presented with plans for developing a new way of commissioning enhanced services from GPs for discussion & feedback.

- The Board will be asked to approve the Pharmaceutical Needs Assessment and Process for Supplementary Statements
- The Board will be asked to authorise the Executive Director of Adult Services and the CCG Chief Operating Officer to finalise and agree a new Section 75 Partnership Agreement between the Council and the CCG relating to the commissioning of health & social care services from a pooled Better Care Fund
- The Board will explore a new model of care for Community Short Term Services beds.

Health & Wellbeing Board
24 March 2015
4.00pm
Council Chamber, Hove Town Hall

Who is invited:

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

Who is unable to attend:

Dr Jonny Coxon (Brighton and Hove Clinical Commissioning Group)

Contact: **Caroline De Marco**
Democratic Services Officer
01273 291063
caroline.demarco@brighton-hove.gov.uk

This Agenda and all accompanying reports are printed on recycled paper

Date of Publication - Monday, 16 March 2015


Health &
Wellbeing

AGENDA

Formal matters of procedure

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

Page

62 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

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

63 MINUTES **1 - 22**

The Board will review the minutes of the meetings of the Joint Children & Young People Committee & Health & Wellbeing Board held on 3 February 2015, and the Health & Wellbeing Board held on 3 February 2015, decide whether these are accurate and if so agree them (copies attached).

64 CHAIR'S COMMUNICATIONS

65 PUBLIC INVOLVEMENT

This is the part of the meeting when members of the public can formally ask questions of the Board or present a petition. These need to be notified to the Board in advance of the meeting. Ring the Secretary to the Board, Caroline DeMarco on 01273 291063 or send an email to caroline.demarco@brighton-hove.gov.uk

The Main Agenda

66 REDUCING LATE DIAGNOSED HIV INFECTION **23 - 32**

a) Approved Notice of Motion from Council (copy attached).

b) Report of Director of Public Health (copy attached),

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

Health & Wellbeing

67 JOINT HEALTH AND WELLBEING STRATEGY

Verbal Update from Tom Scanlon, Director of Public Health and Peter Wilkinson, Deputy Director of Public Health.

68 DEVELOPING ENHANCED HEALTH & WELLBEING GP SERVICES **33 - 48**

Report of the Public Health Principal, CCG (copy attached).

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

69 PHARMACEUTICAL NEEDS ASSESSMENT - FINAL REPORT AND THE PROCESS FOR FUTURE PNAS AND SUPPLEMENTARY STATEMENTS **49 - 62**

Report of the Public Health Principal, CCG (copy attached),

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

70 BETTER CARE SECTION 75 POOLED BUDGET **63 - 68**

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

Contact:	*Denise D'Souza, Geraldine Hoban*	*Tel: 29-5032, Tel: 01273 574863*
Ward Affected:	*All Wards*	

71 EXPLORING OPTIONS FOR THE FUTURE OF COMMUNITY SHORT TERM SERVICES REHABILITATION BEDS **69 - 74**

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

Contact:	*Jane MacDonald, Keith Hoare*	*Tel: 29-5038, Tel: 01273 574773*
Ward Affected:	*All Wards*	

WEBCASTING NOTICE

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

Health & Wellbeing

For further details and general enquiries about this meeting contact Caroline De Marco, (01273 291063, email caroline.demarco@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

Public Involvement

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

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

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

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

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

Health & Wellbeing

1. Procedural Business

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

(b) Declarations of Interest:

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

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

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

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

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

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

BRIGHTON & HOVE CITY COUNCIL

JOINT CHILDREN & YOUNG PEOPLE AND HEALTH & WELLBEING BOARD

4.00pm 3 FEBRUARY 2015

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Health and Wellbeing Board: Councillor J Kitcat (Chair), Councillors K Norman, Jarrett, Morgan and G Theobald, Dr Christa Beesley, Dr Jonny Coxon, Geraldine Hoban, Dr George Mack, Mia Brown, Denise D'Souza, Pinaki Ghoshal, Frances McCabe, and Tom Scanlon.
Present: Children & Young People Committee: Councillor Shanks, Councillor Littman, Councillors Wealls, Brown, Gilbey, A Kitcat, Robins, Powell and Simson, Ann Holt, Martin Jones, Amanda Mortensen, Marie Ryan, Eleanor Davies, Ben Glazebrook, Amy-Louise Tilley and Riziki Millanzi.

PART ONE

1 APPOINTMENT OF A CHAIR

1.1 **RESOLVED** – that Councillor Jason Kitcat be appointed as Chair of the Joint meeting.

2 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

2.1 Councillor Robins declared that he was substituting for Councillor Pissaridou. Mia Brown declared that she was substituting for Graham Bartlett. There were no declarations of interest.

2.2 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.

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

3 CHAIR'S COMMUNICATIONS

3.1 The Chair reported that the meeting was being webcast. All Health and Wellbeing Board meetings would be webcast in future.

3.2 The Chair was pleased to report that Tudor House, a residential home for young people with severe learning disabilities had received an outstanding Ofsted report.

3.3 The legal adviser to the meeting explained the voting arrangements for the Joint Children & Young People Committee & Health and Wellbeing Board. When the joint meeting was ready to make a decision, the vote for the Children & Young People Committee would be chaired by Councillor Shanks as lead member of that Committee. The Voting members of the Committee could vote on all the recommendations except Recommendation 2.1.3 which was for the Council members only. This was about early years provision. The decision for the Health and Wellbeing Board would be chaired by Councillor J Kitcat, as Chair of the Board.

4 PUBLIC INVOLVEMENT

4.1 There was none.

5 REVIEW OF SPECIAL EDUCATIONAL NEEDS AND DISABILITY (SEND) INCLUDING BEHAVIOURAL EMOTIONAL AND SOCIAL DIFFICULTIES (BESD)

5.1 The Joint meeting considered a report of the Executive Director, Children's Services which sought approval for the recommendations arising from the review of special educational needs and disability in the Children's Services Directorate of the council. The report included recommendations from the concurrent review of behaviour, emotional and social difficulties (BESD). The report was presented by the Assistant Director of Children's Services.

5.2 The Assistant Director of Children's Services set out the principles of the review (paragraph 3.8 of the report). The aim was to have an outcome focused provision centred on children and their families. Children should have access to inclusive activities and there should be better transition into adulthood. There had been wide ranging consultation and the conclusions had tried to reach a broad consensus.

5.3 Pinaki Ghoshal stressed that there had been a very thorough and important review. There were recommendations proposing more integration and a more personal offer to young people. The report related to the report on the Health and Wellbeing Board meeting agenda (immediately following this meeting) titled 'A Good, Happy & Healthy Life" A Strategy for Adults with Learning Disabilities in Brighton & Hove. This was not the end of the process and following decisions taken at this meeting, both the Health & Wellbeing Board and the Children and Young People Committee would receive future reports with specific items for decision. This was an important first phase.

5.4 Councillor Shanks thanked the Assistant Director of Children's Services and other people involved in the review. She felt the review was a heartfelt cry for the integration of services and a very good start.

5.5 Councillor Wealls thanked the Assistant Director and her colleagues for the huge amount of good work. He stressed that it was important to keep the political parties on board with regard to difficult and controversial decisions. Councillor Wealls made the following comments and raised the following questions. A) It was not always clear what was meant by commissioning throughout the report. The need to re-commission in-house services was not mentioned in the report. B) There was little mention of ICT in the report. C) With regard to the funding formula for schools for SEN – funding for non-statemented SEN pupils did not necessarily flow properly. There was a need to look at this funding pressure. D) The recommendations section of Section 5 – Learning and Achievement - (page 70 of the agenda) spoke about outcomes. GSCE was not an appropriate measure for SEN. How would SEN pupils be measured? E) With regard to short breaks and direct payments – What was the transition time period? What happened to families who did not have that resource? F) Page 57 of the agenda spoke about 'Further investment from schools in this area (On site BESD provision) is needed to ensure all young people can access in-school support……' Councillor Wealls expressed concern about school budgets. G) Cuckmere House had an outstanding Ofsted. The report did not explain why. What did the data reveal? H) There was a need to consider the lack of provision for children with High Functioning Autistic Spectrum Disorders. I) With regard to transition into further education, Sussex University was working on a summer school for year 12 & 13 children with Autistic Spectrum Disorders. The Committee/Board might wish to support this.

5.6 The Assistant Director of Children's Services replied as follows. With regard to SEN and the pressures of funding – The funding formula had been altered to take account of schools with high levels of children with SEN. Schools would be receiving more funding. However it was hard to do this for non statemented children. Officers were willing to talk informally to schools about support. In terms of direct payments, there was a strong desire to give parents more power. Most of the provision offered was of a very high quality but often high cost and poorly co-ordinated. Direct payments should help parents moderate some of these costs. Parents did not have time to 'best market' and would need support. There needed to be a gradual transition in a phased programme.

5.7 Councillor Gilbey referred to the table on page 7 of the agenda. A) She asked why more money was spent on short breaks (respite) for 'looked after' disabled children than for disabled children? B) The transition age had now been raised to 25. What happened to young adults who were now in their early 20s and reached transition age at 18/19? Would they receive retrospective support? C) Why did the conclusions refer to parents but not to carers? D) Councillor Gilbey suggested talking to Brighton University. They had an SEN department and would be interested in talking about similar support.

5.8 The Assistant Director of Children's Services replied as follows. A) With regard to short breaks, 'looked after' included children who received a lot of respite not just children in care. B) Over 19s who felt the need for a plan would receive support. C) She agreed that carers should be specifically mentioned. The reference to parents had meant carers as well.

5.9 Amy-Louise Tilley, Youth Council thanked Councillor Shanks for explaining the data in the report. She supported the recommendations.

5.10 Riziki Millanzi, Youth Council referred to the problem of bullying. The Assistant Director of Children's Services replied that officers were aware that SEN young people were more subject to bullying. This problem would be dealt with.

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5.11 Ben Glazebrook referred to paragraph 4.1.4 in the report (page 9) with regard to CVS commissioning. He asked about the time period for the re-commissioning of contracts and whether new services would be offered to the whole market. The Assistant Director of Children's Services explained that contracts were being reviewed along with what commissioning would be required in the future. There would be new opportunities in the future, with all kinds of different models.

5.12 Frances McCabe asked how the proposals related to cost, and what services would end up looking like in terms of change and provision. The Assistant Director of Children's Services explained that there were substantial ways to make savings, especially in terms of management costs. Officers were looking to pool budgets.

5.13 Ms McCabe referred to the pace of change and asked for assurances that the new way of providing services was fully in place. The Assistant Director of Children's Services explained that it was difficult to give exact timescales. She was conscience of a potential impact on families and would consult very closely.

5.14 Councillor Brown questioned if moving from a high cost service was achievable given the failure to implement previous report recommendations. Meanwhile, the problems of transition had not been resolved and had been known about for a number of years.

5.15 Rizaki Millanzi, Youth Council asked how disabled members of the Youth Council would be kept informed. The Assistant Director replied that there would be an easy read version of the report.

5.16 Councillor Littman considered the report to be excellent. He stressed that services needed to be designed around the needs of young people and their families. Procedures should be put in place to ensure that once service provision was changed there was no slipping back. The Assistant Director agreed that there should be no slipping back. Joint commissioning processes would be put into place.

5.17 Martin Jones commented that a huge amount of work had gone into the report. It was good to see some parents' needs worked out in greater services. It was not just about education but about what was being undertaken across the city. It was

important to see an integrated whole service, for example, how a child has respite, if a child has transport to school etc. These matters would impact on outcomes. Throughout the report there had been reference to the 'realities of the budget'. Mr Jones stressed that this was talking about capacity rather than finances. The idea was that management costs would be reduced leading to savings. Looking after children up to the age of 25 would increase the need for capacity. The percentage of children with SEND was likely to increase. That meant higher capacity. Unless these matters were addressed by efficiency savings there would be a need for more money. Meanwhile, this was an equality issue for the city. There was very little in the report about the Equality Act or the need for the Council to increase equality. Mr Jones referred to page 65 of the report which stated '…parents want to be confident that all parents get the support they need, not just the most articulate, those who shout loudest or those who are 'in the know'. Mr Jones felt that there was no evidence of this. Many parents believed that their children needed intervention and Mr Jones felt that the statement should not remain in the report. It spoke of a fight for intervention and therefore a lack of capacity rather than parents taking from the system when they shouldn't. The Assistant Director of Children's Services explained that the quotation was a frequent comment. An open and transparent set of criteria had been published. Everything in the report was about equalities and an equalities impact assessment would be published.

5.18 Councillor Jarrett stressed the need to make use of resources. Support staff had a wide range of abilities and experience. Meanwhile more help and support was needed in the home for parents and carers. Councillor Jarrett thought the increase in the transition age to 25 was an excellent idea. The few extra years could help an SEN Child achieve similar attainments to other children. Councillor Jarrett stressed the importance of vocational achievements, not just educational achievements such as GCSEs. The Assistant Director of Children's Services agreed with the comment about support staff. Support received in the home was central to the review.

5.19 Councillor Powell quoted paragraph 4.1.17. 'The range of identification of SEN across the city's schools is from 4.5% t 75%, raising some issues for further exploration at individual school and school cluster levels.' It was important to identify SEN to ensure transition was effective across the city. The offer of foundation courses was a big piece of work. She asked how this would be tackled. The Assistant Director of Children's Services concurred with the comment about transition. It was very important to get courses right. Currently young people had to repeat courses as there was no vocational pathway. There was a commitment to ensure better opportunities for young people in the future.

5.20 Amanda Mortensen stressed the importance of communicating with parents. What would reduced services look like for parents with regard to communication and support services? The Assistant Director of Children's Services agreed that communicating to parents was a high priority. Schools and families were equal and all training should be offered to parents as well as professionals with immediate implementation.

