Brighton & Hove City Council

Health & Wellbeing Overview & Scrutiny Committee

Title:	**Health & Wellbeing Overview & Scrutiny Committee**
Date:	**10 September 2014**
Time:	**4.00pm**
Venue	**Banqueting Suite, Hove Town Hall**
Members:	**Councillors:** Rufus (Chair)C Theobald (Deputy Chair), Bennett, Bowden, Cox, Marsh, Meadows and Sykes **Co-optees:** Jack Hazelgrove (OPC), Youth Council and Healthwatch
Contact:	**Kath Vlcek, Scrutiny Officer** 01273 290450 kath.vlcek@brighton-hove.gov.uk

	**The Town Hall has facilities for wheelchair users, including lifts and toilets**
	**An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter and infra red hearing aids are available for use during the meeting. If you require any further information or assistance, please contact the receptionist on arrival.**
	FIRE / EMERGENCY EVACUATION PROCEDURE **If the fire alarm sounds continuously, or if you are instructed to do so, you must leave the building by the nearest available exit. You will be directed to the nearest exit by council staff. It is vital that you follow their instructions:** • **You should proceed calmly; do not run and do not use the lifts;** • **Do not stop to collect personal belongings;** • **Once you are outside, please do not wait immediately next to the building, but move some distance away and await further instructions; and** • **Do not re-enter the building until told that it is**

AGENDA

Part One		Page
9	Procedural Business	**1 - 2**
	To consider (a) Declaration of Substitutes (b) Declaration of Interest (c) Declaration of Party Whip, and (d) Exclusion of Press and Public	
10	Minutes of Previous Meeting	**3 - 10**
11	Chair's Communications	
12	Health & Wellbeing Board restructure Verbal update from Geraldine Hoban, Chief Operating Officer of Brighton and Hove CCG and Pinaki Ghoshal, Executive Director of Children's Services, Brighton & Hove City Council.	
13	Children's Commissioning Changes Report from Pinaki Ghoshal, Executive Director of Children's Services, Brighton & Hove City Council.	**11 - 22**
14	Dementia Care Update Report from Simone Lane, Brighton & Hove CCG.	**23 - 34**
15	Mental Health Services - update on Model of Care Report from Brighton & Hove CCG, to be presented by John Child, Sussex Partnership Foundation Trust	**35 - 50**

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

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

Meeting papers can be provided, on request, in large print, in Braille, on audio tape or on disc, or translated into any other language as requested.

For further details and general enquiries about this meeting contact scrutiny@brighton-hove.gov.uk

Date of Publication 2 September 2014

Agenda Item 1

To consider the following Procedural Business:

A. Declaration of Substitutes

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

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

B. Declarations of Interest

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Declaration of Party Whip

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

D. Exclusion of Press and Public

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

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

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

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE

4.00pm 11 JUNE 2014

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Rufus (Chair)

Also in attendance: Councillor C Theobald (Deputy Chair), Bennett, Bowden, Marsh, Meadows, Sykes and Wealls

Other Members present: Healthwatch; Older People's Council; Youth Council

PART ONE

1 PROCEDURAL BUSINESS

1.1 Councillor Andrew Wealls was attending as substitute for Councillor Graham Cox.

1.2 Councillor Bowden declared a non-prejudicial interest in item 6, the GP challenge, as he works with Health and Social Care information Centre. This was noted.

1.3 There were no declarations of party whip.

1.4 There was no exclusion of press and public.

2 MINUTES OF PREVIOUS MEETING

2.1 The minutes of the meeting on 22 April were agreed.

3 CHAIR'S COMMUNICATIONS

3.1 The Chair welcomed everyone to a new year of Health scrutiny.

3.2 He welcomed new members Councillors Bennett, Bowden and Meadows who were replacing Councillors Buckley, Robins and Wealls. He thanked those members who had left. The education co-optees and the parent governor co-optee have also moved on to the Children and Young People's committee; they were thanked for their involvement.

3.3 The Care Quality Commission carried out a major inspection of the hospital site in May 2014, with 50 inspectors looking at BSUH, and local GPs so HWOSC will hear more about that in due course.

3.4 The Chair congratulated the Scrutiny Team and all involved in their Centre for Public Scrutiny award, for the impact of the trans equality scrutiny panel.

.

4 UPDATE ON THE 3TS HOSPITAL DEVELOPMENT PROPOSAL

4.1 Professor Duane Passman, Director of 3Ts, Brighton and Sussex University Hospitals NHS Trust, gave a verbal update on progress with the 3Ts development of Royal Sussex County Hospital.

4.2 Professor Passman said that this was the first time that he had been to HWOSC since the Trust had gained approval from central government for the outline business case, which had been approved on 1 May 2014. This was a huge step forward. Professor Passman said that he and his team were hugely grateful for all of the support that they had been given over the last five years.

4.3 The next stage is to complete the full business case, which will be completed over summer 2014. BSUH would like to have full approval before May 2015 so that it is granted before the general election. This would mean that work on the main part of the development could then start in September 2015 as currently planned. Professor Passman noted that, despite the title of outline business case, this had been a very detailed document and represented the major hurdle which had to be cleared to allow the development to proceed. The full business case would have greater detail in certain areas (and this was being discussed) but it was hoped that approval would be a smoother process.

4.4 Some preparatory work has already taken place; St Mary's Hall has been refurbished and administrative staff moved into the site, which will free up space for some demolition and some development work. There are a number of other small-scale moves currently under way. BSUH have made sure that they notify all neighbours of planned work in order to minimise the disruption.

One new building is needed to allow for the larger scale moves and redevelopments to take place. This building will be in the north-east corner of the hospital site; it has to go through planning permission but BSUH is hopeful that this will be granted. The Trust will be undertaking engagement and consultation on this over the coming months.

4.5 Professor Passman said that this was a brief update but that he would be very happy to come back to a forthcoming HWOSC in order to provide a fuller update. This was welcomed.

4.6 HWOSC members all congratulated Professor Passman and his colleagues for their achievement in gaining approval to the outline business case. They also asked questions and made comments.

4.7 Members asked for more details of what the next stage was. Professor Passman said that they now had to present the full business case for approval. The outline business

case which has been approved was very detailed but they have been asked for more detail in certain areas so this will be provided. There are a number of different organisations who have to give approval; they are being grouped together in a national programme board which, it was hoped, should streamline the process.

4.8 Members asked about road closures; Professor Passman said that Eastern Road will have to be closed in parts. The Trust and its contractors have committed to a communication protocol which has worked well so far.

4.9 Members asked about whether there was scope for a kitchen on site. Professor Passman said that kitchens were not included in the development proposals, as there was so much clinical demand for the money. The Trust will continue to subcontract the meal provision. It should be noted that the Trust tries to supply some of their food locally where possible. Professor Passman offered to give more information about this to HWOSC members; this was welcomed.

4.10 Members queried why it had taken so long for outline business consent to be given. Professor Passman said that the application was made during the start of the period of public financial constraint in 2009. Much more information was requested than had ever been before. This reflected the financial climate and need for increased scrutiny of public expenditure. There had been some Trusts in the country who had completed large redevelopment projects and then found that they could not financially sustain the development which had major implications for the service provision. This has naturally led to later projects being more closely scrutinised to provide assurances that they can stay stable and not destabilise the local health economy.

4.11 Members asked whether the redevelopment plans ought to be updated given the amount of time it has taken to gain approval. Professor Passman said that the scheme is reviewed every six to eight months, internally and with contractors and commissioners to ensure that it is still fit for purpose. The reviews have not identified any significant updates to the scheme.

4.12 HWOSC members noted the update from Professor Passman and welcomed the further update due later in the year.

5 BETTER CARE FUND/ FRAILTY PILOT - PHASE ONE

5.1 Geraldine Hoban, Chief Operating Officer, Brighton and Hove CCG, updated HWOSC on the Better Care Fund. Denise D'Souza had sent her apologies that she was not able to attend HWOSC as well.

5.2 Ms Hoban recapped the Better Care Fund; it is a pooled fund between health and social care providers to provide support for the most frail and vulnerable in Brighton & Hove. This will not just be elderly people but also people with psychological, social or mental health needs. It is a fund of £18 million locally and is administered by the Health and Wellbeing Board. Practitioners are actively looking for people and aiming to get involved at an early stage, rather than waiting for people to hit crisis point. They are also looking

to standardise care planning, and wrap care around the individual with individual led outcomes.

Brighton and Hove is in a lucky position of being able to pump-prime some of the contracts as there is some financial capacity at present which means that we can invest now in integrated care in order to ultimately release spending elsewhere in the system.

All GPs were invited to apply to take part as pilot groups; there was very high interest with over 50% of practices applying. The two pilot groups will be St Peter's Practice in Park Crescent and a group of practices in the west of the city. They have very different cohorts of patients, with St Peter's practice dealing more with people experiencing social deprivation and the west dealing more with residents in care homes. This means that the practitioners can test the system for different frailty approaches.

There is also a strand of work for an integrated homeless care team, based around Morley Street surgery. They have 1,000 service users registered and will work with the Red Cross, housing services etc.

They are appointing a manager to oversee all of the pilots and manage the operational delivery of integrated care.

5.3 Ms Hoban said that there has been a lot of national attention on negative sides to the Better Care Fund, including how long it will take for programmes to release savings. Brighton & Hove does not have the same pressures as it has some funding capacity; it does not have to see savings released for three years.

5.4 Ms Hoban said that there had been queries about whether it was the right time to release money from the acute sector given the 3T development. The feeling was that there was a real synergy with the 3T work; if it reduces the number of A&E admissions and leads to shorter stays it will help the aims of the 3T development.

5.5 Members asked whether some services which are currently charged for, eg physiotherapy for care home residents, would be free to all. Ms Hoban confirmed that the integrated teams would give a consistent service. There had been a level of inequity until now but this should be resolved.

