Brighton & Hove City Council

Shadow Health & Wellbeing Board

Title:	**Shadow Health & Wellbeing Board**
Date:	**12 September 2012**
Time:	**5.00pm**
Venue	**Council Chamber, Hove Town Hall**
	Board Members
Councillors:	Jarrett (Chair), Bennett, Duncan, Meadows, K Norman, Shanks (Deputy Chair) and Turton
BHCC: CCG Youth Council HealthWatch	Terry Parkin, Statutory Director of Children's Services Denise D'Souza, Statutory Director of Adult Social Care Dr. Tom Scanlon, Statutory Director of Public Health Dr. Xavier Nalletamby, Clinical Lead Geraldine Hoban, Non-clinical member Hayyan Asif Robert Brown
Contact:	**Caroline De Marco** Democratic Services Officer 01273 291063 caroline.demarco@brighton-hove.gov.uk

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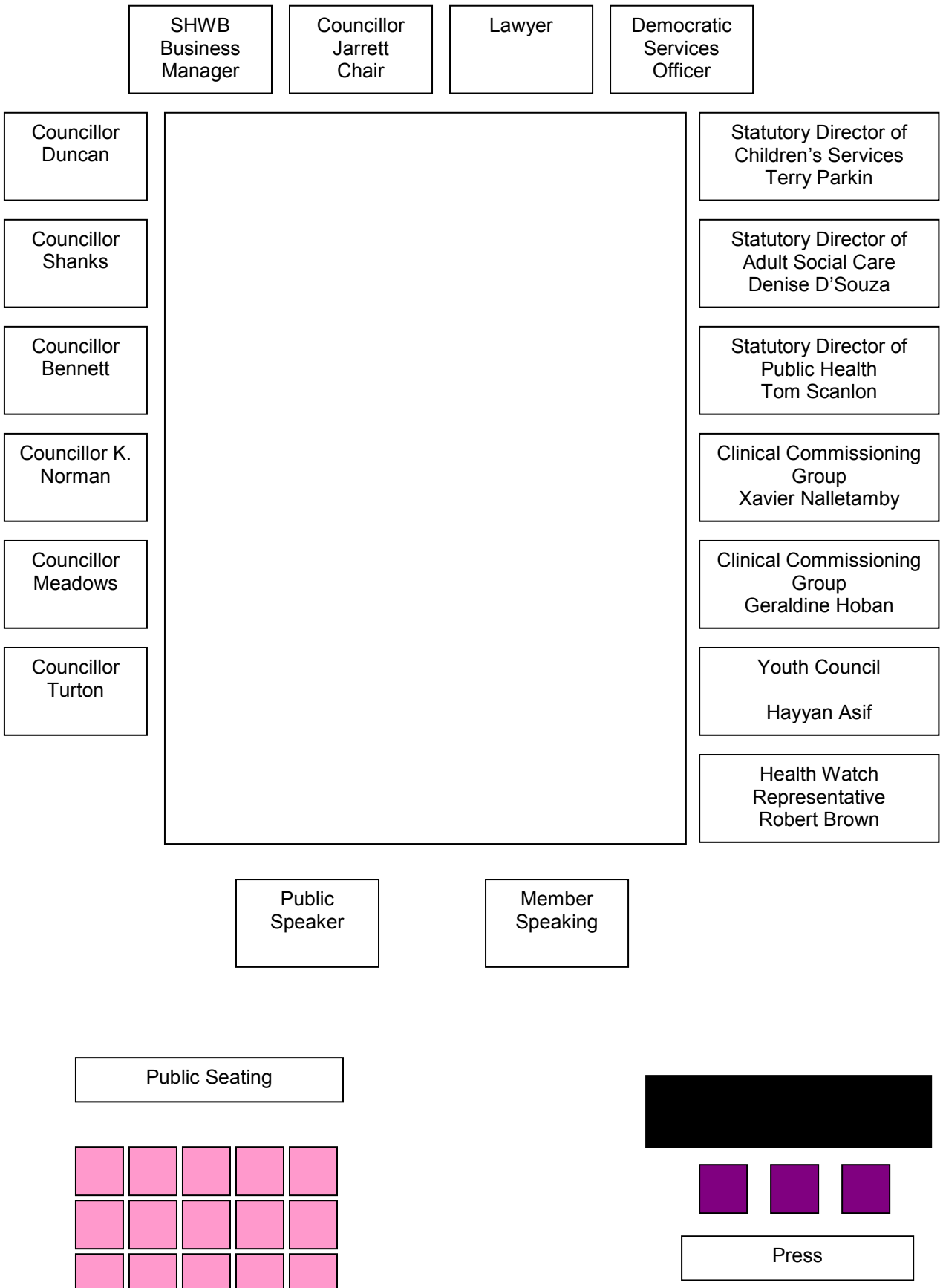
Democratic Services: Shadow Health & Wellbeing Board



AGENDA

PART ONE **Page**

10. PROCEDURAL BUSINESS

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

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

(c) 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 Two of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.*

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

11. MINUTES 1 - 8

Minutes of the meeting held on 30 May 2012 (copy attached).

12. CHAIR'S COMMUNICATIONS

13. PUBLIC INVOLVEMENT

To consider the following matters raised by members of the pubic:

(a) **Petitions** – to receive any petitions presented to the full council or at the meeting itself;
(b) **Written Questions** – to receive any questions submitted by the due date of 12 noon on the 5 September 2012;
(c) **Deputations** – to receive any deputations submitted by the due date of 12 noon on the 5 September 2012.

14. ISSUES RAISED BY COUNCILLORS AND MEMBERS OF THE BOARD

To consider the following matters raised by councillors:

(a) **Petitions** – to receive any petitions submitted to the full Council or at the meeting itself;

(b) Written Questions – to consider any written questions;
(c) Letters – to consider any letters;
(d) Notices of Motion – to consider any notices of motion.

15. CHILD POVERTY UPDATE

Presentation by Sarah Columbo, Child Strategy Manager/Families in Multiple Disadvantage.

16. JOINT STRATEGIC NEEDS ASSESSMENT SUMMARY 2012 **9 - 20**

Report of Director of Public Health (copy attached).

Contact Officer: *Kate Gilchrist, Alistair Hill* *Tel: 01273 339133,*
Ward Affected: *All Wards*

17. JOINT HEALTH & WELLBEING STRATEGY (JHWS) **21 - 72**

Report of Strategic Director, People (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 291038*
Ward Affected: *All Wards*

18. DEPARTMENT OF HEALTH CONSULTATION ON JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) AND JOINT HEALTH & WELLBEING STRATEGY (JHWS) **73 - 96**

Report of Strategic Director, People (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 291038*
Ward Affected: *All Wards*

19. CCG VISIONS/VALUES & STRATEGIC COMMISSIONING PRIORITIES

Presentation by Xavier Nalletamby.

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 and deputations to committees and details of how questions and deputations can be raised can be found on the website and/or on agendas for the meetings.

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POLICY & RESOURCES COMMITTEE

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

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Date of Publication - Tuesday, 4 September 2012

SHADOW HEALTH & WELLBEING BOARD	Agenda Item 11 Brighton & Hove City Council

BRIGHTON & HOVE CITY COUNCIL

SHADOW HEALTH & WELLBEING BOARD

5.00pm 30 MAY 2012

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Jarrett (Chair), Councillors Bennett, Meadows, K Norman and Shanks (Deputy Chair), Terry Parkin, Statutory Director of Children's Services, Denise D'Souza, Statutory Director of Adult Social Services, Dr Tom Scanlon, Statutory Director of Public Health, Dr Xavier Nalletamby, Clinical Commissioning Group (clinical lead), Geraldine Hoban, Clinical Commissioning Group, Non-Clinical member, Hayyan Asif, Youth Council and Robert Brown, HealthWatch

PART ONE

1. PROCEDURAL BUSINESS

1A Declarations of Substitute Members

1.1 There were none.

1B Declarations of Interests

1.2 There were none.

1C Exclusion of the Press and Public

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

1.4 **RESOLVED** - That the press and public be not excluded from the meeting.

2. CHAIR'S COMMUNICATIONS

Status of the Shadow Health and Wellbeing Board

2.1 The Chair informed members that the Shadow Board would become a statutory Health and Wellbeing Board in April 2013. In order to ensure that the Board was operating

effectively, it would be run in a shadow form during 2012/13. The membership of the Board was unusual in that it included councillors and officers. Legislation states that there should be a minimum of one councillor, three statutory directors (Adult Social Services, Children's Services and Public Health), a representative of each local Clinical Commissioning Group and a Health Watch representative. In addition there was some flexibility given to each council to decide on the precise composition of the Board. The Shadow Board had therefore appointed a member of the Youth Council.

2.2 The Chair welcomed everyone to the meeting and also welcomed the Chair of the Local Safeguarding Children Board and staff from the Community and Voluntary Sector Forum who were in attendance to observe the meeting.

3. PUBLIC INVOLVEMENT

3.1 There were no petitions, written questions or deputations from members of the public.

4. ISSUES RAISED BY COUNCILLORS AND MEMBERS OF THE BOARD

4.1 There were no petitions, written questions, letters or notices of motion from councillors or other members of the Board.

5. ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH

5.1 The Board considered a report of the Director of Public Health which informed members that Directors of Public Health are required to publish an independent annual report focusing on the health of the local area. Members were asked to consider and comment on the Annual Report for 2011, which was presented in magazine style. The Annual Report for Brighton & Hove would be published in the summer 2012.

5.2 Dr Tom Scanlon gave a presentation setting out the main themes of this year's report. A copy of the report had been circulated to members before the meeting.

5.3 Councillor Norman noted the different approach with this year's report. He thought it was a good report and dealt with a great many issues. He asked how widely the report would be distributed. Dr Scanlon replied that he had ordered an extra 100 copies of the report in order to send a copy to every GP practice manager in the city.

5.4 Robert Brown asked how the Annual report related to the work of the Clinical Commissioning Group and the City Council. Dr Scanlon explained that the JSNA and strategy were more methodical. The report had been presented to the CCG and it would make a substantial difference. Geraldine Hoban (CCG) explained that it was useful to highlight primary care. This was key work for the CCG who would address primary care across the city.

5.5 Dr Xavier Nalletamby considered the presentation of the report to be a good and different approach.

5.6 **RESOLVED** – (1) That the changes detailed in the report be noted.

6. JOINT STRATEGIC NEEDS ASSESSMENT SUMMARY

6.1 The Board considered a report of the Head of Public Health Intelligence, the Consultant in Public Health and the Head of Performance & Analysis which explained that from April 2013, local authorities and clinical commissioning groups would have equal and explicit obligations to prepare a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy. The duty would be discharged by the Health and Wellbeing Board.

6.2 Members were informed how the JSNA process provided a greater understanding of the current and future health and wellbeing needs of local residents to inform the Health and Wellbeing Strategy, and strategies of the Clinical Commissioning Group & Brighton & Hove City Council. It also presented the highest impact health and wellbeing issues for the city identified in the 2012 JSNA summary.

6.3 Members received a presentation from the Head of Analysis and Performance, and the Consultant in Public Health.

6.4 Robert Brown asked how the LINk and patients participation groups would be involved in the development of future JSNAs, and how they could feed into the consultation. He also asked how local neighbourhoods would feed back into the system.

6.5 The Consultant in Public Health explained that the LINk were members of the City Needs Assessment Group which had an overarching operational role. The Group would report to the three statutory directors up until April 2013. After that date the accountability of the group would transfer to the Health and Wellbeing Board. There would be a specific question in the consultation to ask how different partners and stakeholders such as neighbourhoods wanted to be involved in the ongoing development of the JSNA.

6.6 Geraldine Hoban explained that Patient Participation Groups (PPGs) would have a critical role to play in setting an agenda for the JSNA and commenting on the outcomes. There had already been some engagement with the PPGs.

6.7 Councillor Shanks asked about the cost impact which was an important determinant. The Consultant in Public Health explained that the summary did include financial data, but it was recognised that this aspect should be further developed in the future.

6.8 Dr Tom Scanlon was pleased to see a broad JSNA with a local basis for commissioning across the city. He asked if there had been any thought as to how the consultation would be carried out.

6.9 The Consultant in Public Health explained that officers would be using the consultation portal. This would link to a wide mailing group. There had been discussions on how to reach a wider group and videos and You Tube could be used to reach community groups. There would be paper based and internet based consultation.

6.10 Terry Parkin stated that he expected that there would be consensus on the first two recommendations. The third recommendation was worthy of more consideration. It

stated that the focus would be on high impact issues. This could have a big impact on the health of the city and colleagues required the authority to have that focus.

6.11 The Consultant in Public Health explained that it was proposed that the Shadow Health & Wellbeing Board would focus on high impact areas, however all issues needed to be tackled. The Head of Analysis and Performance stated that the JSNA summary had been the product of a broad process of engaging people. It was a live process and there would be constant opportunities to engage.

6.12 **RESOLVED** – (1) That the draft JSNA Summary be supported and go out to Public Consultation (the final version to be brought to the Board for consideration in September 2012).

(2) That it is noted that from April 2013, the Board will become responsible for the JSNA.

(3) That high impact health and wellbeing issues identified within the JSNA be noted and used to inform the development of the Joint Health & Wellbeing Strategy.

7. PROPOSAL FOR THE DEVELOPMENT OF THE JOINT HEALTH & WELLBEING STRATEGY

7.1 The Board considered a report of the Director of Public Health and a presentation from the Lead Commissioner, Children, Youth & Families and the Consultant in Public Health. The report and presentation set out the recommendations for the Board and explained the aims and underpinning principles of the Joint Health and Wellbeing Strategy (JSNW) and how it was proposed to develop and structure the strategy locally and the process for identifying the local priority outcome areas. Members were informed of the consultation process and the recommended prioritisation of the high impact social issues for the JHWS.

7.2 The recommended high impact social issues for the JHWS were: Healthy weight and good nutrition, Emotional health & wellbeing, including mental health, Smoking, Cancer & access to cancer screening, Flu immunisation and dementia. The issues not recommended to be included were alcohol, domestic and sexual violence, disability, HIV & AIDS, Diabetes, and Coronary Heart Disease.

7.3 The Chair supported the inclusion of smoking in the prioritisation and recognised that a great deal of work was already being carried out in relation to disability. He shared the desire to keep focused and not have too many targets.

7.4 Terry Parkin considered the report to be an excellent paper. However, he wondered why diabetes was not included as a priority. There were an increasing number of children with diabetes. Having a focus on diabetes might have a profound impact on outcomes.

7.5 The Consultant in Public Health considered diabetes to be a commissioning issue for the CCG. Geraldine Hoban (CCG) explained that the CCG wanted to ensure that the pathways for children with diabetes were working. Dr Xavier Nalletamby explained that there was a huge amount of work already going on in this area. Diabetes was a failure

of healthcare. In addition, the priority for healthy weight and good nutrition relates directly to Type 2 diabetes.

7.6 Councillor Shanks referred to cancer screening and mentioned that there had been a debate about whether breast cancer screening was effective. She wanted to be assured that breast screening was clinically effective and a good use of money. The Consultant in Public Health explained that there is an ongoing national review of the breast screening programme. Locally the cervical cancer screening programme coverage is improving but is still below the national target. As part of the national programme there is a local bowel cancer screening programme. The Chair asked for clarification at a future meeting on the position relating to breast cancer screening.

7.7 Geraldine Hoban stated that the CCG welcomed the inclusion of emotional health and wellbeing including mental health, healthy weight and nutrition and cancer and access to screening. She noted that substance misuse and suicide were not included. The Consultant in Public Health explained that these areas had not been identified as stand alone high impact issues from the JSNA.

7.8 Dr Tom Scanlon considered that the six priority areas would entail a great deal of work. He suggested that flu immunisation should be dropped from the list of priorities. He considered that it was too narrow an area for the Board to provide any additional benefit to the work already being carried out.

7.9 Robert Brown mentioned that Albion in the Community was involved in work to provide information about bowel and other cancers. He asked if these people were qualified NHS staff. He asked how people who received information could feed back on the effectiveness of the campaign. The Consultant in Public Health explained that there was a national campaign, as well as a local campaign, aimed at raising awareness about the early signs and symptoms of certain cancers. The CCG had commissioned the Albion to carry out work to provide information and advice to people in Brighton & Hove. The people involved in this work were properly trained.

7.10 Denise D'Souza was pleased to see dementia included in the list of priorities. She noted the wider determinants such as employment and unemployment which would link in with emotional health & wellbeing, including mental health.

7.11 Councillor Norman supported Dr Tom Scanlon regarding his view that flu immunisation should be dropped from the list of priorities. He considered that focusing on healthy weight and good nutrition would have a greater impact.

7.12 Hayyan Asif considered emotional health and wellbeing and mental health to be most important. Domestic and sexual violence and suicide were all linked to emotional health and wellbeing.

7.13 Alan Bedford, Chair of the Local Safeguarding Children Board expressed the view that with a focus on five areas, there was a risk of having a negative impact elsewhere. He asked when there would be a process by which matters not included on the list of priorities were tackled. The Chair replied that if a subject was excluded from the initial focus, it needed to be made clear that work was being carried out and that the matter should be reviewed and reports prepared on these items.

7.14 Denise D'Souza reported that there was an in depth commissioning plan for recommended and non recommended priorities.

7.15 Terry Parkin stated that child poverty work was underway. A report on this matter could be brought to a future meeting.

7.16 **RESOLVED** – (1) That the outline structure of the Joint Health and Wellbeing Strategy be agreed.

(2) That the top priorities for inclusion in the Joint Health & Wellbeing Strategy and which will be led by the Shadow Health & Wellbeing Board are: Healthy weight and good nutrition; Emotional health & wellbeing – including mental health; Smoking; Cancer & access to cancer screening; and Dementia.

(3) That the following areas (led from elsewhere) be recommended to officers, where further Shadow Health & Wellbeing Board monitoring input might add value – Child Poverty; Education; Employment & Unemployment and housing.

(4) That a further report should be brought to the Shadow Health & Wellbeing Board in September 2012 setting out detailed plans for improving outcomes in each of the draft priority areas.

8. SHADOW HEALTH & WELLBEING BOARD IN-YEAR REVIEW/PEER REVIEW

8.1 The Board considered a report of the Strategic Director, People which explained that as part of the process of learning during the shadow year of Health & Wellbeing Board development, officers supporting the Board intended to commission an in-year review of the effectiveness of Shadow Health & Wellbeing arrangements. The report addressed issues relating to the timing of the review and the type of review to be undertaken.

8.2 The HWB Business Manager reported that a summer review was recommended as it would feed into the work of the Board before the JHWS was agreed in September 2012. With regard to the type of review, it was recommended that the peer review be facilitated by OPM (Office for Public Management). OPM had identified Wandsworth as a peer-review partner for Brighton & Hove.

