Brighton & Hove City Council

Shadow Health & Wellbeing Board

Title:	**Shadow Health & Wellbeing Board**
Date:	**20 March 2013**
Time:	**5.00pm**
Venue	**Council Chamber, Hove Town Hall**
	Board Members
Councillors:	Jarrett (Chair), Bennett, Duncan, Meadows, K Norman, Shanks (Deputy Chair), Wilson
BHCC: CCG Youth Council HealthWatch	Heather Tomlinson, Interim 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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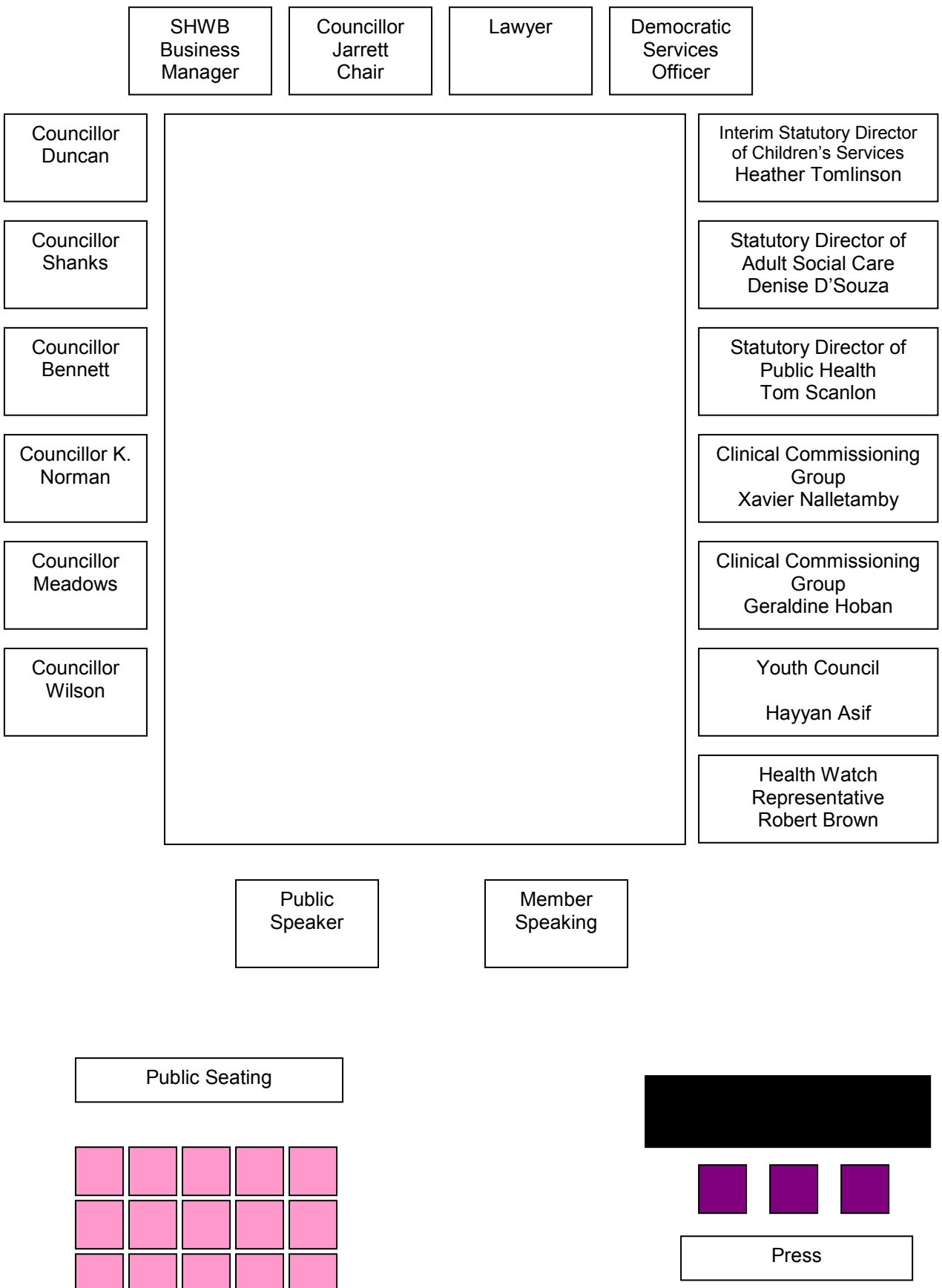
Democratic Services: Shadow Health & Wellbeing Board



AGENDA

PART ONE **Page**

30. 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.

31. MINUTES 1 - 10

Minutes of the meeting held on the 5 December 2012 (copy attached).

32. CHAIR'S COMMUNICATIONS

33. PUBLIC INVOLVEMENT

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

(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 13 March 2013.
(c) **Deputations** – to receive any deputations submitted by the due date of 12 noon on the 13 March 2013.

34. ISSUES RAISED BY COUNCILLORS AND MEMBERS OF THE BOARD 11 - 12

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 (copy attached).
(c) Letters – to consider any letters.
(d) Notices of Motion – to consider any notices of motion.

35. JOINT HEALTH & WELLBEING PRIORITIES **13 - 22**

a) Cancer & access to cancer screening (copy attached).

b) Dementia (copy attached).

(Presentations and Q&A on each priority action plan. The action plans will be presented by the lead commissioners in each service area.)

36. JOINT STRATEGIC NEEDS ASSESSMENT UPDATE **23 - 28**

Report of Director of Public Health (copy attached)

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

37. SHADOW HEALTH & WELLBEING BOARD: ACHIEVEMENTS AND CHALLENGES **29 - 38**

Report of Director of Public Health (copy attached).

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

38. CCG AUTHORISATION

CCG presentation.