5.6 The Youth Council representative asked whether there would be special provision for homeless young people within the service. Ms Hoban said that she was not sure, but she would find out and let members know.

The Youth Council representative also highlighted the importance of consulting with young people when re-designing services. This was noted.

5.7 Members asked how GP clusters were formed. Ms Hoban said that you needed an optimum population of 20,000-25,000 for a critical mass for service delivery without losing the personal link. The CCG suggested to GP practices that they work with this size population but left it to the practices to arrange themselves in whatever way they preferred. The CCG would particularly welcome high performing practices buddying up with ones that may be struggling to share learning.

5.8 Members asked about time frames for when the Better Care Fund will be rolled out. Ms Hoban said that the working group is taking its lead from the national Better Care Fund framework.

5.9 Members noted the report and thanked Ms Hoban. She said that she could come back in six months, when the pilots will be in operation. This was welcomed.

6 GP CHALLENGE- LOCAL PILOT SCHEME

6.1 Dr Jonathan Sarjeant and Zoe Nicolson from Brighton Integrated Care Service (BICS) spoke to HWOSC members about the GP Challenge pilot.

BICS is a non-profit membership organisation which was set up six and a half years ago. Its 250 members include a range of health professionals including GPs and nurse practitioners. Their aim is to transform local health services and find new solutions to problems, working in partnership with GPs. They deliver a range of services in Brighton & Hove including mental health provision, MSK and dermatology.

The GP Challenge fund is a national pilot aimed at increasing access to health services. There were 250 bids nationally, and BICS was chosen as a pilot. Their pilot is called EPIC. BICS will work with 18 practices and pharmacies locally, to try and improve access for patients whilst at the same time recognising the workload pressures on GPs.

They are aiming to achieve this through a number of ways:

- A skill mix between pharmacies and GPs; enabling pharmacies to access medical records (with explicit patient consent) so that you do not have to attend GPs
- Using 61 trained volunteers as care navigators to spend time with people with more complex needs, helping them to access local support services etc
- Increasing opening hours at GPs by clustering them into modules and sharing the extended hours between them. They will also trial video consultations.

BICS will support the implementation of the 12 month pilot; they have experience of developing transformational change.

BICS will aim to involve users as much as possible and work with Patient Participation Groups (PPG).

6.2 Members thanked Dr Serjeant and Ms Nicolson and asked questions.

How would the new system address stress levels and work pressures for GPs? Dr Sarjeant said that they want to try and use this pilot to understand and map the problems. GPs are clustering together for support, using pharmacy and nurse practitioner staff to address the simpler medical issues. Pharmacists having access to medical records will be a huge boost in freeing GP time for repeat prescriptions etc. The care navigators will be able to oversee what support is available

6.3 Members asked about the timeframe. Dr Sarjeant said that the pilot was for a year, starting on 1 April 2014. BICS had grouped the practices involved in the pilot into various groups, some of which will be early adopters, and others who will start later. Both will have a three month programme of design etc to enable the best service and gather the best data. There is only a short amount of time to collect the data about what works and what is less successful. There is also a National Evaluation Team to give monthly feedback to the pilots.

6.4 Councillor Bowden said that he had an interest in this as he worked with the Health and Social Care Information Centre. He queried how the data would be kept safe. Was there a risk that the information could be sold on?

Ms Nicolson said that she was the Senior Responsible Information Officer. There would be due governance on sharing data; every time someone goes through the triage process to get to the pharmacist, they would have to give consent. The data would be part of the consultation and would not be a transfer of data to pharmacies; they would be accessing data for the benefit of patient consultation.

BICS was designing the correct level of information at present. There is also a national group on governance of sharing data who could give advice.

There was no intention to pass information on to companies at any stage.

Dr Sarjeant added that they would welcome Councillor Bowden's professional input.

6.5 Members also asked about how the digitally excluded would be included in the pilots. A number of GP practices do not have internet access.

Dr Sarjeant said that it could not be a one size fits all approach, some people will still have to attend GPs or telephone them. There was also a role for the care navigators to find those people who were not attending GPs to proactively work with them.

6.6 Healthwatch asked how BICS/ the CCG would manage patient expectations after the pilot ended. Ms Hoban from the CCG commented that the pilot was intended to see what worked and should be commissioned. At present CCGs do not commission primary care but they are involved in some of the discussions.

6.7 Members asked about the timeframe for feedback. Dr Sarjeant said that it would be best to give the pilot schemes a few months to operate before feeding back. BICS could come back to HWOSC in February 2015. They would let HWOSC know if there was any information from the national evaluation team that was relevant to Brighton and Hove.

6.8 Members noted the report and thanked BICS.

7 PROGRESS REPORT ON MUSCULOSKELETAL (MSK) AND DERMATOLOGY PROCUREMENT

7.1 Dr Sarjeant and Ms Nicolson from BICS spoke to the members about BICS's successful bid for the MSK and dermatology procurement. There is an MSK partnership between four organisations; BICS, Sussex Partnership Foundation Trust, Susssex Community Trust and Horder. Horder is a charity based locally, recognised as a national expert in MSK care.

This is a unique mixture of providers, who want to integrate mental health and physical priorities.

The MSK contract commences on 1 October 2014, the dermatology contract begins in August 2014.

What is going to be different under the new contract? There are going to be multi-disciplinary co-located teams. There will be two MSK centres of excellence, one at Brighton General Hospital where patients will be able to have a one day assessment with full diagnostics – and Hove Polyclinic. There will much more focus on self-management and patient facing solutions.

Ms Hoban said that they were not allowed to make much comment on the unsuccessful bidders but she was happy to say that BICS had a lot of local knowledge and a real inreach into local services.

7.2 Members asked how the Social Value act had been applied during the procurement process. Ms Hoban said that the MSK contract had been the first procurement where social value had been applied. The CCG was very keen to use the lever of commissioning for the best local effect. They have been keen to see how providers would invest in a local workforce or use SME for example. They also considered sustainability indicators.

Ms Nicolson said that social value was very important as they are a social enterprise. All staff are employed locally and BICS makes significant investment into local communities. SCT and SPFT have strong track records in training and apprenticeship schemes too.

The MSK contract is huge, at over £200 million over 5 years. There has to be a social value attached to it. BICS is considering how best to evaluate the ongoing impact.

7.3 The Youth council representative was concerned that there might be pressure put on people to return to work too soon at a cost to their health. Ms Hoban said that MSK conditions were one of the main reasons that people were off work with long term health conditions, along with mental health problems. There is a real need to support people appropriately. Ms Nicolson said that clinicians were trained to work with patients to set their own goals to support shared decision making. Return to work may be a part of this.

7.4 Members thanked BICS and Ms Hoban for the update.

8 SCRUTINY PANEL ON BULLYING IN SCHOOLS - FINAL REPORT

8.1 HWOSC considered the scrutiny panel report on bullying in schools.

The Youth Council representative said that they welcomed the report and appreciated the weight that had been given to young people's evidence. They suggested that one change be made to the recommendations; parents might not want the school to arrange an exit interview if they have been unhappy with the school's performance. This could be changed to allow for a third party to make the arrangements instead.

8.2 Members thanked the scrutiny panel members for a thorough piece fo work. They commented that they hoped that schools would take notice and share learning where appropriate.

8.3 The report was agreed, with the one amendment at 8.2.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 13 Brighton & Hove City Council

Subject:		**Commissioning Children's Services in Brighton & Hove**
Date of Meeting:		**10 September 2014**
Report of:		**Executive Director of Children's Services**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 29-1038**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 At its July 2014 meeting the Brighton & Hove Health & Wellbeing Board (HWB) considered and approved joint council and CCG plans to improve the commissioning of children's services in the city.

1.2 As the HWOSC is responsible for scrutinising local council and NHS services for children, this report has been referred to the HWOSC for information.

1.3 The HWB report and its appendices are included as **Appendices 1** and **2** to this report.

2. RECOMMENDATIONS:

2.1 That members consider and comment on the plans to improve the commissioning of children's services (see **Appendices 1** & **2**).

3. CONTEXT/ BACKGROUND INFORMATION

3.1 These are detailed in the report to the HWB (see **Appendix 1**).

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Please see the report to the HWB (**Appendix 1**) for more information.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 Please see the report to the HWB (**Appendix 1**) for more information.

6. CONCLUSION

6.1 Please see the report to the HWB (**Appendix 1**) for more information.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this report for information. Please see the report to the HWB (**Appendix 1**) for more information.

Legal Implications:

7.2 None to this report for information. Please see the report to the HWB (**Appendix 1**) for more information.

Equalities Implications:

7.3 None to this report for information. Please see the report to the HWB (**Appendix 1**) for more information.

Sustainability Implications:

7.4 None to this report for information. Please see the report to the HWB (**Appendix 1**) for more information.

Any Other Significant Implications:

7.5 None to this report for information. Please see the report to the HWB (**Appendix 1**) for more information.

SUPPORTING DOCUMENTATION

Appendices:

1. Report on Commissioning Children's Services (July 14 HWB)

2. Report on Commissioning Children's Services (July 14 HWB): Governance Appendix

Documents in Members' Rooms

None

Background Documents
None

Subject:		**Commissioning Children's Services in Brighton & Hove**
Date of Meeting:		**29 July 2014**
Report of:		**Executive Director of Children's Services, BHCC/ Chief Operating Officer, CCG**
Contact Officers:		**Pinaki Ghoshal** **Geraldine Hoban**
	Email:	**Pinaki.ghoshal@brighton-hove.gcsx.gov.uk** **Geraldine.hoban@nhs.net**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The purpose of this report is to set out the mechanisms for strengthening joint commissioning arrangements between the Council and CCG following dissolution of the Section 75 Children's Commissioning Agreement on 1st October 2014.

