Brighton & Hove City Council

# Overview & Scrutiny

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| Title: | **Health Overview & Scrutiny Committee** |
| Date: | **17 September 2008** |
| Time: | **4.00pm** |
| Venue | **Council Chamber, Hove Town Hall** |
| Members: | **Councillors:**<br>Mrs Cobb (Chairman)<br>Alford, Allen, Barnett, Harmer-Strange, Hazelgrove, Kitcat, Rufus and Turton |
| Contact: | **Giles Rossington**<br>**Scrutiny Support Officer**<br>giles.rossington@brighton-hove.gov.uk |

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# AGENDA

**Part One** **Page**

**27. PROCEDURAL BUSINESS** **1 - 2**

(copy attached).

**28. MINUTES OF THE PREVIOUS MEETING** **3 - 10**

Minutes of the meeting held on 23 July 2008 (copy attached).

**29. CHAIRMAN'S COMMUNICATIONS**

**30. PUBLIC QUESTIONS** **11 - 14**

(i) No public questions have been received for this meeting;

(ii) A public question was received at the 23 July 2008 meeting and an answer requested from Brighton & Hove City Teaching Primary Care Trust in time for this meeting. The relevant papers are attached to this agenda (copy attached).

**31. NOTICES OF MOTION REFERRED FROM COUNCIL**

No Notices of Motion have been received.

**32. WRITTEN QUESTIONS FROM COUNCILLORS**

No written questions have been received.

**33. LETTERS FROM COUNCILLORS**

No letters have been received.

**34. HEALTHIER PEOPLE, EXCELLENT CARE: REGIONAL IMPLEMENTATION OF THE 'DARZI' REVIEW OF THE NHS** **15 - 30**

Presentation by the South East Coast Strategic Health Authority (copy attached).

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

**35. PUBLIC HEALTH** **31 - 54**

Report of the Director of Strategy & Governance on the major Public Health challenges facing Brighton & Hove. Dr Tom Scanlon, Director of Public Health, will present to the Committee and answer members'

questions (copy attached).

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

**36. DRAFT CITY STRATEGIC COMMISSIONING PLAN** **55 - 70**

Report of the Director of Strategy and Governance on Brighton & Hove City Teaching Primary Care Trust's public and stakeholder consultation exercise in regard to the development of a Citywide Strategic Commissioning Plan (copy attached).

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

**37. BRIGHTON & HOVE LOCAL INVOLVEMENT NETWORK (LINK)**

Update on progress towards establishing a Brighton & Hove Link. Presentation from Janice Hoiles, LINk Manager (verbal update).

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

**38. HEALTH OVERVIEW & SCRUTINY COMMITTEE (HOSC) WORK PROGRAMME 2008/2009** **71 - 74**

Updated HOSC Work Programme in tabular form (copy attached).

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

**39. ITEMS TO GO FORWARD TO CABINET OR THE RELEVANT CABINET MEMBER MEETING**

To consider items to be submitted to the next available Cabinet or Cabinet Member.

**40. ITEMS TO GO FORWARD TO COUNCIL**

To consider items to be submitted to the next Council meeting for information.

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

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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.

**HEALTH OVERVIEW & SCRUTINY COMMITTEE**

For further details and general enquiries about this meeting contact Nara Miranda, (, email giles.rossington@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

Date of Publication - Tuesday, 9 September 2008

# Agenda Item 27

**To consider the following Procedural Business:**

## A. Declaration of Substitutes

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

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

## B. Declarations of Interest

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## C. Declaration of Party Whip

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

## D. Exclusion of Press and Public

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

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

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

# Agenda Item 28

## BRIGHTON & HOVE CITY COUNCIL

### HEALTH OVERVIEW & SCRUTINY COMMITTEE

**4:30pm 23 JULY 2008**

**HOVE TOWN HALL**

**MINUTES**

Present: Councillor Cobb (Chairman); Councillor Allen (Deputy Chairman); Councillors Barnett, Kitcat, Harmer-Strange, Marsh, Rufus

Co-optees: Jack Hazelgrove (Older People's Council)

(Informal) Brighton & Hove Local Involvement Network (LINk) Representative: Robert Brown

**PART ONE**

**ACTION**

**16. PROCEDURAL BUSINESS**

**16A. Declarations of Substitutes**

1.1 Councillor Mo Marsh declared that she was attending the meeting as Substitute Member for Councillor Craig Turton.

**16B. Declarations of Interest**

16.2 There were none.

**16C. Declarations of Party Whip**

16.3 There were none.

**16D. Exclusion of Press and Public**

16.4 The Committee 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 Schedule 12A, Part 5A, Section 100A(4) or 100 1 of the Local Government Act 1972 (as amended).