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

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

SHADOW HEALTH & WELLBEING BOARD

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Date of Publication - Tuesday, 12 March 2013

SHADOW HEALTH & WELLBEING BOARD	Agenda Item 31 Brighton & Hove City Council

BRIGHTON & HOVE CITY COUNCIL

SHADOW HEALTH & WELLBEING BOARD

5.00pm 5 DECEMBER 2012

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Jarrett (Chair) Councillors Bennett, Meadows, Shanks (Deputy Chair), Wealls and Wilson

Other Members present: Heather Tomlinson, Interim 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, Geraldine Hoban, Clinical Commissioning Group, Hayyan Asif , Youth Council , Robert Brown, HealthWatch.

PART ONE

20. PROCEDURAL BUSINESS

20A Declarations of Substitute Members

20.1 Councillor Wealls declared that he was substituting for Councillor Norman.

20B Declarations of Interests

20.2 There were none.

20C Exclusion of the Press and Public

20.3 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.

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

21. MINUTES

21.1 **RESOLVED:** That the minutes of the meeting held on the 12th September 2012 be approved as a correct record of the proceedings and signed by the Chair.

22. CHAIR'S COMMUNICATIONS

Welcome to Councillor Chaun Wilson and Heather Tomlinson

22.1 The Chair welcomed Councillor Wilson and Heather Tomlinson, Interim Statutory Director of Children's Services, as new members of the Board.

Clinical Commissioning Group Developments

22.2 The Chair asked Geraldine Hoban to provide an update on the development of the Clinical Commissioning Group. Ms Hoban informed the Board that the PCT would be handing over responsibility to the CCG on 1 April 2013. There had been a process of authorisation over the last few months. The NHS Boards were judging the process by 360 degree stakeholder questioners, desk top review of plans and 120 key lines of enquiry. There had been a visit by the NHS Commissioning Board. Against the 120 criteria, all but 12 criteria had been approved, and a small amount of work was required on these 12 criteria. A more formal mechanism for collaborative commissioning with other CCG's was required. The CCG had come out strongly with regard to its work within the city. There was a clear coterminous relationship with the local authority.

22.3 Members were informed that the CCG had appointed nearly all members of the governing body and the local authority were represented. There were three clinical leads for Brighton. One had been appointed already. The CCG were planning to start holding Boards in public from January 2013.

22.4 The Chair thanked Ms Hoban and stated that he hoped she would give a further update to the next meeting.

23. PUBLIC INVOLVEMENT

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

24. ISSUES RAISED BY COUNCILLORS AND MEMBERS OF THE BOARD

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

25. NOMINATION OF A MEMBER TO REPRESENT THE SHWB TO THE KENT, SURREY & SUSSEX LOCAL EDUCATION & TRAINING BOARD

25.1 The Board considered a report of the Director of Public Health which explained that the Local Education & Training Boards (LETB) were part of the new NHS structures, working alongside NHS providers to manage and co-ordinate NHS training on a regional basis. The Kent, Surrey & Sussex LETB had written to all Shadow Health & Wellbeing Boards in its patch requesting that the SHWBs each nominate a board member to act as the board's representative in dealings with the LETB.

25.2 Robert Brown asked if the Local Education and Training Board would be looking to deliver training on a multi-agency basis and whether local education providers would be involved such as the Friends Centre, the Whitehawk Inn and Bridge.

25.3 Robert Brown further asked how the Board would ensure that local people would benefit the most from training opportunities.

25.4 Geraldine Hoban replied that she would be happy to be the Board's representative to the LETB. She had attended a stakeholder event on this matter last week. Ms Hoban did not know the level at which the LETB offered training. However it seemed quite a high level. She would find out and share what she learnt with the Board.

25.5 Tom Scanlon stated that he would collaborate with Ms Hoban on this matter.

25.6 The Chair stated that Geraldine Hoban could report back to the Board at what level the LETB were operating.

25.7 **RESOLVED** – (1) That it be agreed to nominate the CCG Chief Operating Officer to represent the Board to the Local Education & Training Boards (LETB).

26. JOINT HEALTH & WELLBEING PRIORITIES

a) Smoking

26.1 The Board considered a presentation from Tim Nichols, Head of Regulatory Services and Sue Venables, Health Development Specialist (Tobacco Control) on Stop Smoking & Tobacco Control in Brighton & Hove. Mr Nichols explained that he chaired the Tobacco Control Alliance and Ms Venables was the main project worker.

26.2 The presentation explained why tobacco control was key. It set out the cost of treating smoking related diseases to the NHS, explained that smoking was the primary cause of premature death and stressed the large numbers of young people under the age of 16 who either lived with someone who smoked or tried smoking for the first time. Research had suggested that targeting routine and manual workers would have the greatest gain in reducing health inequalities as they found it harder to quit.

26.3 The presentation explained that smoking had three indicators under the Public Health Outcome Framework. These were 1. Reducing Smoking Prevalence – Adults (18s). 2. Reduce the prevalence of smoking among 15 year olds. 3. Smoking status at time of delivery.

26.4 Members were informed of national updates, such as the vending machine ban and the ban on tobacco displays and plain packs.

26.5 Members were informed of the work of the Brighton & Hove Stop Smoking Service and the Brighton & Hove Tobacco Control Alliance. Finally the Board was reminded of the Joint Health and Wellbeing Strategy, Areas for Stronger Partnership Working in relation to smoking.

26.6 Councillor Meadows referred to the slide that compared the number of referrals to number of quitters per quintile. This showed that deprived areas had the least quitters. Councillor Meadows stressed that people in these areas had a lot to deal with in their lives. She asked officers whether they worked with other agencies to help people with

their problems. Councillor Meadows also asked where work was being carried out in schools.

26.7 Ms Venables explained that the Stop Smoking Service ran clinics in deprived areas. These were hard to reach clients as they had other things to deal with in their lives. Ms Venables agreed that there was a need to help this community. Work had been carried out at three schools, Vardean, Dorothy Stringer and Hove Park.

26.8 Denise D'Souza asked how many people went back to smoking after quitting. The Deputy Director of Public Health explained that NICE estimated the number of people still quitting after one year was 14% to 20%.