2. RECOMMENDATIONS:

That the Health and Wellbeing Board:

2.1 Endorses the mechanisms for strengthened collaborative commissioning arrangements between the CCG and Council (outlined in Part 3 of this report);

2.2 Agrees that the LA and the CCG develop a joint strategy for children's health and wellbeing services which will be brought back to the Health & Wellbeing Board in 2015. This will be informed by the recommendations agreed by the Health & Wellbeing Board in early 2015.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The Children's Act 2004 placed a statutory duty on Local Authorities to produce single strategic plans for children and young people. Whilst this statutory duty was withdrawn in 2010, the wider duty for both health and local authorities to co-operate with partner agencies to improve health and wellbeing of young people in the City is still very much in force.

3.2 In addition, the Children and Families Act, due to be implemented from September 2014, places a statutory requirement on the Council and health services to operate joint commissioning arrangement for services provided to children with special educational needs and disabilities.

3.2 Since 2007, the City Council and the PCT have maintained their commitment to joining up the strategic planning and commissioning of children's services via a Section 75 Commissioning Agreement. As part of this agreement, the PCT transferred a sum annually to the Council and delegated the commissioning function for children's services such as community disability; special education needs; CAMHS; school nursing; health visiting, and support services provided by the Third Sector. Through this agreement the council commissioned NHS health providers to deliver a range of health services. Many of these services are delivered by NHS staff working in an integrated way with council staff through a Section 75 Provider Agreement with Sussex Community Trust. At the time that these agreements were put in place the council was unable to employ NHS staff directly.

3.3 Following significant changes to the NHS as a result of Health and Social Care Act which came into effect on 1st April 2013, CCGs were established and the responsibility for commissioning a range of children's health services transferred to NHS England (health visiting, screening programmes and specialist acute care) and Public Health, situated with Local Authorities (school nursing, sexual health, teenage pregnancies, substance misuse, alcohol and health promotion programmes).During authorisation, the CCG agreed to maintain its commitment to the Children's Section 75 commissioning arrangement but to review this agreement during its first year of operation.

3.4 Following due consideration, the CCG concluded:

- Mechanisms for jointly setting the strategic direction for children's health and well-being services needed to be strengthened. Whilst the CCG, until recently, has been represented on the Children's Committee, its remit increasingly focused on issues relating to education and there was the need for a renewed emphasis on our aspirations for children's health and wellbeing;

- More robust mechanisms for contract monitoring and the performance management of providers needed to be established;

- Our respective roles and responsibilities around safeguarding and quality assurance need to be clarified;

- Governance and accountability to the CCG Governing Body around statutory duties needed to be strengthened;

- Clinical leadership and management resource within the CCG for children needs to be increased.

3.5 Consequently on 1st April 2014 the CCG signalled its intention to withdraw from the Section 75 Arrangement for Children and gave 6 months' notice under the terms of the Section 75 Agreement. By doing so it is the CCG's intention to fully engage with and strengthen collaborative commissioning arrangements rather than continue to devolve that responsibility to a joint commissioning team based at the Council.

3.6 In parallel with the developing thinking taking place within the CCG the Council has also been considering its role in relation to the Section 75 commissioning role. Key events and developments that have informed this thinking have included the following:

- The sweeping SEND reforms within the Children and Families Act require an enhanced level of joint commissioning and joint delivery of services between all agencies contributing to Education, Health and Care Plans for children and young people aged 0-25 years;

- With the recent refreshing of the terms of reference for the Health & Wellbeing Board there has been an opportunity to consider new and more robust governance arrangements regarding children's health and wellbeing;

- The Council has instituted a thorough review of disability and special educational needs, as discussed in more detail at the previous meeting of the Health & Wellbeing Board, including a consideration of the health provision within the Integrated Disability Service;

- Discussions with the Public Health Team regarding their future commissioning intentions have started, and this will be discussed at the Health & Wellbeing Board in the Autumn;

- The need for the Council to have a clear and senior lead officer for health and wellbeing who will liaise closely with the CCG, Public Health and NHS England. At present this role has been undertaken by the Acting Assistant Director of Children's Services, Regan Delf;

- The opportunities provided by the recent changes in the NHS for the Council to improve the level of integration between NHS and Council staff.

3.7 Proposal.

Additional resource has been identified within the CCG to take a more proactive lead on children's services, and following the appointment of Regan Delf to her current Acting role the Council now has a senior point of contact with regards to the delivery of health services for children and young people. With these developments, meetings have taken place between the respective commissioning teams within the CCG and Council. It is proposed that building on the extended remit of the newly constituted Health and Wellbeing Board, more robust collaborative commissioning arrangements are established as follows:

a) <u>Strategic Oversight and Direction for Children's Health & Wellbeing Services</u>
The newly constituted Health and Wellbeing Board will set the aspirations for children's health and wellbeing in the City, sign off commissioning plans and hold commissioners and partners to account for delivering on agreed outcomes. Given current specific areas of concern in the City around children's health and wellbeing outcomes, the Board may want to consider whether a refresh of our joint strategic plans for children in the City is required.

b) <u>Senior Management Leadership for Children's Commissioning</u>

A senior Officers Group will translate the aspirations of the H&WB into annual commissioning plans and oversee delivery through strengthened systems for joint contract/performance management and quality assurance/safeguarding.

c) Operational Management of Delivery

Regular contract, performance and quality meetings will be put in place to ensure providers are being held to account for delivery and key issues are being identified early and escalated/resolved when necessary. Joint panels for setting and reviewing individual packages of care will be established.
In addition, specific reviews or service redesign groups will be established under the auspices of the Officers Group in order to address specific issues.

d) Mechanisms for Quality Assurance/Safeguarding

It is proposed that there will be further strengthening of the existing process already in place to monitor quality and safeguarding of providers to include children's service delivery. In most areas this will take place within the already established structures for monitoring quality performance and safeguarding. Additional structures are being developed for areas where gaps have been identified.

In addition within the CCG and Council there are a series of internal working arrangements that will ensure that each agency maintains oversight of the quality of provision. Overall oversight of safeguarding arrangements will be maintained by the Local Safeguarding Children's Board

e) Formalising the Joint Approach

It is proposed that a clear annual memorandum of understanding be drawn up which outlines how the CCG and Council will work together collaboratively on the joint commissioning of children's services.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The CCG considered the option of staying within the current Section 75 Commissioning arrangement and continuing to discharge its commissioning of children's community health and CAMHS services via the Council. On balance for the reasons stated above it was felt that a joint approach rather than a delegated function would be more effective.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 This was considered not applicable as it relates to the commissioning function only and no changes to the delivery of children's services are being proposed.

6. CONCLUSION

6.1 The CCG and Council are committed to comprehensive and robust mechanisms for jointly commissioning children's services.

6.2 The need for effective mechanisms for collaboration, particularly in relation to packages of care for children with special educational needs and physical disability is about to be strengthened through the implementation of the Children and Families Act in September.

6.3 Following a review, the CCG felt the Section 75 Commissioning Arrangement for Children was not delivering the right level of joint ownership for children's services and signalled its intention to withdraw from the arrangement from 1st October 2014.

6.4 Enhanced capacity within the Council and CCG around the Children's commissioning agenda has enabled more regular discussions to take place and a mechanism for strengthening the governance and accountability around children's services is proposed.

6.5 This new way of working will be underpinned by a memorandum of understanding which the CCG and Council will refresh and sign annually.

6.6 It is also felt that the time is right for a refresh of our joint aspirations for children in the City in order to inform longer term commissioning strategy and ultimately improve outcomes.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 Last year the commissioning arrangements for children's health funding changed with the CCG, via Brighton & Hove Council as lead commissioner, no longer having responsibility for certain services. Public Health took over responsibility for School Nursing and NHS England became responsible for Health visitors, immunisations and the child health information system. Services not commissioned by the CCG are not covered by the section 75 agreement. The indicative budgets for 2014/15, including those services commissioned and provided though Children's Services, are:

Brighton & Hove CCG	£ 4.376m
Public Health (BHCC)	£ 1.090m
NHS England	£ 4.028m
Children's Services (BHCC)	£55.283m

Changes to the health commissioning arrangements this year will not impact on the amount of money available to children services, the only difference being that funding previously directed via Brighton & Hove City Council will instead be held directly by the CCG working alongside the council as co-commissioners.

The funding for council provided children's services of £55.283m is not directly affected by any of the changes to the NHS commissioning arrangements.

Finance Officer Consulted: David Ellis *Date: 11/07/14*

Legal Implications:

7.2 The body of the report sets out the legal framework in which the CCG and City Council are operating.

7.3 Part 3 of the Children and Families Act 2014, which comes into force on 1 September 2014, introduces a new, single, system from birth to 25 for all children and young people with SEN and their families. Section 26 of the Act requires local authorities and local CCG's to work in partnership and make arrangements for commissioning special educational provision, healthcare provision and social care provision for children and young people with SEN for whom the Authority is responsible. It does not specify the form which the arrangements should take as this should be agreed locally.

7.4 The LSCB's main function is to agree how the relevant organisations in each local area co-operate to safeguard and promote the welfare of children in that locality, and to ensure the effectiveness of what they do. The LSCB is not accountable for their operational work. In law each LSCB partner retains their own existing lines of accountability for safeguarding and promoting the welfare of children by their services. Thus each agency is ultimately responsible in law for ensuring that the services provided meet their own statutory and regulatory duties to children, including safeguarding duties, and monitoring arrangements need to reflect this . In the case of the City Council this will be with reference to the statutory guidance, 'The Roles and Responsibilities of the Lead Member for Children's Services and the Director of Children's Services' (2013)

Lawyer Consulted: Natasha Watson *Date: 18.07.14*

Equalities Implications:

7.5 None identified at this point. Appropriate assessments of the potential impact of changes upon protected groups will be undertaken.