8.3 Robert Brown considered that it would be difficult to review the Board after one meeting. He asked how feedback from the patients participation groups and voluntary sector would be presented to the review. The HWB Business Manager explained that there had been work on planning for the Board for the past 18 months. The views of public stakeholders would be taken into account over the shadow year rather than through the peer review. In the first instance, views could be expressed through the HWB Business Manager and later to the Chair of the Board.

8.4 Councillor Meadows stated that although she understood the reason why it was recommended that the review be carried out early, she was not clear if this was a cost effective way of proceeding. The HWB Business Manager explained that the peer-review was relatively low cost. Costs were met through the Statutory Directors budgets. As the Health and Wellbeing Board was a new body, he was not confident that an internal review was appropriate.

8.5 The Chair stated that he would not be comfortable with having an internal review.

8.6 **RESOLVED** – (1) That the preferred option outlined in the report for an in-year review of the effectiveness of the shadow HWB (summarised at point 3.11 of the report) be agreed.

9. THE USE OF SUBSTITUTES AT MEETINGS OF THE SHADOW HEALTH & WELLBEING BOARD

9.1 The Board considered a report of the Strategic Director, Resources which set out a proposed protocol in relation to substitutes for Health and Wellbeing Board members, taking into account the varied membership of the HWB and their roles.

9.2 The Health & Wellbeing Board Business Manager explained that the proposed protocol was set out in paragraph 3.6 of the report. The protocol allowed for substitutes for everyone on the Board except the Statutory Directors. They would be able to send a representative from their service area to advise the Board, but the representative would not be a full member or be entitled to vote.

9.3 Councillor Meadows stated that she was happy for the Statutory Directors to send a representative to advise the Board as long as they did not vote. She stressed that it was important to have the expertise of the Directors or their representatives at the Board meetings.

9.4 Terry Parkin stated that the Statutory Directors were in agreement with the protocol.

9.5 Geraldine Hoban, CCG (Non-Clinical Member) requested that the protocol should state that the substitutes should include one clinical and one non-clinical member of the CCG in order to maintain balance.

9.6 **RESOLVED** – (1) That the protocol for the use of substitute members be agreed as set out in paragraph 3.6 in the report, with the following amendment. The substitutes should maintain one clinical lead substitute and one non-clinical substitute of the CCG.

The meeting concluded at 7.15pm

Signed Chair

Dated this day of

Shadow Health and Wellbeing Board	Agenda Item 16 Brighton & Hove City Council

Subject:		**Joint Strategic Needs Assessment Summary 2012**		
Date of Meeting:		**12th September 2012**		
Report of:		**Kate Gilchrist, Head of Public Health Intelligence Alistair Hill, Consultant in Public Health**		
Contact Officer:	**Name:**	**Kate Gilchrist**	**Tel:**	**29-0457**
	Email:	**Kate.gilchrist@bhcpct.nhs.uk**		
Ward(s) affected:		**All**		

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 From April 2013, local authorities and clinical commissioning groups will have equal and explicit obligations to prepare a Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy. This duty will be discharged by the Health and Wellbeing Board. The purpose of this item is to update the shadow Health & Wellbeing Board on the progress of the 2012 JSNA Summary and to ask the Board to support its publication. It also presents the results from the consultation on the Summary in July 2012.

2. RECOMMENDATIONS:

2.1 That the Board supports the publication of the JSNA Summary 2012.

2.2 That the Board notes the feedback from the 2012 JSNA consultation.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The needs assessment process aims to provide a comprehensive analysis of current & future needs of local people to inform commissioning of services that will improve outcomes & reduce inequalities. To do this needs assessments should gather together local data, evidence from service users & professionals, plus a review of research & best practice. Needs assessments bring these elements together to look at unmet needs, inequalities, & provision of services. They also point those who commission or provide services towards how they can improve outcomes for local people.

3.2 The Local Government & Public Involvement in Health Act (2007) placed a duty on local authorities & Primary Care Trusts to work in partnership & produce a JSNA. The Health & Social Care Act 2012 states that the responsibility to prepare the JSNA will be exercised by the Health and Wellbeing Board from April 2013. The guidance signals an enhanced role for JSNAs to support effective commissioning for health, care & public health as well as influencing the wider determinants that influence health & wellbeing, such as housing & education. Interim Department of Health guidance published in December 2011 advised that emerging Health and Wellbeing Boards should proceed with progressing the refreshing of JSNAs and development of a Joint Health and Wellbeing Strategy.

3.3 There are three elements to the local needs assessment resources available:

Each year, **a JSNA summary**, giving an high level overview of Brighton & Hove's population, & its health & wellbeing needs is published. It is intended to inform the development of strategic planning & identification of local priorities.

A **rolling programme of comprehensive needs assessments**. Themes may relate to specific issues e.g. adults with Autistic Spectrum Conditions, or population groups e.g. children & young people. Needs assessments are publically available & include recommendations to inform commissioning.

BHLIS (www.bhlis.org) is the Strategic Partnership data & information resource for those living & working in Brighton & Hove. It provides local data on the population of the city which underpins needs assessments across the city.

3.4 Since August 2009, a **city needs assessment steering group** has overseen the programme of needs assessments. In 2011 membership includes the Community & Voluntary Sector Forum (CVSF), Sussex Police & the two universities, in addition to the existing members from the city council, Clinical Commissioning Group & LINks. With the establishment of the Health & Wellbeing Board, the steering group will become a subgroup of the Board in relation to JSNA from April 2013.

3.5 The 2011 summary was a 56 page document. For the 2012 refresh we have produced a series of summaries grouped under key outcomes. Building on previous years most of the sections have been co-authored by a member of the Public Health team & a relevant lead in Adult Social Care, Children's Services, the Community & Voluntary Sector, or other statutory partners.

3.6 The structure was informed by the NHS, Public Health and Social Care outcomes frameworks & the forthcoming Child Health Outcomes Strategy; The Marmot report, which advocated adopting a "life course approach"; & the consultation described in section 4.

3.7 In previous summaries we have simply listed the health & wellbeing issues for the city. This year we have attempted to measure the relative impact of the issues identified within this summary in a systematic way & present this as an impact matrix. These are being used in the development of the Joint Health and Wellbeing Strategy.

3.8 Since the last Shadow Board a public consultation of the summary has taken place with the results and recommendations are given in section 4.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 The CVSF conducted a gap analysis of the JSNA summary in January 2012 and changes were made to the proposed structure as a result.

4.2 An involvement event to inform the JSNA and JHWS development was held on the 1st March, which was attended by over 70 representatives from BHCC, the transitional CCG, NHS Sussex, health providers and the community and voluntary sector (CVS).

4.3 Two sessions were held in order to complete the impact matrix. Those invited included members of the City Needs Assessment Steering Group; further representatives from Public Health, Children's Services & Adult Social Care; & Community & Voluntary Sector Health & Wellbeing elected representatives.

4.4 The draft JSNA Summary, supported by the Board, went out for public consultation in July 2012 focussing on how the JSNA can be further developed. This included sending out details to the Shadow Health and Wellbeing Board, the Local Strategic Partnership, thematic partnerships, local providers, senior leadership and commissioners in the CCG and City Council, and local CVS organisations. Hard copies of the summary, & consultation questions were also available in the city's libraries.

4.5 The consultation also included three workshops with CVS organisations on the JSNA and Joint Health & Wellbeing Strategy. These were attended by around 50 individuals. In addition there were 15 online responses to the consultation.

4.6 Feedback on the JSNA was positive: 84% strongly agreed or agreed that the JSNA Summary describes the health and wellbeing issues of the city; 84% strongly agreed or agreed with the highest impact health and wellbeing issues for the city and; 69% strongly agreed or agreed that the content of the JSNA was presented in a clearly understandable way (the remaining 31% neither agreeing nor disagreeing).

4.7 Some revisions to the 2012 JSNA summary have been made in response to the feedback received including:

- Additions to the carers section
- Cross referencing disability section in Population groups and Improving health and promoting independence sections

4.8 Some consultation responses asked for the full impact grid to be made available and this will be published in September 2012 alongside the JSNA Summary. Other comments received will inform the future development of the JSNA for example:

- Accessibility for young people and other groups
- Involving communities further

4.9 At the workshops the main discussion was around how CVS organisations can contribute evidence to future JSNA. It was agreed that the Head of Public Health Intelligence would work with CVSF to develop this. This work will be taken forward under the work programme of the City Needs Assessment Steering Group. In addition it was agreed that further feedback on the JSNA would be

sought from community and voluntary sector partners after the publication of the 2012 summary.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The JSNA will inform the development of the council and health budget strategies.

Finance Officer Consulted: Anne Silley Date: 08/08/12

Legal Implications:

5.2 The statutory duty imposed upon Local Authorities and PCT's to work together to produce a JSNA is described in the body of this report. It will be a core function of the Health and Wellbeing Board to approve the JSNA process from April 2013 and is therefore important that the Shadow Board are fully involved in the process.

Lawyer Consulted: Elizabeth Culbert Date:13/08/12

Equalities Implications:

5.3 The City Needs Assessment Steering Group, including equalities leads for BHCC & NHS Brighton & Hove, has strengthened the city needs assessment guidance to include equalities strands. Strategies using the evidence in the needs assessment will require an EIA. This year's summary has more systematically identified local inequalities in terms of equalities groups; geography & socio-economic status. Each report section has inequalities clearly evidenced. In addition, there are sections which bring together the key needs of each group.

Sustainability Implications:

5.4 Sustainability related issues are important determinants of health & wellbeing and these have been integrated in the summary. The JSNA will support commissioners to consider sustainability issues.

Crime & Disorder Implications:

5.5 None

Risk and Opportunity Management Implications:

5.6 None

Public Health Implications:

5.7 The JSNA summary sets out the key health and wellbeing and inequalities issues for the city and so supports commissioners across the city in considering these issues in policy, commissioning & delivering services.

Corporate / Citywide Implications:

5.8 This supports the city's duty, through The Local Government and Public Involvement in Health Act (2007), for the city council and PCT to work in partnership and produce a JSNA.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Not applicable

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 It is a statutory duty imposed upon Local Authorities and PCT's to produce JSNA. It will be a core function of the Health and Wellbeing Board to approve the JSNA process from April 2013 and is therefore important that the Shadow Board are fully involved in the process.

SUPPORTING DOCUMENTATION

Appendices:

1. Brighton and Hove Community and Voluntary Sector workshops summary (JSNA & JHWS consultation).pdf

Documents in Members' Rooms

1. None

Background Documents

1. Department of Health JSNAs and joint health and wellbeing strategies – draft guidance consultation http://www.dh.gov.uk/health/2012/07/consultation-jsna/

2. Current portfolio of needs assessments for the city available publically at www.bhlis.org/needsassessments

3. The 2012 JSNA Summary drafts are available at www.bhlis.org//jsna2012

CVSF and LINk Health and Wellbeing event: Well-thy City: Make it Happen! 17th July 2012

Joint Strategic Needs Assessment & Joint Health & Wellbeing Strategy Workshops

Run by:

- Kate Gilchrist, Head of Public Health Intelligence NHS Brighton & Hove / Brighton & Hove City Council
- Giles Rossington, Health & Wellbeing Board Business Manager, Brighton & Hove City Council

In each workshop Kate & Giles set out the progress to date regarding two of the main duties of the city's new Health & Wellbeing Board (HWB): the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy. Both are currently out to consultation & participants were encouraged to respond to the consultation in addition to feeding back at the workshop.

Workshop 1

There were a number of questions & discussion around the **Health & Wellbeing Board** make up and remit. These included:

- Why there was no CVSF representation on the Board? The Health & Social Care Act (2012) sets out a mandatory core membership for HWBs (this can be found on the slides for the session) but other than this the membership is down to local decision making. Giles said that whilst not universal, most areas did not have provider organisations on the Board and the decision had been reached in Brighton & Hove that the Board would be a commissioning only board & hence could not have CVS representation due to the potential for conflict of interest as the HWB will make decisions which will influence commissioning plans.
- Given that the Youth Council represents the views of those aged 11 or over & HealthWatch adults, who represents views of children younger than 11? Giles said he would take this point back to the City Health & Wellbeing Group.
- How is the prioritisation process (& the Board's decision making) of the priorities for the first Strategy documented? This needs to be made clearer & be available to all and will be set out in the strategy. The minutes from the Health & Wellbeing Board meeting where the priorities were decided are available on the City Council Website (at http://present.brighton-hove.gov.uk/ieListDocuments.aspx?MId=4173)
- With so many partnership boards in the city, how will it be ensured that partnerships are not working in silos & duplicating effort? Could the mapping of the links between the Health & Wellbeing Board be included in the Strategy? In many parts of the country Health & Wellbeing Boards are either replacing poorly functioning partnerships or creating new bodies where none previously existed. In contrast, Brighton & Hove has a long established history of effective partnership working, and there is neither the desire nor the necessity for the Health and Wellbeing Board to replace existing partnerships. In the shadow year, the HWB will explore how best to interact with other city partnerships, ensuring that there is minimal duplication and that any potential gaps are identified. Mapping of this will be looked at for the strategy, or within the shadow year if not possible within the timescale of the strategy development.

Joint Strategic Needs Assessment (JSNA): There was a focussed discussion around how evidence from CVS organisations could be better gathered to input into the JSNA in future. Kate set out that this was not just about gathering numbers of people accessing services: in any good needs assessments there are three main types of evidence which should be included & CVS organisations held/were brokers to all three: Data (both quantitative & qualitative information); Voice (of the public, services users & themselves as professionals); & the Evidence base & best practice.
This was seen as a positive challenge by one participant who said within their organisation they had looked at how they could better track individuals to produce more robust information.
The things that participants said would help them to be able to contribute to the JSNA evidence were:

- A structured, consistent approach at the same time each year. Kate said she would be very interested in developing this and asked for involvement from individuals within CVS organisations in drawing up this structure so that what was being asked for made sense to CVS organisations.
- Organisations collecting a core set of information in the same way. Time, capacity & cost for organisations in doing this were highlighted as issues.
- An evaluation portal where organisations could upload & share evaluations & standard evaluation tools.
- A longer consultation period. Kate & Giles recognised the difficultly of the consultation time being four weeks, which is constrained by the timetable for the Board for the shadow year. Kate suggested that whilst the consultation to inform this year's JSNA & Strategy going to the Board in September had to be fixed, that the JSNA consultation could either remain open/reopen after this date to enable people to feed in to the process for next year. The group welcomed this and Kate agreed to take this back to action.
- Timing & roadmap of consultations. As a general point there was discussion on the number of consultations that organisations were expected to feed into and the time & financial costs to them of doing this well. A roadmap of consultations from statutory organisations would help.

There was a specific question on why no environmental factors were in the highest impact issues in the JSNA: The impact matrix can be made available to show the evidence this was based upon & in some cases it was that there was a lack of either local or national evidence to demonstrate this impact.

Joint Health and Wellbeing Strategy: In addition to the discussion around the decision making process of the Board described above, there were specific questions on the strategy including:

- Why disability was not a priority for the board? HWB members recognise the vital importance of disability as an issue in the city. Those priorities not chosen were where other partnerships in the city covered issues well; were recently established; or issues where more work was needed to know about how other partnerships worked on them before the HWB considered them as priorities.
- For each of the priorities, how will impact be measured? Giles said this would be looked at by the lead for each priority, and that this was one of the key

questions in the consultation on the strategy – participants were encouraged to respond to the consultation with ideas on how to measure impact. Kate added that this would also be informed by the National Outcomes Frameworks (for the NHS, Public Health & Adult Social Care), with the example of smoking which has moved from numbers of people quitting smoking in NHS stop smoking services to adult & child smoking prevalence.

Workshop 2

Health & Wellbeing Board: As in workshop 1, there were a number of questions on the make up of the Board:

- Why youth representation on the Board when other groups are not represented in this way? HealthWatch are there to represent the views of adults, but there is a question about whether HealthWatch can statutorily represent the views of children and young people and so the decision was taken locally to include a Youth Council member on the Board.
- Who made the decision on the make up of the Board? It was decided by the city council at full council, with advice from officers.
- What age does the youth council cover? Generally 11-18 years
- What powers will the Board & its Chair have? Until April 2013 the Board has no powers in its shadow form. From April it will be the power brought by the people sitting on the Board. The Board must formally consider the commissioning plan of the Clinical Commissioning Group & can refer it to the NHS Commissioning Board if it does not take account of the JSNA and Strategy in its plan (so not just the five priorities selected by the Board but also the wider evidence in the JSNA).

Other questions were around the Board's prioritisation for **the Joint Health & Wellbeing Strategy:**

- How did the Board decide on the priorities from the highest impact issues in the JSNA? Based on which were considered core partnership issues & where it was felt that partnership working could be improved.
- How do we influence the board's prioritisation? The prioritisation is evidence based in that it is informed by the JSNA. The HWB wants to maintain this rigor rather than simply prioritising topics which fit with a particular political agenda or where there is particularly effective lobbying. This is not to say that local political considerations; the corporate priorities of the city council, the CCG and key city partners; or the voices of local people and advocacy organisations do not have a valid role to play in discussions; but the evidence should be the dominant factor.
- One participant said it was reassuring to hear that whilst the Board has its five priorities that this did not mean that other issues were not priorities for the city, but that these were being dealt with organisations or other partnership boards already.

Joint Strategic Needs Assessment:

- How was consensus reached on the high impact issues in the JSNA? This was done in groups of 5-6 people looking at the evidence of each issue from the JSNA and agreeing the rating for each element of the impact matrix &

recording the evidence used to make this decision. All groups were then brought together to look at consistency of assessment across groups.(See JSNA impact section for more details: http://www.bhlis.org//Custom/Resources/4%20Impact1.pdf)

- How do organisations feed in a greater level of detail than that already included from them in the JSNA? Kate described the discussion around calls for evidence in the first workshop and reiterated that she would like to invite people to be involved in drawing up the process and structure for how this was done. The wider authorship of the JSNA should help with this.