26.9 Tom Scanlon stated that he was worried that the figures might be affected by smokers imported from elsewhere. He would like see a target that was aimed at residents of Brighton & Hove. This was something that could be looked at after one year.

26.10 Councillor Shanks suggested that there should be targets for reducing smoking. The emphasis was currently about quitting. The Head of Regulatory Services stressed that there were no safe levels of smoking.

26.11 Questions were raised about the cost efficiency of concentrating on deprived areas. The Deputy Director of Public Health stated that it made sense to concentrate on urban deprived areas. He stressed the benefit to the health service. However, he accepted that dealing with inequalities would require additional resources.

26.12 Heather Tomlinson asked for views about which areas of Healthy Schools which needed strengthening. She mentioned a plan to promote a smoke free environment around the entrances to schools.

26.13 Tim Nichols explained that the Joint Health and Wellbeing Strategy had previously had three areas for stronger partnership working in relation to smoking. A fourth had now been added "Promoting smoke free environments, such as children's play areas in parks, areas of the beach and school entrances." A voluntary approach was required.

26.14 Councillor Meadows referred to the working age statistics. She suggested that the operation and productivity of business should be investigated in relation to smoking. Smokers could often be seen outside hospitals and council buildings.

26.15 Tom Scanlon referred to failed test purchases and asked what sanctions were in place.

26.16 Tim Nichols explained that small convenience stores were more likely to fail test purchases. An offence could attract a fixed penalty notice. Meanwhile Trading Standards officers ran training to support businesses. This tended to be more successful than enforcement.

26.17 Robert Brown referred to the £2.7 billion cost to the NHS in treating smoking related diseases in 2006/7. He asked if the tax on cigarettes would cover that amount.

26.18 Tim Nichols replied that it was not possible to work out if the taxation system was enough to cover the cost of treating smoking related illnesses.

26.19 Hayan Asif asked if collages and universities were targeted. Sue Venables explained that officers did carry out work in universities and colleges.

26.20 The Chair thanked Mr Nichols and Ms Venables for their presentation. He suggested they attended a future Board meeting to provide an update.

26.21 **RESOLVED** – That the presentation be noted.

b) Health, Weight & Good Nutrition

26.22 The Board considered a presentation from Lydie Lawrence, Public Health Development and Improvement Manager, BHCC and Vic Borrill of the Brighton & Hove Food Partnership. The presentation considered the challenges to healthy weight and nutrition. The presentation set out the case for tackling obesity as prevalence of obesity in England was one of the highest in Europe.

26.23 Members were informed of the estimated prevalence of adult obesity in Brighton & Hove and percentages for reception year children and year 6-11 year olds who were overweight & obese, compared with South East Coast SHA and England. A graph showed the prevalence of obesity by decile of deprivation for 4-5 year and 10-11 years. Ward maps showed figures for children with a healthy weight 4-5 years and 10-11 years.

26.24 The presentation gave details of prevention and the management and treatment of obesity. Members were informed of the work of the Healthy Weight Programme Board and collaborative work with partners.

26.25 Councillor Meadows mentioned that there were older people in Moulsecoomb who were referred to a lunch club to ensure they had good nutrition. She stated that the NHS used to fund the Healthy Neighbourhood Fund. This funding had been lost and there were fewer of these types of activity taking place. She asked how they could be replaced. Vic Borrill explained that discussions were taking place in the Active for Life Team and Sport Development Team to keep the programme running. Tom Scanlon confirmed that officers were trying to identify funding to keep projects running in neighbourhoods.

26.26 Robert Brown asked the following questions. 1. What provision was being made for obesity amongst populations that have higher risks of obesity? In particular: BME communities, adults with learning disabilities, and those with mental health issues. 2. What is the role of public institutions (for example hospital, care homes, universities) in promoting a good diet? 3) The Council's allotment strategy is due to be drafted soon, what is the role of allotments in promoting healthy eating and exercise in the city and how much is allocated for community gardens?

26.27 Mr Brown was informed that officers were working closely with BME communities to give advice on cultural diets. Work was also taking place with people with Learning Disabilities. There were lunch clubs for people with Learning Disabilities. Dieticians visited the clubs once a month. It was acknowledged that there was a gap in services for people with mental health problems. This matter needed to be considered by the Healthy Weight Programme Board.

26.28 Lydie Lawrence spoke about the role of public institutions in promoting a good diet. She explained that officers carried out a great deal of work in schools on healthy diets and keeping active. Work was being carried out in care homes and nursing homes with the Food Partnership. Officers did not work specifically in hospitals. Hospitals had their own procurement programmes. It was acknowledged that allotments were where older people could get exercise and healthy food. More research could be carried out in that area.

26.29 Councillor Bennett mentioned that some people had success with diets they had paid for privately. She asked if there could be funding towards these diets.

26.30 Xavier Nalletamby replied that some diets were dangerous otherwise the NHS would support them.

26.31 Tom Scanlon informed Councillor Bennett that Public Health paid for recognised private companies such as Weight Watchers and the Rosemary Conley classes. However less successful diets were not funded.

26.32 Denise D'Souza asked if the work on diet and smoking was being carried out in partnership. She was informed that in terms of the Healthy Weight Programme, there was a close relationship with the Stop Smoking and Tobacco programme. Meanwhile it was known that people who reduced alcohol intake were losing weight.

26.33 Councillor Wilson referred to sugar addiction. There were women who had lost weight by eradicating sugar from their diets. Councillor Wilson mentioned that public community areas such as grass verges could be used as allotments.

26.34 Councillor Wilson was informed that any plan recommended by public health needed to have a balanced approach to losing weight. That included sugar reduction. Harvest Brighton & Hove was a programme to encourage local people to grow their own food. More communal sites needed to be found for such projects.

26.35 Tom Scanlon suggested that work could be carried out in hospitals as many NHS staff were obese. He referred to the childhood statistics on obesity and healthy weight. The impact of takeaway food was an area that needed to be investigated. For example, portion size needed to be considered. Mr Scanlon stated that he would like to see more work with takeaways and pubs to ensure there was a healthy choice. There needed to be more focus on where people ate.