Sustainability Implications:

7.6 None identified in this report

Any Other Significant Implications:

7.7 None identified at this point.

SUPPORTING DOCUMENTATION

Appendices:

1. Flow chart showing proposed new governance structures

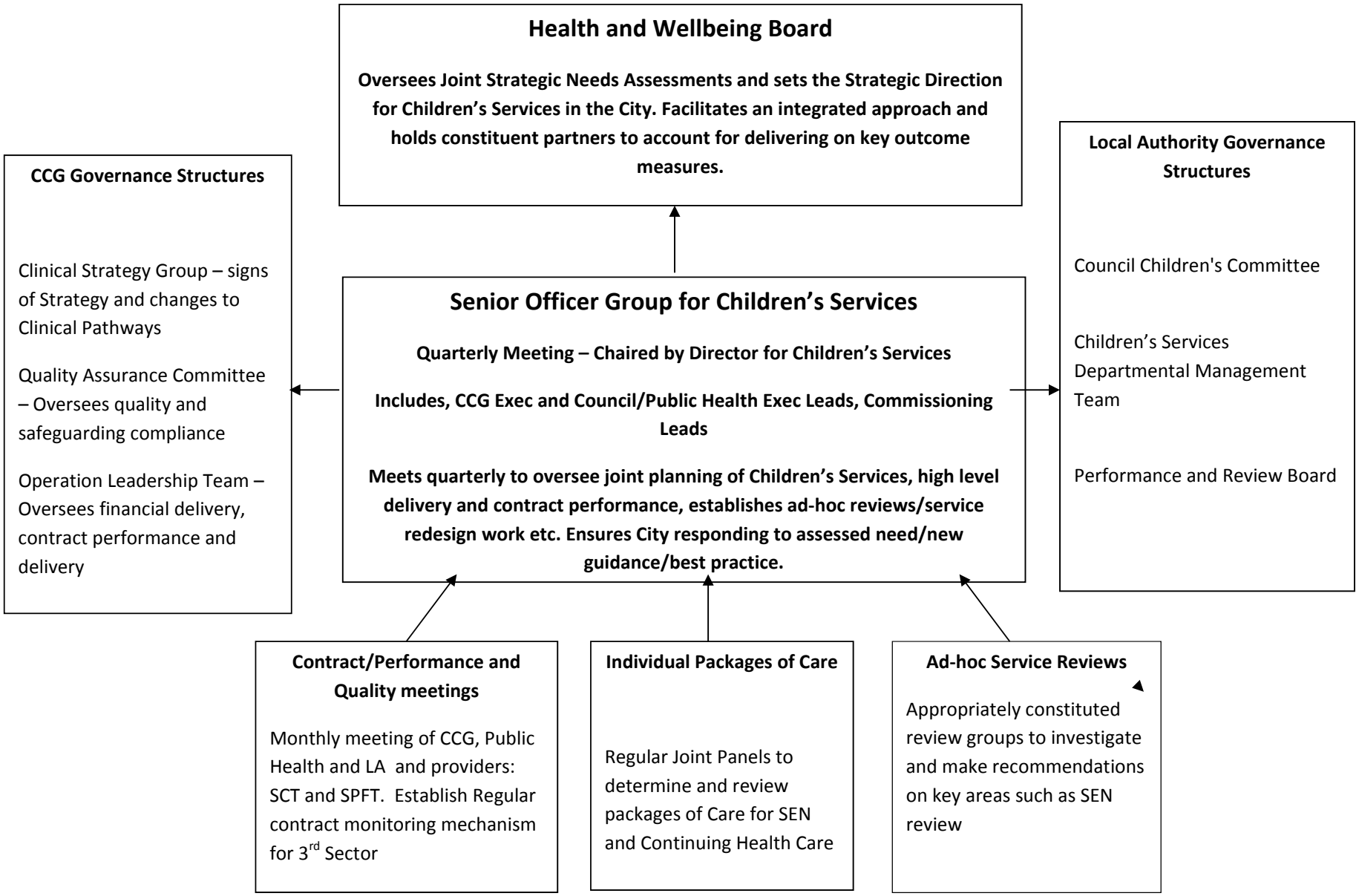
Documents in Members' Rooms

None

Background Documents

None

Appendix 1


Health and Wellbeing Board
Oversees Joint Strategic Needs Assessments and sets the Strategic Direction for Children's Services in the City. Facilitates an integrated approach and holds constituent partners to account for delivering on key outcome measures.
CCG Governance Structures
Clinical Strategy Group – signs of Strategy and changes to Clinical Pathways
Quality Assurance Committee – Oversees quality and safeguarding compliance
Operation Leadership Team – Oversees financial delivery, contract performance and delivery
Senior Officer Group for Children's Services
Quarterly Meeting – Chaired by Director for Children's Services
Includes, CCG Exec and Council/Public Health Exec Leads, Commissioning Leads
Meets quarterly to oversee joint planning of Children's Services, high level delivery and contract performance, establishes ad-hoc reviews/service redesign work etc. Ensures City responding to assessed need/new guidance/best practice.
Local Authority Governance Structures
Council Children's Committee
Children's Services Departmental Management Team
Performance and Review Board
Contract/Performance and Quality meetings
Monthly meeting of CCG, Public Health and LA and providers: SCT and SPFT. Establish Regular contract monitoring mechanism for 3rd Sector
Individual Packages of Care
Regular Joint Panels to determine and review packages of Care for SEN and Continuing Health Care
Ad-hoc Service Reviews
Appropriately constituted review groups to investigate and make recommendations on key areas such as SEN review

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 14 Brighton & Hove City Council

Subject:		**Update on Dementia Services**	
Date of Meeting:		**10 September 2014**	
Report of:		**Monitoring Officer**	
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The purpose of the report is to provide HWOSC with an update on further developments in dementia services in Brighton and Hove.

2. RECOMMENDATIONS:

2.1 That HWOSC members consider the information in the report, assessing progress in line with the National Dementia Strategy.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 HWOSC members last heard a report about local work in dementia services in May 2013.This report updates them on work that has happened since then.

3.2 Brighton and Hove developed a Joint Dementia Plan since 2012 that set outs the Brighton and Hove strategic vision for improving care and support to people with dementia and their carers.

The central aim of the plan was to increase awareness of the condition, ensuring early diagnosis and intervention as well as improving the quality of care for people with dementia and their carers. The CCG's strategic approach to dementia is to treat dementia as a 'long-term condition', aligning many dementia services with physical health services so a holistic approach is taken to the care of people with dementia.

3.3 Key updates since the last report include.

3.4 A **New Memory Assessment Service** was started in June 2013, to increase the number of people in the city diagnosed with dementia and is now fully operational. This service is delivered from three local GP surgeries as well as in patients' homes. Patients can be referred to this service by their GP and the service does accept self-referrals. Patients are offered advice and support, for up to a year after diagnosis by Dementia Advisers.

3.5 Improved support to people with dementia admitted to general hospitals

- A dementia champion post based at the Royal Sussex County Hospital is driving forward improved services for people with dementia across the hospital. In addition this year, a specialist Dementia nurse role to support the champion has been funded.

- 90% of people who are over the age of 75, and are in hospital for 72 hours or more have received a memory screen, to identify if they have symptoms of memory loss and refer on to the Memory Assessment Service

- The hospital has adopted the Butterfly scheme which provides a framework for rolling out education and an approach to caring for patients with dementia across the whole trust. It allows people whose memory is permanently affected by dementia to make this clear to hospital staff and provides staff with a simple, practical strategy for meeting their needs.

- The Emerald Unit on the Royal Sussex County site opened in May 2014, with the aim of providing specialised nursing, therapies and mental health care for people with a dementia. The Dementia Champion and nurse specialist are based within this unit. It is envisaged that through the Emerald Unit, BSUH will establish a 'hub' for dementia care, to ensure that patients and staff can access appropriate advice, care and expertise.

3.6 Crisis Support Dementia Crisis & Short Term Support

Additional resource has continued to be put into the Community Rapid Response Service (CRRS), to enable more people with dementia to be supported at home and avoid unnecessary admissions to hospital. This service has also employed a mental health liaison nurse

3.7 Living Well with Dementia Team

The Living Well with Dementia Service was put in place in summer 2013. This is the integrated secondary mental health service for people with complex and challenging needs relating to their dementia, other diagnoses, health and social care needs. This is a multi-disciplinary team consisting of psychiatry, neuropsychology, occupational therapy, nursing, social work, dietician, physiotherapy and Speech and Language Therapy. The service is provided 7 days a week for 365 days a year from 9am to 7pm. Most patients have complex dementia, challenging behaviour and treatment and care co-ordination issues.

3.8 Care Homes

- The Care home in-reach service provides support to care homes to improve their ability to care for and support their residents who have dementia. This service was reviewed in 2013; the service is now permanently funded with a change in staff mix to provide additional occupational therapy.

- Two new large care homes Maycroft Manor and Dean Wood have recently opened in the city and a third is currently being developed. These care homes all have capacity to admit patients with memory loss and dementia.
  However, because of the comparatively high level of fees at these new providers,

places in these new care homes tend to be available to people who are able to fund their own care.

3.9 **Dementia Cafes" and "Singing for the Brain**"

Objective 5 of the National Dementia Strategy is to develop structured peer support and learning networks. This is evidence based and supported by statements received from people with dementia and their carers, that they draw significant benefit from being able to talk to other people living with dementia and their carers, to exchange practical advice and emotional support.