Workshop 3

Health & Wellbeing Board:

- How many members of each party sit on the Board? There are 3 Green members, 2 Labour & 2 Conservative
- As in workshop 1 there was a question on why is there no Board representation from voluntary groups and specialist services and Giles set out the reasoning described under the workshop 1 notes. Reflecting that the Board would meet four times a year and as important was what sat beneath the Board.
- With the level of political influence on the Board does it run the risk of being dysfunctional? There's always some risk of this in an organisation with a democratic mandate, particularly in a place like Brighton & Hove where, traditionally, no one group dominates local politics. However, with political influence comes democratic engagement: the chance for local people, via their elected representatives, to influence decision-making.
- How does the Board fit with the City Wide Forum? This is not yet clear and part of the shadow year of the Board is to work out some of these relationships.
- One participant said they had previously been told that the Youth Council and HealthWatch members would not have voting rights. All members of the Board have equal voting rights. Although if the Board is reaching the point of voting it would not be functioning well as a partnership Board.
- As for workshops 1 & 2 participants wanted more information on how the Board prioritised the issues from the JSNA (summarised in previous workshop write up).
- Will the Board have a practical function? (The example given was in dealing with issues of lack of recording of data on equalities groups by statutory provider organisations). It was felt that down the line the Board may have this type of function but this would take time to develop.
- What is the route for the public to the Board? This is the role of HealthWatch on the Board. Robert Brown, who sits on the Health & Wellbeing Board with this role was in this workshop. He emphasized that this was a representative function and HealthWatch would need to work with organisations to fulfil this role well. In addition, with seven elected members, individuals can go to their ward councillor with issues which may feed through to the Board in this way.

Joint Health & Wellbeing Strategy:

- It was commented that the priorities & process would need to be very clearly communicated so that people, and the media, did not think that the five priorities were the only issues being tackled in the city.
- Will the strategy be impact assessed? Yes
- There was discussion around the life of the Strategy & when priorities would be reviewed. Giles said it was not currently clear how long the strategy would be for but that the priorities would be reviewed each year. He emphasized that a priority being solved for the Board would be about the Board being assured that the issue was now being dealt with effectively by organisations or another partnership. Other issues would likely then be added to those being focussed on by the Board.

Joint Strategic Needs Assessment:

- Is there potential that under recording of data by providers means that issues may "score" less highly in the impact matrix? Kate recognised that there is potential for this. However, within the JSNA sections this was highlighted in many cases where there was known underreporting or where there is no information in the "What we don't know" section. But of course there could also be unknown under reporting and this could feed through into the evidence used in the impact matrix in some cases.
- Where the JSNA has highlighted gaps in data/evidence, organisations may well have evidence to feed in & fill some of these gaps. They are encouraged to do so as part of the consultation & on an ongoing basis. Again participants were keen on the JSNA consultation reopening/remaining open for longer. Plus the suggestion from the earlier workshop to look at a consistent, structured way to gather evidence from the sector and to involve CVS organisations in developing this.

SHADOW HEALTH & WELLBEING BOARD	Agenda Item 17 Brighton & Hove City Council

Subject:		**Joint Health & Wellbeing Strategy (JHWS)**
Date of Meeting:		**12 September 2012**
Report of:		**Strategic Director, People**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 29-1038**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 From April 2013 each local Health & Wellbeing Board will have a statutory duty to publish a Joint Health & Wellbeing Strategy (JHWS).

1.2 At its 30 May 2012 meeting the Brighton & Hove Shadow Health & Wellbeing Board (SHWB) agreed that the local JHWS should focus on five high priority areas: smoking; dementia; cancer and access to cancer screening; healthy weight and good nutrition; and emotional wellbeing (including mental health).

1.3 An action plan for each priority area has been produced by officers from the city council, the Brighton & Hove Clinical Commissioning Group (CCG) and the Brighton & Hove Public Health team. These action plans form the basis of the draft JHWS presented to members for their endorsement (see **Appendix 1**).

1.4 The JHWS does not become a statutory requirement until April 2013, and the SHWB does not assume statutory powers until the same date. The JHWS will therefore need to be signed off formally by the Health & Wellbeing Board post-April 2013. However, it is important that a draft JHWS be adopted at an earlier date so that Council and CCG commissioners can use it to inform their commissioning plans for the coming financial year.

2. RECOMMENDATIONS:

2.1 That the Shadow Health & Wellbeing Board endorses the draft Joint Health & Wellbeing Strategy (**Appendix 1** to this report).

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The Health & Social Care Act (2012) requires upper-tier local authorities to establish a partnership Health & Wellbeing Board (HWB) from April 2013. Each HWB has general duties to encourage closer partnership working in health and social care and to involve local stakeholders and members of the public in decision-making etc. HWBs also have more specific duties, including the requirement to publish a local Joint Health & wellbeing Strategy (JHWS).

3.2 The Department of Health has given local HWBs considerable autonomy in terms of producing the JHWS, essentially only requiring that a local JHWS should:

- Be strategic and take into account the current and future health needs of the entire population
- Prioritise the issues requiring greatest attention, whilst avoiding trying to take action on everything at once
- Focus on things that can be done better
- Identify how local assets can be used to meet identified needs
- Be key to understanding local inequalities and the factors that influence them.

3.3 In Brighton & Hove we began developing the JHWS via a 'prioritisation process' where we scored each of the 82 JSNA areas against a series of measures, including the number of people affected by the issue; its impact upon life expectancy; its impact upon wellbeing; its impact upon equalities groups; a comparison with national/regional/comparator performance; performance against national/local targets (where applicable); and the trend direction.

3.4 The highest impact issues identified via the prioritisation process were then assessed to determine whether they were 'core' partnership issues, or primarily the responsibility of one body. Those highest impact partnership issues were further assessed to identify those areas where there was the greatest potential to improve services via better partnership working.

3.5 Issues in the category of the "wider determinants of health" (i.e. non-health issues which may nonetheless have a significant impact upon health and wellbeing such as worklessness, poor quality housing, child poverty etc) were excluded at this stage, as the primary responsibility for them rests with bodies other than the HWB – for instance with the family of partnerships that constitutes the Local Strategic Partnership. The relationship between the HWB and these partnerships, both in terms of the wider determinants and in terms of the JHWS, will develop over time, but initially the focus of the HWB, and its JHWS, will be on core health, public health and social care issues.

3.6 It is by no means the case that the areas identified as priorities via this process should be considered as examples of failed partnership working. On the contrary, there may be excellent partnership relationships to build on in all the priority areas; identification as a priority area simply indicates that there is the potential to make practical improvements to services by building broader or more effective partnerships. Similarly, if an issue is not a JHWS priority it does not mean that it is not a priority for the city – in many instances it simply indicates that another body is already dealing with the matter effectively.

3.7 This assessment process produced six priority areas which were recommended to the SHWB at its May 2102 meeting. The SHWB agreed that the JHWS should include five of these issues: dementia; smoking; emotional health and wellbeing (including mental health); healthy weight and good nutrition; and cancer and access to cancer screening. The SHWB chose not to prioritise Flu immunisation, arguing that the issue was better dealt with by the responsible agencies.

3.8 An officer working group, including city council commissioners from adult social care and children's services, CCG commissioners and public health experts, then met to develop action plans for each of the priority areas. In developing each action plan officers sought an appropriate level of input from the council, CCG and public health as well as from relevant stakeholders. Each action plan seeks to:

- Establish what the issue is, and why it is important for Brighton & Hove
- Detail what we are already doing well
- Detail where there are currently gaps in services
- Suggest ways that these gaps could be filled/services improved
- Suggest how we might measure improvement (e.g. what outcomes we want to see achieved).

3.9 The draft JHWS also includes information on the JSNA process, inequalities, and a guide to which bodies or partnerships are principally responsible for the high impact issues that do not form part of the JHWS.

3.10 The JHWS is intended as a high-level document: it identifies health and social care priorities for the city and suggests some ways in which services could be improved, but it does not go into operational detail. This detail will be provided by the relevant council and CCG commissioning plans, both in terms of core health, public health and adult and children's social care commissioning, and in terms of broader commissioning plans which may impact significantly upon health and wellbeing. Having set a JHWS, it will be the duty of the SHWB going forward to work closely with commissioners and with city partnerships to ensure that the JHWS outcomes are met.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 Development of the JSNA entailed a wide range of community engagement, including a gap analysis of JSNA data conducted by the local Community & Voluntary Sector Forum (CVSF). CVSF was also a partner in the JSNA prioritisation process, and community and voluntary sector representatives were amongst those who attended a workshop on the JSNA/JHWS in March 2012.

4.2 The JSNA and JHWS priorities have also been presented to a range of community and voluntary sector organisations via a day-long workshop session organised by CVSF in July 2012. At this event we discussed the JSNA/JHWS with representatives of more than 30 local organisations.

4.3 The JSNA and JHWS priorities have been out to public consultation over summer 2012, via the council's consultation portal.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The Health and Wellbeing Board will not have any budgetary powers but through the Joint Health and Wellbeing Strategy will be able to inform the priorities within the developing budget strategies for the city council, health and partner organisations.

Finance Officer Consulted: Anne Silley Date: 16/08/12

Legal Implications:

5.2 As set out in the body of the report, Heath and Wellbeing Board will be required to approve a Joint Health and Wellbeing Strategy from April 2013 under the Health and Social Care Act 2012. There are no further legal implications arising from this report.

Lawyer Consulted: Elizabeth Culbert Date: 15th August 2012

Equalities Implications:

5.3 Development of the JSNA included a focus on the impact on equalities groups in regard to each of the 82 JSNA areas. There was an additional focus on equalities issues in the JSNA prioritisation, with the council Equalities team a partner in this process, and a specific 'Impact on equalities group' category included in the matrix of measures against which each JSNA area was scored.

5.4 The JHWS priorities were therefore chosen with due regard to equalities concerns, although the weighting of the prioritisation process was such that priorities were always likely to be issues that impacted upon a large number of people across the city rather than matters affecting only equalities group(s) or any other minority community.

5.5 Detailed equality impact assessments have not yet been undertaken in the JHWS priority areas. It is evident that there are significant equalities implications for each of the priorities, and these will need to be addressed in terms of detailed planning for service improvements. However, this detailed planning will be undertaken by commissioners rather than by the HWB via its JHWS, which is a high-level plan addressing population health issues. The HWB will need to ensure that it adequately addresses equalities issues when it assures city commissioning plans and partnership strategies against the JHWS goals, and it may wish to further development of equalities matters in relation to each priority to facilitate this, but there is no requirement for the JHWS itself to include detailed assessment of equalities issues in relation to each priority

Sustainability Implications:

5.6 None directly, although some of the recommendations within the JHWS do relate to sustainability issues (e.g. encouraging more local sourcing of food for public

sector catering; encouraging more exercise etc). More detailed exploration of sustainability issues will be undertaken when the high-level JHWS priorities are translated into practical commissioning intentions.

Crime & Disorder Implications:

5.7 There is little in the JHWS that relates directly to crime and disorder, although some issues may have crime & disorder implications (e.g. illegal tobacco in terms of the smoking priority). More detailed exploration of these issues will be undertaken when the high-level JHWS priorities are translated into practical commissioning intentions.

Risk and Opportunity Management Implications:

5.8 Ongoing risk assessment of the development of a local Health & wellbeing Board has addressed general risks/opportunities associated with the development of the JHWS.

Public Health Implications:

5.9 The Joint Health and Wellbeing Strategy (JHWS) sets the priorities for local action to tackle the health and wellbeing needs and inequalities identified through the JSNA. The five priorities within the strategy span the life course and include both social issues and specific conditions. The action plans included in the strategy build on and aim to strengthen the work being done within these areas, including addressing inequalities. The JHWS is not about taking action on everything at once and the strategy identifies some of the partnerships working on other high impact issues from the JSNA not prioritised within the JHWS.

5.10 The strategy includes a brief section on inequalities. Using a framework based on the Marmot Review of Inequalities in England's key policy and priority objectives, the local high-level partnerships working in the different areas have been identified. Because of the clear links between inequalities and the wider social determinants of health such as housing and education the Health and Wellbeing Board will be working with other local partnerships to understand the contribution they make to tackling inequalities.

Corporate / Citywide Implications:

5.11 Reducing inequalities is a key corporate priority, and is also a priority for the JHWS. More detail on this is included in the 'inequalities' section of the JHWS (**Appendix 1**).

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Details of the prioritisation process are included in this report (points 3.3 through 3.6), in the draft JHWS (**Appendix 1**) and in the report of the Director of Public Health: "Proposal for the Development of the Joint Health & Wellbeing Board" which was considered at the May 30 2012 SHWB meeting. The latter report includes an appendix detailing reasons for the non-inclusion of a number of high priority issues.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 From April 2013, publishing a JHWS will be a statutory responsibility for every local HWB. There is therefore a legal obligation to approve some form of Joint Strategy. Asking the SHWB to endorse a draft JHWS at this point is not a statutory requirement, but it will enable council and CCG commissioners to take the emerging views of the SHWB into account at a point when commissioning plans for 2013/14 are still being prepared, and to vary their planning accordingly.

SUPPORTING DOCUMENTATION

Appendices:

1. The draft JHWS

Documents in Members' Rooms

None

Background Documents

1. The Health & Social Care Act (2012) and relevant DoH guidance.

2. "Proposal for the Development of the Joint Health & Wellbeing Board" – report of the Director of Public Health to SHWB May 30 2012.

Appendix 1

Draft Brighton & Hove Joint Health & Wellbeing Strategy (JHWS)

Contents

Introduction

What is the Joint Health & Wellbeing Strategy?

The 2012 Health & Social Care Act requires all upper-tier local authorities to set up a Health & Wellbeing Board (HWB). HWBs are partnership bodies bringing together Councillors, NHS commissioners, senior council officers and local people. HWBs have a general duty to ensure that health and social care systems in the local area work effectively together; that the care delivered reflects the needs of local people; and that local people are fully involved in designing these services.

More specifically, HWBs have two major duties: to deliver the local Joint Strategic Needs Assessment (JSNA) and to agree a Joint Health & Wellbeing Strategy (JHWS).

Joint Strategic Needs Assessment: JSNA. The JSNA is an ongoing process in which a wide range of data is analysed in order to establish what the health and social care needs of the local population are, how far local services meet these needs, and where any gaps may be. The JSNA, and the data which informs it, provides the key evidence-base for health, public health and social care commissioning across the local area. A summary of JSNA findings is currently published annually, and much more detailed information about each of the 82 JSNA categories is available via the BHLIS web resource.

The JSNA is not a new initiative, although it is currently undergoing a significant revamp at a national level which is likely to give local areas considerably more freedom to make their JSNA fit with local needs. Currently, the JSNA is signed off by the local Directors of Public Health, Adult Social Services and Children's Services, but this duty will pass to the HWB from April 2013.

Joint Health & Wellbeing Strategy: JHWS. Agreeing a local JHWS is a new responsibility. Although the Department of Health has published some guidance, and the Health & Social Care Act lays out some minimal responsibilities, the Government, in line with its commitment to localism, has not been prescriptive: HWBs have a great deal of freedom to design a JHWS that is appropriate for the local area.

This is important, because local areas are very different from one another, and for some areas, particularly those with both a County Council and District Councils, or with several Clinical Commissioning Groups, the JHWS will need to bring together these distinct and potentially competing voices to produce a shared, coherent vision for the local area.

Fortunately, Brighton & Hove has a single political authority – the City Council - and one Clinical Commissioning Group responsible for buying the bulk of NHS services for the whole of the city. There is also a long and successful history of partnership working in Brighton & Hove, with formally shared council/NHS services, close informal partnerships between the council and the NHS, and a thriving strategic partnership structure, with the council, NHS commissioners and providers, city universities, the police, the fire service, voluntary sector organisations and local businesses working together across a variety of themed partnerships.

Therefore, the Brighton & Hove JHWS will not be a grand over-arching document describing the whole of health and social care planning across the city – this is already being done via existing council and NHS commissioning strategies. Nor will it seek to impinge upon the territory of established, successful partnerships working across the city. Instead, the JHWS will focus on a few very high priority areas, where we know that there is a really significant need for better outcomes and where we also know that current partnership working could be made more effective, delivering real and measurable improvement for local people. The JHWS aims to complement existing strategies and partnerships, identifying gaps in partnership networks and pathways. It does not aim to replace existing strategies and partnerships or to duplicate the work that they do.

The areas included in the Brighton & Hove JHWS should be amongst the highest impact issues for the city population, then. They should also be 'core' partnership issues: areas where an effective response demands joined-up partnership working, particularly between the council and the NHS. And additionally, they should be issues where we know that the current partnership structures are not as effective as they might be – i.e. areas where, by improving the ways that the city council and the local NHS (and potentially other partners) work together, we can make real improvements to services.

Given this focused approach to the JHWS it should be clear that the absence of an issue from the JHWS does not imply that it is not a city priority. In some instances it may be that an issue has not been included because, although its impact is high, there are other issues which present an even greater challenge. However, in other instances, a very high priority issue may have been excluded from the JHWS because it is essentially the responsibility of one organisation rather than a true partnership issue. Similarly, even with 'core' partnership issues, it may be the case that there is already a robust partnership in place, and therefore little to be gained from inclusion in the JHWS. This approach is consistent with Government guidance, which stresses both that the JHWS should prioritise local issues rather than attempting to tackle everything, and that the focus of the JHWS should be on driving improvements via better partnership working.

Neither is it necessarily the case that being included as a JHWS priority means that partnership working in a particular area is sub-standard. Rather, it is likely to mean that we have identified an opportunity to improve services by building on and extending current partnership working arrangements.

In summary then, the local JHWS will be a tightly-focused plan, concentrating on the highest impact local issues where effective partnership-working can make a real difference to outcomes, and where, for whatever reasons, the current partnership arrangements offer room for improvement. The JHWS may include targets for improving outcomes, but it is not where the operational detail will be agreed: this will be done via individual NHS and council commissioning plans.

Prioritisation
Government guidance makes it clear that the local JHWS must be based on the evidence gathered through the JSNA process, although it is up to each area to determine the best way of doing this.

Locally, we divided the JSNA data into 82 themed areas, ranging from specific conditions (cancer, diabetes, coronary heart disease etc), through social issues which impact upon health (smoking, obesity, alcohol etc), to the wider determinants of poor health (inadequate housing, childhood poverty, worklessness etc). A team of public health experts, GPs, council and NHS commissioners and voluntary sector representatives then 'scored' each area in terms of a series of criteria, including impact on life expectancy; quality of life; impact on particular groups (e.g. equalities groups); whether we were hitting national/local targets; and whether the local trend was moving in a positive or a negative direction.

This scoring left us with 18 issues which were deemed to have the highest impact upon the local population. Several of these areas related to the 'wider determinants' of health – that is, non-health issues which can be amongst the most important causes of poor health, such as housing, worklessness and child poverty. The local Shadow HWB[1] decided that it would restrict its focus to core health, public health and adult and children's social care matters rather than looking directly at these much broader issues, all of which fall within the remit of other city partnerships. Over time the HWB will seek to build relations with these city partnerships, ensuring that there are no gaps between partners; but there are presently no plans for the HWB to take over responsibility for any of these wider determinants. For these reasons, the wider determinant JSNA areas were not taken forward as JHWS priorities.