26.36 Hayan Asif asked how the Older People's Council and Youth Council and secondary schools could input on this issue.

26.37 Ms Lawrence explained that primary schools had been mentioned in the context of the child measurement programme. It was recommended that there was a great deal of work that could be carried out in secondary schools. Public Health was in discussion with some secondary schools. The council did not have control of school meals in secondary schools as they did with primary schools.

26.38 Vic Borrill informed the Board that it was known that girls and young women often stopped being active in sport. The Albion and Active for Life were targeting schools.

26.39 Ms Lawrence explained that she would refer the question about the involvement of the Youth Council/Older People's Council and community groups to the Healthy Weight Programme Board.

26.40 The Chair thanked Ms Lawrence and Mr Borrill for the presentation.

26.41 **RESOLVED** – That the presentation be noted.

27. SHADOW HEALTH & WELLBEING BOARD REVIEW - FACILITATION BY LOCAL GOVERNMENT ASSOCIATION

27.1 The Board considered a presentation from Jeremy Crabb of the Local Government Association on Brighton and Hove Health and Wellbeing Board development. Mr Crabb stressed that it was important to consider how services joined up and worked together.

27.2 Mr Crabb informed members that it was necessary to consider the identity and role of the Board. He suggested setting up confidential one to one telephone interviews for those who were happy to take part.

27.3 Mr Crabb discussed the LGA Health and Wellbeing Development tool, the purpose of which was to help HWBs go beyond assessing how ready a Board is, towards how effective it was in practice, and how that effectiveness was enhanced over a period of time. The Board might want to think about what its unique contribution was, and might want to think about leadership values, relationships and ways of working.

27.4 Robert Brown asked if wider stakeholders in the city would be engaged in the review (for example, residents and Community Associations and voluntary sector) and if so how.

27.5 Mr Crabb explained that this would be the Board's decision. The Board would have the say on stakeholder work.

27.6 Councillor Meadows referred to the development tool example and made the point that the Board would be working with organisations such as the Brighton and Sussex University Hospitals NHS Trust which covered other areas in Sussex as well as Brighton & Hove.

27.7 Mr Crabb suggested the issue of how the Board engaged effectively with large organisations such as the hospital trust could be discussed in a joint session.

27.8 Hayyan Asif asked if the Board would assess other Health and Wellbeing Boards. Mr Crabb replied that he had knowledge of the Health and Wellbeing Boards he was working with. He could inform Mr Asif of how matters were dealt with elsewhere.

27.9 The Chair asked members to let the Shadow Health & Wellbeing Board Business Manager know if they were happy to be contacted for one to one sessions.

27.10 Mr Crabb suggested that a slot be arranged in January for a joint session.

27.11 **RESOLVED –** (1) That Board members inform the Shadow Health & Wellbeing Board Business Manager if they would like to be contacted for one to one sessions.

(2) That a joint session with Mr Crabb be arranged in January 2013.

28. REFERRAL FROM HWOSC: "TALK HEALTH" PARENT CARERS' VIEWS ON HEALTH SERVICES

28.1 The Board considered a letter from Councillor Sven Rufus, Chair of the Brighton & Hove Health & Wellbeing Overview and Scrutiny Committee and "Talk Health" a paper produced by the Parent Carers' Council and Amaze on Parent Carers' views on health services in Brighton & Hove 2012.

28.2 The Chair informed the Board that the letter and report had been submitted for information.

28.3 Xavier Nalletamby stated that it was a helpful report and an important area of healthcare. The CCG could share the report with its partners. The report related to a group of parents with particular health concerns. Dr Nalletamby had brought the report to the attention of his practice last week and there had been a good discussion regarding reprioritising appointments.

28.4 Geraldine Hoban informed members that the CCG had a Transforming Children's Services Group. Amaze was a member of that group. The CCG wanted to have a regular dialogue with them.

28.5 Councillor Meadows asked why the Health & Wellbeing Overview and Scrutiny Committee had not endorsed the recommendations. She asked if the Parent Carers' Council was working with the Carers Centre which worked with both adults and children.

28.6 The Shadow Health & Wellbeing Board Business Manager explained that there had been a discussion with the Carers Centre and Amaze. They did not want the HWOSC to agree the recommendations but to work as champions.

28.7 Councillor Shanks explained that Amaze was funded by the council. There were a number of support groups within Amaze which was a guiding organisation. She was not sure how the Parent Carers' Council related to the Carers Centre. The Chair remarked that this matter could be checked.

28.8 Tom Scanlon stated that he did not think that Amaze should be appointed as a member of the Health & Wellbeing Board. Their concerns could be considered under the category of emotional wellbeing.

28.9 The Chair stated that the question of further representation onto the Board could be discussed after the Board had worked with Jeremy Crabbe of the Local Government Association.

28.10 The Chair asked Xavier Nalletamby to provide a written version of his response. This was agreed by Dr Nalletamby.

28.11 **RESOLVED** – (1) That the letter from Councillor Rufus and the "Talk Health" paper be noted.

29. LOCAL SAFEGUARDING CHILDREN'S BOARD (LSCB) ANNUAL REPORT FOR 2011/12

29.1 The Board considered a report of the Local Safeguarding Children's Board Independent Chair which presented the Brighton & Hove Local Safeguarding Children Board Annual Report 2011-12. The report explained that the Apprenticeship, Skills, Children and Learning Act 2009 introduced a requirement for Local Safeguarding Children's Boards (LSCBs) to produce and publish an Annual Report on the effectiveness of safeguarding in the local area. The council had a statutory duty to ensure that there was an effective LSCB, and also was a provider of safeguarding services and a member of the LSCB.

29.2 Alan Bedford, LSCB Independent Chair presented the report. He stated that there was no requirement to take the annual report to the Shadow Health and Wellbeing Board and there needed to be some thought about the relationship with the Board and safeguarding.