5.21 Councillor Norman commented that council resources were declining as demand was growing. It was not possible to continue without change. There was a need to ensure that outcomes were achieved in the future within the limits of resources.

5.22 Councillor Shanks asked the voting members of the Children and Young People Committee to vote on each of the recommendations detailed in paragraphs 2.1 to 2.1.10 on pages 2 and 3 of the agenda. (Recommendation 2.1.3 was for council members only).

5.23 RESOLVED:

The Children and Young People Committee agreed the following:

(1) That the review of the services for children with special educational needs and disabilities (SEND) and behavioural, emotional and social difficulties (BESD) is noted;

(2) That the recommendations to be considered by the Health and Wellbeing Board (the Board) in relation to the review are noted;

(3) That in the future development of services for children with special educational needs and disabilities, and behavioural, emotional and social difficulties there shall be a commitment to integrated and inclusive service delivery across education, health and care/ disability services, with families at the heart of the service offer;

(4) That proposals to integrate provision for children with disabilities in the Early Years by creating inclusive specialist nursery provision within one or more existing mainstream nurseries, with relevant health and care services be developed for further consideration by the Board and the Committee;

(5) That proposals to integrate provision for children with disabilities and complex, severe and profound special educational needs of school or college age, by extending the remit of specialist and mainstream provision to include greater opportunities for inclusion, extended day/respite and potentially residential facilities with relevant health and care services co-located on site, be developed for further consideration by the Board and the Committee;

(6) That proposals to integrate existing educational, health (including mental health) and care provision, for children and young people with behavioural, emotional and social difficulties, so as to provide extended day and potentially residential facilities, with a strong focus on further education and vocational routes, be developed for further consideration by the Board and the Committee;

(7) That schools and colleges with lower than expected outcomes for children with SEND and wider achievement gaps receive challenge and support visits from expert advisers commissioned by the LA, with a view to raising standards and promoting vocational and further education opportunities for young people with SEND and

BESD and especially in secondary and post 16 provision;

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

(9) That there is agreement to the co-location of relevant health professionals and particularly speech therapists and occupational therapists with the combined communication and support service, to enrich the integrated support on offer;

(10) That the combined new communication and support service shall promote partnership working between families and schools by offering support to both as routine, enabling planning across home and school, and involving parents as well as school staff in training, support, advice and guidance; and

(11) That a refreshed cohesive and well-publicised workforce development offer for mainstream and special schools and associated professionals across all relevant services is developed by the new communication and support service, and that this programme is open to parents as well as professional staff, and where appropriate is co-produced with parents and young people.

5.24 The Chair asked members of the Health & Wellbeing Board if they agreed to the recommendations set out in paragraphs 2.2 to 2.2.11 on pages 3 and 4 of the agenda.

5.25 RESOLVED:

The Health and Wellbeing Board agreed the following:

(1) That the Board notes the review of the services for children with special educational needs and disabilities (SEND) and behavioural, emotional and social difficulties (BESD), and agrees the response to the autism report contained therein.

(2) That the Board notes the recommendations to be considered by the Children and Young People Committee (the Committee) in relation to the review.

(3) That the joint strategy for children's health and wellbeing services currently being developed by the LA and the CCG for consideration by the Board in 2015 will incorporate the provision of services for children with SEND and BESD, and transition services through to 25 years, informed by the review.

(4) That in the future development of services for children with special educational needs and disabilities and behavioural, emotional and social difficulties there shall be a commitment to integrated and inclusive service delivery across education, health and care/ disability services, with families at the heart of the service offer.

(5) That proposals to integrate provision for children with disabilities and complex, severe and profound special educational needs of school or college age, by extending the remit of specialist and mainstream provision to include greater opportunities for inclusion, extended day/respite and potentially residential facilities, with relevant health and care services co-located on site, be developed for further consideration by the Board and the Committee.

(6) That proposals to integrate existing educational, health (including mental health) and care provision, for children and young people with behavioural, emotional and social difficulties, so as to provide extended day and potentially residential facilities with a strong focus on further education and vocational routes, be developed for further consideration by the Board and the Committee.

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

(8) That the Director of Children's Services is delegated to publish a clear and transparent set of criteria for determining the basis on which families of disabled children receive respite and short break services, and other disability and care support, and that these criteria are fairly and consistently applied by means of a representative panel.

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

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

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

(12) That the Children's Services Directorate of the City Council will seek to address the serious concerns being raised by schools and families about resources for promoting emotional and mental health by strengthening the support via the Early Help Hub and from the council's community CAMHS team to further develop skills and expertise amongst school staff via training, support and guidance.

The meeting concluded at 5.12pm

Signed Chair

Dated this day of

5.00pm 3 February 2015

Council Chamber, Hove Town Hall

Minutes

Present: Councillor J Kitcat (Chair) Councillor K Norman (Opposition Spokesperson), Jarrett, Morgan and G Theobald, Dr Jonny Coxon, Dr Christa Beesley, Geraldine Hoban, Dr George Mack, Denise D'Souza, Statutory Director of Adult Social Care, Pinaki Ghoshal, Statutory Director of Children's Services, Tom Scanlon, Director of Public Health, Mia Brown, Brighton & Hove Local Safeguarding Children's Board and Frances McCabe, Healthwatch,

Also in attendance: Councillors Shanks and Wealls.

Part One

54 PROCEDURAL MATTERS

54.1 There were no substitutes or declarations of interest.

54.2 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.

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

55 MINUTES

55.1 **Resolved** - That the minutes of the Health & Wellbeing Board held on 9th December 2014 be agreed and signed as a correct record.

56 CHAIR'S COMMUNICATIONS

Eaton Place

56.1 The Chair reported that one of the local GP Practices was in the process of purchasing the building at Eaton Place and intended to open a branch surgery and operate from that premises. The Area Team had supported this application in principle and was working closely with the GP Practice in question. It was unclear just now how long the purchase would take and when the branch surgery would be in a position to commence registering patients. In the short to medium term patients were therefore being advised to register with one of the 15 GP Practices within a 2 mile radius of Eaton Place to ensure continuity of care. It was hoped however, that in due course re-registering at Eaton Place would be an option for people in East Brighton.

Urgent Care

56.2 The Chair reported that The Royal Sussex County Hospital, like many others across the NHS, experienced a substantial increase in demand for urgent care services over the Christmas period. The numbers of very poorly, elderly patients in particular presenting at A&E and requiring admission to hospital was significantly higher than in previous years. The Hospital responded by opening additional beds, cancelling non-urgent operations and taking all the other actions required when in a high state of escalation. Other partner agencies in the local system increased their input to the Hospital over the Christmas period and into January, focusing their attention on avoiding unnecessary admissions and ensuring patients were appropriately but swiftly discharged. Higher levels of staff sickness across the whole health economy over the past month had also contributed to the challenges. The Hospital was beginning to recover from this period of intense pressure. Performance in A&E had improved from 75% of patients being seen and treated in A&E within 4 hours over the Christmas period to 80% in the last week.

Progress Report on Integrated Community Equipment Service Transfer

56.3 The Chair reported that it was agreed at Policy & Resources Committee on 17th November 2014 that the supply and delivery of equipment currently delivered by the Integrated Community Equipment Service (ICES) would be transferred to Nottingham Rehab Supplies (NRS), who were successful in the West Sussex tender.

Transition plans were in place and options were being explored to ensure a delivery and staff base within the Brighton and Hove City boundary. Some staff at ICES had visited potential sites for the replacement equipment store in Hove.

Current ICES staff who are employed by Sussex Community Trust and Brighton & Hove City Council were being kept up to date with progress via meetings and would receive regular information bulletins.

Nottingham Rehab Supplies were having discussions with Sussex Community Trust and the Council with a view to the staff and service being transferred on 1st October 2015.

Nottingham Rehab Supplies were very experienced in transfers of this nature and were working closely with staff in the Council, CCG and Sussex Community Trust to ensure a smooth transition that would not adversely affect the delivery and collection of community equipment.

The service specification was being finalised and included timed delivery slots and better access for customers. The West Service specification included delivery six days a week and discussions were also being held regarding the delivery of equipment 7 days a week for Brighton and Hove given the move towards increased seven day working.

Engagement with Brighton & Hove residents was taking place on 4th February to ensure that the specification for the new service took into account any specific local requirements.

South East Seven (SE7) letter

56.4 The Chair drew attention to a letter from South East 7, a partnership of seven upper tier authorities in the South East. The letter drew attention to a number of key issues about the current challenges facing health and social care. The SE7 Councils were fully committed to developing sustainable health and social care systems which reflected local need and circumstances, in partnership with organisations across the sector. The letter stressed the importance of shared system leadership via Health and Wellbeing Boards. The Chair stated that he would ensure that the letter was circulated to Board Members.

Representation on the Health and Wellbeing Board

56.5 The Chair stressed that in order for the Board to work effectively, it needed to be limited in size. Whenever a particular group was affected by a decision made by the Board, they would be fully consulted. The Board meetings were open to the public to attend and ways of having public involvement were being reviewed.

57 FORMAL PUBLIC INVOLVEMENT

Written Question

57.1 Anthea Franks, Chair of the National Osteoporosis Service asked the following question:

Osteoporosis Service

"It has been found in the US that for women over 55, bone fractures due to osteoporosis lead to more hospitalisations and health costs than heart attacks, strokes or breast cancer, according to a new study. There, between 2000 and 2011 osteoporotic fractures accounted for 40% of hospitalisations. In the UK one out of four orthopaedic beds is occupied by a patient with a hip fracture. The mortality rate is 20% in the first year of a hip fracture. Morbidity and mortality increases with age for patients who have had a vertebral fracture.

In Brighton & Hove there were 247 fractures in 2013; in 2002 it was estimated that the cost of a hip fracture was £12.000 including social care. This brings the total conservative cost for hip fractures alone at £2,294-000 in Brighton & Hove at 2002 cost. This also affects Community Services.

Brighton & Hove Joint Health & Wellbeing Strategy Board Plan for Better Care includes many topics including healthy ageing. An osteoporosis service is not mentioned. Does the board not think that such a service would be beneficial by offering primary and secondary prevention of osteoporotic fractures, thereby decreasing hospital cost, attendance at A&E and social care, not to mention patients' wellbeing?"

57.2 The Chair replied as follows:

"I acknowledge that osteoporosis is a significant health issue for many older people and agree that with proper testing and preventive treatment the health impact and financial cost of treating fractures can be much reduced. The forthcoming strategy, as we will discuss at the Health & Wellbeing Board today is very likely to include a priority of 'Giving Every Person the Best Chance of Aging Well'. The detail of this is still to be worked though, however the views of groups like Age UK, Alzheimer's Society, National Osteoporosis Society and their local representatives will be considered in any development of this theme."

57.3 Christa Beesley informed Ms Franks that a DXA scan service was available for people in Brighton & Hove. There was also a falls prevention service.

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

58 THE OUTCOME OF THE LEARNING DISABILITY REVIEW & 'A GOOD, HAPPY & HEALTHY LIFE. A STRATEGY FOR ADULTS WITH LEARNING DISABILITIES IN BRIGHTON & HOVE

Introduction

58.1 The Board considered a report of the Executive Director of Adult Services which informed members that an independent review of Learning Disability services took place in October 2014, in order to inform the future commissioning and provision of services for adults with learning disabilities. The current paper presented both the outcome from the Learning Disability Review and a new vision and strategy for adults with Learning Disabilities in Brighton & Hove. The review made 26 recommendations, organised into four areas, Vision, Commissioning, Engagement and Providers. The report was presented by Denise D'Souza and the Commissioning Manager for Adults with Learning Disabilities.

Questions & Discussion

58.2 Pinaki Ghoshal stressed that this review was closely linked to the review of special educational needs and disability including behavioural emotional and social difficulties (considered earlier at the Joint Meeting).

58.3 Councillor Jarrett informed the Board that the report back from the Learning Disability Partnership Board had suggested quite a few changes to the language of the review, which had been written from the perspective of adults who did not have a learning difficulty. Representatives from Speak Out had been very definite that they wanted greater ability to make choices, have their say and do their own thing. Councillor Jarrett felt that some of the services on offer for adults did not always make that possible.

58.4 Councillor Jarrett stated that there was an appetite for change and improvement. The Partnership Board had a small number of representatives. There was a wider group of parents and carers across the city whose views also had to be taken into account.

58.5 Councillor Norman stressed the need to continually move forward and to be prepared to change and improve. He thanked everyone involved in preparing the report. Councillor Norman referred to the paragraph concerning political context on page 25 of the agenda. This stated that 'There has been a lack of decision making about the future of Learning Disability services …' Councillor Norman stated that he was not sure if he agreed with that statement. There would always be political differences; however there was a need to make sure that these differences were kept to a minimum in order to move forward.

58.6 Councillor Norman referred to paragraph 2.2 on page 27 of the agenda in relation to commissioning. This referred to macro and micro commissioning. Not everyone

would know what this meant and Councillor Norman suggested that this should possibly be defined differently.

58.7 Councillor Morgan welcomed the report and acknowledged all the work carried out by officers. Councillor Morgan stated that outcomes mattered and that every individual should have the opportunity to be given the support to fulfil their individual potential. There was a need to keep parents and carers on board and to ensure that where Day Centres remain appropriate a provision should be available. Councillor Morgan stressed that supported employment and routes into work would be vital to the success of the strategy and he would like to see work within commitment from employers. There would be a decision in the budget with regard to Able and Willing and Councillor Morgan wanted to inform that decision with some indication of how that decision fitted into the strategy.

58.8 Denise D'Souza replied that Able and Willing and the shift of people's aspirations from day services were closely linked. There was a need to look at that relationship. There were some people who would need day services. However there was also a need to help more people with learning disabilities to gain employment.