This left 13 very high impact issues remaining. This long-list was then assessed against the key criteria of "partnerships": were these core partnership issues, and if so, was there scope to improve outcomes via better partnership working? This second assessment process eventually produced a shortlist of six key priorities, five of which were endorsed by the Shadow HWB (HWB members decided that one issue, flu immunisation, would be better dealt with by other means).

[1] HWBs have been established in shadow form in preparation for assuming statutory respo9nsibilities in April 2013.

The five priorities are:

- cancer and access to cancer screening
- dementia
- emotional health and wellbeing (including mental health)
- healthy weight and good nutrition
- smoking

The Contents of this Report

The following sections of the Strategy explore each of these priority areas: briefly describing the nature of the issue; giving an outline of local services, including where we are already doing well and where we could be doing better; suggesting measures to improve outcomes; and detailing how we will know if things have improved. The focus is fundamentally on partnership working; on how we can work together more effectively and efficiently to deliver better outcomes for local people.

Preceding the action plans for each priority area is a brief explanation of the JSNA process and description of the demographic challenges posed by the population of Brighton & Hove. Following the action plans is a short section on inequalities, explaining how reducing inequalities is a major driver for this strategy. The draft JHWS ends with a table listing the bodies and partnerships which are chiefly responsible for addressing the high impact issues which are not JHWS priorities, and with a note outlining consultation and engagement thus far..

We hope that this introduction has made it clear what the JHWS is and what it is not, and particularly, that people are reassured that the absence of a particular issue from the JHWS priorities does not necessarily indicate that the issue is a non-priority for the city.

Finally, the JHWS prioritisation process is intended to be evidence-based and objective (although we freely acknowledge that it is a work in progress). In seeking to identify the highest impact issues with the most potential to improve outcomes through better partnership working, we did not set out with any preconceptions about the issues we wanted in the JHWS, and we could in theory have ended up with a list of priorities which had little in common with each other.

However, it quickly became obvious to us that the priorities chosen share some very significant common properties, and that improving outcomes in each area may involve some similar strategies: encouraging people to take a little more responsibility for their own lives, and to take a little more interest in the lives of their families, friends and neighbours; enabling local communities to be more supportive of people with health or social care needs; working together to create a city where everyone, but particularly our most vulnerable citizens, feels supported to live safe, secure lives.

Joint Strategic Needs Assessment in Brighton and Hove

The needs assessment process aims to provide a comprehensive analysis of current and future needs of local people to inform commissioning of services that will improve outcomes and reduce inequalities. To do this, needs assessments should gather together local data, evidence from the public, patients, service users and professionals, plus a review of research and best practice. Needs assessments bring these elements together to look at unmet needs, inequalities, and overprovision of services. They also point those who commission or provide services towards how they can improve outcomes for local people. The common name for these needs assessments is Joint Strategic Needs Assessment (JSNA).

In Brighton and Hove there are three elements to the needs assessment resources available:

- Each year, a JSNA summary is published, giving an high level overview of Brighton and Hove's population, and its health and wellbeing needs. It is intended to inform the development of strategic planning and identification of local priorities, including the Joint Health and Wellbeing Strategy;

- A rolling programme of comprehensive needs assessments for the city;

- BHLIS (Brighton and Hove Local Information Service – www.bhlis.org) is the Strategic Partnership data and information resource for those living and working in Brighton and Hove. It provides local data on the population of the city. This data underpins needs assessments across the city.

This section gives some key information on the city from the JSNA – with more information available at www.bhlis.org/jsna2012

The population of Brighton and Hove

Brighton and Hove city is located between the sea and the South Downs. It is known for its easy-going approach to life, quirky shopping, restaurants, festivals and beautiful architecture. Many people choose to come and live in the city for the opportunities it offers.[2] However, Brighton and Hove is one of the most deprived areas in the South East and has a population with significant health needs and inequalities.

The city has an unusual population compared to the national picture. There are relatively large numbers of people aged 20 to 44 years, with fewer children and older people. However, there are relatively more very elderly people (85 years or over), particularly women, who are likely to have an increased need for services.

[2] Brighton and Hove Strategic Partnership, *Creating the City of Opportunities A sustainable community strategy for the City of Brighton & Hove*, 2010. Available at http://www.bandhsp.co.uk/downloads/bandhsp/

According to the 2011 Census there are 273,400 people living in the city. The population is predicted to increase to 291,000 by 2030.[3] With the greatest increases in those aged 25-34 and 50-59. There will be more children under 15 years old and slightly more people aged 75 years or over.

Key population groups in the city:

Gender: Brighton & Hove has a fairly even population split by gender with 51% of the population female & 49% male.

Age: There are 41,700 children aged 0-14 years in the city (15% of the population), 195,700 people aged 15-64 years (72% of the population) and 35,700 people aged 65 years or over (13% of the population).[4]

Migrants: The city is a destination for migrants from outside the UK with 15.1% of the city's population born outside the UK, higher than the South East (11.0%) and England (12.8%).[5]

Black and Minority Ethnic (BME) groups: The most recent estimates for 2009 show that 81% of the city's population are White British and 18% are from a BME group.

LGBT: Local estimates suggest that there may be 40,000 LGBT people living in Brighton and Hove, around 15-16% of the city's population, the largest concentration of LGBT people in England outside London.[6,7]

Carers: In the 2001 Census, 21,800 (9%) residents in Brighton and Hove identified themselves as carers. This is lower than the UK which had 12% of adults caring according to the Census.[8]

Military veterans: Applying national estimates suggests around 17,400 military veterans in the city. A veteran is anyone who has served in Her Majesty's Armed Forces at any time, irrespective of length of service.

Students: Brighton and Hove is a city with a substantial student population with two universities: University of Brighton and University of Sussex. Students represent 13% of the city's total population.[9]

Life expectancy, healthy life expectancy and inequalities

Life expectancy in Brighton and Hove is 77.7 years for males and 83.2 for females. Whilst females in the city can expect to live on average six months longer than nationally, life expectancy for males is almost a year lower than in England (78.6 years for males and 82.6 years for females). Healthy life

[3] ONS sub national population projections (2010 based) http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Sub-national+Population+Projections [Accessed 26/07/2012]
[4] Office for National Statistics. Census 2011. Data available at http://www.statistics.gov.uk/statbase/product.asp?vlnk=15106 [Accessed 08/08/2012]
[5] ONS Migration Statistics Quarterly Report, August 2011 http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-222711 [Accessed 26/07/2012]
[6] Oxford Consultants for Social Inclusion (OSCI), Developing Appropriate Strategies for Reducing Inequality in Brighton and Hove, 2007
[7] Webb, D. and Wright, D. Count Me In: Findings from the lesbian, gay, bisexual and transgender community needs assessment 2000. University of Southampton, Southampton; 2001.
[8] Carers UK. http://www.carersuk.org/media/k2/attachments/Facts_about_Carers_2009.pdf [Accessed 21.04.12]
[9] These figures include students based at other campuses outside the city.

expectancy is 67.9 years for males and 72.9 years for females meaning that, on average, around 10 years of life is spent in ill health.

As has been seen nationally, whilst mortality rates in the city are falling in all groups, they are falling at a faster rate in the least deprived quintile (i.e. the wealthiest 20% of the population) and so inequalities are widening. The gap in life expectancy between the most and least deprived people in the city is 10.6 years for males and 6.6 years for females in Brighton and Hove. These inequalities also exist in healthy life expectancy.

Highest impact health and wellbeing issues

In previous years in the JSNA we have listed the health and wellbeing issues for the city. This year we have tried to more systematically identify the impact on the city's population. This fed into the prioritisation process for the Joint Health and Wellbeing Strategy. The issues with the greatest impact on health and wellbeing in the city, mapped across the life course, are:

Wider determinants which have the greatest impact on health & wellbeing

	Children & young people	Adults	Older people
Child poverty			
Education			
Employment & unemployment	Youth unemployment	Unemployment & long term unemployment	
Housing			
Fuel poverty			

High impact social issues

	Children & young people	Adults	Older people
Alcohol	Alcohol & substance misuse – children & young people	Alcohol (adults & older people)	
Healthy weight & good nutrition	Healthy weight (children & young people)	Healthy weight (adults & older people)	
	Good nutrition & food poverty		
Domestic & sexual violence			
Emotional health & wellbeing – including mental health	Emotional health & wellbeing & mental health		
Smoking	Smoking (children & young people)	Smoking (adults & older people)	
Disability	Children & young people with a disability or complex health need	Adults with a physical disability, sensory impairment & adults with a learning disability	

Further information

Specific conditions

	Children & young people	Adults	Older people
Cancer & access to cancer screening			
HIV & AIDS			
Musculoskeletal conditions			
Diabetes			
Coronary heart disease			
Flu immunisation			
Dementia			

www.bhlis.org/jsna2012

Cancer and Access to Cancer Screening

A Cancer

What is the issue/why is it important for Brighton & Hove?

Cancer is one of the biggest causes of death, and accounts for about 38% of all deaths in the under 75's - 266 premature deaths in 2010.

Around 1150 people in the city are diagnosed with cancer each year; of these, over half are for the four main cancers (210 female breast, 135 prostate, 150 lung and 140 colorectal cancers). These cancers are also responsible for about half the premature deaths (75 from lung cancer, 26 from breast cancer, 23 from colorectal cancer and 6 from prostate cancer).

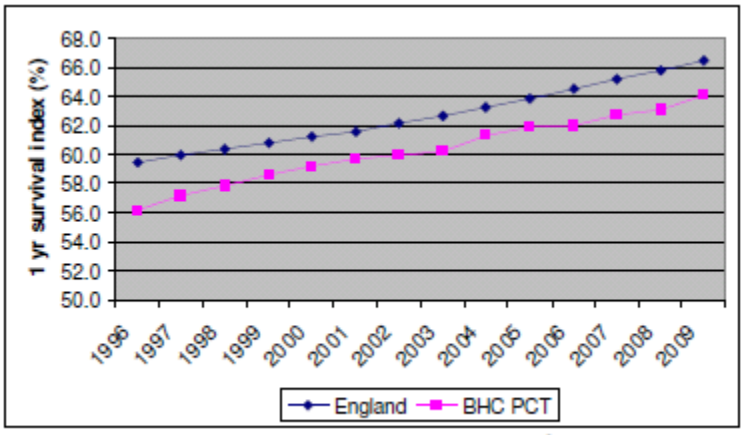
Incidence and mortality from cancer is considerably higher amongst the more deprived groups, largely due to lifestyle factors, such as higher smoking rates. The mortality gap between the poorest groups and the most affluent appears to be widening.

Despite improvements in cancer treatments, and mortality in recent decades, outcomes in the UK are poor compared to the best in Europe.

The death rate amongst the under 75's in the city is higher than the national death rate. At a national level, this rate has been steadily decreasing, but this is not the case in Brighton and Hove, where the decline has been very small.

Using a new index of cancer survival, Brighton and Hove has poorer survival than England, although it is gradually improving. (Graph 1)

1 year survival index (5) for all cancers combined, by calendar year of diagnosis: all adults (15-99), England and Brighton and Hove



Source: ONS Statistical Bulletin, August 2011.[9]

The tables below indicate the relative 1 and 5 year survival rates in Brighton and Hove compared with other areas of Sussex and nationally. These indicate the poorer survival rates across the city – particularly for colorectal and lung cancer.

1 year relative survival for common cancers (2004-8 and alive up to end 2009)

PCT	Breast	Colorectal	Lung	Prostate
Brighton and Hove	95.5	70.8	21.2	93.3
East Sussex, Downs and Weald	95.5	73.3	29.9	94.3
Hastings and Rother	96.4	68.3	21.7	91.5
Sussex Cancer Network	95.8	72.3	21.5	94.6
West Sussex	96.1	74	27.9	96.4
England	95.9	74.2	29.4	95.1

5 year relative survival for common cancers (2000-2004, and alive to end 2009)

PCT	Breast	Colorectal	Lung	Prostate
Brighton and Hove	82.9	47.5	6.8	79.1
East Sussex Downs and Weald	84.7	56.6	6.3	86.4
Hastings and Rother	82.4	52.9	5	71.7
West Sussex	85.5	56.8	7.4	85.1
Sussex Cancer Network	84.3	57.4	6.2	82.8
England	83.7	53	8	82.7

***(Note:** Red indicates significantly worse than national average, and green significantly better).*

Prevention of cancer is as important as treatment. Tobacco smoking remains the single most important avoidable cause of cancer, followed by diet, excess weight and alcohol consumption. Together, these four account for about 34% of all cancers.

In April 2011 the Department of Health published Improving Cancer Outcomes and set a target of '*Saving 5,000 Lives'* per annum nationally by 2014/15.The challenge is to diagnose and treat cancers earlier, and significantly reduce the number of cancers newly diagnosed as emergencies.

What are we doing well already/where are there gaps?

Investment in cancer services has increased over the past three years, allowing for improvements in treatment.

Substantial programmes of work tackling local awareness and early diagnosis have been undertaken including:

- Local public awareness campaigns promoted by the Public Health team and provided by Sussex Community NHS Trust and by Albion in the Community to raise awareness of the symptoms of bowel, lung and breast cancer across the city. The focus has been on training health coordinators and volunteers to promote key messages amongst targeted groups within the community.

- A programme of improvement initiatives including:
  - Participation of half of all local general practices in an audit of cancer cases in 2010, which stimulated a series of practice developments and collaborative work with hospital services to reduce delays in the referral process.
  - 13 local practices took part in the piloting of a primary care risk assessment tool to support practices in diagnosing cancer earlier and making appropriate referrals. Following an evaluation of its effectiveness, the tool has now been made available to all practices nationally.

- Holding regular education events for local GP practice staff to promote early diagnosis initiatives and encourage appropriate use of protocols for 2 week wait referrals

The impact of these initiatives has contributed to a significant rise in referrals to hospital which supports the drive towards earlier diagnosis of cancer. However the increase in diagnostic tests places a pressure on the capacity of some local services to maintain appropriate waiting times – particularly for endoscopy services. The PCT and the Sussex Cancer Network are therefore supporting Brighton and Sussex University Hospitals NHS Trust improvement plans to increase capacity and reduce waiting times for endoscopy investigations. These plans will also enable the age extension of the bowel screening programme to those aged over 70 years of age.

What we can do to make a difference

<u>Continue to invest in reducing the avoidable causes of cancer and support cancer survivors to lead a healthy lifestyle</u>

The lifestyle issues associated with cancer are very similar to those related to heart disease or diabetes. Major campaigns are in hand to identify and support people whose risks are high - e.g. NHS Health Checks, and referral to specific services - such as Stop Smoking or weight management. Many agencies are engaged in helping people exercise, manage weight or reduce alcohol consumption, and this work needs to continue and be strengthened.

Continue to invest in raising awareness of cancer signs and symptoms and providing support to primary care to encourage earlier presentation and referral, particularly in the more deprived parts of the city.

A repeat of the national campaign to raise awareness of the symptoms of bowel cancer will be run during September 2012. This will again focus on encouraging patients with symptoms to present early to their GP and will largely be run through national TV advertising and media.

The local Brighton &Hove lung cancer awareness campaign continues throughout the summer. The Sussex Cancer Network (SCN) also aim to hold events aimed at primary and secondary care clinicians to consider how local referral pathways and survival from lung cancer can be improved.

Support implementation of Sussex Cancer Network's delivery plans

The Sussex Cancer Network is fully engaged in the work on early awareness and delivery. In addition, it has identified a number of specific goals to help tackle other local issues:

- Improve cancer waiting times in the acute sector
- Improve diagnostic capacity, particularly endoscopy
- Increase access to radical treatments (surgery, chemotherapy and radiotherapy) instead of palliative treatments
- Improve access to laparoscopic surgery and enhanced recovery
- Improve access to radiotherapy , including new technologies which can target treatment more precisely and improve outcomes

SCN will also be working with Brighton & Hove CCG to review variations in cancer referrals from GP practices and explore what further measures can be developed to support GPs to achieve appropriate early diagnosis. Furthermore the SCN and CCG are collaborating with Macmillan with the aim of appointing primary care GP and nursing leads to support the coordination of primary care cancer management within the CCG. The intention is to focus on early intervention and preventative measures as well as supporting people living with cancer post-treatment.

Outcomes

From the Public Health Outcomes Framework:

- Reduce age standardised mortality from all cancer for persons aged under 75
- Reduce age standardised preventable mortality from all cancers in people aged under 75
- Increase the number of people diagnosed with cancer at Stage 1 and 2, as a proportion of all cancers diagnosed

From the NHS Outcomes Framework:

- Reduce premature mortality from the major causes of death, including one and five year survival from colorectal cancer, breast cancer and lung cancer; under 75 mortality from all cancers

B Cancer Screening

What is the issue/why is it important for Brighton & Hove?

Cancer screening saves lives. It is estimated that in England every year cervical screening saves 4,500 lives and breast screening 1,400; and that regular bowel cancer screening reduces the risk of dying from bowel cancer by 16%. Despite the introduction of a national target in the mid 1990s the cancer mortality rate in the under 75s in Brighton & Hove has been slow to decline. Increasing the up-take of NHS cancer screening programmes will contribute to reducing cancer mortality.

In 2010/11:

- bowel cancer screening up-take was lower in Brighton and Hove (53%) than in England (57.09%).
- cervical cancer screening coverage (the percentage of eligible women recorded as screened at least once in the previous five years) was lower in Brighton & Hove (76%) than England (79%).
- breast cancer screening coverage (the percentage of eligible women screened in the previous three years) in Brighton and Hove (71%) was lower than England (77%).

What are we doing well already/where are there gaps?

Whilst cervical screening coverage is lower in Brighton & Hove than England it is reported that this is the only area of the country where rates are increasing. Actual rates of cervical cancer are low.

Breast cancer screening coverage rates met the national target in 2010/11 and a recent quality assurance visit praised the local clinical services provided for women requiring treatment for breast cancer.

Bowel cancer screening up-take rates appear to be increasing although final 2011/12 data will not be available until October 2012.

Since 2005-06, the PCT has commissioned a cancer health promotion team - employed by Sussex Community Trust - to increase cancer screening rates. A service specification is in place identifying where efforts should be targeted.

What we can do to make a difference

<u>Bowel cancer</u>

- Publicise the bowel cancer screening programme and encourage people to participate; once people have done so once, the data shows that they are much more likely to do so again.
- Increase up-take particularly amongst men, minority ethnic groups and people living in the more deprived areas of the city where up-take rates tend to be lower.

- Work to reduce endoscopy waiting times, allowing us to extend the offer of bowel screening to people aged over 70 (up to 75).