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

## 17. MINUTES

17.1 **RESOLVED** – That the minutes of the meeting held on 11 June 2008 be approved and signed by the Chairman.

## 18. CHAIRMAN'S COMMUNICATIONS

18.1 The Chairman announced that she wished to organise an "awayday" for HOSC members, co-optees and officers to develop closer working links and advance the Committee work programme. A date will be arranged in the Autumn.

## 19. PUBLIC QUESTIONS

19.1 The Committee received a Public Question from the Older People's Council:

"The Older People's Council (OPC) is concerned that some older people in the city are not able to easily access the free eye testing to which they are entitled. Recognising the importance of maintaining good eyesight for the promotion of wellbeing and independence, the OPC would like to ask the Primary Care Trust (PCT):

1) How does the PCT promote free eye testing for older people and how does it monitor its delivery by local opticians?

2) What has been the take-up of free tests for each year over the past 5 years, identifying those older people who are:
   - aged 60+ exercising their right to a bi-annual free test;
   - aged 60 + receiving more frequent free eye tests on the recommendation of their optometrist;
   - aged 70+ exercising their right to an annual free test;
   - aged 70 + receiving more frequent free eye tests on the recommendation of their optometrist?

3) How does the city compare nationally, regionally and with comparator cities in respect of free eye testing? (Please provide figures for the same time-frame and for the same categories as requested in 2 above.)

4) Some older people have said that they feel they have been placed under pressure to purchase spectacles etc. when visiting an optician for their free eye test. Can the PCT detail the steps it takes to ensure that city opticians do not inappropriately use free eye testing sessions to push for sales?"

19.2 The Chairman welcomed the Public Question and told the Older People's Council representative that she would ensure this question was addressed at the September 2008 HOSC meeting.

## 20. LETTERS FROM COUNCILLORS

20.1 There were none.

## 21. NOTICE OF MOTION REFERRED FROM COUNCIL

21.1 There was none.

## 22. SUSSEX PARTNERSHIP TRUST (SPT): PLANNED DEVELOPMENT OF SERVICES

22.1 Richard Ford, Executive Director of SPT (Brighton & Hove locality), addressed the Committee in regard to a number of aspects of the development of the Trust's services. Terry Pegler of SPT also spoke to the Committee about the implications of the Mental Health Act (2007).

22.2 Members were informed that the new Mental Health Act contains provision for a broader range of officers to become involved in the process of approving detention under sections of the Mental Health Act than was formerly the case (responsibility may be extended to officers including occupational therapists rather than limited to certain social workers). It was stressed that these officers would be highly skilled and very experienced, and that this was not a dilution of the safeguards surrounding the sectioning process, but rather a reflection of the fact that mental health care was now much less medicalised and institutionally based than it used to be.

22.3 Robert Brown, representing the Brighton & Hove Local Involvement Network (LINk), noted that he had regular contact with occupational therapists and could vouch for their high levels of experience and ability.

22.4 In answer to a question regarding recruitment of occupational therapists, Mr Pegler told the Committee that there were no plans to greatly increase the numbers working in the city.

22.5 In response to a query as to whether the new Mental Health Act made it easier or more difficult to detain someone under a "section", the Committee was informed that there had been little if any practical alteration to the definition of who should be detained: the new Act simplified the terminology of the 1983 Mental Health Act to some degree and increased emphasis on treatment being made available for people held under a section rather than changing the basis of sectioning.

22.6 In answer to a question concerning the likely governance arrangements of the Sussex Partnership Trust (SPT) should it achieve NHS Foundation Trust status, Mr Ford explained that the Trust would

have 41 governors, a minority appointed by local "partners" (Local Authorities, NHS Trusts etc.); the majority elected by members of the public, service users, carers and staff. Mr Ford offered to provide more details of this governance structure to members. **GR**

22.7 In response to a query concerning how SPT could improve its services, members were told that services were generally of a high standard, but that key areas for improvement included accommodation, clinical governance and staff-management procedures. The Trust is particularly keen to ensure that it is a "mindful employer", doing all that it can to safeguard the mental health of its staff.