58.9 Councillor Theobald thanked the Commissioning Manager for the honest independent report. Councillor Theobald recollected that last year a decision had been postponed with regard to making a decision about the reconfiguration of services. This related to 7 council supported living services, all in the voluntary and independent sector. The current report pointed out that the council services were 17% more expensive than those provided by similar councils. The council's in house provision came under particular criticism, with the report describing them as lacking ambition for service users and providing old fashioned paternalistic services rather than the personal ones that should now be the norm.

58.10 Councillor Theobald regretted the delay in making a decision to modernise the service and wanted to know whether the recommendations in the current report revived the plans from the June 2014 report to re-commission these services.

58.11 The Chair replied that he considered that the Board were better off as a result of having a review of the whole service. The review had been joined up with the review of young people's services and there was now a consistent approach for all people in the city who were affected by these disabilities.

58.12 Denise D'Souza stressed that with regard to personalised services, there would need to be a more holistic approach with individual assessments. As a result, services provided would need to be reviewed. It was necessary to consider what did the person needed; whether they needed to be somewhere else; whether they wanted to be somewhere else; and what services they wanted. Recommendation 3.3 might result in some service changes. For example, there might be a need for more employment provision and fewer day services options. There might be a need for more supported living and fewer residential services. These decisions would be brought back to the Board.

58.13 Frances McCabe was pleased to see that people with learning disabilities had the right to universal services. She questioned whether there were levers and sanctions for the local authority & health services to ensure this happened. With regard to markets and opportunities, Ms McCabe stressed that these opportunities and options should be available so that people could see that there was a different way of having the life they wanted. She asked what was being done to ensure this happened and to ensure that the right sort of staff, with the right kind of cultural attitudes, were in place to enable services to change.

58.14 The Chair stressed that the report was about a cultural shift that needed to be embedded.

58.15 Denise D'Souza concurred with regard to universal services. People with learning disabilities wanted to access the same services as everyone else. Meanwhile, there was a good diverse market in the city. As a result of changes at Buckingham Road, people had been able to visit these services to test them out before making choices.

58.16 The Commissioning Manager acknowledged that there had been much concern about the independent sector. However, when people experienced trying out these services the feedback had been positive. There had been massive growth in diversity, range and quality of provision in the independent sector.

58.17 Geraldine Hoban stressed that universal services were key. The Clinical Commissioning Group carried out an annual learning disabilities self-assessment which looked at the range of access across all health care services and identified where more work was needed in terms of targeted support. The CCG had a number of facilitated workers in primary care looking at GP access, care, and annual health checks for people with learning disabilities. There were also some facilitator posts within the acute trust in order to try and make all universal services as appropriate to the needs of people with learning disabilities as possible.

58.18 Ms Hoban noted that there were many similarities in terms of the personalisation agenda and what was being done through Better Care and in Children's Services. She questioned whether there was a way of joining up some of the challenges that were being tackled in terms of brokerage and developing the market rather than delivering different pieces of work in parallel.

58.19 **RESOLVED:**

(1) That the Board approve *"A Good, Happy & Healthy Life": Adults with Learning Disabilities in Brighton & Hove* (Appendix 1), a Strategy for adults with learning disabilities in Brighton & Hove.

(2) That delegated authority be granted to the Executive Director of Adult Services (Denise D'Souza) and, as appropriate, the Chief Operating Officer of the CCG

(Geraldine Hoban), to develop a Delivery Plan in accordance with the aims and objectives set out in the Strategy and in this paper.

(3) That it is noted that any aspects of the Delivery Plan that require specific decisions to be made by the Board will be presented at the relevant time.

59 FEES PAID TO PROVIDERS 2015/16

Introduction

59.1 The Board considered a report of the Executive Director of Adult Services which outlined current fees paid to independent, voluntary and community care providers. It made recommendations for fees to be paid in 2015/16. Those affected would be care providers and potentially the vulnerable for whom they provided care and support. The report was presented by Denise D'Souza and the Commissioning Manager.

Questions and Discussion

59.2 George Mack commented that this was a thorough piece of work. He referred to paragraph 4.6.2 in the report and asked why the response to the audit of local care homes fees was sparse with only 17% of homes submitting data. The Commissioning Manager replied that information was provided to a number of homes and the result was disappointingly low.

59.3 Geraldine Hoban reported that the fee increases had been discussed and agreed at the Clinical Commissioning Group in terms of mirroring the recommendations for the increase. There had also been a discussion about having a strategic approach to the care home market in the city. Ms Hoban stressed that the market was under pressure and capacity was becoming more restricted. There was a need to secure an appropriate number of care homes in the city and for the CCG to work with the Council over the next 3 to 5 years on managing the market. One focus of work would be to see how the need for care homes could be reduced by the work being carried out through Better Care.

59.4 Councillor Jarrett informed the Board that he had met with the Registered Care Homes Association and a number of concerns they raised were taken into account, particularly in relation to the level of support for dementia patients. The Registered Care Homes Association also had problems in engaging with care homes. It was possible that the homes were too busy running their businesses to take time to engage.

59.5 **RESOLVED:**

(1) That the proposed fee increases be agreed, as set out in the table below.

Description of service	Recommended fee increase
In city care homes for people needing physical support where set rates apply	1% increase
In city care homes set rate for people needing memory/mental health support, where set rates apply	2% increase
In city care homes/ supported living where no set rates apply	0% change
Out of city care homes/supported living where set rates apply	To reflect host authority set
Shared lives carers	1%
Out of city care homes where no set rates apply	0% change
Home care	2%
Direct payments	1%
Service contracts	0% change

(2) That providers supporting people with a diagnosis of dementia living in registered care homes where people needing physical support rates apply, should be rewarded appropriately. A 1% increase will apply until a policy for this is agreed.

60 ADULT SOCIAL CARE SERVICES CHARGING POLICY

Introduction

60.1 The Board considered a report of the Executive Director of Adult Services which provided recommendations to uprate maximum and fixed rate charges. The report was presented by Denise D'Souza.

60.2 The Board was informed that 3400 people were in receipt of these services and a high proportion were not charged. Some charges were discretionary. Carers would not be charged. There was a new responsibility with regard to deferred payments. An administration fee could be charged and interest could be charged on deferred payments. The Care Act which would come into effect in April 2015 would bring together all aspects of charging.

60.3 **RESOLVED:**

That with effect from 6th April 2015

(1) That the council continues with the current charging policies for residential care and non-residential care services which are compliant with the requirements of Section 17 of the Care Act 2014.

(2) Where applicable charges continue to apply for preventive services provided under Section 2 of the Care Act.

(3) That no charge will be made to carers for any direct provision of care and support to them.

(4) That an initial fee for setting up Deferred Payment Agreements should be set at £475 plus any additional costs incurred for property valuations.

(5) That Deferred Payment Agreements are subject to the maximum interest rate as set by the Government and reviewed on an annual basis. This will be 2.65% from April 2015.

(6) That the following table of charges are agreed with effect from 6th April 2015

Maximum Charges	**2014/15**	Proposed for 2015/16
Means Tested Charges		
In-house home care/support	£20.00 per hour	£21 per hour.
Day Care	£30.00 per day	£34 per day
Maximum weekly charge	£900 per week	£900 per week
Fixed Rate Charges		
Fixed Rate Transport	£3.00 per return,	£3.50 per return
Fixed Meal Charge /Day Care	£3.90 per meal,	£4.30 per meal

Carelink:	£14.50 month – with 2 key holders,	£16.00
	£17.83 month – with 1 key holder -	£18.50
	£22.17 month – with key safe jointly	£22.17 (no change)

Additional telecare devices remain free of charge.
No increase for the mobile phone based service 'CareLink Anyway' at
£5 per month for existing CareLink Plus users and
£12 per month for people to have this service alone.
No increase for key safes at £50 per unit.

61 UPDATE ON THE DEVELOPMENT OF THE JOINT HEALTH & WELLBEING STRATEGY

Introduction

61.1 The Board considered a report of the Director of Public Health which summarised the results of engagement to date on the development of a new Joint Health and Wellbeing Strategy, and in particular the results of the first Health and Wellbeing

Partnership meeting held on Thursday 27th November 2014. The report was presented by Tom Scanlon. The current strategy covered five discreet areas. In October 2014 the Board provisionally agreed on draft strategic priorities as set out in paragraph 4 of the report.

Questions and Discussion

61.2 Mia Brown referred to draft strategic priority 2 - Give every child in the city the best chance in life. She expressed surprise that there was no mention of the high number of looked after children or the numbers on drug section plans and repeat drug section plans. The Chair stressed that the report summarised suggestions made at the Health and Wellbeing Partnership meeting in November. The suggestions would not necessarily be included in the final strategy. The Chair agreed that the issues raised by Ms Brown were important.

61.3 Frances McCabe referred to Emerging Themes set out in Section 4 of the report - Build a resilient population. These themes resonated with matters picked up by Healthwatch and Ms McCabe hoped that the themes would be considered in the strategy. Ms McCabe referred to Further Considerations under section 4 on page 73 of the agenda concerning the severe pressures on national and NHS services both in primary and secondary care. The Health and Wellbeing Board was asked to consider whether the adoption of a separate priority on health service delivery was appropriate. Ms McCabe agreed that something along those lines was appropriate.

61.4 Councillor Shanks referred to the emerging themes section of 2 - Give a child the best chance of life on page 69 of the agenda. She made the point that home educated children had never been a priority before. Councillor Shanks asked where this suggestion had come from. The Chair replied that the report was outlining the comments made at the first Health and Wellbeing Partnership meeting held on 27 November 2014.

61.5 Councillor Morgan highlighted section 1 – Reduce inequalities across Brighton & Hove. This referred to BME issues and the LGBT community but not to financial inequalities. This was a big element missed out and it needed to be included. Matters of importance were inequalities with regard to GP provision and inequalities due to poor diet and use of food banks. Some of these issues were geographical.

61.6 Councillor Jarrett referred to education. There was an issue of people's knowledge and the ability to make the right choices for themselves. There was a need to look at education very broadly and include wider adult community education. Many people did not know how to manage their long term health.

61.7 Denise D'Souza commented that when there was talk about the quality of care homes this was referring to the quality of care homes in neighbouring authorities. There was a capacity issue in Brighton & Hove rather than a quality issue. Ms D'Souza referred to the Further Considerations section of 4 - Give every person the

best chance of aging well. She felt that mental health partners should be included in this section as they were under acute pressure.

61.8 The Chair summed up by stating that not everything reflected in the comments from the partnership meeting reflected the concerns of the Board. He entrusted Tom Scanlon and his colleagues to use the feedback from this meeting along with the wider data sets to develop draft thinking for the next meeting. The final strategy would be signed off post election.

61.9 Councillor Jarrett asked if there was a timeframe for further comments. Tom Scanlon replied that further comments could be received throughout February.

61.10 **RESOLVED:**

(1) That the progress on developing the new Joint Health and Wellbeing Strategy be noted.

(2) That the emerging themes from the Health and Wellbeing Partnership event be noted.

(3) That a proposal that the Directors of Public Health, Children and Adult Social Care and the Chief Operating Officer of the CCG consider the information from the Partnership event in conjunction with the JSNA and local NHS pressures, be supported. They will then present a draft strategy for consideration by the Health and Wellbeing Board in March 2014. If approved, the draft strategy will go out for formal consultation with a view to final Health and Wellbeing Board approval following the May election.

The meeting concluded at 6.24pm

Signed Chair
Dated this day of

Council	Agenda Item 55(a)
11 December 2014	Brighton & Hove City Council

NOTICE OF MOTION

HIV DIAGNOSIS – HALVE IT

"This Council resolves to:

1) Become a supporter of the Halve It Coalition whose aim is to halve both the proportion of people diagnosed late with HIV and the proportion of people living with undiagnosed HIV by 2020.

2) Request that the Director of Public Health brings a report to the Health & Wellbeing Board setting out what needs to be done locally in commissioning and provision of services by Brighton & Hove City Council and the Brighton & Hove Clinical Commissioning Group in order to achieve Halve It's aims in this city.

3) Request the Health & Wellbeing Board to ensure that rates of late diagnosed HIV are specifically included as an indicator in its Joint Strategic Needs Assessment (JSNA)."

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

1. Reducing late diagnosed HIV infection

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

1.2. This paper is for the Health & Wellbeing Board meeting on the 24th March 2015.

1.3. Author of the Paper and contact details

Stephen Nicholson, Lead commissioner HIV and sexual health
Stephen.nicholson@brighton-hove.gov.uk
01273 296554

2. Summary

This report is provided in response to Brighton & Hove City Council's Notice of Motion of 11th December 2014 on the HIV Diagnosis – Halve It campaign. The Halve-It campaign is a coalition of national experts in HIV who seek to reduce the proportion of people undiagnosed and diagnosed late with HIV through public policy reform and implementation of good practice. This paper describes HIV infection in Brighton and Hove and the current initiatives to reduce the number of people diagnosed late and living with undiagnosed HIV infection.

3. Decisions, recommendations and any options

For Members to note and support the approaches being taken to reduce late diagnosed HIV infection.

3. Relevant information

3.1 HIV infection continues to present a major public health challenge nationally and locally. Early diagnosis enables better treatment outcomes and reduces the risk of transmitting the virus to others.

3.2 In 2013 in the UK, over 107,000 people were estimated to be living with HIV. A quarter of whom are thought to be unaware of their infection and remain at risk of passing on HIV, mainly through having sex without condoms.

3.3 The overall prevalence of HIV in the UK is 2.8 per 1,000 population aged 15-59 years (1.9 per 1,000 women and 3.7 per 1,000 men).

3.4 HIV infection is not equally distributed among the population. In 2013 the prevalence rate of HIV was approximately 30 times higher for men who have sex with men (MSM) and black Africans compared to the general population in England.