29.3 Mr Bedford stressed that two big issues to consider were the changes taking place in public services and the number of referrals.

29.4 Councillor Meadows referred to section 5.4 of the Annual Report with regard to home education. This stated that children may be at potential risk due to possible social isolation. Councillor Meadows questioned the quality of home education. Meanwhile, Councillor Meadows asked if there had been any thought to having joint work on a child and adult strategy.

29.5 Mr Bedford replied that home education and safeguarding was an important area to investigate. The relationship with adult safeguarding was also very important.

29.6 The Chair stated that there was a link between the two safeguarding boards and this matter should be investigated.

29.7 Councillor Shanks stated that it was important to support women with children. If women could be supported in the first place it would prevent problems occurring.

29.8 Geraldine Hoban agreed that early intervention to support families was important. A workshop was being planned around that issue.

29.9 The Shadow Health & Wellbeing Board Business Manager informed members that the current revised guidance for children's safeguarding stated that future Annual reports would be submitted to the Health & Wellbeing Boards.

29.10 Robert Brown asked Mr Bedford what strategies and support would be put in place to prevent children from being the subject of a Child Protection Plan a second or subsequent time. The report stated that the percentage of children affected had had almost doubled.

29.11 Alan Bedford explained that the most important thing was to manage the review of cases. There had been a slight increase in the number coming back a second time. It was possible that some children were taken off the plan too early. The scrutiny of decision making was key.

29.12 **RESOLVED** - (1) That the content of the report be noted.

(2) That it is noted that the report had been submitted to the Children and Young People Committee on 12 November 2012.

The meeting concluded at 7.34pm

Signed Chair

Dated this day of

SHADOW HEALTH & WELLBEING BOARD	Agenda Item 34B Brighton & Hove City Council

WRITTEN QUESTIONS FROM COUNCILLORS

(a) Councillor Graham Cox

'The RNIB has produced a template for local authorities which can assist organisations when developing their needs assessment for blind and partially sighted people. Can you confirm that the City Council's Health and Wellbeing Strategy identifies the need of blind and partially sighted people living in our area and of those at risk of losing their sight? Will the Health and Wellbeing Board be including information on sight loss, and how it will meet the needs of the blind and partially sighted, in the future?'

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).

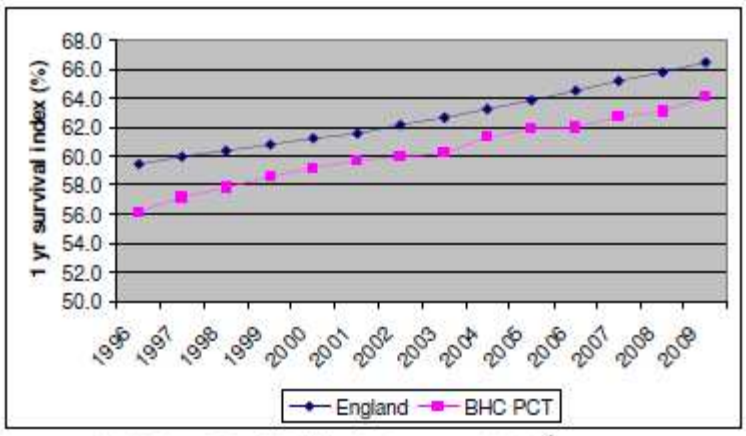
Incidence and mortality from cancer is considerably higher amongst the more deprived groups, largely due to lifestyle factors, such as higher smoking rates. The mortality gap between the poorest groups and the most affluent appears to be widening.

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

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

SHADOW HEALTH AND WELLBEING BOARD

Agenda Item 36

Brighton & Hove City Council

Subject:		**Joint Strategic Needs Assessment Update**
Date of Meeting:		**20 March 2013**
Report of:		**Tom Scanlon, Director of Public Health**
Contact Officer:	**Name:**	**Kate Gilchrist** **Tel: 29-0457**
	Email:	**Kate.gilchrist@brighton-hove.gov.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). This duty will be discharged by the Health and Wellbeing Board. The purpose of this item is to ask the Shadow ***Board to approve the production of the JSNA summary for 2013.*** The planned programme of in depth needs assessments for 2013/14 will be brought to the May Board for approval.

2. RECOMMENDATIONS:

2.1 That the Shadow Board considers, and agrees, an option for the 2013 JSNA summary (see 3.6). The recommended option of the City Needs Assessment Steering Group is Option 2.

2.2 Subject to recommendation 2.1, that the Board approves the suggested plan and timetable for the 2013 JSNA summary.

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.

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.

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 City Needs Assessment Steering Group will become a subgroup of the Board in relation to JSNA from April 2013.**

3.5 The JSNA summary structure is 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 2012 consultation. For the 2012 refresh we have produced a series of summaries grouped under key outcomes. Building on previous years most of the sections will be 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 options for the 2013 JSNA summary are:

3.6.1 Option 1: Do not update the JSNA summary in 2013. This would save resource in terms of officer time. However, the 2012 consultation highlighted areas for further improvement in the JSNA including:

- Ensure equalities are systematically included in the JSNA and where possible evidence strengthened.
- Make the JSNA summary more accessible
- Increasing evidence from the community and voluntary sector to strengthen the JSNA
- Improving engagement in the JSNA
- Continue to embed an assets approach within JSNA
- Increase "Voice" in the JSNA

With option 1, these would not be considered in 2013.

3.6.2 Option 2: Update the summary and strengthen evidence in the areas identified in the action plan, but do not repeat the assessment of high impact health and wellbeing issues conducted in 2012 or hold a formal consultation. This option would involve a review of the JSNA sections (already underway) and the following activities to strengthen the evidence in the JSNA:

- Sections reviewed and updated
- Recommendations updated and action from previous year added

- New data from the 2011 Census and the 2012 Health Counts survey incorporated into the summary
- A call for evidence from the community and voluntary sector
- An easy read summary of the JSNA produced
- Equalities gap analysis taken to the City Inclusion Partnership
- Review of assets approach to JSNA in other areas

This option would require officer time for authors and the Public Health team in coordinating, editing and publishing the JSNA.