Dementia cafes provide space for open discussion of the diagnosis of dementia and its consequences in an informal, social environment in the presence of and supported by peers (people with dementia, their carers and families). The cafés in Brighton & Hove are generally directed at people in the earlier stages of dementia, although it is acknowledged that cafés have developed according to local need and some cafés include people at different stages of dementia where appropriate

Singing for the Brain sessions follow an accepted structure, designed around the principles of music therapy and singing. The service is designed to help families with dementia to feel part of society where they have a right to artistic and social stimulation.

3.10 Dementia Friendly Environment Bid

A £1 million capital funding application to support improving the environment of care for people with dementia was awarded in June 2013. This was a partnership bid which aimed to adapt the environment in a number of settings that people with dementia access. The bid supported local aspirations for every care experience of people with dementia to be within a built environment which supports orientation, calming, stimulation, safety, continence, independence and dignity.

3.11 Dementia Friends

In May 2014 The Alzheimer's Society launched a new campaign called Dementia Friends. Dementia Friends gives people an understanding of dementia and the small things they can do that can make a difference to people living with dementia – from helping someone find the right bus to spreading the word about dementia. The Alzheimer's society wants to create a network of a million Dementia Friends across England by 2015. At the Health & Wellbeing Board June 2014 the Chief Executive informed members that she had signed up to be a Dementia friend and suggested that the Health and Wellbeing Board should sign up to be Dementia Friends as well. This was agreed by the Board.

3.11 **Dementia Challenge Fund**

The Trust for Developing Communities have developed a toolkit to support voluntary and community groups in making the city more dementia friendly, which will be launched in September 2014.

3.12 More detail on some of the initiatives above can be found in Appendix 1.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 None to this cover report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this cover report.

Legal Implications:

5.2 None to this cover report.

Equalities Implications:

5.3 None to this cover report.

Sustainability Implications:

5.4 None to this cover report.

Crime & Disorder Implications:

5.5 None to this cover report.

Risk and Opportunity Management Implications:

5.6 None to this cover report.

Public Health Implications:

5.7 Dementia is a key health issue for the city and has been identified as one of Health and Wellbeing Board's highest priorities.

Corporate / Citywide Implications:

5.8 None to this cover report.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 None to this cover report.

SUPPORTING DOCUMENTATION

Appendices:

1. Update from the CCG

HWOSC Update – July 2014
Dementia

Purpose of the Report

The purpose of the report is to provide HWOSC with an update on further developments in dementia services in Brighton and Hove, since the last report provided to the HWOSC in May 2013. (See appendix 1)

1. National Context

Dementia is a syndrome that can be caused by a number of progressive disorders. It affects memory, thinking, behaviour and the ability to perform everyday tasks. Alzheimer's disease is the most common type of dementia. It mainly affects older people. One in 14 people over 65 years and one in six over 80 years in the UK have a form of dementia. It is estimated people live on average 7-12 years after diagnosis.

Dementia is an important issue because it affects a large proportion of people and the numbers are increasing as the population is ageing. It places pressure on all aspects of the health and social care system: An estimated 25% of hospital beds are occupied by people with dementia, who have longer lengths of stay, and more readmissions. Approximately two-thirds of care home residents are estimated to have dementia and one in three people will care for someone with dementia in their lifetime.[1]

Nationally, there is increasing focus on dementia as an issue, including prevention, treatment, and demand for services and creating dementia friendly communities. The National Dementia Strategy was published in 2009 and the Prime Minister launched his Dementia Challenge in 2012.

2. Local Context

Brighton & Hove has a higher proportion of people aged 16-64 years and a lower proportion of 65 years and over (13%) compared to 17% in the South East and 16% in England, dementia needs are not on the same level as other parts of the country. The overall population of Brighton & Hove is predicted to increase from 273,000 people in 2011 to 289,900 by 2021 (a 6.2% increase). However, the number of over 65s is estimated to rise by around 12%, which are about 40,000 people by 2021.[1] This will be particularly felt in the parts of the city where the older population is concentrated i.e. Rottingdean Coastal, Woodingdean, Hangleton & Knoll, Hove Park and Patcham wards.

The Health and Wellbeing Board has identified dementia as a priority for the city and dementia is included in the City's first Joint Health and Wellbeing Strategy

[1] Department of Health. Dementia. A state of the nation report on dementia care and support in England. November 2013

[1] http://www.poppi.org.uk/index.php?pageNo=314&areaID=8330&loc=8330

3. Developments Over the Last Year and Strategic Vision

Brighton and Hove developed a Joint Dementia Plan since 2012 that set outs the Brighton and Hove strategic vision for improving care and support to people with dementia and their carers. The central aim of the plan was to increase awareness of the condition, ensuring early diagnosis and intervention as well as improving the quality of care for people with dementia and their carers. Our strategic approach to dementia is to treat dementia as a 'long-term condition', aligning many dementia services with physical health services so a holistic approach is taken to the care of people with dementia. The Dementia Plan for 2013-14 is included in Appendix 2. Key updates since the last report follow.

3.1 New Memory Assessment Service.

Good quality early diagnosis is vital for all, without a diagnosis many people may not be able to access the right care and support, so increasing the rate of diagnosis is a priority. In 12/13 Brighton & Hove's dementia diagnosis rate was 44.4%, up from 38.9% the previous year. (data on the diagnosis rate for 13/14 should be available in October 14). A New Memory Assessment Service was started June 2013, to increase the number of people in the city diagnosed with dementia. This service is provided by partnership between Brighton & Hove Integrated Care Service (BICS), Sussex Partnership NHS Foundation Trust, the Alzheimer's Society and Carer's Centre.

- The service started on in June 2013 and is now fully operational. This service is delivered from three local GP surgeries in Portslade, Patcham and Saltdean as well as in patients' homes. It aims to increase the number of people diagnosed with dementia, and provide improved support to people suffering from dementia, as well as their carers. Patients can be referred to this service by their GP and the service does accept self-referrals. Patients are offered advice and support, for up to a year after diagnosis by Dementia Advisers.

3.2 Improved support to people with dementia admitted to general hospitals

- A dementia champion post is based at the Royal Sussex County Hospital and is driving forward improved services for people with dementia across the hospital. In addition this year, a specialist Dementia nurse role to support the champion has been funded.

- 90% of people who are over the age of 75, and are in hospital for 72 hours or more have received a memory screen., to identify if they have symptoms of memory loss and refer on to the Memory Assessment Service

- The hospital has adopted the Butterfly scheme and this was launched in June on the Sussex County and Princess Royal sites. The Butterfly scheme provides a framework for rolling out education and an approach to caring for patients with dementia across the whole trust. It allows people whose memory is permanently affected by dementia to make this clear to hospital staff and provides staff with a simple, practical strategy for meeting their needs.

- The Emerald Unit on the Royal Sussex County site opened in May 2014, with the aim of providing specialised nursing, therapies and mental health care for people with a dementia. The Dementia Champion and nurse specialist are based within this unit. It is envisaged that through the Emerald Unit, BSUH will establish a 'hub' for dementia care, to ensure that patients and staff can access appropriate advice, care

and expertise. The development of the ward was supported by the trust securing capital funding from the Department of Health, as part of the Dementia Friendly environments partnership bid.

- BSUH has recently produced a 2 year clinical strategy for dementia that is attached in Appendix 2

3.3 Crisis Support Dementia Crisis & Short Term Support

Additional resource has continued to be put into the Community Rapid Response Service (CRRS), to enable more people with dementia to be supported at home and avoid unnecessary admissions to hospital. This service has also employed a mental health liaison nurse.

Living Well with Dementia Team

The services that Sussex Partnership NHS Foundation Trust provided for dementia were reviewed in 12/13 and the Living Well with Dementia Service was put in place in summer 2013. This is the integrated secondary mental health service for people with complex and challenging needs relating to their dementia, other diagnoses, health and social care needs. The team includes both SPFT and Brighton & Hove City Council (BHCC) staff. This is a multi-disciplinary team consisting of psychiatry, neuropsychology, occupational therapy, nursing, social work, dietician, physiotherapy and Speech and Language Therapy. The service is provided 7 days a week for 365 days a year from 9am to 7pm. Most patients have complex dementia, challenging behaviour and treatment and care co-ordination issues. The target client group include:

On-going and active involvement with those individuals who are known (or will be taken on) by the team, but who are currently receiving acute in-patient care.
People who have complex diagnostic needs referred on from the MAS
Individuals assessed by the MAS whose conditions have deteriorated and/or need a more comprehensive intervention and treatment portfolio as agreed by service specification requirements
Existing clients with complex dementia-related needs and other concurrent mental health problems

3.4 Care Homes

- The Care home in-reach service provides support to care homes to improve their ability to care for and support their residents who have dementia. This service was reviewed in 2013; the service is now permanently funded with a change in staff mix to provide additional occupational therapy.

- Two new large care homes have recently opened in the city Maycroft Manor and Dean Wood and a third is currently being developed. These care homes all have capacity to admit patients with memory loss and dementia. However, because of the comparatively high level of fees at these new providers , generally places in these new care homes are available to people who are able to fund their own care

3.5 Dementia Cafes" and "Singing for the Brain"

Objective 5 of the National Dementia Strategy is to develop structured peer support and learning networks. This is based on evidence and supported by statements received from people with dementia and their carers, that they draw significant benefit from being able to talk to other people living with dementia and their carers, to exchange practical advice and emotional support.

The Alzheimer's society received funding in 2012/13 and 2013/14 to "Provide Singing for the Brain" sessions and "Dementia Cafes" in Brighton & Hove.

Dementia cafes provide space for open discussion of the diagnosis of dementia and its consequences in an informal, social environment in the presence of and supported by peers (people with dementia, their carers and families). They provide practical information provided by a range of sources in a structured social setting that provides opportunities for people with dementia, their families and carers to ask questions and learn. The cafés in Brighton & Hove are generally directed at people in the earlier stages of dementia, although it is acknowledged that cafés have developed according to local need and some cafés include people at different stages of dementia where appropriate

Singing for the Brain sessions follow an accepted structure, designed to provide a facilitated structured group session for people with dementia and their carers designed around the principles of music therapy and singing. The Singing for the Brain sessions are planned to incorporate social interaction, peer support, engagement and active participation. The service is designed to help families with dementia to feel part of society where they have a right to artistic and social stimulation.