Breast
- Increase up-take in areas where rates are low or falling, and pro-actively follow-up women who do not attend for screening using the GP lists produced 6 months after the completion of the screening round.

Cervical
- Increase cervical screening up-take in GP practices with the lowest rates and amongst more disadvantaged groups where up-take tends to be lower.
- Focus on increasing rates in both younger (25-34 yrs) and older (50-64 years) women where rates are lower.
- Raise awareness of the need for lesbian women to be screened.
- Ensure HPV testing is introduced into the local NHS screening programme in line with national recommendations

All programmes
- Provide training about screening for primary care practitioners, other key workers and members of the community, and encourage them to promote the screening programmes to their patients, clients and contacts.

Plan for improvement including key actions

- Conduct a literature review to identify effective interventions for increasing screening up-take for the three NHS cancer screening programmes
- Externally evaluate the health promotion service provided by Sussex Community Trust
- Set local improvement targets for the next three years and monitor annually focusing on those populations and groups, and GP practices, where rates are lowest

Outcomes

Increased up-take (and coverage) rates for all three screening programmes, particularly in groups/geographical areas where rates are lowest

Emotional Health and Wellbeing (including Mental Health)

What is the issue/why is it important for Brighton & Hove?

- One in four people experience a mental health problem at some point in their lives. This is of particular importance to Brighton and Hove as the local prevalence of mental illness continues to be generally higher than the average for England for both common mental health problems, such as anxiety and depression and severe mental illness, such as schizophrenia or bi-polar disorder.

- One in 10 children between 5 and 16 has a mental health problem [10] .Taking the Brighton and Hove population of 5-16s to be approximately 31,000 (ONS mid year estimates 2010) this would equate to 3,100 children and young people.

- Levels of self-harm are high: over the last 5 years, the number of children and young people presenting at the Accident and Emergency (A&E) department of the Royal Sussex County Hospital with serious self harm has increased significantly from 63 per year in 2009 to 91 per year in 2011 and with high numbers predicted for 2012. For adults the number of A&E attendances and admissions related to self-harm are also very high. Between 1 April 2011 and 31 March 2012, there were 1703 attendances related to self-harm: the highest number of attendances are from those under 30 years old.

- The cost of mental ill health to the economy in England for adults has been estimated at £105 billion. This includes the cost in terms of sickness absence or unemployment. Where young people experience significant mental health needs there is the cost of the service provision to be considered, but also potential loss of time in education and the subsequent likelihood of poor educational outcomes and thus more difficulty achieving work.

- Poor physical health is a significant risk factor for poor mental health and poor mental health is associated with poor self-management of long term conditions and behaviour that may endanger physical health such as drug and alcohol abuse.

- Mental illness still carries considerable stigma.

[10] No Health without Mental Health: A Cross-Government Mental Health Outcomes strategy for People of all Ages HM Govt 2011 pg27

Inequalities

There are a number of risk factors for poor emotional health and wellbeing, including:

- Deprivation: on average the prevalence rate for mental illness is up to 2.75 times higher for the most deprived quintile of the population than that for the most affluent.

Some groups within the population have a higher risk of developing mental ill-health: homeless people, offenders, certain BME groups, LGB people, veterans, looked after children, transgender people, gypsies and travellers, vulnerable migrants, victims of violence, people approaching the end of life, bereaved people, people with a dual diagnosis or complex needs, and people with learning disabilities have all been identified as at higher risk[11].
Brighton and Hove has relatively high proportions of some of these groups including homeless, LGB and transgender people.

- Count Me in Too found that 79% of the city's LGBT population reported some form of mental health difficulties.

- There is evidence that Brighton and Hove follows the national trend for there to be twice the rate of mental health hospital admissions among people from a BME background and lower uptake of primary care mental health services[12].

- There are high numbers of looked after children and child protection cases (5th highest LA in the country). On average approximately 85 Looked After Children (LAC) are referred to Child and Adolescent Mental Health Services (CAMHS) each year - this is 5% of the total CAMHS population. This is a disproportionate reflection of the number of LAC in the total child population (approximately 1% as of May 2012) and demonstrates the higher propensity of LAC for mental health issues. (CAMHS monitoring data)

Emotional wellbeing and health promotion

The government's strategy, *No Health without Mental Health* defines wellbeing as 'a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.'

The Office for National Statistics has been commissioned to carry out a subjective wellbeing ('happiness') survey. The first local data were published in July 2012[i], and show that the city's residents reported higher average levels of happiness than the national average:

[11] HM Government. No health without mental health: implementation framework. London: July 2012.
[12] Black and minority ethnic health needs analysis, Hazel Henderson, Brighton and Hove City PCT, 2008.

- Proportion with medium or high life satisfaction – Brighton and Hove 81.3% (75.9% in the UK)
- Proportion with medium or high worthwhileness – Brighton and Hove 83.8% (80% UK)
- Proportion with medium or high happiness yesterday – Brighton and Hove 72.5% (71.1% UK)

The City Tracker survey shows a high level of satisfaction with Brighton and Hove, and the local area, as a place to live particularly amongst 25 – 34 year olds.

What are we doing well already/where are there gaps?

Adults:

- We have a jointly agreed mental health strategy for adults focusing on prevention and providing services in community settings. Examples of service redesign that are being progressed include:
  - Development of a new Wellbeing Service providing access to psychological therapies in a range of primary care and community settings. Access to the service has been widened through a new option of self-referral.
  - Recognition of the role and value of the community and voluntary sector. We have consulted on proposals to redesign community mental health support services and are currently inviting bids via a Commissioning Prospectus for a range of services including employment support, and targeted out-reach support for the most vulnerable and at risk groups in Brighton & Hove.
  - Redesign of the supported accommodation pathway – making more flexible use of resources and targeting resources more effectively to those with the most complex needs.

Emotional wellbeing:

- A city mental health promotion strategy has been developed in line with No Health without Mental Health and circulated to key stakeholders for comment.
- A programme of mental health promotion services is commissioned from the voluntary and community sector (value approximately £100,000).
- A small grants scheme to support local mental health promotion projects was established in 2012. So far 19 proposals have been funded across the city ranging from allotment groups to art and photography.
- World Mental Health Day and World Suicide Prevention Day will both be marked within the city.

Children and young people

- Single point of access to tiers 2 and 3 CAMHS[13]
- Provision of duty service and urgent care
- Effective liaison between social care team and CAMHS re young people presenting at A&E with self harming behaviours
- Development of a 14-25 service to bridge the gap between CAMHS and adult services
- There is a well developed and engaged third sector providing a range of services in the community
- Children's centres and parenting programmes (e.g. Triple P) promote resilience and early help
- Right Here project (for young people 16-25) focuses on resilience building and prevention of the escalation of mental health issues

What we can do to make a difference

- Start to think about emotional health and wellbeing in a different way - part of everyone's business and as important as physical health .
- Map the recommended actions in the implementation framework for No Health without Mental Health against current activity and plans in Brighton and Hove.
- Hold a public consultation and public awareness campaign around the 'Five Ways':
  - Connect – with the people around you, family, friends and neighbours
  - Be active – go for a walk or a run, do the gardening, play a game
  - Take notice – be curious and aware of the world around you
  - Keep learning – learn a new recipe or a new language, set yourself a challenge
  - Give – do something nice for someone else, volunteer, join a community group
- Take a broader city wide approach to risk factors for poor mental health.
- Ensure emotional health and mental health wellbeing is integrated as far as possible into service provision rather than being separately provided in a medical model by "specialist mental health" service providers.
- Continue to shift the balance of spend and focus more on providing support to build resilience and maintain mental wellbeing.

[13] CAMHS services are arranged in terms of 'tiers' ranging from Tier 1 (community-based support provided by non-mental health professionals such as school nurses or health visitors); through Tier 2 (community support provided by dedicated CAMHS staff); to Tier 3 (clinic-based services delivered by CAMHS staff); and Tier 4 (specialist services, often in-patient services for people with severe mental illness).

- Work across a care pathway to ensure more effective transition from children and young people's services to adult services.
- Develop more effective links across adult and children's commissioning and services so that the issues of parental mental health, including in the antenatal and post natal phases are well understood and the impact on child development minimised.
- Better understand the profile of self harm in the city and improve awareness of the issues and appropriate responses within universal and specialist services.
- Consider the sustainability of resilience and health promotion projects and how they can be embedded in good practice.
- Extend service-user engagement in service developments
- Extend access to psychological therapies providing evidence based earlier treatment and support to more people
- Develop more holistic care and treatment for both adults and young people with dual needs – both mental health and alcohol/substance misuse.
- Encourage greater uptake of physical activities – linked with improving mental health and wellbeing.
- Promote mental health and wellbeing in the workplace.
- Promote mental health and wellbeing in schools, including a focus on the problem of bullying and its impact upon wellbeing.
- Ensure that the Stronger Families Stronger Communities Partnership addresses issues of mental health and wellbeing as they relate to the city's most vulnerable families.
- Extend partnership approach to mental health beyond Health & Adult Social Care to include partners who can impact in terms of the wider determinants.
- Seek to have an elected member identified as 'mental health champion'.

Achieving these is likely to require a city-wide all ages mental health and wellbeing strategy, and a multi-agency mental health and wellbeing steering group.

Outcomes

- More people in good mental health
- Better mental health for those in high risk groups
- Increase in employment for people with a mental health condition
- Reduction in pre-mature death for people with serious mental illness

Dementia

What is the issue / why is it important for Brighton & Hove?

Dementia is both complex and common, and it requires joint working across many sectors. Timely diagnosis is the key to improving quality of life for people with dementia and their carers. Dementia is a life limiting illness and people can live up to 12 years after diagnosis with increasing disability and need for support. There is evidence that people with dementia have worse clinical outcomes than people with the same conditions without dementia. However, there is also evidence that early information, support and advice at the point of diagnosis enables people to remain independent and in their own homes for longer.

In Brighton and Hove in 2012, it is estimated that there are:

- 3,061 people aged 65 years or over with dementia – projected to increase to 3,858 by 2030
- around 60 younger people with dementia
- 2,300 people who are carers of people with dementia.
- Around one third of people with dementia who actually have a formal diagnosis (among the lowest nationally).

Prevalence increases with age and one in three people over 65 will develop dementia. The age profile in Brighton & Hove differs from the national average (the city has a relatively young population and we are not expecting the rate of increase in terms of an aging population to be as significant as other parts of the country) but an increase of dementia prevalence of about 30% is expected by 2030. Carers of people with dementia are often old and frail themselves, with high levels of depression and physical illness and a diminished quality of life.

Nationally dementia is a priority, with Clinical Commissioning Groups (CCGs) and local authorities expected to implement the National Dementia Strategy (NDS) and the Prime Minister's Challenge on Dementia.

What are we doing well already / where are the gaps?

In 2009 extensive consultation was carried out with people with dementia, their carers and other stakeholders in the city. All plans for improving dementia services in the city stem from this consultation and from the National Dementia Strategy.

Nationally four priorities have been identified from the 17 objectives of the National Dementia Strategy. These are

i. Good quality early diagnosis and intervention for all
ii. Improved quality of care in general hospitals
iii. Living well with dementia in care homes
iv. Reduced use of antipsychotic medication

Sussex-wide system modelling of the cost avoidance enabled by implementing the National Dementia Strategy found that the combined benefit of implementing the four key priorities was greater than the individual benefits alone and that whole system working is necessary to best realise the benefits.

Good quality early diagnosis and intervention for all

- A new integrated memory assessment service will commence in April 2013. We are also exploring the possibility of joint neurology/psychiatry memory clinics.
- We are seeking to improve 'case finding' in primary care as we know that there are people with dementia who are not identified on GP disease registers.

Improved quality of care in general hospitals

- A dementia champion has been appointed at Royal Sussex Country Hospital (RSCH).
- An additional resource has been allocated into Mental Health Liaison at RSCH to support older people with mental health needs when they are in the general hospital.
- Development of a care pathway for dementia.
- Implementation during 2012 of the national requirements to complete a memory screen on all people 75 or over who are admitted to hospital.
- A dementia strategy and steering group established with senior level engagement.

Living well with dementia in care homes

- A Care Home In-Reach team supports person-centred approaches to dementia, in particular identifying alternatives to antipsychotic medication.
- There are measures in place to improve quality of care. From April 2013, contracts for care homes will include a Competency Framework for nurses, and staff in care homes are being offered specific training in working with people with dementia.
- Dementia training is referenced in contracts for all services that accept clients with dementia or memory loss.

Reduced use of antipsychotic medication

- Care Home In-reach Service to support individuals and staff in the care home.
- Enhancing Quality scheme which incentivizes providers to ensure that prescribing is in line with NICE guidance.
- Primary care audits on antipsychotic prescribing.

Other developments

- End of Life and dementia project.
- Brighton & Sussex Medical School and Sussex Partnership NHS Trust are recruiting a Professor of Dementia Studies.

- Increased integration towards 'long-term condition' model for dementia including community short term services and crisis services.
- Carers Strategy for Brighton & Hove.

What can we do to make a difference?

Governance
The Sussex Dementia Partnership (SDP), accountable to NHS Sussex, provides strategic direction for the implementation of the National Dementia Strategy at Sussex level. It includes senior representation from NHS commissioners, voluntary sector, local authorities, mental health, community and acute trusts, and primary care.

Brighton and Hove CCG has a GP Lead for dementia who chairs the dementia implementation group which has membership from the voluntary sector, local authority, mental health, community and acute trusts. The implementation group reports to the SDP. However, currently there is no commissioner-led implementation board for dementia in Brighton and Hove. A joint local authority and CCG board will be established to drive forward improvements for people with dementia and their carers and provide strategic direction and mandate to the implementation group.

PM's Challenge on Dementia Innovation Fund
Brighton and Hove CCG is leading a bid in conjunction with the local authority and other partners in the city for three projects:

- A community development worker to scope out the potential of developing dementia friendly communities, aligned with Age Friendly Cities, community development work and health promotion.
- The promotion of assistive technology to support independence at home for those people with dementia, and to offer reassurance to families
- DementiaWeb information resource on dementia and services for people with dementia in the city.

Needs Assessment
Currently there is limited information about people with dementia in the city, and it is based mostly on national estimates. There is no joint strategic needs assessment for dementia. A needs assessment would assist in commissioning plans going forward.

Carers
A number of organisations are involved in implementing the Carers Strategy for Brighton & Hove. The NHS Sussex-wide target of support for carers of people with dementia needs to align with this local strategy.

Plan for improvement including key actions

Brighton and Hove has a joint dementia action plan published in 2012 which sets out key plans for dementia in the city.

Outcomes

How will we measure success?

- Increased diagnosis rates to achieve 70% of expected prevalence by 2016
- Improved access to information support and advice at point of diagnosis
- Reduced prescribing of antipsychotics for people with dementia
- Accreditation as a Dementia Friendly Community
- Increased numbers of Carers Assessments completed at an early stage
- A Dementia Board to take forward developments

Healthy Weight and Good Nutrition

What is the issue / why is it important for Brighton & Hove?

- In Brighton and Hove an estimated 43,632 adults are obese and 6,500 are morbidly obese. An estimated 14,000 children and young people aged 2-19 years are overweight or obese. This is predicted to increase to 16,400 by 2020.
- Obesity is strongly correlated with inequalities and deprivation.
- The estimated annual cost to the NHS in the city related to overweight and obesity was £78.1 million in 2010. This is predicted to increase to £85 million by 2015.
- Excess weight is a major risk factor for diseases such as type 2 diabetes, cancer and heart disease. Each year in the South East coast area around 3,000 people die from heart disease and stroke attributable to overweight and obesity.

What are we doing well already?

- The local prevalence of overweight and obesity in children aged 10-11 years is below the national prevalence.
- Commissioning a range of weight management support in community and health care setting for both children and adults. These include MEND, Shape Up, and cooking and growing courses.
- Developing and delivering regular, sustainable programmes for children and adults to increase their physical activity levels. These include free swimming, the Active For Life programme, Healthwalks, Bike It, and exercise-referral schemes.
- The interventions currently in place are based on evidence and NICE guidance and on evidence of local needs through the JSNA. Service outcomes and effectiveness of interventions are regularly evaluated using the National Obesity Observatory Standard Evaluation Framework.
- Breastfeeding rates at 6 weeks are consistently much higher than nationally. Targeted work in areas of inequalities in the city shows an increase in breastfeeding rates in these areas. (Children who are breast-fed are less likely to become obese in later life).
- The Healthy School and School Meal teams are working with schools to promote healthy eating through teaching and learning opportunities across the curriculum.
- The local “Spade to Spoon: Digging Deeper” food strategy aims to improve the access of local residents to nutritious, affordable and sustainable food and to support the local population to eat a healthier and more sustainable diet. Brighton and Hove City Council One Planet Living’s Local and Sustainable Food Working Group is taking forward particular actions within the strategy including: procurement through catering contracts (sourcing seasonal local food and promoting good nutrition) both for Local Authority’s premises and NHS Trusts (including

Meals on Wheels, care homes, school meals); reducing food waste; and expanding land used for growing food.

- A recent Embrace audit found that, out of more than 500 community activities supporting vulnerable people talking place in Brighton & Hove every week, over 50 were food related. These included lunch or supper clubs and others focusing on supporting weight loss and or promoting active lifestyles. The activities are provided by voluntary and community based organisations.

- Promoting the Workplace Wellbeing Charter to all local businesses.

What are the gaps?

The current specialist weight management service is very limited and results in people being actively considered for bariatric surgery when alternative intensive support may have a similar successful outcome. There is a gap in the pathway for the weight management programme delivered in primary care for patients with co-morbidities associated with overweight and obesity.

- There are currently no reliable local data on adult obesity.
- Low levels of satisfaction in the community with local sports facilities.
- Low provision of physical activities in some local neighbourhoods – therefore people have to travel to leisure centres/other locations
- Availability and use of local produce by local organisations to provide healthy meals for the local population.

What can we do to make a difference?

The transfer of public health responsibility to the local authority provides a unique opportunity for collaborative working between planners, transport planners, environment health and licensing, healthy school teams and school meal teams to address the influences that contribute towards obesity – the “obesogenic environment”.

- Engagement at a local level from large retailers/supermarkets who have signed up to the national Public Health Responsibility Deal food pledges. In particular engaging local supermarket chains in proximity of schools in the city to promote healthier choices for children.
- Engagement from local take-away outlets in proximity of schools to influence food preparations (for e.g. salt content; use of trans-fats etc).
- Develop community assets to encourage the provision of neighbourhood based physical activities and food production e.g. allotments and gardens. Schools could be the hub for a community.
- Improve the quality of food served to people by public organisations-using local produce whenever possible.
- Explore extending the boundaries of the healthy settings programme to aim for the “ideal” healthy school.
- Improve the quantity and quality of local leisure and sports facilities.
- Work with local employers to make sure the workplace charter is actually being delivered.