3.5 In Brighton and Hove 1,670 residents attended NHS HIV treatment services in 2013. The overall prevalence of diagnosed HIV in Brighton and Hove is 7.96 per thousand population aged 15-59 years.

3.6 Brighton and Hove has the 8th highest prevalence of diagnosed HIV in the UK and the highest outside of London.

3.7 In Brighton and Hove, 91% of people living with HIV are male and the majority (84%) of people (92% of males) probably acquired the infection through sex between men. The majority of people living with HIV locally are white but 54% of women with HIV in Brighton and Hove are black African.

3.8 People living with HIV can expect a near normal life-span if they are diagnosed promptly. Late diagnosis of HIV is the most important predictor of HIV -related illness and death. People diagnosed late have a tenfold increased risk of dying within the first year of diagnosis.

3.9 It is estimated that more than 50% of new HIV infections occur through transmission from individuals who are unaware of their infection, and studies have shown that the risk of transmitting HIV to an un-infected partner is reduced by up to 96% when infection status is known.

3.10 Each new HIV infection costs the NHS between £280,000 and £360,000 in lifetime treatment costs. Direct medical costs are almost twice as high for late presenters compared to patients who are diagnosed early.

3.11 It is therefore very clear that there are significant benefits to individual health, the public health and the health and care economy in ensuring the timely diagnosis of HIV infection.

3.12 This importance is recognised by the national Halve-It campaign and its objective to reduce the proportion of people undiagnosed and diagnosed late with HIV.

3.13 Over the last 13 years the proportion of individuals diagnosed late nationally has decreased significantly from 60% in 2002. The decrease in late diagnoses has slowed in recent years but a steady downward trend continues. The table below shows the proportion of diagnoses made late over the last 4-5 years in England, the South East and in Brighton & Hove:

The proportion of HIV diagnoses made late in England, the South East and Brighton and Hove, 2009/11 to 2011/13

	Brighton & Hove %	South East %	England %
2009-11	34	50	50
2010-12	34	47	48
2011-13	31	46	45

3.14 Late diagnosis rates are significantly lower (better) in Brighton and Hove than have been achieved nationally or in the South East region. Brighton and Hove is ranked the 12th best local authority in England for late HIV diagnoses.

3.15 This reflects two local factors. The first is that the majority of people living with HV locally are MSM who are more likely to be offered, and to accept, HIV testing at the sexual health clinic and to test more frequently, and so be diagnosed earlier. Secondly, commissioners and providers have worked together to ensure that there is easy and timely access to pro-active HIV testing in a range of health and community settings.

3.16 HIV testing is currently offered in the following settings in Brighton and Hove:

- All attendees at the sexual health (GUM) clinic;

- MSM are offered annual screening or more frequent if changing sexual partners;
- The community contraception and sexual health (CASH) clinic;
- All pregnant women attending ante-natal screening;
- All acute medical admissions to the Royal Sussex County Hospital;
- At registration with some general practices;
- All women undergoing termination of pregnancy
- All new registrations at substance misuse services
- Service users of the First Base Day Centre for the homeless and insecurely housed
- Community settings, venues and outreach targeting men who have sex with men (MSM) and black Africans.

3.17 Scaling-up testing will continue to reduce the number of people who are diagnosed late, if it is evidence-based and targeted.

3.18 Brighton and Hove has been at the forefront in developing innovative approaches to increase the uptake of HIV testing. Brighton and Sussex University Hospitals Trust (BSUHT) and the former Brighton and Hove Primary Care Trust (PCT) received two of eight national grant awards from the Department of Health to pilot offering opt-out HIV testing to patients being admitted to hospital and patients registering with general practice respectively.

3.19 The results of these pilot schemes demonstrated that opportunistic, opt-out HIV testing was feasible and acceptable in primary care and hospital settings and informed the Health Protection Agency recommendation that HIV testing in primary care and in general medical admissions to hospital should be prioritised in areas with a high HIV prevalence.

3.20 Opt-out HIV testing continues to be offered to patients being admitted to the Royal Sussex County Hospital as it was found to be effective and continues to identify previously undiagnosed infections.

3.21 HIV testing for patients registering with primary care has not been as successful in identifying new cases of HIV locally. This is largely because the epidemiology of HIV in Brighton and Hove means that routinely testing large numbers of white, heterosexuals with no risk factors or symptoms is unlikely to lead to many new diagnoses.

3.22 Plans are being developed locally to implement the NICE guidelines on increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among men who have sex with men and black Africans.

3.23 These guidelines recommend the offer of HIV testing to all men and black African women for whom a blood test is being requested by general practices. This targeted approach will better reflect the local epidemiology of HIV. From April 2015, primary care practitioners will be supported to implement this recommendation as well as to offer more targeted testing to at-risk patients who are not having a blood test.

3.24 Following a successful pilot study we are also developing plans for a national procurement of a home sampling for HIV testing service. Black Africans and MSM will be able to order self-sampling kits for either blood or saliva on-line that will be sent to a laboratory for testing and the results communicated back to the individual directly. This work is being led by Public Health England. Brighton and Hove is representing the South East in the development of this service.

3.25 As well as increasing opportunities to test for HIV and reduce un-diagnosed infection it is important to improve our understanding of the local picture of HIV through surveillance and reporting. The Public Health Outcomes Framework includes an indicator on late diagnosis of HIV and the new contract for the integrated sexual health service includes a requirement on the exception reporting of late diagnoses of HIV as serious incidents. Increased understanding of how and why late diagnoses occur will help us to reduce the number in the future.

3.26 All of the interventions and opportunities to test described above make Brighton and Hove very well placed to continue to reduce undiagnosed and late diagnosed HIV infection locally. As currently available data provide only three time points it is not possible to commit to a trajectory of that reduction at this time.

3.27 The lack of trend data and the already relatively low late diagnosis rates locally also make it difficult to commit to halve late diagnoses by 2020. Nevertheless, we are determined to continue the downward trajectory and ensure that late diagnosis rates are as low as they can be in Brighton and Hove.

3.28 Increasing the uptake of HIV testing and reducing undiagnosed infection is underpinned by a programme of targeted HIV prevention that aims to provide those at risk of infection with the knowledge, skills and resources to protect themselves from HIV in the first place.

3.29 HIV prevention methods and interventions include:

- Provision of free condoms and lubricant;
- Targeted outreach and campaigns;
- Printed information and resources on-line (eg www.swish.org.uk);
- Ensuring that drug and alcohol related risk-taking is addressed by sexual health services; and
- Sexual risk-taking is addressed by drug and alcohol services;
- One-2-one support for high risk MSM and those who attend sexual health clinics repeatedly;
- Work with faith and community groups to support and normalise condom use and HIV prevention messages

3.30 More recent innovations in HIV prevention have also been developed alongside the emerging digital and social media. The Terrence Higgins Trust (THT) who provide HIV prevention services for MSM locally are actively and successfully engaging men through platforms that provide real-time social networking opportunities.

3.31 Correct and consistent condom use remains an extremely effective way to prevent HIV transmission. This, alongside increasing targeted, testing coverage will help to ensure a reduction in the incidence of HIV infection in Brighton and Hove.

4. Important considerations and implications

4.1 Legal
There are no direct legal implications arising from this report which is presented for information only. Jill Whittaker 3/3/2015.

4.2 Finance
Most of the activity is funded through current contracts and there is a dedicated budget for additional HIV testing of £30k, which is funded from the Public Health ring-fenced grant.

Finance Officer consulted: Mike Bentley Date:03/03/2015.

4.3 Equalities

4.4 Sustainability

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

5 Supporting documents and information

N/A

1. Formal details of the paper

1.1. Title of the paper
Developing enhanced health and wellbeing GP services

1.2 Who can see this paper?
All

1.3 Date of Health & Wellbeing Board meeting
March 24th 2015

1.4 Author of the Paper and contact details
Nicola Rosenberg, Public Health Principal
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Suzanne Novak, Interim Primary Care Transformation Lead
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Katie Stead, GP Lead for Primary Care Quality and Public Health
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2. Summary

2.1 This paper is presented to keep the Health and Wellbeing Board briefed and to take the Board's feedback on the work to develop and enhance primary care in the city and to ask for support for the overall process.

The Clinical Commissioning Group (CCG) in collaboration with Brighton and Hove City Council (BHCC) is developing a new way of commissioning enhanced services[1] from GP practices. Through this new approach GP practices will work together in clusters (see appendix 1 for current cluster list) covering registered patient lists of approximately 40,000 to improve health and wellbeing outcomes.

The purpose of this work is to respond to the findings from a premature mortality audit, improve the quality and length of life for people chronic conditions, to address inequalities in health and to improve patient experience. The work will include both the CCG

[1] The formal term for these services is Locally Commissioned Services.

and BHCC public health services to join up commissioning and delivery.

This new way of commissioning will be different from how services are individually commissioned at the moment and provide an opportunity for GPs to lead and develop initiatives together to improve health outcomes and reduce health inequalities. GPs will be able to take more of a leadership role in joining up services at community level. There will be more opportunities for GPs to work with others to improve and address patients' health and wellbeing needs.

3. Decisions, recommendations and any options

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

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

4. Relevant information

The problems we are seeking to tackle

Poor health

The Joint Strategic Needs Assessment for Brighton and Hove and the recent Preventing Premature Mortality Audit (see supporting document) show that we have a relatively high number of people suffering and dying from preventable causes. In particular, chronic diseases such as diabetes, heart disease, cancer and respiratory disease are causing our residents reduced quality and length of life.

Variable patient access to enhanced primary care:

At present Brighton and Hove CCG have multiple separate contracts with local GPs to provide 15 different enhanced primary care services to their patients: wound closure, neonates, phlebotomy, palliative care, intermediate care, leg ulcers, student health, suture removal, diabetes, depression, Ambulatory Blood Pressure Monitoring, drug monitoring, rabies and proactive care. These services are above and beyond the core services GPs are contracted to provide by NHS England. Practices are paid on

activity of these enhanced services. GPs enter into the contracts voluntarily and so the uptake is variable between practices with some offering their patients only a few enhanced services, often due to space and staff constraints. Until 2014 the CCG budget for these services was approximately £650,000 although not all was claimed for by GPs. Within 2014/15 the CCG budget was increased to just under £3m to introduce a new service called Proactive Care and funding associated with preventing premature mortality.

Brighton and Hove City Council (BHCC) currently commission 8 different enhanced services from GPs: alcohol reduction, stop smoking, NHS Health Checks, HIV, young people's sexual health, contraceptive implants, Intrauterine Contraceptive Devices (IUCDs) and substance misuse shared care.
The annual budget 2014/15 was £758,075. Uptake and levels of a activity of these services is also variable between practices.

<u>Our objectives</u>
Through the new commissioning approach the CCG is proposing to focus on improving health outcomes and bringing all different contracts together into one new contract with practices, invest up to a further £2 million and extend it further to:

- **Achieve universal coverage for all local patients** by requiring GPs to work in groups of practices ("clusters") covering populations of about 40,000 or more[2]

- **Expand GP capacity so there is dedicated GP time to take a more proactive approach to identifying, managing and improving the quality and length of life for patients with complex needs** working with other local organisations to better co-ordinate care around the holistic needs of the individual.

- **Support GPs to develop a greater focus on reducing preventable premature mortality** by taking a proactive approach to identifying patients at risk and working with other organisations to help reduce that risk and keep people as healthy as possible

- **Enable GPs to have dedicated time to improve the health and wellbeing of children and young people, to address inequalities in health and to improve patient experience** of primary care, working with other local organisations

[2] National research and guidance suggests that GPs working together "at scale" provides a more viable structure for integration with other services locally and facilitates a more proactive approach to care.

BHCC is proposing to collaborate with the CCG and to incorporate its commissioned services from GPs within the new proposed CCG contract. It is planned that the BHCC public health commissioned services would form a distinct part of the new joint contract.

Through the new contract the CCG and public health would be supporting each other's aims and ensure as much as possible that the new contract leads to improved health outcomes. Building on and being part of the new contract will result in better use of resources and more joined-up efforts to improve health and wellbeing and reduce health inequalities in the city.

The evidence and rationale behind our proposed approach

The BHCC Public Health Directorate and CCG have looked at research and evidence to find out the best way to commission and contract with GPs to achieve these objectives[3]. Evidence shows this new way of working can be an effective route to commissioning for improving outcomes.

The new commissioning approach will specify outcomes such as reducing deaths from heart disease for people aged under 75 which all parties agree to work together to achieve (see framework in appendix 2). The new contract would be based on the clusters working together to achieve the health and patient experience outcomes as specified by the CCG and BHCC for their whole population of 40,000+.

It is planned that the "clusters" of practices will invest in GP capacity and capability because the evidence shows this will be an effective way to improve the health outcomes. The CCG is currently considering offering a five year contract term to provide the necessary stability of income to enable investment in clusters and to recruit more doctors and nurses to do this work.

The CCG will ensure the new contract mandates appropriate patient and public representation in the decision making structures of the clusters and their collaboration at city level. Information on the performance of the clusters and details of action and investment plans and progress on implementing the new contract will be publically available and actively shared between clusters and elsewhere widely. This "open book" approach is a key feature of the new way of working.

[3] For the research and evidence base underpinning the plans for the new approach see http://www.brightonandhoveccg.nhs.uk/primary-care-transformation-evidence.

There will also be close working with BHCC regarding social care and other services such as housing.

Progress to date and plans

This new way of working is a big change for the CCG, BHCC and for Primary Care. At present the GP practices are starting to form clusters. There are six clusters covering every GP practice in the city. They have all agreed a Memorandum of Understanding about how they will work together, their values and objectives.