3.6 Dementia Friendly Environment Bid

A £1 million capital funding application to support improving the environment of care for people with dementia was awarded in June 2013. This was a partnership bid which aimed to adapt the environment in a number of settings that people with dementia access. The bid supported local aspirations for every care experience of people with dementia to be within a built environment which supports orientation, calming, stimulation, safety, continence, independence and dignity. This work included:-

Improvements in BSUH to create a dedicated space in Accident and Emergency, and 2 inpatient wards through: quiet zones: improving signage: orientation clocks: visual boards and supporting the development of a specialist dementia inpatient unit

Funding to improve 6 GP surgeries in the city by, improving signage, orientation clocks, visual boards etc.

Dementia friendly improvements to Brunswick Specialist Dementia ward in the Neville Hospital, Sussex Partnership NHS Foundation trust (SPFT). Changing internal fittings, introduction a new lighting system and creating new access to and improvements to a dementia friendly garden area.

Work in residential short tern services unit, to ensure environments support people with dementia to maximise physical recovery. By increasing awareness, uptake and

usage of Telecare and other assistive technologies e.g. day/night clocks and lighting to assist sleep patterns.

Work in Ireland Lodge and Wayland Avenue day care centres to increase awareness, uptake and usage of telecare and other assistive technologies, and develop space/garden that were engaging and safe.

Funding grants being given to 38 mainstream residential care homes to help resident's orientation by: improving signage; acoustics :handrails: flooring: lighting, pictorial/colour coded signage: colours to support way finding, and contrasts in bathroom areas and creating more dementia friendly gardens.

3.7 Dementia Friends

In May 2014 The Alzheimer's Society launched a new campaign called Dementia Friends. The Alzheimer's Society say: "People with dementia sometimes need a helping hand to go about their daily lives and feel included in their local community. Dementia Friends is giving people an understanding of dementia and the small things they can do that can make a difference to people living with dementia – from helping someone find the right bus to spreading the word about dementia. The Alzheimer's society wants to create a network of a million Dementia Friends across England by 2015. The Alzheimer's Society in Brighton & Hove is now setting up a rolling programme of sessions for different groups such as Pharmacists, front line staff in GP surgeries, Adult Social Care staff and many other groups. At the Health & Wellingbeing Board June 2014 the Chief Executive informed members that she had signed up to be a Dementia friend and suggested that the Health and Wellbeing Board should sign up to be Dementia Friends as well. This was agreed by the Board.

3.8 Dementia Challenge Fund

Brighton and Hove received a small funding grant for 1 year from the National Dementia Challenge Fund and this was used to fund the Trust for Developing Communities to work on supporting the voluntary and community sector. In partnership they have developed a toolkit to support voluntary and community groups in making the city a more dementia friendly, which will be launched in September 2014.

3.9 Brighton & Hove Joint Strategic Needs Assessment (JSNA

In May 2014 a Brighton & Hove Joint Strategic Needs Assessment (JSNA) http://www.bhconnected.org.uk/sites/bhconnected/files/JSNA%20dementia%202014.pdf was completed to look at current and future unmet needs, assets and gaps in relation to dementia care. In response to the recommendations of the JSNA, a Joint Strategic Delivery Plan is being drafted and consulted upon. The draft plan will be discussed at the Health and Well Being Board in September 2014 and can be shared with the HWOSC.

The Joint Strategic Delivery Plan will respond to the JSNA recommendations; it will aim to treat dementia as a 'long-term condition'. Aligning many dementia services

with physical health services, so a holistic approach is taken to the care of people with dementia. . With increasing numbers of people with dementia a key part of our approach is to improving dementia care, is to skill up the generalist workforce (i.e. staff in care home, general hospital, primary care about, providing more care and support in the community, preventing hospital admissions and making better use of our overall resources. We also aim to ensure that dementia is firmly embedded into the frailty model being developed for the City as part of Better Care.

Appendix 1

Dementia Plan 2013

Appendix 2

HWOSC Update May 13th

Appendix 2

BSUH Dementia Strategy 2014

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 15 Brighton & Hove City Council

Subject:		**Mental Health Services- Update on Model of Care**
Date of Meeting:		**10 September 2014**
Report of:		**Monitoring Officer**
Contact Officer:	**Name:**	**Kath Vlcek** **Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 HWOSC has considered a number of reports since November 2011 regarding the initially temporary closure of 19 mental health beds. The decision was made to make this a permanent closure in 2013.

1.2 The recommendation in November 2013 was for funding released from closing acute mental health beds to be ring-fenced to be re-invested; this was agreed.

1.3 This paper provides a summary of:

- Bed usage and the impact of the additional capacity secured from the Priory Hospital, Hove.
- The recommendations for further development of community mental health services.

2. RECOMMENDATIONS:

2.1 That HWOSC members consider, note and comment on the four proposals for further development of community mental health services.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 In November 2013 an update was provided to the HWOSC about the model of care for mental health in Brighton and Hove following whole system modelling work that indicated there was scope to shift the balance of mental health care to provide more care in community settings.

3.2 The recommendation in November 2013 was for funding released from closing acute mental health beds to be ring-fenced to be re-invested in:

- Additional local acute mental health bed capacity to respond flexibly to fluctuations in demand and
- Further investment in community mental health services.

3.3 The key aim in terms of quality of care for Brighton and Hove residents is to ensure that wherever possible a local bed is made available. Placing people out of area can have a detrimental impact on patient and their families / carers

experience. It is recognised that there will sometimes be periods where demand for access to beds surges and the local target is 95% of all admissions to be to a Brighton and Hove bed. Since November 2013 performance in terms of access to local beds has not substantially changed and the number of residents admitted to a bed outside the City in any week has ranged from zero to nine.

3.4 Since November 2013, a total of 45 Brighton and Hove residents have been admitted to beds outside the City in the private or independent sector. An additional 15 patients have been admitted to the Hove Priory Hospital. Demand has been predominantly for male beds and often these individuals have additional complexities around risk, dual diagnosis, forensic histories, failed accommodation and tenancies all of which impact on length of stay.

3.5 Whilst the Hove Priory has been able to provide some additional local capacity it has not had the effect of preventing all out of area admissions. This is largely due to other system pressures for mental health beds including the demand at the Hove Priory by private patients as well as demand for NHS beds from other NHS Trusts across the South East. In addition, on occasions referrals to the Hove Priory were declined on grounds of risk and acuity.

Update on Improvements to Community Mental Health Services

3.6 In February 2014, four new accommodation contracts have been put in place which provides 120 units of accommodation support, 100 of which were new units to the economy. The services operate within the Mental Health Accommodation Pathway, receiving referrals from SPFT and between each other to facilitate discharge and move on to greater independence and independent living. The providers meet regularly with each other, and SPFT to assist movement through the pathway, and to share information and skills.

Further Improvements to Community Mental Health Services

3.7 Since the last HWOSC report, a piece of scoping work has been undertaken led by front line staff (SPFT and Community & Voluntary Sector) with the objective of developing proposals to develop community mental health services with the aim of reducing the need for in-patient admissions, Reducing the length of stay for inpatient admission where clinically appropriate and reducing demand for A&E.

Four proposals have been made:

3.8 **Enhancement to the Urgent Care Service** to enable sufficient community capacity 7 days a week. An enhanced urgent care pathway “Brighton Urgent Response Service” was established in January 2013 and evaluated during its first year. The service provides a 24/7 single access phone line for urgent mental health response and receives 200 to 300 referrals a month. During the day time (8.00am to 8.00pm) the service is provided in the community. Overnight the phone line is answered by the Mental Health Liaison Team (MHLT) based at the Royal Sussex County A&E Department. Key finding from the pilot phase:

- 70% of people supported by the Mental Health Liaison Team at A&E are known to SPFT services indicating the potential to provide further support in the community.

- Attendance at A&E continues to peak in the evening indicating scope to extend the hours of the community support into the evenings.
- The skill mix of the team doesn't always enable swift prescribing of drugs at the right time which limits the ability to provide a complete urgent response.
- Insufficient capacity to support patients beyond the immediate same day response, sometimes creating gaps in care pathways until patients receive a response from the appropriate onward service.

3.9 The proposal is to develop the service further to provide:

- Extended services in the community until 10pm in the evening.
- Increase the capacity for medication review and clinical support by establishing a non-medical/independent prescriber role within the service.
- Expansion of the remit to include capacity for short term case management (up to 5 days) to support appropriate onward transfer.

3.10 **Improving Access to Psychological Therapies** for patients with psychosis under the care of SPFT's Assessment and Treatment Service. An audit indicated that only 5 (less than 1%) of the 445 patients received psychological therapy.

3.11 A recent paper provided evidence of two psychological therapies for psychosis – family therapy and Cognitive Behavioral Therapy. The main findings were:

- The NHS spent £2 billion on services for people with psychosis in 2012-13 over half of which is devoted to inpatient care. This means expenditure is skewed to the relatively expensive part of the health system (inpatient care on average costs £35 per day compared with £13 day for community services (page 6).
- There is strong clinical and cost effective ness evidence for both family therapy and cognitive behavioural therapy and the National Institute of Clinical Effectiveness (NICE) recommends that all people with psychosis should be offered one or both of these interventions.

3.12 The proposal is for an additional psychologist to provide support for an additional 25 to 30 people with psychosis per annum and also provide support in terms of building psychological expertise in the team through multi-disciplinary working with colleagues such as social workers, nurses, medics and therapists. If this approach proves successful plans will be developed to extend this.