Plan for improvement including key actions:

- Establish the Obesity Programme Board to provide the framework to bring together a wide range of organisations from the voluntary, public and private sectors (in particular food retailers).The Board's Action Plan outlines four separate domains with a series of actions for each of the partners, the funding sources and key performance indicators. The key objective is to strengthen local action to prevent overweight and obesity through a life course approach and to address obesity through appropriate treatment and support.
- Ensure the development of a comprehensive weight management service for children and adults from primary through to tertiary care.
- To build on the work with the local community to identify and develop local venues for healthy weight and good nutrition linked programmes.
- To consider the further development of schools as community hubs for promoting physical activity and healthy eating and the development of "stretched" healthy schools outcomes.
- To further develop the partnership with local leisure centre providers to increase local community participation.
- To strengthen the ongoing work with the local economic partnership to promote healthy eating and lifestyle to employees via the workplace.
- To use education initiatives to promote healthy and sustainable food choices and the skills to cook.
- To improve the information for people, particularly vulnerable people, about healthy eating options available in their local area.

Outcomes

- Reduction in prevalence of overweight/obese children from the National Child Measurement Programme dataset for children aged 10-11 years.
- Increase the proportion of children and young people achieving the Chief Medical Officer's recommendation for levels of physical activity including an increase in school based activity.
- Reduction in the prevalence of adults who are overweight or obese (estimated until the national data set is put in place)
- Increase the proportion of adults doing at least 30 minutes of moderate physical activity per week.
- An increase in the number of community assets linked to physical activity, cooking skills and healthy eating.

Smoking

What is the issue / why is it important for Brighton & Hove?

- Smoking is the greatest cause of health inequalities and premature mortality. Smoking rates are much higher amongst routine and manual workers and amongst people from some ethnic groups.
- Estimated that 26% of the Brighton and Hove population smoke compared with 21% for England
- 91% of year 7 pupils report never smoking compared with 38% of year 11 pupils.
- On average a lifelong smoker will lose ten years of their life.
- The three most common causes of death from smoking are lung cancer, chronic obstructive pulmonary disease and cardiovascular disease.

What are we doing already?

- The Brighton and Hove Tobacco Control Alliance has been established with multiagency representation. The Alliance has recently developed an action plan with three main areas; helping communities to stop smoking; maintaining and promoting smoke free environments; stopping the inflow of young people recruited as smokers/tackling cheap and illegal tobacco.
- Smoking cessation services are the most cost-effective life saving intervention provided by the NHS. The local stop smoking specialist service co-ordinates the local smoking cessation services and provides training and support for the intermediate services in primary care (general practices and pharmacies). Over the last ten years local smoking cessation services have helped around 30,000 people to try and stop smoking. In 2011/12 the stop smoking services helped 2,353 people to successfully quit.
- The specialist service provides stop smoking sessions in the most deprived neighbourhoods, and through workplaces helps smokers who are routine and manual workers to quit. There is a well established service within the hospital.
- Working with pregnant women. All pregnant women are now routinely screened with carbon monoxide monitors.
- Working with schools to reduce the number of young people starting smoking and to help those who smoke to quit.
- Linking in with national events such as “No smoking Day”

What are the gaps?

- Lack of regular up to date local smoking prevalence information.
- Involving local neighbourhoods and people in reducing smoking prevalence within their communities. The new Public Health outcome target is about prevalence not quitters which will require a different approach.
- Poor uptake of specialist stop smoking services programme by certain ethnic groups

- The Tobacco Control Alliance needs to become more firmly established.
- There is only limited intelligence about the use of illegal tobacco in the city.
- Future plans to promote more smoke free places

What can we do to make a difference?

- Working with communities to explore how they can help their community to reduce its smoking prevalence.
- Working with the community to understand the needs of all ethnic groups for smoking cessation services.
- Working with environmental health and licensing to use their regular and routine contact with restaurant staff and taxi drivers to reach smokers not accessing services. Link with the GMB union to access manual workers.
- Help more schools to develop smoking policies which include referral to stop-smoking services as an option for children who smoke and to provide staff-led stop smoking sessions within the school.
- Work with parents who smoke to help them understand the issues for their children, and to help them to quit.
- Patients who smoke and who are being referred for surgery should be seen by the stop smoking service to enhance their post-operative recovery.
- Encourage general practices to refer patients being considered for smoking cessation treatment to their own practice based intermediate services to improve clinical effectiveness.
- Further communication work including local websites and the use of viral media. Develop a local communications strategy for our local population, to include the promotion of stop smoking services.
- Promote no smoking in outside areas such as play areas, outside schools and on the beach.

Plan for improvement including key actions

- Work with CVSF/community engagement team to explore a community asset based approach to reducing smoking.
- Work with local ethnic communities and groups to develop suitable services
- Develop a plan for promoting no smoking in certain outdoor areas
- Work with all schools to improve education about tobacco and to help schools develop their smoking policies and in-house stop smoking services

Outcomes

- Reduction in smoking prevalence as per the Public Health outcomes framework
- Reduction in the SAWSS based smoking prevalence data on children and young people

- Increased number of smokers from different ethnic groups being seen by the Stop Smoking team

Inequalities

As the Joint Strategic Needs Assessment clearly demonstrates there are major inequalities within Brighton and Hove. For males living in the parts of the city with the highest levels of deprivation, life expectancy is 71.7 years compared with 81.7 years in the least deprived areas. The equivalent figures for females are 80.0 & 84.4 years respectively.

The Joint Health and Wellbeing Strategy is a key part of addressing local inequalities and the factors that influence them. The Health and Wellbeing Board will consider the impact of inequalities on the health and wellbeing of the city's population and also link with those partnerships with responsibility for directly tackling the wider determinants of health.

Inequalities exist across the city in different areas such as education, employment, housing and income. These social determinants have many consequences including affecting the health and wellbeing of the population and individuals, either directly or through their influence on lifestyle choices or their effect on access to health services. Health inequalities such as the variation in life expectancy across the city are the result of these inequalities. Therefore to improve life expectancy and health and wellbeing across the social gradient, both for communities and for individuals, requires action to address the inequalities in the social determinants of health as well as in preventive and treatment health services. Many of the changes required for social determinants will not have an impact for many years and should be considered as longer term interventions. However, there are also opportunities for short-term such as improvements in the identification and treatment of those people at-risk of serious disease disability and medium-term changes related to lifestyle.

In 2010 the Marmot Review "Fair Society, Healthy Lives" into health inequalities in England provided an evidence based strategy to address the broader determinants of health and reduce inequalities. The report emphasises the impact of social factors on inequalities and the need to tackle such variation across the social gradient in proportion to need ("proportionate universalism"). The report set six key policy and priority objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention

The Review provides a framework for approaching inequalities within Brighton and Hove. Tacking Inequality is one of the three priorities in the council's corporate plan for 2011-2015, and is also a duty of the Clinical Commissioning Group. The two other priorities in the council's corporate plan, engaging people who live and work in the city and creating a more sustainable city are also important to addressing inequalities.

Marmot recommendations and the relevant local high-level partnerships.

Key priority and policy objectives	**Examples of recommended interventions**	**Relevant Partnerships**	**Examples of ongoing/planned actions**
1. Give every child the best start in life	Provide good quality early years education and childcare	Learning partnership Health Visitor Implementation Group/Family Nurse Partnership Board Local Safeguarding Children Board Stronger Families Stronger Communities Partnership Board Brighton and Hove Strategic Partnership	Child Poverty Strategy Early Years Strategy Healthy Child programme
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives	Ensure reducing social inequalities in pupil's educational outcomes is a sustained priority.	Learning partnership City Employment and Skills Group City Inclusion Partnership Special Educational Needs Partnership Board Secondary Schools Partnership Adult Learning Group Youth Joint Commissioning Group Stronger Families Stronger Communities Partnership Board	Early Years Strategy City Employment and Skills Plan Equality Standard Special Educational Needs Strategy School Improvement Strategy Adult Learning Strategy Services for young people: joint commissioning strategy. Youth Crime Action Plan
3. Create fair employment and good work for all	Prioritise active labour market programmes to achieve timely interventions to reduce long-term unemployment	City Employment and Skills Group Economic partnership Brighton and Hove Apprenticeship Group	City Employment and Skills Plan Economic Strategy Apprenticeship Strategy

4. Ensure healthy standard of living for all	Develop and implement standards for a minimum income for healthy living.	City Employment and Skills Group Economic partnership Brighton and Hove Strategic Partnership	City Employment and Skills Plan Economic Strategy One Planet Framework
5. Create and develop healthy and sustainable places and communities	Prioritise policies that both reduce inequalities and mitigate climate change.	City Sustainability Partnership Transport Partnership Strategic Housing partnership Economic partnership	One Planet Framework City Plan Local Transport Plan 3 Housing Strategy Economic Strategy Healthy Schools Strategy Equality and Anti-bullying Strategy action Plan
6. Strengthen the role and impact of ill health prevention	Prioritise investment in health prevention and health promotion to reduce the social gradient.	NHS, local authority and voluntary sector partnerships covering issues such as smoking, alcohol, physical activity and healthy eating. Examples include the Alcohol Programme Board, the Sport and Physical Activity Strategy Group and the Tobacco Control Alliance. Youth Joint Commissioning Group	Tobacco Control Alliance Action Plan. CCG working to improve the detection and management of risk factors for premature morbidity and mortality, particularly amongst hard to reach groups. This includes the NHS Health Checks programme. Services for young people: Joint Commissioning Strategy

Local high-level partnerships relevant to the JSNA High impact issues

<table>
<tr><td colspan="5">Social issues</td></tr>
<tr><td></td><td>Children</td><td>Young people</td><td>“Adults”</td><td>Older people</td></tr>
<tr><td rowspan="2">Alcohol</td><td colspan="4">Alcohol programme board
Safe in the City Partnership Board</td></tr>
<tr><td></td><td>Youth Joint Commissioning Board</td><td></td><td></td></tr>
<tr><td>Healthy weight and good nutrition</td><td colspan="4">Physical activity steering group
Transport Partnership</td></tr>
<tr><td>Domestic and sexual violence</td><td colspan="4">Domestic violence working group</td></tr>
<tr><td>Mental health and emotional wellbeing</td><td colspan="2">Emotional Health & Wellbeing Partnership Board (up to25yrs)</td><td colspan="2">Mental health Clinical Reference Group
Suicide prevention group (18+yrs)</td></tr>
<tr><td>Smoking</td><td colspan="4">Tobacco Control Alliance</td></tr>
<tr><td>Disability</td><td colspan="2">Disabled children’s strategic partnership board

Youth Joint Commissioning Board

Transition forum</td><td colspan="2">Learning disability strategy and partnership group
Centre for Independent Living
Carers Group*</td></tr>
<tr><td colspan="5">Specific conditions</td></tr>
<tr><td></td><td>Children</td><td>Young people</td><td>“Adults”</td><td>Older people</td></tr>
<tr><td>Cancer and access to screening</td><td>Sussex Cancer Network</td><td>Sussex Cancer Network</td><td colspan="2">Sussex Cancer Network
Individual cancer screening steering groups for breast, bowel and cervical cancer.</td></tr>
<tr><td>HIV & AIDS</td><td></td><td colspan="3">Sussex HIV Network
Sexual Health Clinical Reference Group</td></tr>
<tr><td>Musculoskeletal</td><td></td><td colspan="3">Ongoing Sussex-wide review group</td></tr>
<tr><td>Diabetes</td><td colspan="4">Diabetes Clinical Reference Group</td></tr>
<tr><td>Coronary Heart Disease</td><td></td><td></td><td colspan="2">Sussex Cardiac Network</td></tr>
<tr><td>Flu immunisations</td><td>Local Immunisation & Vaccination</td><td colspan="3">Seasonal flu group</td></tr>
</table>

	Committee			
Dementia				Sussex-wide Dementia Partnership Brighton & Hove Dementia Strategy Implementation Group Carers Strategy Group
Wider determinants				
	Children	**Young people**	**"Adults"**	**Older people**
Child poverty	Child poverty strategy and task group			
Education	The Learning Partnership Secondary Schools Partnership Healthy Settings Programme Panel		Adult Learning Group	
Employment /Unemployment	Economic Partnership City Employment & Skills Steering Group Employer Engagement Group			
Housing	Strategic Housing Partnership.			
Fuel poverty	Overseen by Strategic Housing Partnership			

*The Carers Group is relevant to most of the areas above.

Engagement and Consultation

There has been broad consultation on the JSNA and JHWS, including:

- A gap analysis of JSNA data conducted by Brighton & Hove Community & Voluntary Sector Forum (CVSF) in January 2012.

- Two stakeholder involvement events focusing on the development of a local Health & wellbeing Board, including a focus on developing a local JHWS.

- An involvement event held in March 2012 bringing together stakeholders from the local community and voluntary sector, the city council, the Clinical Commissioning Group, health providers and NHS Sussex to discuss the JSNA and JHWS.

- Community and voluntary sector involvement in the JSNA 'prioritisation' process.

- Engagement with relevant city council, CCG and community and voluntary sector groups in developing the action plans for each of the JHWS priority areas.

- Participation in a July workshop event organised by CVSF – explaining and debating the JSNA and JHWS with CVSF members.

- Public consultation in summer 2012 on the draft JSNA summary and JHWS priorities.

Feedback from all of these engagement activities has informed the development of the JSNA and the JHWS.

Once a draft JHWS is approved by the Brighton & Hove Shadow Health & Wellbeing Board there will be further consultation on the draft with key partners including city strategic partnerships and service providers. A revised draft JHWS will be taken to the statutory Health & Wellbeing Board in or after April 2013 to be approved as the city Joint Health & Wellbeing Strategy.

Sussex Partnership NHS Foundation Trust - Dementia Services

Sussex Partnership is the main NHS provider of mental health services across Sussex. The Trust has recently announced that tackling dementia is one of its key priorities, and this is detailed below:

Improving services for people with dementia, their carers and families is a top priority for Sussex Partnership. The priorities the Trust is working on support those identified in the National Dementia Strategy, which are:

i. Good quality early diagnosis and intervention for all
ii. Improved quality of care in general hospitals
iii. Living well with dementia in care homes
iv. Reduced use of antipsychotic medication
v. Support at home at a time of crisis

Specialist community teams for older people provide follow up and support to people with dementia, their carers and families. These are integrated health and social care teams that aim to ensure people live well with dementia in their own homes for as long as possible and receive optimal evidence based care. Plans have been agreed with the Clinical Commissioning Group to redesign these community teams to ensure they interface with the Memory Assessment Service for the city that is currently being commissioned and is due to commence in April 2013. As part of the redesign we will be reviewing the potential for greater partnership working with the Royal Sussex County Hospital and with the third sector.

The dementia liaison services the Trust provides work with the Elderly Care Physicians at the Royal Sussex County Hospital to improve the care of people with dementia in hospital. We have established a shared care ward for people with dementia at the Princess Royal Hospital, with great success and we would like to develop a similar service at the Royal Sussex.

Our Care Home Inreach Team consisting of several mental health Professionals has input into 13 Residential and Nursing Homes in the area in order to give advice and training to Residential Home Staff on the appropriate management of people with challenging behaviour due to dementia. This includes reducing the inappropriate use of antipsychotic medication and advising on how to develop advance decision-making for people with dementia living in Residential Care together with the Elderly Physical Care Home Inreach Service. The Inreach Team have had an impact in reducing the number of people in Residential Care who require hospital admission and the Team has a continuing impact on quality of care and financial spend within Brighton and Hove. We have plans to

provide an integrated Dementia Crisis Service in collaboration with the Community Rapid Response Service to help avoid hospital admissions and to reduce length of stay in hospital.

Our inpatient services on Brunswick Ward at Nevill Hospital in Hove provide a comprehensive assessment and multidisciplinary management for people with dementia who are exhibiting challenging behavioural and psychological symptoms of dementia.

All of our dementia services are closely linked with the Research and Development Department in Sussex Partnership so that people with dementia within Brighton and Hove can participate in clinical research trials and have access to the latest evidence-based investigations, treatments and interventions for dementia. Sussex Partnership and Brighton and Sussex Medical School have appointed a leading academic to the new post of Professor of Dementia Studies.

At Sussex Partnership we work with a broad range of commissioners and providers of dementia services through the Sussex Dementia Partnership which is currently chaired by Dr Mandy Assin, Clinical Director. The dementia partnership includes representatives from the Alzheimer's Society, care home providers, acute trusts, GPs, commissioners, and Sussex Partnership senior clinicians and managers.

SHADOW HEALTH & WELLBEING BOARD	Agenda Item 18 Brighton & Hove City Council

Subject:		**Department of Health Consultation on Joint Strategic Needs Assessment (JSNA) and Joint Health & Wellbeing Strategy (JHWS)**	
Date of Meeting:		**12 September 2012**	
Report of:		**Strategic Director, People**	
Contact Officer:	**Name:**	**Giles Rossington**	**Tel: 29-1038**
	Email:	**Giles.rossington@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The Department of Health (DH) has recently begun consulting on its plans to issue statutory guidance, in support of the Health & Social Care Act (2012), with specific regard to the Health & Wellbeing Board (HWB) duties to publish a local Joint Strategic Needs Assessment (JSNA) and a local Joint Health & Wellbeing Strategy (JHWS). The draft guidance and consultation questions are included as **Appendix 1** to this report.

1.2 DH is soliciting stakeholder responses to its consultation questions, and this represents an opportunity for Shadow Health & Wellbeing Board (SHWB) members to express their views on the statutory guidance relating to these major HWB duties.

1.3 The consultation window closes in late September 2012, so any decision to submit a response from the SHWB will realistically have to be made at the 12 September 2012 meeting. In order to make the process of agreeing a submission manageable, officers have drawn up their outline response to the consultation questions plus a brief narrative reaction to the guidance itself (**Appendix 2**). It is recommended that the SHWB uses this response as the basis for its submission, adding, removing or amending elements in accordance with the views of members.

2. RECOMMENDATIONS:

2.1 That the SHWB agrees to submit a response to the DH consultation on statutory guidance relating to the JSNA and JHWS duties;

2.2 That the SHWB uses the officer response to the consultation (**Appendix 2**) as a basis for its submission.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The Health & Social Care Act (2012) transfers responsibility for the publication of a local JSNA to the HWB. It also establishes a duty for the HWB to publish a local JHWS.

3.2 Primary legislation is not very prescriptive in relation to either of these duties; the DH has advised local areas that this is intentional: localities are to be empowered to design locally appropriate systems, within a minimal framework prescribed via statutory guidance.