It is planned that April 2015 to April 2016 will be the "transition year" for the GPs moving from the old and multiple contracts to the new outcome oriented contract. The clusters will agree Development Plans showing how they will function effectively in order to be ready to deliver the new contract. During this time practices will also be formalising a city-wide collaborative structure for overseeing the delivery of enhanced services through the formation of a new "federated/network" model.

The CCG plans to be able to offer the new contract to GP practices in 2015/16 ready for full implementation April 2016 onwards. In order for practices to take up the new contract, they will need to submit costed action and investment plans and details of how they will implement the services (see appendix 2 for a draft of the commissioning framework with outcomes and targets).

5 Important considerations and implications

5.1 Legal

The current GP contracts for enhanced services called locally commissioned services, have been or are being extended to enable the new model to be developed. The proposal is for GP's to be offered the opportunity to exit from current contractual arrangements and take up the new contract once the terms have been finalised and approved. The procurement implications will need to be addressed once the contractual arrangements for the new model are clear.
Lawyer consulted: Jill Whitaker 05/03/15

5.2 Finance

The CCG will be investing up to £2m or more a year.
The BHCC Public Health budget will be met by the ring-fenced public health grant. It is not expected to significantly change from its current funding levels.
Finance Officer consulted: Michael Bentley Date: 25/02/15

5.3 Equalities

A key objective of the new contract is to develop GP leadership focused on addressing inequalities in health. There are specific targets related to addressing inequalities. As part of the consultation on the new way of commissioning the CCG is working with representatives of vulnerable and / or excluded groups to ensure their needs are met.

This new contract provides an opportunity to incorporate Equality Act 2010 requirements and ensure that protected characteristics and vulnerable groups' needs are adequately addressed and monitored.
Equalities Officer: Sarah Tighe-Ford consulted Date: 25/02/15

5.4 Sustainability

It is proposed that one of the standards for the new contract is that clusters of practices have a lead for sustainability and that the cluster regularly reviews their use of resources such as pathology tests to maximise value.
CCG Sustainability lead: Dr Rachel Cottam, consulted 25/02/15

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

Clusters of general practices will be expected to work in an integrated fashion with other local services including social care, children's services, mental health, housing, the police and education.

This has implications for these services because over time GPs taking a lead role in health improvement activities, will want to work more closely with these colleagues to identify people at risk of deteriorating health and to actively reduce that risk by taking effective action.

6 Supporting documents and information

Background Document:

1) Briefing of the Preventing Premature Mortality Audit report

Appendix 1: Map and list of the GP Clusters for ProActive Care

Cluster	Clinical Lead	Managerial Lead
1	Manas Sikdar	Carol Witney
2	Richard Mitchell and Robert Hacking	Clare Marks
3	Andy Hodson/ Catriona Greenwood	Susan Harries/ Cheryl Palmer
4	Rowan Brown	Rick Jones
5	Tom Gayton	Anne Scott
6	Andy Watts	Gary Toyne/ Steve Cribb
TOTAL		

1

No. on Map	Practice name	GP Code	Responsible Population
30	Albion Street	G81090	6,125
42	Ardingly Court Surgery	G81006	6,230
41	Park Crescent	G81028	13,244
45	Pavilion Surgery	G81054	8,913
24	St Peter's Medical Centre	G81011	11,219
31	Brighton Homeless Health Centre	G81689	1,138
25	North Laine Medical Centre	G81103	4,015
28	Boots North Street	G81020	2082
40	Lewes Road Surgery	G81063	2499
			55,465

2

No. on Map	Practice name	GP Code	Responsible Population
38	Avenue Surgery	G81075	6,772
36	Broadway Surgery	G81669	2,346
35	Ridgeway Surgery	G81642	2,334
33	Saltdean & Rottingdean Medical Practice	G81076	9,564
44	School House Surgery	G81613	4,407
29	Ship Street Surgery	G81694	2,068
32	St Luke's Surgery	G81667	2,296
39	Willow House Surgery	G81661	1,959
37	Whitehawk Surgery	G81676	3,339
34	Woodingdean Surgery	G81065	6,485
46	Regency Surgery	G81656	4,118
			45,688

3

No. on Map	Practice name	GP Code	Responsible Population
23	Beaconsfield Surgery	G81042	10,196

21	Preston Park Surgery	G81018	11,101
22	Stanford Medical Centre	G81038	16,226
19	Warmdene Surgery	G81036	9,174
			46,697

4

No. on Map	Practice name	GP Code	Responsible Population
2	Benfield Valley Healthcare Hub	G81680	5,575
5	The Practice Hangleton Manor	Y00079	2,010
6	Hove Medical Centre	G81001	8,730
3	Links Road Surgery	G81663	5,818
1	Mile Oak Medical Centre	G81073	7,641
4	Portslade Health Centre	G81046	12,186
9	Wish Park Surgery	G81083	5,894
			47,854

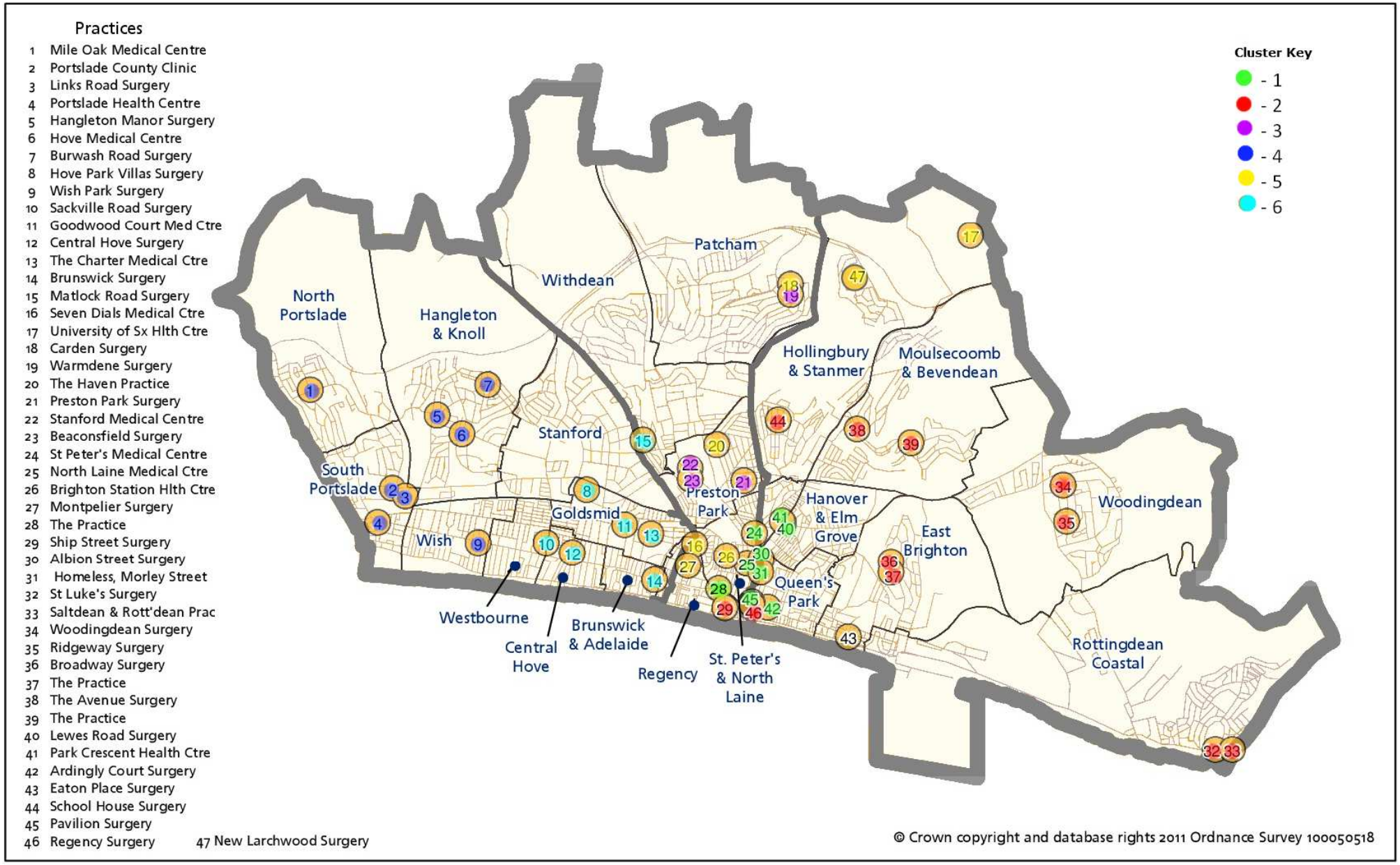
5

No. on Map	Practice name	GP Code	Responsible Population
26	Brighton Station Health Centre	Y02676	5,767
18	Carden and New Larchwood Surgery	G81014& Y02404	5,731& 1,008
16	Seven Dials Medical Centre	G81047	7,848
20	Haven Practice	G81646	3,067
17	University of Sussex	G81071	16,925
27	Montpelier Surgery	G81044	6,101
			49,147

6

No. on Map	Practice name	GP Code	Responsible Population
14	Brighton Health and Wellbeing Centre	G81638	8,188
12	Central Hove Surgery	G81070	5,458
13	Charter Medical Centre	G81034	17,923
11	Goodwood Court Medical Centre	G81687	9,747
8	Hove Park Villas Surgery	G81094	4,473
10	Sackville Road Surgery	G81009	11,289
15	Matlock Road	G81684	2,999
			60,077

Brighton and Hove GP Practices, Dec 2014



Appendix 2: Draft commissioning framework for developing enhanced health and wellbeing GP services

The following tables show the current DRAFT stage of development of the framework for enhanced health and wellbeing GP services. Clusters of GP practices will submit plans which will include their proposed target percentages (replacing the Xs shown in the below framework).

DRAFT Priority Cluster Goals for Enhanced Services	
Reduce premature mortality in key disease areas	Specifically: Reduce preventable premature deaths for the specified patient group by X% in 3 years and X% in 5 years
Deliver proactive care of people with complex needs & "frail" and improving quality of life for people with chronic conditions	Specifically: In the 5 year period: reduce exception reporting of QOF by X% ensuring all high risk patients are actively managed; agree and deliver measurable improvements in patient reported experience outcome measures through integrated multi-disciplinary working; reduce emergency readmission rates by X% and A&E attendances by X% for this patient group
Addressing inequalities in health especially in the above groups	Specifically: Reduce the link between preventable premature mortality in the specified patient group and deprivation by X% by year 5
Improve patient experience for the above groups	Specifically: Deliver the patient experience outcomes agreed with the local community and a comprehensive care approach with continuity where it matters
	Ensuring enhanced access is achieved

Improved health of children & young people	Specifically: Deliver GP led health programmes leading to measurable improvements in sexual health, mental health and reductions in obesity, smoking, alcohol and substance misuse
Addressing inequalities in health especially in the above groups	Specifically: Reduce the difference between the rates of smoking, obesity, alcohol amongst children and young people from deprived areas and non-deprived areas by 50% by year 5
Improve patient experience for the	Specifically: Deliver the patient experience outcomes agreed with the local community (children and young people)

above groups	Ensuring enhanced access is achieved (children and young people)

REDUCING PREMATURE MORTALITY - Reducing under 75 mortality rate from cardiovascular disease	X% reduction or maintenance of under 75 mortality rate for CVD considered preventable X% improvement in estimated percentage of detected CHD per cluster or practice per year X% improvement in CHD patients immunised against flu per year Annual increase of X% of those eligible living within the most deprived quintile receiving an NHS Health Check X% increase in referrals to health improvement services for weight management per year

REDUCING PREMATURE MORTALITY - Reducing under 75 mortality rate from respiratory disease	X% reduction of under 75 mortality from respiratory disease considered preventable X% improvement in estimated percentage of detected COPD prevalence per year X% improvement in exception rate for COPD indicators per year X% reduction of smoking prevalence X% increase in smoking cessation treatment and support offered (certain conditions) per year – *overlaps with QOF* X% more smokers quitting per year X% increase uptake of seasonal flu vaccine 65+ per year - *overlaps with QOF*

REDUCING PREMATURE MORTALITY - Reducing under 75 mortality rate from liver disease	X% reduction of under 75 mortality rate from liver disease considered preventable X% increase in number of alcohol brief interventions per year

REDUCING PREMATURE MORTALITY - Reducing under 75 mortality rate from cancer	X% reduction of mortality rate from all cancers considered preventable X% increase in lung cancer survival at one year X% increase in breast cancer survival rate at 5 years X% increase in prostate cancer survival rate at 5 years X% reduction of cancer diagnosis by emergency routes per year X% increase cancer recorded at early stage of diagnosis per year X% improvement in attendance of Two Week Referral appointments per year X% improvement per year of women aged 25-64 with a record of cervical screening (last 5 years) per year X% improvement in % of men and women aged 60-74 with a record of bowel cancer screening every 2 years X% improvement in % of women aged 47-73 with a record of breast screening every 3 years

REDUCING PREMATURE MORTALITY - Reducing excess under 75 mortality rate in adults with serious mental illness	X% reduction in excess under 75 mortality rate in adults with serious mental illness
	X% increase in % of patients on the mental health register with cholesterol check in the preceding 12 months per year

REDUCING PREMATURE MORTALITY - Reducing excess under 60 mortality rate in adults with learning disability	X% reduction in excess under 60 mortality rate in adults with learning disability
	Implement LD programme for the Cluster

ENHANCING THE QUALITY OF LIFE FOR PEOPLE WITH LONG TERM CONDITIONS	X% increase in proportion of people feeling supported to manage their condition per year
	X% increase in the % of patients reporting their care was joined up around their needs

IMPROVING THE QUALITY OF LIFE - people with COPD	Increase of X% people with COPD and medical Research Council Dyspnoea scale ≤3 referred to pulmonary rehabilitation programme per year