3.13 Increased Capacity at the Lighthouse Centre for People with Personality Disorder. The Lighthouse Centre was established in May 2013 to provide 7 day a week support in the community targeting people with a diagnosis of personality disorder who have had admissions to hospital. The service has proved successful in terms of numbers of people being supported and there is evidence that since the service has been set up that there the number of inpatient admissions for people with a diagnosis of personality disorder has reduced particularly for females.

3.14 There are currently 30 people on the waiting list to join the Lighthouse Centre and the proposal is to increase the number of treatment places by 30.It is anticipated that this additional capacity will enable more people to be supported in the community and it will continue to impact in terms of avoiding unnecessary hospital admissions.

3.15 **Improved Discharge Planning for Acute In-patient Services.** Bed occupancy is affected by both the number of admissions as well as the length of stay and the original modeling work highlighted Brighton and Hove was an outlier in terms of higher than average length of stay. Improvements to the care pathway have already been made but there is still potential to making further improvements to the pathway.

3.16 In any given month 30-40% of patients discharged from acute inpatient care in Brighton and Hove are not known to mental health services which creates challenges in terms of the ability to arranged onward care and treatment in the community The proposal is for further improvements to the discharge care pathway including:

- **Development of 2 Link Nurse for the Assessment and Treatment Service**. These new community based link nurses would attend ward reviews and support the inpatient teams to agree discharge plans. They would agree the ongoing community care treatment plan including identification of the right ongoing referral pathway.

- **Increased psychological therapy to inpatient beds and CRHT**. **Additional 2.1 WTE.** Currently the CRHT does not have any dedicated psychological therapy input and the acute ward input is limited at two sessions a week. Additional investment in the CRHT will support holistic assessment and treatment planning to support recovery as well as development crisis and care plans in the community with the aim of supporting people at home.

- Additional technician resource in the hospital (0.5 WTE) will enable routine physical health checks to be undertaken and help speed up processes in inpatient services.

3.17 The proposals have had been developed and prioritized through a collaborative process involving Healthwatch and there will be ongoing Healthwatch representation in the steering group that will oversee the implementation of the proposals. In addition there are plans for MIND to organize a focus group to discuss the proposals from a user and carer perspective prior to implementation.

4 ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Please see Section 3 above.

5 COMMUNITY ENGAGEMENT & CONSULTATION

5.1 There was public consultation in 2010; further information was provided to HWOSC in previous meetings. The proposals have come about through collaborative scoping work.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 Approximately £900,000 has been released from the closure of the beds and £50,000 of this is being ring-fenced to continue to buy additional local capacity at the Hove Priory. The balance of £850,000 will be invested in the further development of community services. Please see appendix 1 for more financial information.

Legal Implications:

7.1 Section 244 of the National Health Service Act 2006 and associated regulations (The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013) permit the council to review and scrutinise any matter relating to the planning, provision and operation of the health service in its area. The council has arranged for these functions to be discharged by its Health & Wellbeing Overview & Scrutiny Committee.

In exercise of that power, the Committee is permitted to make reports and recommendations to a relevant NHS body, a relevant health service provider, or the council itself, on any matter it has reviewed or scrutinised.

Lawyer Consulted: Oliver Dixon *Date: 23/10/13*

Equalities Implications:

7.2 There are no additional equalities implications identified.

Sustainability Implications:

7.3 There are no sustainability implications.

Any Other Significant Implications:

7.4 The mental health service provision has implications for public health and for Brighton and Hove residents generally. These have been considered throughout the temporary closure process.

SUPPORTING DOCUMENTATION

Appendices:

1 Mental Health Services in Brighton and Hove, Model of Care, CCG

Mental Health Services in Brighton and Hove

Update on Model of Care

September 2014

1. Background

1.1 In November 2013 an update was provided to the HWOSC about the model of care for mental health in Brighton and Hove following whole system modelling work that indicated there was scope to shift the balance of mental health care to provide more care in community settings. Further detailed information regarding the background is contained in Appendix A.

1.2 The recommendation in November 2013 was for funding released from closing acute mental health beds to be ring-fenced to be re-invested in:

- Additional local acute mental health bed capacity to respond flexibly to fluctuations in demand and
- Further investment in community mental health services.

1.3 Subsequently an arrangement has been put in place to secure additional local bed capacity from the Priory Hospital, Hove and a collaborative piece of work involving the Brighton and Hove Clinical Commissioning Group, Sussex Partnership Foundation Trust (SPFT), Healthwatch and community and voluntary sector providers of care, has been undertaken that has resulted in proposals for further development of community mental health services.

1.4 This paper provides a summary of:

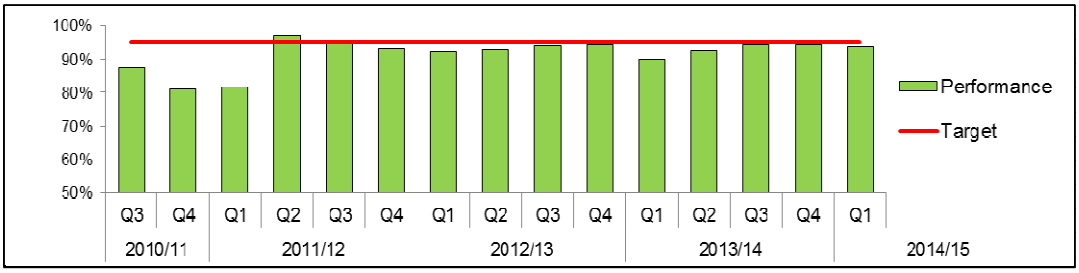
- Bed usage and the impact of the additional capacity secured from the Priory Hospital, Hove.
- The recommendations for further development of community mental health services.

2. Access to Acute Mental Health Beds

2.1 The key aim in terms of quality of care for Brighton and Hove residents is to ensure that wherever possible a local bed is made available. Placing people out of area can have a detrimental impact on patient and their families / carers experience. It is recognised that there will sometimes be periods where demand for access to beds surges and the local target is 95% of all admissions to be to a Brighton and Hove bed.

2.2 Since November 2013 performance in terms of access to local beds has not substantially changed and the number of residents admitted to a bed outside the City in any week has ranged from zero to nine. Figure 1 below shows trend in terms of access acute mental health beds in Brighton and Hove and figure 2 shows a more detailed summary for the period April to June 2014.

Figure 1 Access to Acute Mental Health Beds in Brighton and Hove.



3. **Figure 2: Location of Acute Mental Health Admission for Brighton and Hove Residents April to June 2014**

Location of Hospital	**Usage (% of Total Bed Days)**
SPFT - Brighton and Hove Hospital (Mill View and The Nevill Hospitals)	93.5%
Brighton and Hove Hospital (Hove Priory)	0.1%
SPFT – Other Hospitals in Sussex (Eastbourne, Crawley, Worthing, Hastings)	6%
Hospitals Outside Sussex	< 0.5%

3.1 Since November 2013, a total of 45 Brighton and Hove residents have been admitted to beds outside the City in the private or independent sector. An additional 15 patients have been admitted to the Hove Priory Hospital. Demand has been predominantly for male beds and often these individuals have additional complexities around risk, dual diagnosis, forensic histories, failed accommodation and tenancies all of which impact on length of stay.

3.2 Working with the Priory has been positive and there is a joint protocol with Sussex Partnership Foundation Trust covering areas such as admissions, bed management, and discharge and safeguarding. Whilst the Hove Priory has been able to provide some additional local capacity it has not had the effect of preventing all out of area admissions. This is largely due to other system

pressures for mental health beds including the demand at the Hove Priory by private patients as well as demand for NHS beds from other NHS Trusts across the South East. In addition, on occasions referrals to the Hove Priory were declined on grounds of risk and acuity.

4. Update on Improvements to Community Mental Health Services

4.1 The last report submitted to the HWOSC in November 2014 provided detail of a range of improvements that had been made including investment in care co-ordinator posts, the crisis resolution treatment team and the establishment of the Lighthouse Centre.

4.2 In February 2014, four new accommodation contracts have been put in place which provides 120 units of accommodation support, 100 of which were new units to the economy. The contracts were awarded as follows:

- Brighton Housing Trust, Shore House, provides 20 units of High Support Accommodation.
- Sanctuary Supported Living provide 30 units of Medium Support Accommodation.
- Southdown Housing Association provide 30 units of floating support.
- Brighton Housing Trust provides 40 units of tenancy support.

4.3 All units are fully operational and operating near to capacity. The services operate within the Mental Health Accommodation Pathway, receiving referrals from SPFT and between each other to facilitate discharge and move on to greater independence and independent living. The providers meet regularly with each other, and SPFT to assist movement through the pathway, and to share information and skills.

5 Further Improvements to Community Mental Health Services

5.1 Since the last HWOSC report, a collaborative piece of scoping work has been undertaken led by front line staff (SPFT and Community & Voluntary Sector) involving the Clinical Commissioning Group and Healthwatch with the objective of developing proposal to develop community mental health services with the aim of:

- Reducing the need for in-patient admission.
- Reducing the length of stay for inpatient admission where clinically appropriate.
- Reducing demand for A&E.

5.2 An initial half day workshop was held in January 2014 where core themes and priorities were identified. These have been worked into four proposals which are summarised below.