With this option it is not proposed that the assessment of high impact health and wellbeing issues is conducted in 2013. This was undertaken in 2012 and involved significant resource from officers, the CCG, GPs and the community and voluntary sector to develop. As the first Joint Health and Wellbeing Strategy will be published early in 2013/14 and the population level impact will not change significantly from year to year, it is proposed under this option that the impact assessment be conducted every three to five years.

Under this option it is also not proposed to undertake a formal consultation on the JSNA in 2013. Given the 2012 consultation and the suggested engagement outlined above, it is proposed that another consultation in 2013 would not be a good use of the resources involved and that ongoing engagement during the year is more appropriate.

3.6.3 **Option 3: As option 2 but repeat the impact assessment conducted in 2012 and hold a formal consultation.** This option would require significant resource in terms of officer time. Given the 2012 consultation and the suggested engagement outlined under option 2, it is suggested that another consultation in 2013 would not be a good use of the officer resource involved and that ongoing engagement during the year is more appropriate and more in line with the City Engagement Framework. As the first Joint Health and Wellbeing Strategy will be published early in 2013/14 and the population level impact will not change significantly from year to year, it is recommended that the impact assessment be conducted every three to five years.

3.7 **The recommended option of the City Needs Assessment Steering Group is Option 2.**

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 The consultation report on the 2012 summary was presented as part of the JSNA item at the September 2012 shadow Board.

4.2 It is proposed that the 2013 summary has no formal consultation period. However, the following activities have been undertaken, or are planned, as part of the ongoing engagement in the JSNA under option 2:

- Gap analysis on equalities evidence within the JSNA to the March City Inclusion Partnership
- Community and Voluntary Sector call for evidence for the JSNA

- HealthWatch role to be agreed once established in April 2013

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The estimated impact on resources is set out in paragraph 3.6. The resources required to develop the summary can be met within the public health budget for 2013/14.

Finance Officer Consulted: Anne Silley Date: 18/02/13

Legal Implications:

5.2 The statutory duty imposed upon Local Authorities and Clinical Commissioning Groups to work together to produce a JSNA is set out in the Health and Social Care Act 2012. 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: 21st February 2013

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. The summary identifies local inequalities in terms of equalities groups; geography & socioeconomic status. Each report section has inequalities clearly evidenced. In addition, there are sections which bring together the key needs of each group. The inclusion of Census and Health Counts data in 2013 would strengthen the equalities evidence within the JSNA. In addition, a gap analysis on equalities will be taken to the City Inclusion Partnership in March 2013.

Sustainability Implications:

5.4 Sustainability related issues are important determinants of health & wellbeing and these are integrated in the summary. The JSNA will support commissioners to consider sustainability issues. There is a close link between the JSNA and the One Planet Living priorities, and these are informing implementation of this initiative.

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 for the City Council and CCGs to work in partnership and produce a JSNA.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 The options are set out in section 3.6 of this Report

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 From April it is a statutory duty for Local Authorities and CCGs 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:

None

Documents in Members' Rooms

None

Background Documents

1. Department of Health JSNAs and joint health and wellbeing strategies – draft guidance http://www.dh.gov.uk/health/2012/07/consultation-jsna/ (Final guidance yet to be published)
2. Current portfolio of needs assessments for the city available publically at www.bhlis.org/needsassessments
3. The 2012 JSNA Summary is available at www.bhlis.org//jsna2012

SHADOW HEALTH & WELLBEING BOARD	Agenda Item 37 Brighton & Hove City Council

Subject:		**Shadow Health & Wellbeing Board: Achievements and Challenges**
Date of Meeting:		**20 March 2013**
Report of:		**The Director of Public Health**
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 Health & Social Care Act (2012) requires all upper-tier local authorities to establish a partnership Health & Wellbeing Board (HWB) by 01 April 2013. In line with Department of Health (DH) guidance, it was locally decided to establish a HWB in shadow form from April 2012, so as to be best prepared for the assumption of statutory duties in 2013.

1.2 This report briefly describes some of the achievements of the HWB in its shadow year of operation, and outlines the challenges the board faces in 2013-14 and beyond.

1.3 Proposed revised Terms of Reference for the HWB, which are to be agreed by Full Council in March 2013, are included for reference as **Appendix 1** to this report.

2. RECOMMENDATIONS:

2.1 That HWB members consider and comment on the contents of this report, particularly in terms of plans for HWB development.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 HWB duties and development to date

3.11 HWBs will become statutory bodies on 01 April 2013, assuming legal responsibility for publishing a local Joint Strategic Needs Assessment (JSNA) and a local Joint Health & Wellbeing Strategy (JHWS) and ensuring that relevant Council and Clinical Commissioning Group (CCG) commissioning plans are responsive to JSNA data and in line with JHWS priorities. HWBs also have more general responsibilities to encourage joint working between the NHS and the local authority, and to ensure that local people are able to participate in decision-making about their care and wellbeing services. In addition to these mandated responsibilities, local areas can choose to discharge a wide range of functions through the HWB (although HWBs are specifically excluded from discharging statutory health scrutiny functions).

3.12 Locally, and in line with DH guidance, it was decided to establish a shadow HWB from April 2012, giving board members a year to settle into their roles before assuming statutory responsibilities, and giving officers 12 months in which to prepare a JHWS and to develop and review HWB structures, ways of working etc.

3.13 The development of a local HWB model has been overseen by an officer-led Public Health & Wellbeing Project Group, jointly chaired by the Directors of Public Health and Adult Social Services, and including senior officers from the CCG, from BHCC Policy, Children's Services, Legal Services, Finance, Communities & Equalities, Project Management and Public Health. Brighton & Hove has also been actively involved in regional best practice groups facilitated by the Department of Health.