3.3 The DH has recently published a draft of this guidance and is currently consulting with stakeholders. In general, the draft guidance accords with informal advice from the DH over the past few months and is in line with the commitment to localism detailed above.

3.4 Officers have therefore welcomed the guidance, although there are some areas where it could be clearer. These are described in more detail in the draft officer response (**Appendix 2**).

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 No formal consultation has been undertaken in relation to this report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are no financial implications arising from this report.

Finance Officer Consulted: Anne Silley Date: 17/08/12

Legal Implications:

5.2 There are no legal implications arising from this report.

Lawyer Consulted:Elizabeth Culbert Date: 17/08/12

Equalities Implications:

5.3 None directly: there are significant equalities issues to consider in the context of both the JSNA and JHWS, but the draft DH guidance does not focus on these areas.

Sustainability Implications:

5.4 None directly: both the JSNA and JHWS may have implications for sustainability, but these do not feature in the draft DH guidance.

Crime & Disorder Implications:

5.5 None directly: both the JSNA and JHWS may have implications for crime and disorder, but these do not feature in the draft DH guidance.

Risk and Opportunity Management Implications:

5.6 There is a risk management process in place for both the JSNA and JHWS (the latter as part of the risk management of the development of a local HWB). The draft JHWS and JSNA guidance generally accords with our current practice/planning for these areas, and would not increase any identified risk. The suggestions for amending the guidance included in the draft officer response (**Appendix 2**) would, if adopted by the DH, help clarify some issues, further reducing some risks.

Public Health Implications:

5.7 The latest draft guidance clearly identifies the duties of the key local organisations regarding the preparation of the JSNA and JHWS. The guidance also highlights potential data and information sources, including the identification of community assets which should help to strengthen the JSNA and JHWS.

Corporate / Citywide Implications:

5.8 The JSNA and JHWS are both important tools to be used to meet corporate and citywide commitments to reduce inequalities and improve the health and wellbeing of the local population. The draft DH guidance accords with our current planning for these matters, but could be improved by adopting the suggestions outlined in the draft officer consultation response (**Appendix 2**).

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 The draft officer response to the DH draft guidance (Appendix 2) generally welcomes this iteration of the guidance, which is more concise and less ambiguous than previous versions, and accords with planning in relation to the JSNA and JHWS. Officers agreed on the minor changes they would recommend be made and there was no serious consideration of other options.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The recommendations included in the draft officer response to the DH consultation (Appendix 2) seek to clarify some elements of the draft guidance, making it easier to plan the work of the HWB in relation to the JSNA and JHWS. A submission based on these recommendations may therefore help influence the DH to make some positive amendments to its guidance.

SUPPORTING DOCUMENTATION

Appendices:

1. Department of Health draft guidance on JSNA and JHWS and consultation questions.

2. Draft officer response to the DH consultation questions/guidance.

Documents in Members' Rooms

None

Background Documents

1. Health & Social Care Act (2012)

Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – draft guidance

Proposals for consultation

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	**Social Care / Partnership Working**

Document Purpose	Consultation/Discussion
Gateway Reference	17858
Title	Draft Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
Author	Department of Health
Publication Date	**31 July 2012**
Target Audience	NHS Trust CEs, Foundation Trust CEs , Directors of PH, Local Authority CEs, Directors of Adult SSs, Allied Health Professionals, GPs, Communications Leads, Directors of Children's SSs, Healthwatch England and local pathfinders, CCG pathfinders, shadow HWBs, voluntary and community sector organisations
Circulation List	
Description	The purpose of this publication is intended to support health and wellbeing boards and their partners in undertaking and contributing to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS) within the modernised health and care system.
Cross Ref	Joint Strategic Needs Assessments and joint health and wellbeing strategies explained. Equity and excellence: Liberating the NHS, Liberating the NHS: Legislative framework and next steps and The Government response to the NHS Future Forum report.
Superseded Docs	N/A
Action Required	N/A
Timing	**N/A**
Contact Details	Freya Lock People, Communities and Local Government LG05 Wellington House 133-155 Waterloo Road SE1 8UG 0207 972 4237
For Recipient's Use	

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Contents

1. Purpose

The Health and Social Care Act 2012[1] ('the Act') amends the Local Government and Public Involvement in Health Act 2007 ('the 2007 Act') to introduce duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs). This statutory guidance explains these duties and powers. Further materials, including advice on good practice will be published with this statutory guidance to support health and wellbeing boards.

2. Context

In the Act, the Government has set out a new vision for the leadership and delivery of public services – that decisions about services should be made as locally as possible, involving people who use them and the wider local community. The Act supports local clinical leadership and democratically elected leaders working together to deliver the best health and care services based on the best evidence of local needs. JSNAs and JHWSs are an important means by which they can achieve this.

The aim of JSNAs and JHWSs is to improve the health and wellbeing of the local community and reduce inequalities for all ages. They are not an end in themselves, but a continuous process of strategic assessment and planning. They will be used to help to determine what actions local authorities, the NHS and other partners need to take to meet health and social care needs and to address the wider determinants that impact on health and wellbeing[2].

3. Duties and powers under the 2007 Act (as amended by the Act)[3]

3.1 Who is responsible for JSNAs and JHWSs?

Local authorities and clinical commissioning groups (CCGs) have an equal and joint duty to prepare JSNAs and JHWSs, through the health and wellbeing board[4]. The responsibility falls on the health and wellbeing board as a whole and so success will depend upon all members[5] working together throughout the process.

Two or more health and wellbeing boards could choose to work together to produce JSNAs and JHWSs, covering their combined geographical area[6].

Local authorities and health and wellbeing boards can decide to include additional members on the board beyond the core members[7]. Additional members, such as service providers, health and care professionals, representatives of criminal justice agencies, local voluntary and community sector organisations, or representatives of military populations and their families, can bring expert knowledge to enhance JSNAs and JHWSs.

The NHS Commissioning Board (NHS CB) must participate in JSNAs and JHWSs. Someone who is not from the NHS CB can act for it. This could be someone from a clinical CCG, if the health and wellbeing board agrees[8].

3.2 What are Joint Strategic Needs Assessments (JSNAs)?

JSNAs are local assessments of current and future health and social care needs that could be met by the local authority, CCGs, or the NHS CB[9]. They are produced by health and wellbeing boards[10], and are unique to each local area.

In preparing JSNAs and JHWSs, health and wellbeing boards must have regard to any guidance issued by the Secretary of State[11]. This includes this guidance, and any future guidance issued.

A range of quantitative and qualitative evidence should be used in JSNAs. They can also be informed by more detailed local needs assessments such as at a district or ward level, looking at specific groups (such as those likely to have poor health outcomes), or on wider issues that affect health such as crime, community safety, planning or housing. Health and wellbeing boards can request relevant information from some members (and others)[12] when preparing JSNAs or JHWSs – and those asked have a duty to supply the information. They should ensure that staff supporting JSNAs and JHWSs have easy access to the evidence they need.

JSNAs must consider health and social care needs for the health and wellbeing board area. This includes mental health, health protection, and prevention; it could include looking at the role of personal budgets and universal advice. Therefore health and wellbeing boards will need to consider:

- the needs of the whole community including how needs vary for people at different ages, and may be harder to meet for those in disadvantaged areas or vulnerable groups who experience inequalities, such as people who find it difficult to access services;
- wider social, environmental and economic factors that impact on health and wellbeing – such as access to green space, air quality, housing, community safety, employment; and
- what health and social care information the local community needs, including how they access it and what support they may need to understand it.

Within JSNAs, health and wellbeing boards should also consider what local communities can offer in terms of assets and resources[13] to help meet the identified needs.

3.3 What are Joint Health and Wellbeing Strategies (JHWSs)?

JHWSs are strategies for meeting the needs identified in JSNAs[14]. As with JSNAs, they are produced by health and wellbeing boards[15], and are unique to each local area. They should explain what health and wellbeing priorities the health and wellbeing board has set in order to tackle the needs identified in their JSNAs. This is not about taking action on everything at once, but about setting priorities for joint action and making a real impact on people's lives.

Outcome measures from the separate NHS, Adult Social Care and Public Health Outcomes Frameworks, the Commissioning Outcomes Framework and outcome strategies, will be useful to help inform joint priorities, although they should not overshadow local evidence.

In preparing JHWSs, health and wellbeing boards must have regard to the Secretary of State's mandate[16] to the NHS CB[17].

3.4 Using JSNAs and JHWSs

JSNAs and JHWSs are fundamental to the new system because of how they are used, and the evidence base they provide for the planning of services.

CCGs, the NHS CB, and local authorities' plans for commissioning services must be informed by JSNAs and JHWSs. Where plans are not in line with JSNAs and JHWSs, CCGs, the NHS CB and LAs must be able to explain why[18].

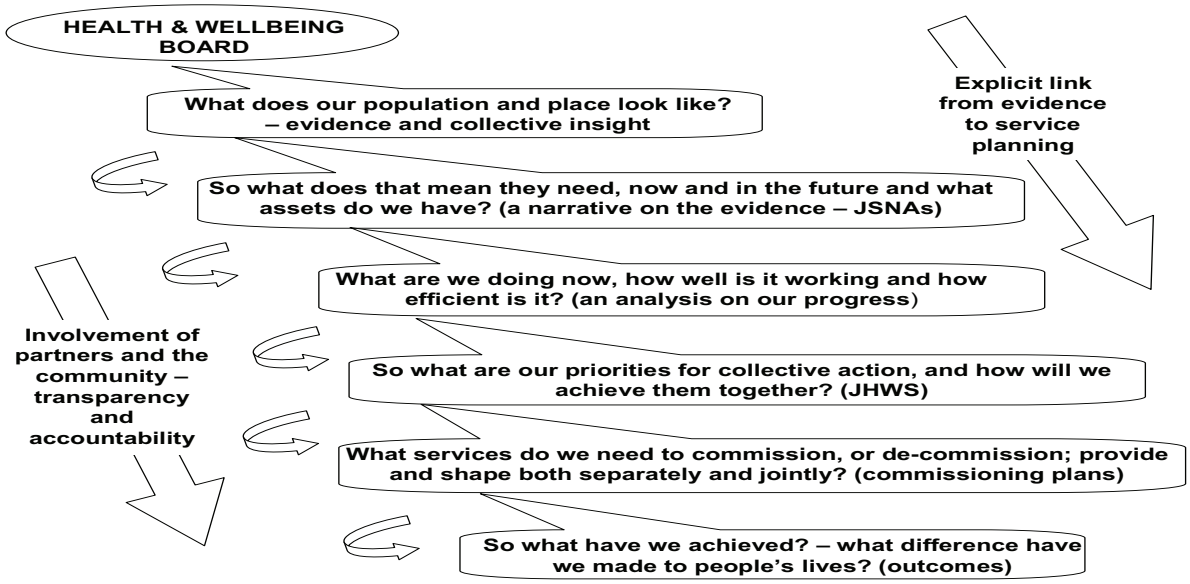
CCGs must also involve the health and wellbeing board in the preparation of (or when making significant changes to) their commissioning plans[19]. CCGs must consult health and wellbeing boards on whether their commissioning plans take proper account of the JHWSs[20]. When asked, health and wellbeing boards must give a view on this, which must be included in the published plan[21]. It would be good practice for local authorities and the NHS CB to also involve health and wellbeing boards when developing their plans for commissioning to make sure that each plan is informed by the JHWS. By their nature, commissioning plans will need to cover a broad range of services – inclusion of plans for services which meet needs in addition to those prioritised in the JHWS does not in itself mean the plans do not take account of the JHWS

If a health and wellbeing board thinks that a CCG has not taken proper account of the relevant JHWSs it can make this known in very clear and certain terms to the CCG, and also to the NHS CB[22]. As mentioned above, the CCG must be able to justify any parts of their plans which are not consistent. The NHS CB can take action if it believes that the plan is not in line with the JHWS, without a good reason[23].

Under the Act, upper-tier local authorities are required to work to improve the health of their populations[24]. This duty is an opportunity for local authorities to embed health improvement in all policy- and decision-making, which will also help address needs identified in JSNAs and priorities agreed in JHWSs.

If the health and wellbeing board does not believe that a local authority has taken account of the JSNAs or JHWSs, it can raise its concerns with the local authority[25].

Figure 1 – How JSNAs, JHWSs and commissioning plans fit together



3.5 Timing

JSNAs and JHWSs are continuous processes, and are an integral part of CCG and local authority commissioning cycles [26]. Health and wellbeing boards will need to decide for themselves when to update JSNAs and JHWSs or undertake fresh ones to ensure that they are able to inform local commissioning plans over time - JSNAs and JHWSs do not need to be done from scratch every year.

4. Promoting integration between services

JHWSs can help health and social care services to be joined up with each other and with health-related services[27], such as housing, the economy or the environment.

Health and wellbeing boards must encourage integrated working between health and social care commissioners, and support and encourage partnership arrangements for health and social care services[28], such as pooled budgets, lead commissioning, or integrated provision[29]. In JHWSs, health and wellbeing boards must consider how far needs can be met more effectively by working together in this way[30].

Health and wellbeing boards can encourage close working between commissioners of health-related services and themselves; and commissioners of health and social care services[31]. This could potentially involve considering the commissioning of health-related services either with or by a broad range of local partners, such as district councils, local authority housing commissioners, local community safety partnerships, Police and Crime Commissioners, local probation trusts, prisons, children's secure estates and schools. In this way health and wellbeing boards can use the priorities agreed in JHWSs to influence other services that also affect health to improve outcomes and also to encourage the integration of services.

The NHS CB must encourage partnership arrangements between CCGs and local authorities[32] where it considers this would ensure the integrated provision of health services and that this would improve the quality of services or reduce inequalities[33] and CCGs must integrate services to achieve this, where possible. This should help encourage joint working between CCGs and local authorities in order to tackle the priorities jointly agreed in JHWSs.

The Act supports joint working by allowing local authorities to delegate functions to the health and wellbeing board[34]. This could result in health and wellbeing boards taking on health-related functions, such as preparing housing strategies, which could help in tackling the agreed local priorities. To avoid potential conflicts of interest the power of delegation does not include health scrutiny functions[35]. Health scrutiny is an important way that the local authority (and through it, local people) can hold some health and wellbeing board members to account for delivering health services, or consider how the JSNA and JHWS process is used to plan services.

JHWSs could consider how services might be reshaped and redesigned to address needs identified in JSNAs and reduce inequalities. Using local JSNA evidence and agreed JHWS priorities means local service change plans will complement other local commissioning, and this will encourage greater integration across health and social care services.

5. Working in partnership to carry out JSNAs and develop JHWSs

Health and wellbeing boards for county councils must involve the relevant district councils in developing JSNAs[36]. They should seek to work with district councils when preparing JHWSs and to agree with district councils how they will do this.

Health and wellbeing boards must involve the local Healthwatch organisation[37] and the local community[38], and this should be continuous throughout the JSNA and JHWS process. When involving the local community, health and wellbeing boards should consider inclusive ways to involve people from different parts of the community to ensure that differing health and social care needs are reflected and can be addressed by commissioners, recognising the need to engage with parts of the community that are socially excluded and vulnerable[39].

Health and wellbeing boards should also work closely with other partners such as Police and Crime Commissioners, criminal justice agencies, youth justice services, troubled families co-ordinators, local authority housing services, schools, voluntary and community organisations, Local Nature Partnerships, representatives of military populations and their families; and Department for Work and Pensions local partnership teams[40], to get a thorough understanding of local needs and how to address them.

Local Healthwatch and the voluntary and community sector (including organisations that represent specific groups) can provide information to help JSNAs better reflect the needs and views of people in vulnerable circumstances and this can support the development of a JHWS to meet those needs. Most local areas will have a Compact agreement[41] setting out how local authorities and the NHS will work with voluntary and community organisations for mutual benefit and these should be considered during the process.

Service providers[42] can also provide important evidence about local needs and take action to improve outcomes, although health and wellbeing boards will need to consider how any conflicts of interest will be managed.

6. Transparency and accountability

JSNAs and JHWSs must be published[43]. Making them public will explain to the local community what the health and wellbeing board's assessment of the local needs and assets is and what their proposals to address them are, with clear measures of progress over time. It will also show what evidence has been considered, what priorities for action have been agreed and why. The publication should include a summary of community views, how they have been used; and also whether any other relevant views have been considered.

Sharing the analysis behind JSNAs, and (if appropriate) safely making the data they have used accessible, will help health and wellbeing boards make their decision-making process transparent to their community and to be held to account[44].

7. Other duties

As a local authority committee, a health and wellbeing board must meet the Public Sector Equality Duty under the Equality Act 2010 throughout the JSNA and JHWS process. This is not just about how the community is involved, but about considering the effects decisions have or are likely to have on people with protected equality characteristics[45], and perhaps other groups identified as vulnerable in JSNAs. Integrating equality considerations into the JSNA and JHWS process, can help public sector organisations to discharge their responsibilities under the Public Sector Equality Duty[46].

Preparing JSNAs and JHWSs can support other legal duties, for example, in relation to the reduction of crime (including antisocial behaviour)[47]. They can also contribute to other local partnerships such as Community Safety Partnerships (CSPs)[48] or where they exist, Local Enterprise Partnerships (LEPs)[49].

8. Conclusion

By having full engagement of all health and wellbeing board members, wider local partners and the local community, JSNAs will provide a unique picture of local needs and assets. By agreeing joint local priorities in JHWSs to inform joint action to tackle these needs, health and wellbeing boards will be able to lead action to improving people's lives and reduce inequalities.

9. Consultation Questions

1. Does the guidance translate the legal duties in a way which is clear in terms of enabling an understanding of what health and wellbeing boards, local authorities and CCGs *must* do in relation to JSNAs and JHWSs?

2. It is the Department of Health's (DH's) view that health and wellbeing boards should be able to decide their own timing cycles for JSNAs and JHWSs in line with their local circumstances rather than guidance being given on this; and this view was supported during the structured engagement process. Does the guidance support this?

3. Is the guidance likely to support health and wellbeing boards in relation to the content of their JSNAs and JHWSs?

4. Does the guidance support the principle of joined-up working, between health and wellbeing board members and also between health and wellbeing boards and wider local partners in a way that is flexible and suits local circumstances?

5. The DH is working with partners to develop wider resources to support health and wellbeing boards on specific issues in JSNAs and JHWSs, and equality is one theme being explored.
a) In your view, have past JSNAs demonstrated that equality duties have been met?
b) How do you think the new duties and powers, and this guidance will support health and wellbeing board members and commissioners to prevent the disadvantage of groups with protected characteristics, and perhaps other groups identified as in vulnerable circumstances in your area?