22.8 In answer to a question concerning the protection of Brighton & Hove interests within the Sussex-wide SPT, members were told that decisions on the future structure of SPT would be made by the Trust's senior management. SPT management does recognise the value of a management structure which encourages a high degree of local autonomy, making it likely that a significant element of independence for each locality would be retained.

Although locally managed and provided services are of key importance in many aspects of the Trust's work, there is also a strong case for the provision of more specialised services on a county-wide basis when there is insufficient demand to make local services practicable (e.g. acute intensive care for women).

22.9 In response to a question concerning the large number of Governors that the new Foundation Trust would have, members were told that there was a challenge in dealing with so many Governors, and that innovative methods would have to be adopted to ensure that all Governors were fully involved in the strategic development of the Trust.

22.10 In answer to a query regarding the availability of enhanced access to psychological therapies for young people, the Committee was told that the pilot scheme for improving access to these therapies was targeted at adults, but that SPT was committed to improving access to Cognitive Behavioural Therapy (CBT) and related therapies for the whole 14-25 age group.

22.11 In response to a question concerning early intervention in instances of mild depression etc, members were told that this linked directly with improved access to psychological therapies, as the most effective treatment for mild depression was frequently CBT or an allied therapy. CBT is also key in tackling "worklessness" issues, as it may be the most appropriate intervention for people in danger of losing their jobs due to mental health issues, and the most effective way of helping those currently claiming Incapacity Benefit back into employment.

22.12 Mr Ford also informed the Committee about successful developments to SPT's local vocational services, with many former users of vocational services now in mainstream employment. Changes are also planned to the Trust's day services, with third sector organisations

being invited to tender to run these services. Mr Ford stressed that there would be no dilution of the quality of this support, although the focus will change with much greater emphasis being placed on developing services which are user-led. There was considerable national agreement that this sort of service was best run by third sector organisations, with NHS Trusts concentrating on providing clinical services.

22.13 Mr Ford also told the Committee that a greater emphasis on self-directed care would have a major impact upon SPT's services, particularly in terms of people with severe and long-standing mental health conditions living in long-term supported housing. These clients could prove very challenging to support, and a good deal of work needed to be done in this area, involving SPT working closely with the Primary Care Trust and the City Council to ensure that appropriate support could be provided at the same time as entrenching the principle of (a high degree of) client self-determination in the planning of such services.

22.14 In response to questions concerning the planned closure of the Nevill Hospital, Mr Ford told members that the planned provision of a dementia ward and a non-dementia older people's ward at Mill View Hospital would more than compensate for the loss of the Nevill facilities. Although there would be fewer acute beds than are currently available at the Nevill, the Nevill rarely operates to its true capacity. (Even when the Nevill is full, this tends to be due to delays in transferring patients who no longer require acute care into appropriate community settings, rather than because the hospital's full capacity is actually required to treat genuine acute cases.) In addition, better discharge planning and improved access for older people to the Community Mental Health Teams (particularly the Crisis Team) should mean that demand for beds can be better managed.

Space will be found on the Mill View site for these services by re-opening a currently "moth-balled" ward and by the new-build of a dementia ward.

22.15 In answer to members' questions concerning community support, members were told that high levels of community support were now in place, allowing people to receive the appropriate degree of care (up to the level of 24 hour a day support). Mr Ford stressed that community care, even with very high levels of support, was generally much cheaper than acute hospital care. There were also major negative factors associated with acute stays, including "institutionalisation"/loss of independence.

22.16 In response to a query regarding the re-siting at Mill View of the city's assessment suite for people detained by the police under Section 136 of the Mental Health Act, members were told that it was the Trust's intention to assess as many people as possible in the new suite. However, in instances where people manifested extremely violent behaviour, or were very intoxicated, it might be necessary to keep

people in police custody (all section 136 assessments are currently undertaken in police custody).

22.17 In answer to questions concerning public parking provision at the Mill View/Hove Polyclinic site, members were told that care would be taken whilst re-developing the site to retain or improve upon the current provision of public care parking spaces. SPT would seek to incentivise its own staff to access work via public transport and would also seek to work with local public transport providers to ensure that the site was well integrated with the public transport network.

22.18 In response to a query regarding psychiatric cover at the Royal Sussex County Hospital (RSCH) A&E department, the Committee was told that 7 day a week cover was available. Out Of Hours cover is provided by Senior Nurse Practitioners (with doctor-grade staff on hand at Mill View). Mr Ford noted that the main demand for Out Of Hours psychiatric services was in primary rather than secondary (hospital) care, and that resources were best spent accordingly.