3.2 LGA review

3.21 In addition to this internally-focused development, we have taken up the offer of free Local Government Association (LGA) support and have been working with an LGA consultant, who has provided an external assessment of our development plans, checking them against emerging national best practice.

3.22 The LGA support process is still ongoing, but we have received interim assurance that local HWB structures and development plans are robust and in line with national good practice. Our LGA consultant has suggested some specific areas for further development, and these are included in the 'Challenges' section to this report.

3.3 HWB achievements.

3.31 The shadow year has been a busy time, and our achievements have included:

- Setting up a shadow HWB following extensive consultation with elected members, partners and stakeholders
- Managing the JSNA process
- Developing a prioritisation method for analysing JSNA data in order to arrive at objective, evidence-based JHWS priorities
- BHCC, CCG and Public Health commissioners working closely together to develop a local JHWS

- Broad engagement with the local public, stakeholders, elected members and partner organisations around the JSNA and the JHWS
- The LGA has judged our HWB structures and development planning to be fit for purpose.

3.4 HWB challenges.

3.41 We are confident that we are well placed to deliver an effective HWB from April 2013. However, there are still a number of significant challenges facing HWBs in their first year of operation and beyond. These challenges are detailed below. This is a general outline of planned development activity intended to support HWB members, not a detailed development plan for member approval; where it is required/appropriate, formal permission to adopt some or all of these development measures will be sought in the normal way via future reports to committee.

3.42 **Provider Engagement.** There is a clear need for the HWB to engage constructively with health and social care providers. These include NHS trusts (e.g. Brighton & Sussex University Hospitals Trust, Sussex Partnership NHS Foundation Trust and Sussex Community Trust), which are not only the major city providers of clinical services, but also major local employers (and hence potential partners in developing staff-oriented programmes with regard to some of the JHWS priorities – e.g. healthy eating, smoking etc). Providers also potentially include a range of social care providers, commercial sector healthcare providers and a wide variety of local community sector organisations.

In setting up the HWB we have been clear that there are risks in combining commissioner and provider voices at board level, as commissioner and provider priorities can differ significantly, and because providers are clearly not disinterested in local commissioning plans. We have therefore not included local service providers as HWB members, and intend to continue this policy.

A suggestion from the LGA (building on emerging national best practice) has been to engage with providers via a series of informal workshop-style events themed around the JHWS priorities. These events will encourage input from providers as strategic bodies and as local employers, as well as providing the opportunity for expert clinicians to put their views forward and to discuss the JHWS priority action plans with HWB members, commissioners, representatives of service users, local elected members etc.

In addition, it may well be that NHS trusts planning to significantly change or develop services will wish to seek the approval of local HWBs for these plans, and offering HWB input in relation to such initiatives (e.g. the '3T' redevelopment of the Royal Sussex County Hospital as a regional teaching, tertiary care and trauma care centre) offers another opportunity to develop relationships with providers.

3.43 **HWB membership.** The shadow HWB has 14 members: seven elected members (including three from the largest political group, two from official opposition, and two from the other opposition group); the city Directors of Public Health, Adult Social Services and Children's Services; the CCG Chair and Chief Operating Officer; a Brighton & Hove Local Involvement Network (LINk)

representative (to be replaced post April 2013 by a representative of Healthwatch); and a Youth Council representative. All members currently have full voting rights. There are obvious problems in adding additional members to an already large committee, and, as noted above, there are particular issues associated with offering HWB membership to providers. However, the HWB should explore opportunities to further develop relationships with key partners, potentially including Board membership, perhaps particularly with the Sussex Police & Crime Commissioner.

3.44 **Brighton & Hove Strategic Partnership (BHSP).** The HWB will need to work closely with the family of partnerships that constitute the BHSP. This is currently being developed at a senior officer level, and plans will be presented to the HWB at a later date.

3.45 **Oversight of key Public Health initiatives.** Although the main responsibility for public health functions will rest with the Council's Adult Care and Health Committee, the HWB will need to develop a good working relationship with the city public health programme boards (e.g. for alcohol, tobacco control, healthy weight), particularly where there is significant cross-over with JHWS priorities. Again, this is currently being mapped by senior officers, and we will report back to the HWB at a later date.

3.46 **Developing relationships with key BHCC committees.** The HWB will need to work in partnership with the relevant Council decision-making committees, Adult Health & Care (including the Joint Commissioning Board) and Children & Young People (CYP), and with the Health & Wellbeing Overview & Scrutiny Committee which exercises local statutory health scrutiny functions. We will seek to develop these relationships over the next 12 months, where necessary (e.g. with HWOSC) bringing the Chairs of the relevant committees together to integrate work-planning on an informal level, and/or agreeing formal work-sharing protocols.

3.47 **Developing relationships with Healthwatch (HW).** HW is the new statutory body for patient & public involvement in health and social care, replacing Local Involvement Networks (LINks) from April 2013. HW has a mandatory seat on local HWBs and will be a key partner in engaging with city residents. It has not been possible to engage directly to date as the procurement of a HW provider has been ongoing. However, a preferred provider has now been identified and we should soon be able to begin negotiations about the role of HW.

3.48 **Communications Strategy.** The HWB will need to develop a communications strategy, with the aim to engage local residents and service users with regard to the JHWS and other HWB business. This will need to be developed in partnership with HW, given the key HW role in representing local patient and public voices. Similarly, the potential for working alongside GP practice Patient Participation Groups should be actively explored. Particular emphasis will be placed on the need to communicate effectively with equalities groups/hard to reach communities, and the active participation of HW, BHCC Communities & Equalities team and the city's community and voluntary sector (via the Community & Voluntary Sector Forum) will be sought.

3.49 **Developing internal HWB relationships.** A key development point raised by the LGA was that the HWB should seek to develop its internal relationships – between partner organisations, political groups etc. The main suggestion here is that the HWB establishes a regular, informal, forum for work planning – e.g. a work planning meeting to be scheduled in between committee meetings at which the CCG, all political groups, HW, the Youth Council and senior BHCC officers can jointly input into agenda setting.