IMPROVING THE QUALITY OF LIFE - People with diabetes	By year 5 80% of people with diabetes have received nine care processes By year 5 80% of people with diabetes diagnosed less than one year referred to structured education X% improvement in estimated percentage of detected diabetes per cluster or practice per year X% of people diagnosed with diabetes receiving an annual review per year

IMPROVING THE QUALITY OF LIFE - Carers	X% improvement in health related quality of life scores for carers in 5 years X% increase in % of carers receiving an annual health check per year

IMPROVING THE QUALITY OF LIFE - People with mental health conditions	Increased access to community mental health services by people from BME groups by X% per year Increased access to psychological therapy services by people from BME groups by X% per year X% improvement in health related quality of life for people with long-term mental health condition in 5 years
IMPROVING THE QUALITY OF LIFE - People with HIV	X% of people with HIV with a personalised care plan and annual review per year

IMPROVING THE QUALITY OF LIFE - People with Dementia	% of people receiving a dementia diagnosis and referred to appropriate services increased by X% per year

HELPING PEOPLE RECOVER EPISODES ILL HEALTH/INJURY	X% reduction in A&E attendances with primary diagnosis recorded X% reduction in emergency readmissions within 30 days of discharge from hospital X% reduction in alcohol admissions and readmissions X% reduction in mental health readmissions within 30 days of discharge

PATIENT EXPERIENCE OUTCOMES - Ensuring people have a positive experience of care	Patient Report Experience Measures (PREMS), Patient Report Outcomes Measures (PROMs), Patient Defined Outcomes Measures (PDOMs) to be developed with the community Achieving an enhanced level of access as appropriate Ensuring a comprehensive care approach for primary care offering continuity where it matters e.g. palliative care, phlebotomy, leg ulcer care

REDUCING AVOIDABLE HARM Reducing medicines related harms and hospital admissions	% increase medicine use reviews conducted for at risk patients, aged over 75

IMPROVING THE HEALTH OF CHILDREN & YOUNG PEOPLE	X% reduction of alcohol related admissions to hospital in 5 years Numbers attending drop in sexual health clinics at practices X% increase per year

PATIENT EXPERIENCE OUTCOMES - Ensuring people have a positive experience of care	Patient Report Experience Measures (PREMS), Patient Report Outcomes Measures (PROMs), Patient Defined Outcomes Measures (PDOMs) to be developed with the community (children and young people) Achieving an enhanced level of access as appropriate (children and young people)

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

1. Formal details of the paper

1.1. Title of the paper
Pharmaceutical Needs Assessment – Final report and the process for future PNAs and supplementary statements

1.2 Who can see this paper?
All

1.3 Date of Health & Wellbeing Board meeting
24th March 2015

1.4 Author of the Paper and contact details
Nicola Rosenberg, Public Health Principal
Email: Nicola.rosenberg@brighton-hove.gov.uk Tel: 01273 574809

2. Summary

2.1 This paper presents a final Pharmaceutical Needs Assessment (PNA) 2015 report and the process for future PNAs and supplementary statements for approval by the Health and Wellbeing Board (HWB).

HWBs are required to produce **the first PNA by 1 April 2015.** HWBs are required to publish a revised assessment within **three years** of publication of their first assessment. The Pharmaceutical Needs Assessment (PNA) is a comprehensive statement of the need for pharmaceutical services of the population in its area. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 ("the Regulations") set out the legislative basis and requirements of the Health and Wellbeing Board for developing and

updating the PNA and responsibility of NHS England in relation to "market entry".

A draft of the whole PNA report and the conclusions and recommendations section was presented to the Health and Wellbeing Board for discussion 14th October 2014. Recommendations from the October HWB meeting and feedback from the formal consultation period have been incorporated within the final report. The PNA Steering Group has also approved the final version of the PNA presented with this paper.

The process for future PNAs and supplementary has been discussed and agreed by the PNA Steering Group and is similar to processes other HWBs follow.

3. Decisions, recommendations and any options

3.1 Recommendations

3.1.1 The Health and Wellbeing Board (HWB) are asked to approve this final Pharmaceutical Needs Assessment (PNA) 2015 report

3.1.2 The HWB are asked to approve the process for supplementary statements and to delegate authority to the DPH working with the PNA Steering Group to identify and implement any future amendments to the PNA and to bring back a full revised PNA to the HWB in 2018.

4. Relevant information

4.1 Context / background information

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

4.1.2 The provision of NHS Pharmaceutical Services is a controlled market. If someone (a pharmacist, a dispenser of appliances, or in some circumstances and normally in rural areas, a GP) wants to provide NHS pharmaceutical services, they are required to apply to NHS England to be included on a pharmaceutical list. Since April 2013pharmaceutical lists are compiled and held by NHS England. This is commonly known as the NHS "market entry" system.

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

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

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

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

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

4.1.6.2 HWBs are required to publish a revised assessment within **three years** of publication of their first assessment.

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

4.1.7 The current position regarding the PNA is described below:

4.1.7.1 A PNA for Brighton and Hove was published by NHS Brighton and Hove in February 2011. A copy of the PNA can be found on the Brighton and Hove Connected website at http://www.bhconnected.org.uk/content/needs-assessments

4.7.1.2 In March 2013 the PCT Pharmaceutical Committee reviewed the 2011 PNA and published a Supplementary Statement which states that a revised PNA was not required at that point (and would be a disproportionate response). A copy of the Supplementary Statement is availableat:http://www.bhconnected.org.uk/content/needsassessments

4.7.1.3 A further supplementary statement, accurate as at 1st July 2014 was published October 2014 following approval by the Health and Wellbeing Board.

4.1.8 The HWB has instructed the Director of Public Health to produce a report PNA for approval by the HWB by 1st April 2015. The Director of Public Health established a PNA steering group in March 2014 to oversee this process. The steering group is chaired by a Consultant in Public Health. Membership of the group includes representatives of BHCC Public Health Directorate, East Sussex Local Pharmaceutical Committee, Local Medical Committee, NHS England, Brighton and Hove Clinical Commissioning Group and Healthwatch.

4.1.9 **A final version of the PNA report is presented here to the HWB for approval as requested by the HWB 14th October 2014.**

4.1.9.1 Recommendations made at the HWB meeting 14th October 2014 were incorporated within the draft PNA report prior to the consultation period and the final version was approved by the PNA Steering Group before it was published for consultation.

4.1.9.2 The statutory consultation period for the PNA report took place 1st November 2014 – 9th January 2015. There were nine responses to the consultation. Analysis of the responses was carried out and discussed with the PNA steering group. Significant themes were identified from the responses and the report was amended and updated in line with recommendations made. Respondents were from: members of the public (1), health and social care professionals (4), business /sole trader (2) and two were made on behalf of an organisation.

4.1.9.3 All responses considered the information contained in the PNA to be clearly explained and accurate and 85% of respondents agreed that the report reflected the current pharmaceutical service provision within the city.

4.1.9.4 Significant themes drawn from the comments focused on signposting, care and support for older people and carers. To address this feedback additional information has been added to the report on a pilot with pharmacies to support carers, the Care Act duty on local authorities to provide information and advice on care and support in the city and additional recommendations have been added regarding signposting and sharing of information. One detailed comment gave feedback on

substance misuse service and this information has been passed to the relevant commissioner of the service.

4.1.9.5 The responses from the two neighbouring Health and Wellbeing Boards did not raise issues that resulted in a change to this report. Both were satisfied that the report had considered pharmaceutical services within their areas that have an impact on the population of Brighton and Hove and agreed that the information in the report was accurate.

4.1.9.6 Other changes to the PNA report following the consultation period include an update on: a pilot with pharmacies to support carers, the CCG's work with community pharmacy and the potential changes relating to the essential small pharmacy contract for the pharmacy at the University of Sussex.

4.1.10 **The process for revising future PNAs and supplementary statements is presented here to the HWB for approval.**

4.1.10.1 The HWB must make a revised assessment as soon as is reasonably practicable after identifying changes since the previous assessment, which are of a significant extent, to the need for pharmaceutical services in its area, having regard in particular to changes to:
a) the number of people in its area who require pharmaceutical services;
b) the demography of its area; and
c) the risk to the health and wellbeing of people in its area, unless it is satisfied that making a revised assessment would be a disproportionate response to those changes.

4.1.10.2 Pending the publication of a revised PNA, a HWB may publish a supplementary statement explaining changes to the availability of pharmaceutical services since the publication of its PNA. A supplementary statement should be issued where:

a) the changes are relevant to the granting of applications and the HWB is satisfied that making its first or a revised assessment would be a disproportionate response to those changes, or,
b) in the course of making its first or a revised assessment, the HWB is satisfied that immediate modification of its pharmaceutical needs assessment is essential in order to prevent significant detriment to the provision of pharmaceutical services in its area.

Any such supplementary statement becomes part of a PNA. Supplementary statements are statements of fact; they are not an assessment of need. Supplementary statements are a way of updating

what the PNA says about which services are provided and where. Once issued, a supplementary statement becomes part of the PNA (Regulation 3D (3)).

4.1.10.3 The proposed process of future PNAs and supplementary statements is presented within a flowchart in the supporting documents to this paper. As part of this process the HWB is asked to delegate responsibility to the Director of Public Health and the PNA Steering group, chaired by a consultant of public health and lead by the Public Health Directorate Pharmacy Advisor to review the provision of pharmaceutical services and to identify changes following the publication of the PNA and relevance to the granting of control of entry. Should a supplementary statement be required, the Director of Public Health would have delegated authority to publish this statement. If the DPH is satisfied that a revised PNA is required, the PNA is revised and submitted to the HWB for approval.

5. Important considerations and implications

5.1 Legal

The statutory requirement and prescribed process for the HWB to publish a PNA is set out in the body of the overall PNA report. The proposals in the report are consistent with ensuring that the HWB is in a position to discharge its duties.

Lawyer Consulted: Elizabeth Culbert Date: 16/01/14

5.2 Finance

The cost of producing the PNA including public involvement and consultation will be met by the ring-fenced Public Health Grant. There was £20k allocated for the PNA in the 2014/15 Public Health Business Plan for 2014/15.

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

5.3 Equalities

We have incorporated Equality Act 2010 requirements throughout the PNA document. During the PNA process we have taken into consideration protected characteristics and vulnerable groups at each stage of the process and details relating to how services affect different groups are detailed in the main PNA report.

Equalities Officer Consulted: Sarah Tighe-Ford Date: 25/03/14

5.4 Sustainability

There are details in the PNA report regarding schemes aimed to improve sustainability of pharmacy services, such as the green bag campaign, inhaler recycling and reducing medicines waste.
CCG sustainability clinical lead consulted: Dr Rachel Cottam: 29/09/14

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

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

7. Supporting documents and information

1) PNA Report 2015

Appendix 1: PNA Executive summary

This report sets out the draft Pharmaceutical Needs Assessment (PNA) for Brighton and Hove. The PNA is a comprehensive statement of the need for pharmaceutical services of the population in its area. The PNA aims to identify the pharmaceutical needs of the local population by mapping current pharmaceutical services, identifying gaps and exploring possible future needs. It aims to support efforts to reduce health inequalities and improve health and wellbeing of local people. The PNA will be used by NHS England to decide upon applications to open new pharmacies and it will inform all commissioners regarding the commissioning of pharmaceutical services.

Every Health and Wellbeing Board has the responsibility to carry out and publish a PNA by 1st April 2015. The development of this PNA included the analysis of health needs, local information, intelligence, plans and strategies; surveys with the public, pharmacies and GPs; interviews with key stakeholders and a focus group with pharmacists. A formal public consultation lasting 70 days took place between November 2014 and January 2015.

Local population

There are a number of demographic factors that affect the need for pharmacy services within the city. It is estimated that there are 272,952 people living in Brighton and Hove and this number is expected to increase by 4.5% by 2018. The city has a relatively younger adult population than the rest of England with higher proportions of people aged 16-64 years and lower proportions of children and older people aged 65-74. The proportion of the population aged 85 years or over is similar to the rest of the country.

Pharmacy services
Our population has better access than most to pharmacy services with more pharmacies per head of population than neighbouring areas. There are currently 60 community pharmacies within the city. This translates to 22 pharmacies per 100,000 residents which compares favourably with Kent, Surrey and Sussex overall where there are 19 pharmacies per 100,000.The PNA concludes that the current number of pharmacies is sufficient to meet future pharmaceutical needs of residents.

There is good coverage across the city of advanced and public health commissioned locally commissioned services such as smoking cessation in pharmacies. The PNA has not identified any significant gaps in the current pharmaceutical provision.

Residents on the whole are satisfied or very satisfied with pharmacy services however opportunities remain to maximise the role of pharmacies to support reducing health inequalities and improving health and wellbeing.
Respondents to the public survey were largely (83%) satisfied that existing pharmacy opening hours met their needs. However some respondents to the survey found it difficult to access a pharmacy between 9.00am and 5.00pm on a weekday. This report recommends that information about pharmacies opening after 6pm and during the weekends should be made more readily available to residents in different ways to ensure local people are aware of where and when services are available.

The survey with residents and GPs showed that there is a lack of knowledge and understanding about the services delivered by community pharmacies. This report recommends that information on all pharmacy services should be made more readily available locally to different audiences, including GPs and residents.

In conclusion
There are significant opportunities for maximising the role of pharmacies within primary care and public health as part of and in addition to the Better Care and enhancing primary care work in the city. The findings and recommendations within this report should support commissioners to design services to address local health and wellbeing needs and reduce health inequalities.