5.3 **Enhancement to the Urgent Care Service** to enable sufficient community capacity 7 days a week. An enhanced urgent care pathway "Brighton Urgent Response Service" was established in January 2013 initially on a pilot basis. The service was evaluated during its first year and this has informed its ongoing development. The service provides a 24/7 single access phone line for urgent mental health response and receives 200 to 300 referrals a month. During the day time (8.00am to 8.00pm) the service is provided in the community. Overnight the phone line is answered by the Mental Health Liaison Team (MHLT) based at the Royal Sussex County A&E Department. Key finding from the pilot phase:

- 70% of people supported by the Mental Health Liaison Team at A&E are known to SPFT services indicating the potential to provide further support in the community.
- Attendance at A&E continues to peak in the evening indicating scope to extend the hours of the community support into the evenings.
- The skill mix of the team doesn't always enable swift prescribing of drugs at the right time which limits the ability to provide a complete urgent response.
- Insufficient capacity to support patients beyond the immediate same day response, sometimes creating gaps in care pathways until patients receive a response from the appropriate onward service.

5.4 The proposal is to develop the service further to provide:

- Extended services in the community until 10pm in the evening.
- Increase the capacity for medication review and clinical support by establishing a non-medical/independent prescriber role within the service.
- Expansion of the remit to include capacity for short term case management (up to 5 days) to support appropriate onward transfer.

5.5 **Improving Access to Psychological Therapies** for patients with psychosis under the care of SPFT's Assessment and Treatment Service. An audit of psychological therapy provision for people with psychosis for the period 1 May 2013 and 31 August 2013 indicated that only 5 (less than 1%) of the 445 patients received psychological therapy.

5.6 A recent paper *Investing in Recovery* (2014)[1] provided evidence of two psychological therapies for psychosis – family therapy and Cognitive Behavioral Therapy. The main findings were:

[1] Rethink Mental Illness, The London School of Economics and Political Science and Centre for Mental Health (2014) *Investing in Recovery: Making the Business Case for effective interventions for people with schizophrenia and psychosis*

- The NHS spent £2 billion on services for people with psychosis in 2012-13 over half of which is devoted to inpatient care. This means expenditure is skewed to the relatively expensive part of the health system (inpatient care on average costs £35 per day compared with £13 day for community services (page 6).
- There is strong clinical and cost effective ness evidence for both family therapy and cognitive behavioural therapy and the National Institute of Clinical Effectiveness (NICE) recommends that all people with psychosis should be offered one or both of these interventions. In terms of clinical effectiveness family therapy can reduce the probability of hospitalization by 20% and the probability of relapse by around 45%. A summary of the range of clinical and cost effectiveness is attached at appendix B.

5.7 The proposal is for an additional psychologist to provide support for an additional 25 to 30 people with psychosis per annum and also provide support in terms of building psychological expertise in the team through multi-disciplinary working with colleagues such as social workers, nurses, medics and therapists. If this approach proves successful plans will be developed to extend this support to more people would could benefit.

5.8 **Increased Capacity at the Lighthouse Centre for People with Personality Disorder.** The Lighthouse Centre was established in May 2013 to provide 7 day a week support in the community targeting people with a diagnosis of personality disorder[2] who have had admissions to hospital. The service has proved successful in terms of numbers of people being supported and there is evidence that since the service has been set up that there the number of inpatient admissions for people with a diagnosis of personality disorder has reduced particularly for females. The average number of admissions to Caburn Ward for people with a diagnosis of personality disorder has reduced from an average of

---

[2] Personality Disorders are conditions in which an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others.

The main symptoms are:

- being overwhelmed by negative feelings such as distress, anxiety, worthlessness or anger
- avoiding other people and feeling empty and emotionally disconnected
- difficulty managing negative feelings without self-harming (for example, abusing drugs and alcohol, or taking overdoses) or, in rare cases, threatening other people
- odd behaviour
- difficulty maintaining stable and close relationships, especially with partners, children and professional carers
- sometimes, periods of losing contact with reality

Symptoms typically get worse with stress. People with personality disorders often have other mental health problems, especially depression and substance misuse.

Source: NHS Choices - http://www.nhs.uk/Conditions/personality-disorder/Pages/Definition.aspx

11.4 per month (January to May 2013) to an average of 5.6 per month (June to December 2013).

5.9 There are currently 30 people on the waiting list to join the Lighthouse Centre and the proposal is to increase the number of treatment places by 30.It is anticipated that this additional capacity will enable more people to be supported in the community and it will continue to impact in terms of avoiding unnecessary hospital admissions.

5.10 **Improved Discharge Planning for Acute In-patient Services.** Bed occupancy is affected by both the number of admissions as well as the length of stay and the original modeling work highlighted Brighton and Hove was an outlier in terms of higher than average length of stay. Improvements to the care pathway have already been made in terms of increased supported accommodation capacity and increased Crisis Resolution Home Treatment Team (CRHT) capacity but there is still potential to reduce median length of stay by making further improvements to the pathway.

5.11 In any given month 30-40% of patients discharged from acute inpatient care in Brighton and Hove are not known to mental health services which creates challenges in terms of the ability to arranged onward care and treatment in the community The proposal is for further improvements to the discharge care pathway including:

- **Development of 2 Link Nurse for the Assessment and Treatment Service**. These new community based link nurses would attend ward reviews and support the inpatient teams to agree discharge plans. They would agree the ongoing community care treatment plan including identification of the right ongoing referral pathway. It is anticipated that the Link Nurses will help ensure quicker discharge from hospital by ensuring the right treatment plan is put in place as quickly as possible. This is particularly important given the relatively high proportion of people discharged from hospital who are not known to mental health services.

- **Increased psychological therapy to inpatient beds and CRHT**. **Additional 2.1 WTE.** Currently the CRHT does not have any dedicated psychological therapy input and the acute ward input is limited at two sessions a week. Additional investment in the CRHT will support holistic assessment and treatment planning to support recovery as well as development crisis and care plans in the community with the aim of supporting people at home. Additional psychological input to inpatient care will help improve the quality of care through the development of appropriate treatment plans and it anticipated that this will impact in terms of reducing length of stay.

- Additional technician resource in the hospital (0.5 WTE) will enable routine physical health checks to be undertaken and help speed up processes in inpatient services.

5.12 The proposals have had been developed and prioritized through a collaborative process involving Healthwatch and there will be ongoing Healthwatch representation in the steering group that will oversee the implementation of the proposals. In addition there are plans for MIND to organize a focus group to discuss the proposals from a user and carer perspective prior to implementation.

6 Financial Summary

6.1 Approximately £900,000 has been released from the closure of the beds and £50,000 of this is being ring-fenced to continue to buy additional local capacity at the Hove Priory. The balance of £850,000 will be invested in the further development of community services. A breakdown of the financial summary is detailed in Table 3 below.

Table 3: Financial Summary

	Proposal	**Annual Investment Value (£)**
1	Additional Local Inpatient Capacity – Hove Priory	£50,000
2	Further enhancement of the urgent care pathway	£283,000
3	Additional Psychological Therapy Capacity for people with psychosis	£64,000
4	Additional Capacity at the Lighthouse Centre – people with Personality Disorder	£283,000
5	Improved Discharge Planning for Acute Inpatient Services	£220,000
	TOTAL	**£900,000**

7. Summary

7.1 Within a community focused model of care, when an acute mental health bed is needed then it is essential that one is made available. It is also desirable that wherever possible this bed should be available locally. The experience is that for over 9 out of 10 Brighton and Hove residents requiring an acute inpatient admission a local bed has been found. However due to the fluctuation in demand there are times when this isn't possible. The additional local bed capacity secured from the Priory Hospital Hove has been helpful at times when there are surges in demand but hasn't completely prevented the need for all out of area admissions.

7.2 The expectation is that further investment outlined in Sections 4 will provide increased opportunity to support more people in community settings.

8. Future Plans

8.1 Moving forward Brighton and Hove City Council and Brighton and Hove Clinical Group have developed plans as part of the Better Care Programme to integrate care across the City.

8.2 Programmes of work focused on Frailty and Homeless have been established and mental health is integral to both of these programmes. The development of multi-disciplinary care team based around GP practices will provide the opportunity to ensure people with mental illness can receive more support in the community and have better co-ordinated holistic care that addresses both their physical and mental health needs. Further update on the progress of the Better Care Programme will be provided to the HWOSC at regular intervals.

Appendix A
Background Information – HWOSC Update – November 2013


HWOSC Paper
November 2013 FINA

Appendix B Summary of Clinical and Cost Effectiveness of Psychological Therapy for People with Psychosis

1. Clinical effectiveness

1.1. Family therapy can:

- Reduce the probability of hospitalisation by 20%, and the probability of relapse by around 45%.
- Increase compliance with medication.
- Contribute to improved social functioning (e.g. increased independence).
- Reduce burden on families / carers.

1.2 Cognitive Behavioural Therapy can:

- Reduce hospitalisation rates and length of stay compared with care as usual
- Reduce severity of psychiatric symptoms, including depression.
- Improve social functioning.

2. Cost effectiveness

2.1 Family therapy

- Estimated mean economic savings to the NHS from family therapy is £4,202 savings per individual with schizophrenia over a three-year period.
- There is a 97% chance that family therapy will be cost-saving; i.e. the costs of providing family therapy will be more than outweighed by savings made in the health system. The above may underestimate savings as it focuses only on reduction in hospitalisation rates.
- Other areas for savings from family therapy may include: decreased service use from family members, increased employment rates among family members, increase in ability to live independently, shorter hospital stays.
- The economic analysis does not quantify improvements in mental health or wellbeing for the individual with schizophrenia or family members, so if this was taken into account the cost-effectiveness of family therapy would be greater.

2.2 Cognitive Behavioural Therapy

- Cost savings were found to relate to reduction in hospitalisation rates, with an overall net savings to health and social care of £989 per person with schizophrenia.
- Impact on health-related quality of life found an incremental cost per QALY OF £23,273 for CBT for psychosis compared to usual care, which is considered cost-effective.

Source: Rethink Mental Illness, The London School of Economics and Political Science and Centre for Mental Health (2014) *Investing in Recovery: Making the Business Case for effective interventions for people with schizophrenia and psychosis*