3.410 **Developing relationships with the CCG.** Another LGA recommendation was for the HWB to consider developing deeper and broader relationships with the CCG, particularly with local GP CCG members. One route to achieving this may be through GP involvement in themed workshops (see point 3.42 above).

3.411 **Providing robust challenge to CCG and BHCC commissioning plans.** A key role for the HWB is to ensure that relevant CCG and BHCC commissioning plans are based on JSNA data and accord with JHWS priorities. The HWB will need to develop ways of working to manage this effectively – examining the CCG's Annual Operation Plan and its Strategic Commissioning Plan and the BHCC equivalents (e.g. the Corporate Plan).

3.412 **Developing relationships with the NHS Commissioning Board (NHSCB).** The NHSCB, via its sub-regional Area Team for Surrey and Sussex, has responsibility for regional health strategy, specialised commissioning and primary care commissioning. HWBs are expected to develop a good working relationship with the NHSCB, although the exact nature of this relationship has, to a large degree, been left to local determination. It is suggested that the NHSCB be invited to attend HWB meetings as a (non-voting) co-optee.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 Plans for HWB development will include engagement with local residents and user representative groups.

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 and integrated working 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: 08/03/13

Legal Implications:

5.2 As set out in the report, the Council is required to appoint a Health and Wellbeing Board by 1st April 2013. The Board will be a Committee of the Council and Regulations have been made which enable the unique structure of the Board to operate as a Council Committee .The minimum membership and functions of the

Board are set out in the Health and Social Care Act 2012 and the proposals in this report are in line with the statutory requirements.

Lawyer Consulted: Elizabeth Culbert *Date: 060313*

Equalities Implications:

5.3 Equalities groups will need to be specifically considered in terms of the development of a HWB communications strategy, and in terms of determining the role of Healthwatch on the HWB.

Sustainability Implications:

5.4 None identified

Crime & Disorder Implications:

5.5 It is suggested that the Sussex PCC be invited to join the HWB, providing invaluable input into crime, disorder and community safety issues.

Risk and Opportunity Management Implications:

5.6 The plans for HWB development detailed in the report have been drafted with reference to the HWB project Risk Register, and are intended to remove or mitigate risks identified in the Register and to exploit opportunities similarly identified.

Public Health Implications:

5.7 The city public health team has been instrumental in developing the HWB to date and will be similarly involved in future development. The work of the HWB is designed to improve population health and help reduce health inequalities across the city.

Corporate / Citywide Implications:

5.8 The development plans outlined in this report are intended to support the Corporate Priority: tackling Inequality.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 This report is intended to provide a summary of HWB achievements and challenges to mark the close of the HWB shadow year, rather than to present matters for decision.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 This report is intended to provide a summary of HWB achievements and challenges to mark the close of the HWB shadow year, rather than to present matters for decision.

SUPPORTING DOCUMENTATION

Appendices:

1 DRAFT revised Terms of Reference for the Health & Wellbeing Board

Documents in Members' Rooms

None

Background Documents

1. The Health & Social Care Act (2012)

APPENDIX 1

HEALTH & WELLBEING BOARD
Explanatory Note

The Health & Wellbeing Board (HWB) is established as a Committee of the Council pursuant to Section 194 of the Health and Social Care Act 2012 and in accordance with the modifications enacted by the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013. The HWB is responsible for advancing the health and wellbeing of the people in its area through the development of improved and integrated health and social care services. In particular, it is responsible for approving a Joint Health and Wellbeing Strategy and a Joint Strategic Needs Assessment.

The HWB comprises 7 Councillors and 7 further voting members determined having regard to the requirements of Section 194 of the Health and Social Care Act 2012. In addition, the Health & Wellbeing Board may appoint additional non voting co-optees in line with relevant legislation and guidance.

Delegated Functions

1. To promote integration and joint working in health and social care services across the City in order to improve the health and wellbeing of the people of Brighton & Hove;

2. To provide City-wide strategic leadership to public health, health, adults and children's social care commissioning, acting as a focal point for determining and agreeing health and wellbeing outcomes and resolving any related conflicts;

3. To approve and publish the Joint Strategic Needs Assessment (JSNA) for the City;

4. To approve and publish a Joint Health & Wellbeing Strategy (JHWS) for the City, monitoring the outcomes goals set out in the JHWS and using its authority to ensure that the public health, health, adults and children's commissioning and delivery plans of member organisations accurately reflect the Strategy and are integrated across the City;

5. To receive the Clinical Commissioning Group's draft annual commissioning plan and to respond with its opinion as to whether the draft commissioning plan takes proper account of the relevant Joint Health and Wellbeing Strategy. Where considered appropriate by the HWB, to refer its opinion on the annual commissioning plan to the National Health Service Commissioning Board and to provide the CCG with a copy of this referral;

6. To receive the Local Safeguarding Children's Board's Annual Report for comment;

7. To support joint commissioning and pooled budget arrangements where agreed by the HWB that this is appropriate;

8. To establish and maintain a dialogue with the Council's Local Strategic Partnership Board, including consulting on its proposed strategies and reporting on outcomes in line with the City's Performance and Risk Management Framework.

9. To involve stakeholders, users and the public in quality of life issues and health and wellbeing choices, by

    - communicating and explaining the JHW Strategy;
    - developing and implementing a Communications and Engagement Strategy;

10. To represent Brighton & Hove on health and wellbeing issues at all levels, influencing and negotiating on behalf of the members of the Board and working closely with the local HealthWatch;

11. To appoint non-voting co-optees in compliance with relevant legislation and guidance;

12. To operate in accordance with the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013.

13. To review annual progress against city priorities in line with the national public health outcomes framework.

14. To receive reports from relevant programme boards and related multi-sector committees with a remit for public health in order to inform the Health and Wellbeing Strategy including: the Alcohol Programme Board, the Substance Misuse Programme Board, the Healthy Weight Programme Board and the Sexual Health Programme Board.