Appendix 2: Update on DRAFT PNA report recommendations and actions

Below provides a list of the recommendations presented to the Health and Wellbeing Board October 2014 and subsequent action. It has been agreed that these recommendations will also go to the CCG Primary Care Transformation Board for discussion and action. Healthwatch, BHCC Public Health Directorate, Local Pharmaceutical Committee and Local Medical Committee as well as the CCG are all members of the board.

a) To improve the public's knowledge and understanding of the services delivered by community pharmacies. This could be achieved through a national campaign lead by NHS England to improve understanding of pharmacy services across the country. Brighton and Hove City Council and CCG should ensure information is available locally in a number of different ways to different audiences to ensure residents are aware of and have easy access to up to date information about what, when and where services are provided by pharmacies. Pharmacies should also actively promote the services they provide.

NHS England and CCGs have been working with pharmacies to promote the new Electronic Prescription Service. There are online materials for both pharmacies and the public health. NHS Choices continues to provide information on pharmacy services.

The public health pharmacy advisor has been meeting with local pharmacies to discuss how to promote their services with a particular focus on the 12 Healthy Living Pharmacies in the city.

b) For there to be no significant reduction to existing opening hours for pharmacies across the city. Where there are pharmacies open in the evenings, late at night and throughout the weekend, more information should be made available to patients / residents using different avenues (web and non-web based). When a pharmacy is closed a clear notice should be put on the door to state where the closest pharmacy is open.

There has been no significant reduction to existing opening hours for pharmacies. Work is on-going regarding pharmacies placing notices on their doors when closed.

c) To develop and deliver new initiatives including a local campaign regarding safe disposal of medications tailored to target groups as identified by the survey findings.

Lead by the public health pharmacy advisor this will be considered as part of the public health campaigns to be delivered by pharmacies.

d) For NHS England to note that patients would like to know more about the home delivery of medications service that some pharmacies provide.

NHS England has noted this and will consider how share more information about the service, as it is a private service provided by pharmacies.

e) Pharmacies to train staff to communicate well with younger age groups as well as older residents.

To be discussed with the CCG Primary Care Transformation Board.

f) NHS England, Brighton and Hove City Council and CCG and pharmacies to work together to communicate clearly with patients regarding pharmacy services that are already available such as minor conditions advice.

Updated information is available on NHS choices. The public health pharmacy advisor is working with pharmacies to promote existing services in the city.

g) NHS and public health commissioners to consider commissioning new services within pharmacies in response to a given need and to learn from good practice from elsewhere e.g. NHS Health Checks and advice regarding managing long term conditions

To be discussed at the CCG Primary Care Transformation Board.

h) Brighton and Hove CCG to share information regarding Sussex Interpreting Service and for this to be shared widely with both pharmacies and residents to ensure arrangements are made for patients to communicate with pharmacies in their chosen language.

There are plans for the Public health pharmacy advisor to work with the CCG on this.

i) To improve the GPs' and non-medical prescribers' knowledge and understanding of the services delivered by community pharmacies. Brighton and Hove City Council and CCG should also develop training and a local information campaign to ensure GPs and non-medical prescribers are aware of, understand and have easy access to up to

date information about what, when and where services are provided by pharmacies.

To be discussed at the CCG Primary Care Transformation Board.

j) To review and evaluate the impact of the roles pharmacies played within the Expanding primary integrated care (EPiC) project alongside the findings from this PNA to inform future commissioning of services.

The EPiC project evaluation will be published summer 2015. These recommendations will be discussed at the CCG Primary Care Transformation Board.

k) All pharmacies should have an understanding of the 2010 Equality Act requirements for their premises.

Information on the Equality Act has been included in the NHS England and Local Pharmaceutical Committee (LPC) newsletter in response to this recommendation.

l) BHCC Public Health Directorate to further develop the Healthy Living Pharmacy scheme working with pharmacies to focus on efforts on reducing inequalities and addressing needs of vulnerable groups. This will include pharmacies actively promoting public health campaigns and information on access to local authority, voluntary sector and other primary care services including GPs and dentists and appropriate use of NHS services.

A plan for developing Healthy Living Pharmacies is in place and all 12 Healthy Living Pharmacies in the city will be actively promoting public health campaigns.

m) For pharmacies to have more of a lead role regarding repeat dispensing. Pharmacists would inform GPs which patients could go onto repeat dispensing and receive prescriptions and medications directly from the pharmacy without having to go to the GP practice.

To be discussed at the CCG Primary Care Transformation Board.

n) NHS England, Brighton and Hove CCG and City Council, pharmacies and patients to work together to reduce waste of medicines.

To be discussed at the CCG Primary Care Transformation Board.

o) To share practice and pharmacy email addresses between practices and pharmacies. Pharmacists should use an nhs.net[1] email account for communication.

There are currently challenges for some pharmacies to be able to use nhs.net email accounts. Pharmacies are working with NHS England to resolve this by July 2015.

p) To improve more integrated ways of working linked with the Better Care and enhancing primary care work, joint meetings between GPs and pharmacists within local areas should take place. Exchanges and joint meetings should also happen between practice and pharmacy staff to help share understanding of different roles and issues pharmacies and practices both face.

To be discussed at the CCG Primary Care Transformation Board.

New Recommendations

The below recommendations have been added as a result of feedback from the formal consultation or a change in circumstances following October 2014.

q) Should the status of the current pharmacy at the University of Sussex change, BHCC, CCG and NHS England with the local professional representative/s to work together to look at primary care provision at the University of Sussex, both the GP practice and the pharmacy, to ensure sufficient primary care provision is available.

r) Pharmacies use the new online portal being developed by the Council as part its Care Act (2014) duties to provide up to date information to patients and carers in the city. Pharmacies to also use the council website for signposting information, for a wide range of services, such as addressing social isolation and weight management. The links for these key websites to be provided by Brighton and Hove City Council (BHCC) Public Health Directorate. BHCC Public Health Directorate to share web links for information on signposting, emailed to pharmacies with all GP practices.

[1] September 2014 NHS England invited all pharmacies, that didn't already have an nhs.net email account to make a request for one in order to facilitate sharing of information between professionals securely.

Appendix 3: The process for future PNAs and Supplementary Statements 2015

A Health and Wellbeing Board (HWB) HWB must make a revised assessment as soon as is reasonably practicable after identifying changes since the previous assessment, which are of a significant extent, to the need for pharmaceutical services in its area, having regard in particular to changes to—
(a) the number of people in its area who require pharmaceutical services; .
(b) the demography of its area; and
(c) the risks to the health or well-being of people in its area, unless it is satisfied that making a revised assessment would be a disproportionate response to those changes.

Pending the publication of a revised PNA, a HWB may publish a supplementary statement explaining changes to the availability of pharmaceutical services since the publication of its PNA. A supplementary statement should be issued where:

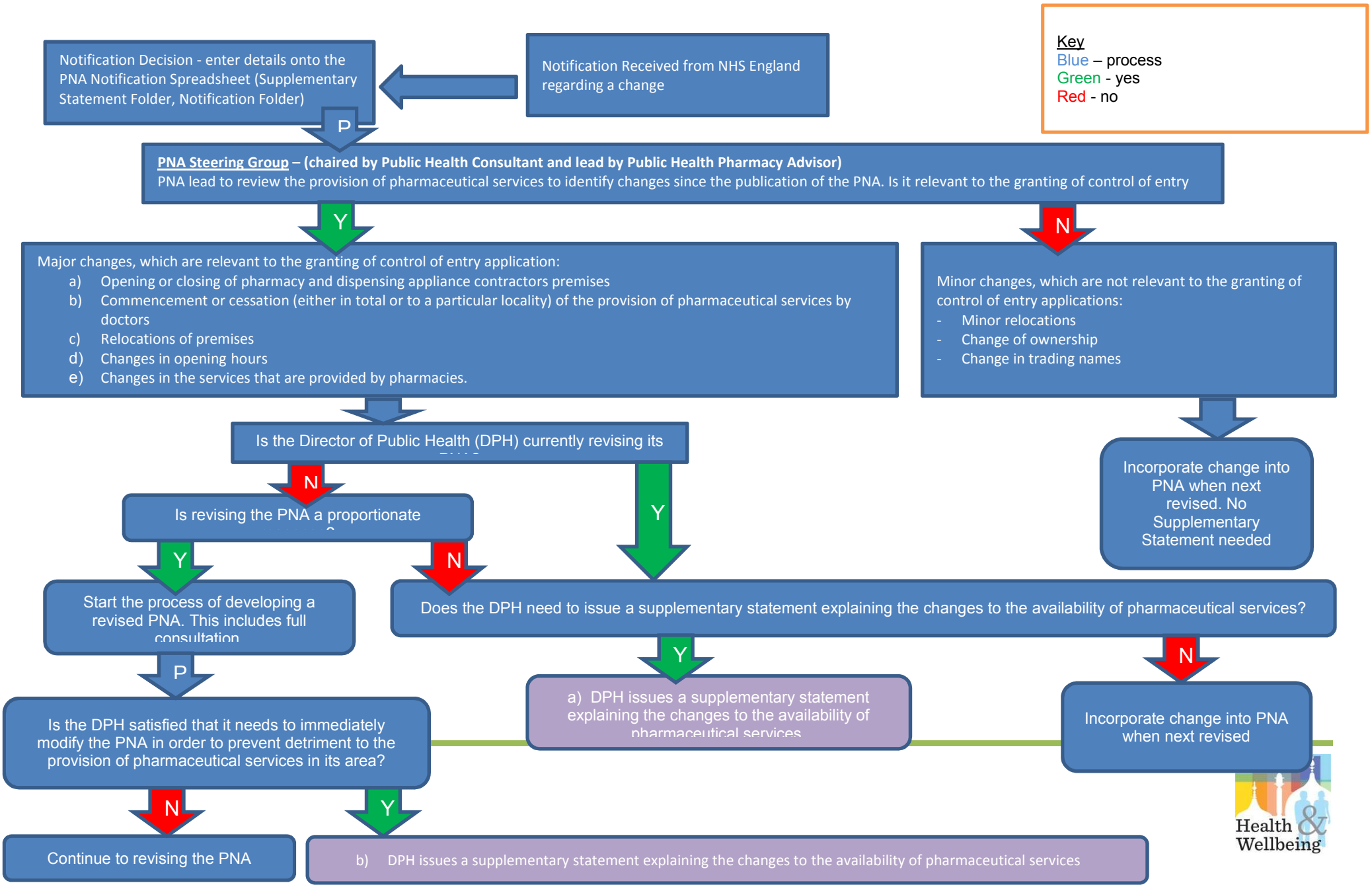
a) The changes are relevant to the granting of applications and the HWB is satisfied that making its first or a revised assessment would be a disproportionate response to those changes, or,

b) In the course of making its first or a revised assessment, the HWB is satisfied that immediate modification of its pharmaceutical needs assessment is essential in order to prevent significant detriment to the provision of pharmaceutical services in its area.

Any such supplementary statement becomes part of that PNA. Supplementary statements are statements of fact; they are not an assessment of need. Supplementary statements are a way of updating what the PNA says about which services are provided and where. Once issued, a supplementary statement becomes part of the PNA (Regulation 3D (3)).

Each HWB must, in so far as is practicable, keep up to date the map which it includes in its pharmaceutical needs assessment (without needing to republish the whole of the assessment or publish a supplementary statement).
After it has published its first pharmaceutical needs assessment, each HWB must publish a statement of its revised assessment within 3 years of its previous publication of a pharmaceutical needs assessment.

In Brighton and Hove the HWB delegates authority to the Director of Public Health (DPH) working with the PNA Steering Group to: identify and implement any future amendments to the PNA, publish an up to date map and supplementary statements and to bring back a full revised PNA to the HWB in 2018.


Key
Blue – process
Green - yes
Red - no
Notification Received from NHS England regarding a change
Notification Decision - enter details onto the PNA Notification Spreadsheet (Supplementary Statement Folder, Notification Folder)
P
PNA Steering Group – (chaired by Public Health Consultant and lead by Public Health Pharmacy Advisor)
PNA lead to review the provision of pharmaceutical services to identify changes since the publication of the PNA. Is it relevant to the granting of control of entry
Y
N
Major changes, which are relevant to the granting of control of entry application:
a) Opening or closing of pharmacy and dispensing appliance contractors premises
b) Commencement or cessation (either in total or to a particular locality) of the provision of pharmaceutical services by doctors
c) Relocations of premises
d) Changes in opening hours
e) Changes in the services that are provided by pharmacies.
Minor changes, which are not relevant to the granting of control of entry applications:
- Minor relocations
- Change of ownership
- Change in trading names
Is the Director of Public Health (DPH) currently revising its
N
Y
Incorporate change into PNA when next revised. No Supplementary Statement needed
Is revising the PNA a proportionate
Y
N
Start the process of developing a revised PNA. This includes full consultation
Does the DPH need to issue a supplementary statement explaining the changes to the availability of pharmaceutical services?
P
Y
N
Is the DPH satisfied that it needs to immediately modify the PNA in order to prevent detriment to the provision of pharmaceutical services in its area?
a) DPH issues a supplementary statement explaining the changes to the availability of pharmaceutical services
Incorporate change into PNA when next revised
N
Y
Continue to revising the PNA
b) DPH issues a supplementary statement explaining the changes to the availability of pharmaceutical services
Health & Wellbeing

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

1. Formal details of the paper

1.1. Better Care Section 75 Pooled budget

1.2 Who can see this paper?
Not restricted

1.3 Date of Health & Wellbeing Board meeting
24th March 2015

1.4 Author of the Paper and contact details
Denise D'Souza, Executive Director Adult Services
denise.d'souza@brighton-hove.gov.uk
Geraldine Hoban Chief Operating Officer, geraldine.hoban@nhs.net

2. Summary

The Better Care Fund was announced in June 2013 and sets out the expectation that the Clinical Commissioning Group and Local Authority have agreed plans and pooled budgets to oversee the plan. The funding is not new money but will need to demonstrate it is meeting objectives of the plans. The Health and Wellbeing board will be responsible for overseeing this agreement.