6. a) In your view, have JSNAs in the past contributed to developing an understanding of health inequalities across the local area and in particular the needs of people in vulnerable circumstances and excluded groups?
b) What supportive materials would help health and wellbeing boards to identify and understand health inequalities?

7. It is the DH's view that health and wellbeing boards should make use of a wide range of sources and types of evidence for JSNAs and they should be able to determine the best sources to use according to local circumstances. This view was supported during the structured engagement process. What supportive materials would help health and wellbeing boards to make the best use of a wide range of information and evidence to reach a view on local needs and assets, and to formulate strategies to address those needs?

8. What do you think NHS and social care commissioners are going to do differently in light of the new duties and powers, and as a result of this guidance? – what do you think the impact of this guidance will be on the behaviour of local partners?

9. How do you think your local community will benefit from the work of health and wellbeing boards in undertaking JSNAs and JHWSs? – what do you think the impact of this guidance will be on the outcomes for local communities?

10. Have your say

The Government has committed to publishing guidance on enhanced JSNAs and JHWSs which are to be undertaken by health and wellbeing boards. The Government wants to hear your views on whether this draft guidance supports health and wellbeing boards, and their partners in understanding the purpose of JSNAs and JHWSs, and the duties and roles of health and wellbeing boards in undertaking them.

Deadline for comments

This is an eight-week consultation running from **31 July 2012** to **28 September 2012**. In order to be considered all comments must be received by **28 September 2012**. Your comments may be shared with colleagues in the Department of Health and/or be published in a summary of responses. Unless you specifically indicate otherwise in your response, we will assume that you consent to this and that your consent overrides any confidentiality notice generated by your organisation's email system.

The eight-week consultation period (which is shorter than the full 12-week period set out in the HMGovernment Code of Practice on Consultation) is because the Government has developed the current draft in collaboration with emerging health and wellbeing boards and undertook a structured engagement exercise during January and February of this year. Over 100 responses were received as a result of the exercise and the draft guidance has been revised to reflect these.

Shadow health and wellbeing boards, once established, will want to consider and prepare for carrying out JSNAs and JHWSs ready for April 2013, when the relevant provisions of the Health and Social Care Act 2012 will come into effect. An eight-week consultation will allow the Government to publish the final guidance in time to support preparations for April 2013.

Consultation timeline

31 July	Consultation document published
28 September	Consultation ends – responses must be returned to the Department of Health by this date
Autumn 2012	Final guidance document and response to consultation published

How to respond

Please submit your responses online at JSNAs and JHWSs draft statutory guidance consultation or by email to JSNAandJHWS@dh.gsi.gov.uk

OR

By hard copy to
JSNA and JHWS development lead
People, Communities and Local Government,
Department of Health
Wellington House
133-155 Waterloo Road
London
SE1 8UG

When responding, please state whether you are responding as an individual or representing the views of an organisation. If responding on behalf of a larger organisation, please make it clear whom the organisation represents and, where applicable, how the views of members were assembled.

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information (FOI) Act 2000, the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOI Act, there is a statutory Code of Practice with which public authorities must comply, and which deals, among other things, with obligations of confidence. In view of this, it would be helpful if you could explain to use why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and, in the majority of cases, this will mean that your personal data will not be disclosed to third parties.

Criteria for consultation

This consultation follows the 'Government Code of Practice', in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible
- be clear about the consultation's process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process
- analyse responses carefully and give clear feedback to participants following the consultation
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at:
Link to consultation Code of Practice

After the consultation

Once the period is complete, the Department of Health will consider the comments it has received, and the response will be published alongside the final guidance.

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at:

Link to DH Consultations

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

Contact Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE
E-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's **Information Charter.**

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

Impact assessment

The impact assessment which accompanied the Health and Social Care Bill assesses the costs, benefits and risks of the enhanced JSNA process and the new duty to develop JHWSs. This guidance, which supports health and wellbeing boards and their partners in undertaking and contributing to JSNAs and JHWSs, will help to support the realisation of the costs and benefits set out in this impact assessment.

[1] The relevant parts of which are expected to come into force on 1 April 2013.
[2] More information can be found in *Fair Society, Healthy Lives (the Marmot Review), 2010*
[3] The duties required by, and the powers conferred by the Act, the 2007 Act (as amended by the Act), and the NHS Act 2006 (as amended by the Act) relating to the preparation of JSNAs and JHWSs are summarised and referenced throughout. Where 'must' is used, this indicates something required by one or other of the Acts. Where 'can' is used, this indicates a power in one or other of the Acts. Where 'could' is used, this indicates an example of how that power could be used if appropriate. Where 'should' is used it indicates something that is statutory guidance – something that is not required by the Acts, but it is recommended in order to achieve the spirit of the Acts or in accordance with sector-led best practice, and to which there is a statutory duty to have regard.
[4] The 2007 Act – section 116 (as amended by the Act – section 192) and section 116A (as inserted by the Act – section 193); and the Act – section 196.
[5] The Act – section 194: each upper tier local authority in England must set up a health and wellbeing board, with a core membership of: a) at least one elected representative – councillor(s) nominated by the leader or the mayor of the local authority (and / or the leader or mayor themselves), or in some cases by the local authority; b) a representative of each clinical commissioning group (CCG) whose area is within or partly within, or coinciding with the local authority area – CCGs may be required to appoint representatives to more than one health and wellbeing board if their area falls within more than one local authority area; c) the directors of public health, adult social services, and children's services; and d) a representative of the local Healthwatch organisation.
[6] The Act – section 198(a) allows two or more health and wellbeing boards to make arrangements for any of their functions to be exercised jointly.
[7] 'Core members' is a reference to the members in the Act (section 194) – see Footnote 4. A local authority or health and wellbeing board can appoint other members to the board.
[8] The duty on the NHS CB to appoint a representative to participate in JSNAs and JHWSs is in section 197(1) and (2) of the Act. Section 197(5) provides that the representative may be someone who is not a member or employee of the NHS CB, with the health and wellbeing board's agreement.
[9] The 2007 Act – section 116 (as amended by the Act – section 192).
[10] The duty falls on local authorities and CCGs but must be discharged by health and wellbeing boards (the Act – section 196(1)). Where the guidance refers to something that health and wellbeing boards must do in relation to JSNAs, the source of this is a duty imposed on the local authority and CCG.
[11] The 2007 Act – section 116 (as amended by the Act – section 192) and section 116A (as inserted by the Act – section 193).
[12] The Act – section 199. Health and wellbeing boards have the power to request information from the local authority, or the CCGs and local Healthwatch organisations represented on the board. They also have the power to request information from members, or those organisations represented by members other than the core members. The request must be made in order to enable or assist health and wellbeing boards to perform their functions – in this context, to enable or assist health and wellbeing boards to undertake JSNAs and JHWSs.
[13] There are a range of assets within local communities that can help meet identified needs and impact on the wider determinants of health. These could include formal or informal resources, capacity in other organisations or the community; such as the ability of groups to take greater control of their own health or manage long-term conditions. Supporting communities and encouraging people to improve their health and wellbeing is central to achieving the Government's vision. Strong communities can improve health and wellbeing, and reduce inequalities *(Foot, J., What makes us healthy? The asset-based approach in practice: evidence, action, evaluation, 2012).* There are a number of methods being developed, (Local Area Co-ordination, Connected Care or Asset-Based Community Development) – these examples may be useful to health and wellbeing boards.
[14] The 2007 Act – section 116A (as inserted by the Act – Section 193).
[15] The duty falls on local authorities and CCGs but must be discharged by health and wellbeing boards (the Act – section 196(1)). Where the guidance refers to something that health and wellbeing boards must do in relation to JHWSs, the source of this is a duty imposed on the local authority and CCG.
[16] This is currently being consulted on.
[17] The 2007 Act – section 116A (as inserted by the Act – section 193).
[18] The 2007 Act – section 116B (as inserted by the Act – section 193) requires local authorities and CCGs, in exercising any functions and the NHS CB, in exercising its commissioning functions in relation to the local area, to have regard to any JSNA and JHWS which is relevant to the exercise of those functions.
[19] The NHS Act 2006 – section 14Z13 inserted by section 26 of the Act. The duty on the CCG is to involve each relevant health and wellbeing board. A relevant health and wellbeing board, in relation to a CCG, is one which is established by a local authority whose area coincides with, or includes the whole or any part of, the area of the CCG – the NHS Act 2006 - section 14Z11 (as inserted by the Act - section 26).

[20] The NHS Act 2006 – section 14Z13 inserted by section 26 of the Act. The duty on the CCG is to consult each relevant health and wellbeing board on whether the draft commissioning plan takes proper account of each JHWS published by the board which relates to the period (or any part of the period) to which the plan relates..
[21] The NHS Act 2006 – section 14Z13 (as inserted by section 26 of the Act). The CCG must include a statement of the final opinion of each relevant health and wellbeing board consulted upon publication of the plan
[22] The NHS Act 2006 – section 14Z13 (as inserted by the Act - section 26).
[23] Action could be taken if the NHS CB has reason to believe that the CCG might fail, have failed, be failing to discharge any of its functions. It could require documents, information or an explanation (the NHS Act 2006 – sections 14Z18 or 14Z19).
[24] The NHS Act 2006 – section 2B (as inserted by the Act - section 12).
[25] The Act – section 196.
[26] The NHS Act 2006 – sections 14Z1 and 14Z24 (as inserted by of the Act – section 26). CCGs must develop commissioning plans to be in place before the beginning of each financial year (or before a date directed by the NHS CB as regards the financial year of establishment) and most local authorities also plan yearly.
[27] The 2007 Act – section 116A (as inserted by the 2012 Act – section 193). Health-related services are those that are not health or social care services, but may have an effect on health outcomes, as defined in the Act – section 195; such as transport, planning or environmental services insofar as they may have an effect on health.
[28] The Act – section 195.
[29] The NHS Act 2006 – section 75.
[30] The 2007 Act – section 116A (as inserted by the Act – section 193).
[31] The Act – section 195.
[32] And also between CCGs where this would lead to improvements and integrated services, which may be prioritised in JHWSs. The NHS Act 2006 - section 13N (as inserted by the Act – section 23).
[33] The NHS Act 2006 – section 13N (as inserted by the Act – section 23). This also applies where the NHS CB considers that partnership arrangements would lead to integrated provision of health services with social care or health-related services, and that this would improve the quality of services or reduce inequalities.
[34] The Act – section 196.
[35] The Act – section 196.
[36] The 2007 Act – section 116 (as amended by the Act – section 192).
[37] The 2007 Act – section 116 (as amended by the Act – sections 192) and section 116A (as inserted by the Act – section 193). The duty to involve the local Healthwatch organisation for the area is separate to (ie, not discharged only by) local Healthwatch being represented on the health and wellbeing board.
[38] The 2007 Act – section 116 (as amended by the Act – sections 192) and section 116A (as inserted by the Act – section 193). The duty to involve the local community is a requirement to involve the people who live or work in the area, and does not distinguish between children and adults.
[39] Such as people with disabilities, homeless people, offenders, victims of crime, or Gypsies and Travellers.
[40] Serving both working age (through Jobcentres), and pension age clients.
[41] More information is provided by Compact Voice.
[42] For instance Foundation Trusts, care homes; and providers of domiciliary care services.
[43] The 2007 Act – section 116 (as amended by the Act – section 192) and section 116A (as inserted by the Act – section 193).
[44] Government Open Data policies provide more information.
[45] This includes age, disability, gender reassignment, pregnancy and maternity, race (includes ethnic or national origins, colour or nationality), religion or belief (includes lack of belief), sex, and sexual orientation.
[46] As public authorities, both local authorities and CCGs have general and specific duties under the Equality Act 2010, designed to integrate consideration of advancing equality; eliminating discrimination and fostering good relations into the day-to-day business of public authorities; and to help them improve their performance on the general equality duty by improving their focus and transparency. These duties will apply to health and wellbeing boards as a committee of the local authority, including when discharging functions on behalf of the local authority and CCGs. Local authorities remain responsible for ensuring that the general and specific equality duties are met.
[47] The Crime and Disorder Act 1998 ('the 1998 Act') – section 6 places a statutory duty on responsible authorities (including local authorities, the Police, Probation Trusts, Fire and Rescue Authorities, and from April 2013 CCGs) to formulate and implement strategies for the reduction of crime and disorder (including anti-social behaviour); for combating the misuse of drugs, alcohol and other substances; and for the reduction of reoffending.
[48] CSP is a term used to refer to the group of responsible authorities under section 5 of the 1998 Act which have duties to prepare the strategies referred to in footnote 50. From April 2013 CCGs will replace PCTs as responsible authorities due to amendments made to section 5 of the 1998 Act by the Act – Schedule 5 paragraph 84. They offer a way for all partners to focus on improving health and wellbeing, and crime outcomes together.
[49] LEPs are non-statutory partnerships between local authorities and business, – *Local Growth White Paper*, 2010

Appendix 2

Draft Officer Response to DH Consultation on the JSNA and JHWS

General comments

- The second draft is much more concise, clearer and more helpful document than the first draft guidance. The emphasis on partnership working and involving the local community is very clear, as is the joint duty of the CCG and Local Authority to prepare the JSNA and JHWS.

- It is acknowledged that the duties of the various organisations and Health and Wellbeing Board are included in an appendix but it would be helpful to have the key duties and powers of the Health and Wellbeing Board regarding the JSNA and JHWS reiterated in the main text.

- To avoid misunderstanding regarding issues not prioritised within the JHWS, it would be helpful to emphasise that the JHWS is not the only local strategic document of importance and that other key issues should continue to be addressed.

Consultation Questions

Q1. Does the guidance translate the legal duties in a way which is clear in terms of enabling an understanding of what health and wellbeing boards, local authorities and CCGs *must* do in relation to JSNAs and JHWSs?

Generally yes - this is clearly described in section 3 of the document. However it would be helpful for the guidance to include clarification on two issues:

- what the HWB's responsibilities are as regards other partnerships such as the Local Strategic Partnership.

- What the relationship between the HWB and Public Health England is (particularly in regard to the duty (p5) to include health protection in the JSNA).

Q2. It is the Department of Health's (DH's) view that health and wellbeing boards should be able to decide their own timing cycles for JSNAs and JHWSs in line with their local circumstances rather than guidance being

given on this; and this view was supported during the structured engagement process. Does the guidance support this?

This is clearly stated in 2.5. This is considered to be a sensible approach.

Q3. Is the guidance likely to support health and wellbeing boards in relation to the content of their JSNAs and JHWSs?

The overarching definition of JSNAs as "assessments of future health and social care needs that could be met by the local authority, CCGs or NHS CB" (p4) seems reductive. JSNAs should reflect health and wellbeing needs that could be met by other organisations or by communities themselves. Indeed the rest of the guidance supports this.

The guidance is more descriptive of JSNA responsibilities than JHWS responsibilities.

Q4. Does the guidance support the principle of joined-up working, between health and wellbeing board members and also between health and wellbeing boards and wider local partners in a way that is flexible and suits local circumstances?

Yes but it would be helpful to have more guidance regarding how HWB will work with other partnerships rather than just the local authority being able to delegate functions to the HWB.

Q5. The DH is working with partners to develop wider resources to support health and wellbeing boards on specific issues in JSNAs and JHWSs, and equality is one theme being explored.
a) In your view, have past JSNAs demonstrated that equality duties have been met?

They have contributed to this but generally their role has been to flag up where inequalities exist rather than ensuring that equalities duties have been met. It is our view that other evidence needs to be considered to demonstrate the extent to which equalities duties have been met. They have also been limited by the availability of data on equalities groups.

b) How do you think the new duties and powers, and this guidance will support health and wellbeing board members and commissioners to prevent the disadvantage of groups with protected characteristics, and perhaps other groups identified as in vulnerable circumstances in your area?

The guidance is not very strong on addressing inequalities. It would be reasonable to propose that the HWB consider adopting a framework such as Marmot's within which to consider local inequalities.

JSNA are a valuable a source of evidence for completion of Equality Impact Assessments, and could also potentially be used by Scrutiny committees to inform their investigations.

Q6. a) In your view, have JSNAs in the past contributed to developing an understanding of health inequalities across the local area and in particular the needs of people in vulnerable circumstances and excluded groups?

Yes but this has often been restricted to comparisons based on age, gender and deprivation, and sometimes ethnicity. The JSNA now has an opportunity to incorporate information from the improved equalities monitoring of service users.

b) What supportive materials would help health and wellbeing boards to identify and understand health inequalities?

It is more about understanding the limitations of the data/information available, the timescales involved in narrowing the gap and that it is really about inequalities not just health inequalities.

Continuing and developing the programme of topic based health profiles currently provided by PH Observatories. There is a clear role for PH England to support consistent national level analysis.

Q7. It is the DH's view that health and wellbeing boards should make use of a wide range of sources and types of evidence for JSNAs and they should be able to determine the best sources to use according to local circumstances. This view was supported during the structured engagement process. What supportive materials would help health and wellbeing boards to make the best use of a wide range of information and evidence to reach a view on local needs and assets, and to formulate strategies to address those needs?

It would be helpful to make it clear for all potential contributors and users the need for the information provided to be quality assured in some way. This is not to minimise the contribution but for all parties to understand that the JSNA will not always be able to use the data provided. Further guidance on asset mapping and their use would be helpful.

Disseminate best practice and research evidence on effective methodologies for asset assessment (building on established work such as A Glass Half Full). Possibly national/regional training or events on this approach would be of value.

Q8. What do you think NHS and social care commissioners are going to do differently in light of the new duties and powers, and as a result of this guidance? – what do you think the impact of this guidance will be

on the behaviour of local partners? Joint Health and Wellbeing Strategies – draft guidance

The new duties and powers and associated guidance will encourage closer working. Initially this is most likely to be between the CCG and local authority, but over time is likely to expand to include other local partnerships and agencies.

The guidance provides an opportunity to place JSNAs at the centre of commissioning but this needs to be reiterated in subsequent guidance and nationally led development of CCGs, NHS CB etc to support HWBBs in maintaining this focus locally.

Q9. How do you think your local community will benefit from the work of health and wellbeing boards in undertaking JSNAs and JHWSs? – what do you think the impact of this guidance will be on the outcomes for local communities?

The establishing of the HWB, and the greater emphasis on community involvement and stronger partnership working will act as a catalyst to progress those areas where improvements can still be made by closer working between partners.

The overall outcomes for local communities should be improved. However, it will be important to manage expectation and communicate that some outcomes will take longer than others to achieve (outcomes should be considered as short, medium and long term).

JSNAs should reflect the outcomes that are important to local communities. Aspects of the guidance on JSNA, eg involvement of Healthwatch and community & voluntary sector groups should support this. As mentioned in Section 6, communities will be able to use the JSNA to scrutinise decisions and hold decision makers to account.