3. Decisions, recommendations and any options

That the Health and Wellbeing Board

3.1 Notes the requirement that the Better Care Fund is operated as a pooled budget between the Clinical Commissioning Group (CCG) and the Council and that the mechanism for establishing a pooled budget is through entering into a Partnership Agreement under Section 75 NHS Act 2006;

3.2 Authorises the Executive Director Adult Services and CCG Chief Operating Officer to finalise and agree a new Section 75 Partnership Agreement between the Council and the Clinical Commissioning Group relating to the commissioning of health and social care services from a pooled Better Care Fund;

3.3 Notes that the Section 75 Agreement referred to at paragraph 3.2 above will include the schemes and schedules as detailed in the body of the report and will take effect from 1st April 2015 with a three year term and with provision to review the Agreement after 12 months.

4. Relevant information

4.1 As a result of the Better Care announcement in 2013, the Local Authority, CCG and other partners have developed a programme of transformation aimed at proactively identifying people who are frail and delivering more integrated care around the needs of those individuals. Phase one started late last year and saw the initiation of two early adopter sites for enhanced multi-disciplinary working and a strengthened multi-disciplinary team for homeless health around Morley Street General Practice. Significant investment was also made to primary care to develop the infrastructure required to proactively identify frail people and clinically co-ordinate care.

4.2 The CCG and Local Authority are required to develop a pooled budget in relation to Better Care and work is progressing around the following areas:

- Keeping people well – focusing on prevention and promoting independence
- Identifying and supporting carers
- Protecting social care within agreed eligibility criteria

- Proactive care – case finding people who are frail or have complex care needs and proactively planning for their ongoing care needs.
- Strengthening multi-disciplinary teams, co-located around 6 GP clusters in the City serving a population of up to 50,000 and integrating care around a cohort of frail people.
- Delivering care that is more person centred, holistic and aided by a greater use of innovation including telecare/telehealth and the piloting of personal health budgets.
- Homelessness – continue to strengthen the multi disciplinary approach around people who are homeless and development of an outreach model.

4.3 National templates for the Section 75 agreement around Better Care have been developed, guidance on completion is still being issued and officers are currently working through the detail to localise the document and populate the following schedules.

Schedule 1 - Scheme Specification

4.4 This section will outline the schemes, provide details of the financial contributions and describe financial management arrangements.

4.5 The schemes covered by the Brighton and Hove Better Care Fund are summarised above. Broadly speaking, the budgets aligned to these schemes which come under the S75 Agreement are:

Scheme	Value	Lead Org
• Proactive Care (Primary Care)	£1.5m	CCG
• Multidisciplinary Community Teams		
○ Frailty	£ 8m	CCG
○ Homeless	£1m	CCG
• Integrated Community Equipment	£1.5m	B&HCC
• Protecting Social Care	£6m	B&HCC
• Carers	£0.8m	B&HCC
• Keeping people well	£0.5	B&HCC
• Increasing dementia diagnosis	£0.3	CCG
• Total	£19.6m	

Schedule 2 - Governance

4.6 This section outlines the governance of the pooled fund ie it is managed by the Better Care Programme Board reporting into the Health and Wellbeing Board.

Schedule 3 - Risk Share and Overspends

4.7 This section describes how any potential overspend or underspend will be identified, action required to bring expenditure back in line with budget will be identified and how the partners will collectively manage the apportionment of over/under expenditure equitably taking into consideration all relevant factors.

Schedule 4 Joint Working Obligations

4.8 This section describes the responsibility of the lead organisation and partner with regards to the commissioning of the schemes.

Schedule 5 – Performance Arrangements

4.9 This schedule describes the quarterly finance and performance arrangements aligned to the Better Care Fund. In addition to a regular financial update it will also include an update on delivery of integrated, proactive care and the City's performance against the Better Care national and local metrics , namely:

- Non-elective admissions
  This is the single Payment for Performance metric that measures the reduction in total non-elective admissions to hospital. Our baseline in 2014 calendar year was 26,149 and have set ourselves a target reduction of 3.7% (956 admissions) for 2015.

- Residential admissions
  This is a supporting metric that measures the reduction in permanent admissions of older people to residential and nursing care homes. Our baseline in 2013/14 was 270 admissions and have set ourselves a target reduction of 11% (30 admissions) by the end of 2014/15 and 13% (32 admissions) for the following year.

- Reablement
  This is a supporting metric that measures the proportion of older people who are still at home 91 days after hospital discharge and into reablement/rehabilitation services. Our baseline in 2013/14 was

80% and have set ourselves a target of 85% by the end of 2014/15 and 89% for the following year.

- Delayed transfers of care
  This is a supporting metric that measures the number of days delayed due to adult patients occupying a delayed transfer of care. Our baseline in 2013/14 was 6,272 delayed days and have set ourselves a target reduction of 5% (320 days) by the end of 2014/15 and 5% (308 days) for the following year.

- Patient/service user experience
  This is a supporting metric and we have chosen to use the frailty MDT measure 'Does the MDT work well together to give you the best possible care and support?' We currently have no baseline or target as this a new measure being collected.

- Dementia diagnosis
  This is a local supporting metric and measures the dementia diagnosis rate across the city. Our baseline in 2013/14 was 51% and we have set ourselves a target of 67% by the end of 2014/15

Better Care Fund Plan

4.10 This section will link to the full Better Care Fund Plan submitted last year.

Policy for the Management of Conflict of Interests

4.11 This section will set out how the Health and Wellbeing Board and CCG manages conflicts of interest. Respective COI policies will be attached and an overarching summary provided.

Information Governance Protocol

4.12 This will attach the Information Governance Protocol developed by the IM&T sub-group of the Better Care Programme Board.

4.13 Officers are now pulling together the supporting documentation for the Section 75 Agreement in line with the national templates. The documentation is being worked through by the finance, legal and senior management teams of both the CCG and the City Council. It is expected that this Agreement will be finalised within the next fortnight enabling signature by the end of March.

5. Important considerations and implications

5.1 Legal

As set out in the report, it is a requirement that the Better Care Fund is managed locally through a pooled budget. The power to pool budgets between the Council and the CCG is set out in the NHS Act 2006 and requires a formal Section 75 Agreement. Regulations prescribe the format and minimum requirements for a Section 75 Agreement and a template Better Care Fund Section 75 Agreement has been produced and will be used for this purpose.

Lawyer consulted: Elizabeth Culbert 2/3/15

5.2 Finance

The S75 agreement sets out the financial governance of the Better Care Fund through a pooled budget arrangement supported by a risk share. The investment in the pooled budget for 2015/16 is £19.6 million as previously agreed by the Health and Wellbeing Board. The allocation of the 2015/16 budget against the programmes is set out in paragraph 3.1 above. The risk share arrangements have been agreed between the CCG & BHCC and these will ensure the protection of social care. The S75 agreement will also set out the reporting and accounting requirements against the pooled budget and the approval process for investment levels for years 2 and 3 of the agreement.

Finance Officer consulted: Anne Silley 2/3/15

5.3 Equalities

There are no equalities implications arising from the pooled fund proposals set out in the report.

5.4 Sustainability
None

5.5 Health, social care, children's services and public health
These are addressed in the body of the report.

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

1. Formal details of the paper

Exploring options for the future of Community Short Term Services Rehabilitation Beds

1.2 This paper can be seen by the general public.

1.3 24th March 2015

1.4 Keith Hoare, Commissioning Manager, Brighton and Hove CCG
Keith.hoare@nhs.net
Jane MacDonald, Commissioning Manager, Brighton and Hove CC
Jane.Macdonald@brighton-hove.gcsx.gov.uk

2. Decisions, recommendations and any options

2.1 The Health and Wellbeing Board is recommended to approve the Clinical Commissioning Group and the City Council undertaking preliminary engagement with potential providers of care to explore a new model of care in partnership.

3. Relevant information

3.1 The current CSTS comprises a range of bed based and home based services that provide rehabilitation and reablement support for people to help them retain or maintain their independence. The service supports both the prevention of admission to, and discharge from, hospital.

3.2 The service is jointly commissioned by Brighton and Hove City Council (BHCC) and Brighton and Hove Clinical Commissioning Group (BHCCG), and is jointly delivered by a partnership of providers comprising BHCC, Sussex Community NHS Trust (SCT), Victoria Nursing Homes (VNH), Integrated Care 24 (IC24) Ltd, Brighton and Sussex University Hospital Trust (BSUH) and Age UK.

3.3 Dependent on the needs of people the service supports people either in their own home or in one of three dedicated bed units, two of which are owned by BHCC and one by an independent provider, VNH. These units provide a total of 65 beds.

- Craven Vale – BHCC – 24 beds
- Knoll House – BHCC – 20 beds
- Highgrove Nursing Home – Victoria Nursing Home – 21 beds

3.4 Craven Vale and Knoll House are registered as residential care homes. The social care and support of people at Craven Vale and Knoll House is provided by BHCC while nursing and therapy is provided by SCT, and medical support by IC24 Ltd and BSUH on an in–reach basis.

3.5 Highgrove is a Nursing Home and VNH provide social care, support and nursing, while therapy is provided by SCT and medical cover by IC24 Ltd and BSUH.

3.6 The national and local strategic approach is for care to be provided in people's own homes wherever possible reducing avoidable admissions to the hospital or care homes. Since 2012 a higher proportion of people are being discharged from hospital straight to their own home with support from community short term services.

3.7 Whilst it is positive that more people are able to return to their own homes the impact of this is that the comparatively smaller proportion of people that do require care in one of the bedded units are the most dependent and have the most complex needs.

3.8 The number of people supported at home has increased over the past two years while the number supported in bed units has varied slightly.

Table 1

	CSTS Beds	CSTS Home	Total
2012/13	805 (32%)	1702 (68%)	2507
2013/14	683 (27%)	1855 (73%)	2,538
2014/15 (Forecast Outturn)	691 (26%)	1956 (74%)	2.647

3.9 The length of stay (LoS) in CSTS beds has also increased over the past two years, ostensibly as a result of the increasing complexity of needs and dependency of clients.

Table 2

Year	Quarter	LoS No. of days	
2013-14	Qtr1	29	*part data only
	Qtr2	29	
	Qtr3	30	
	Qtr4	29	
2014-15	Qtr1	33	
	Qtr2	29	
	Qtr3	33	
	Qtr4*	34	

Note: LoS is average no of days of stay of people discharged within the quarter

3.10 The current service specification for CSTS beds has been in place since 2012, following a review. As described in paragraph 3.6, more people are now discharged from hospital to their own home, the result being that the people requiring support in a bedded unit are those with high levels of dependency and complexity, and with a greater need for more intensive health input.

3.11 The social care led model at Craven Vale and Knoll House (with health support provided on an in-reach basis) increasingly does not align to fully meeting the needs of many of the people who require an admission into a CSTS beds. The impact of this is that admissions to CSTS beds cannot always

be accepted, people may remain for unnecessarily long periods in hospital, and if admitted to a bed unit people may then stay longer than necessary.

Proposal for New Model of Care

3.12 A new model is required for CSTS beds to meet the needs of people with high levels of complexity and dependency that require CSTS beds.

3.13 As the services are jointly commissioned by the CCG & the City Council both parties are committed to working together to commission a new model for CSTS beds. The new model will have an outcomes based specification with clear lines of accountability

3.14 To inform the commissioning process, the CCG and the Council want to explore new models for the delivery of the CSTS beds. The proposal is to invite potential providers to put forward ideas/proposals of what the new model could look like. It would include how a potential provider could work with the CCG & the Council to deliver the service, and what role the interested party may see for themselves in the new model.

3.15 The CCG & the Council are seeking agreement from the Health & Wellbeing Board to undertake a preliminary engagement with potential providers in the city to explore a new model of care for CSTS.

3.16 At this stage this engagement is to determine if there are organisations that would be interested in entering into a process to explore these opportunities in more detail. This does not commit the CCG or Council to undertake any such process.

3.17 The CCG and the Council will report back to the Health and Wellbeing Board on the outcome of this preliminary engagement and whether there is agreement between the CCG and the Council to commission a new model of care for CSTS beds.

4. Important considerations and implications

4.1 Legal

It is a function of the Health and WellBeing Board to make decisions concerning the provision of jointly funded and commissioned health and social care in the City. If approved the preliminary process proposed in this paper will inform future decision making by the Board.

Any procurement legal implications will be addressed when proposals for the new model are drawn up following the preliminary process being recommended.

Sandra O'brien Senior Solicitor

4.2.1 Finance

4.2.1 Any new model of care for CSTS beds would need to be funded within the agreed joint budget envelope for 2015/16.

4.2.2 The following summarises the breakdown of investment by the CCG and the City Council in CSTS bed units for the year 2014/15.

The commissioning funding for 2014/15 is

	BHCC £000	BH CCG £000	**Total**
Craven Vale (24)	£695	£1,171	**£1,866**
Knoll House (20)	£990	£615	**£1,605**
Highgrove (21)	None	£1,144	**£1,144**
Total	**£1,685**	**£2,930**	**£4,615**

Anne Silley Head of Finance

4.3 Equalities

4.3.1 Any new model for CSTS beds will be based on need but the service will primarily benefit older people given the prevalence and incidence of rehabilitation needs amongst this group.

4.3.2 An Equality Impact Assessment has been developed and will be active for the duration of the project.

4.4 Sustainability

4.4.1 The council's One Planet Council approach to sustainability based on the ten One Planet principles was used as a checklist and will be reviewed as the project develops.

Health & Wellbeing

4.5 Health, Social Care, Children's services and Public Health

4.5.1 Known Health, Social Care, Children's services and Public Health implications are covered in the report.

5 Supporting documents and information

5.1 There are no supporting documents.