22.19 Asked to comment on what he saw as the biggest challenge to the Local Health Economy, Mr Ford identified the problem of alcohol as being a particular priority for the city. Mr Ford saw limiting the proliferation of licensed premises, making soft drinks more widely available and more affordable than alcoholic alternatives and encouraging public health education as being key factors in improving the situation. However, there is a limit to what can directly be done at a local level.

22.20 **RESOLVED –**

(i) That none of the plans for developing SPT services (in appendix A to the Item 22 report) should, at this point in time, be regarded as "significant variations in service" requiring more formal consultation with the Health Overview & Scrutiny Committee;

(ii) That the Committee should continue to receive regular updates on SPT's development plans.

The Committee thanked Mr Ford for his presentation.

## 23. HOSC WORK PROGRAMME

23.1 Members considered a report setting out the conclusions of the HOSC Working Group set up to formulate a draft 2008/2009 Committee Work Programme.

23.2 The Chairman noted that Committee members would seek to use part of the planned HOSC "away day" to discuss ideas for HOSC work programme ideas not previously considered by the HOSC Working Group (i.e. ideas generated by the Brighton & Hove LINk or by individual members of the public). To this end, a representative of the

Brighton & Hove LINk will be invited to attend the away day.

23.3 **RESOLVED –** That the draft 2008/2009 HOSC Work Programme be approved as the Committee Work Programme.

## 24. ITEMS TO GO FORWARD TO CABINET OR THE RELEVANT CABINET MEMBER MEETING

24.1 There were none.

## 25. ITEMS TO GO FORWARD TO COUNCIL

25.1 There were none.

The meeting concluded at 6:30 pm

Signed Chairman

Dated this day of 2008

# Agenda Item 30

## Public Question on Eye Testing for Older People

## 1. Introduction

The HOSC on July 23rd received the following question from the Older People's Council. The HOSC asked the PCT to respond to the questions at this meeting.

"The Older People's Council (OPC) is concerned that some older people in the city are not able to easily access the free eye testing to which they are entitled. Recognising the importance of maintaining good eyesight for the promotion of wellbeing and independence, the OPC would like to ask the Primary Care Trust (PCT):

1. How does the PCT promote free eye testing for older people and how does it monitor its delivery by local opticians?

2. What has been the take-up of free tests for each year over the past 5 years, identifying those older people who are:

- aged 60+ exercising their right to a bi-annual free test;
- aged 60 + receiving more frequent free eye tests on the recommendation of their optometrist;
- aged 70+ exercising their right to an annual free test;
- aged 70 + receiving more frequent free eye tests on the recommendation of their optometrist?

3. How does the city compare nationally, regionally and with comparator cities in respect of free eye testing? (Please provide figures for the same time-frame and for the same categories as requested in 2 above.)

4. Some older people have said that they feel they have been placed under pressure to purchase spectacles etc. when visiting an optician for their free eye test. Can the PCT detail the steps it takes to ensure that city opticians do not inappropriately use free eye testing sessions to push for sales?"

## 2. Background information

Optician is a general term that covers both optometrists and dispensing opticians.

Optometrists carry out sight tests to check the quality of vision and eye health. They look for signs of eye disease which may need treatment from a doctor or eye surgeon and prescribe and fit glasses and contact lenses. When visiting an

optician, patients may have a sight test carried out by an optometrist or an ophthalmic medical practitioner. They are trained to recognise abnormalities and diseases in the eye, such as cataract and glaucoma. After the sight test, the optician will give each patient a statement (prescription) and, if glasses are required, may offer to fit spectacles or contact lenses.

Dispensing opticians fit glasses and contact lenses, but do not test eyes. They can give you advice on types of lens, such as single-vision or bifocal, and help patients to choose frames.

The majority of optometrists are self employed or work for larger organisations. In order to practice as an Optometrist they must be on the PCTs local approved provider list.

## 3. Questions from the Older People's Council

### 3.1 How does the PCT promote free eye testing for older people and how does it monitor its delivery by local opticians?

All opticians are required to promote free eye tests and should display posters to this effect.

General Ophthalmic Service's contracts are the legal form for a contract to provide any primary ophthalmic service. The framework comprises three levels, which are referred to as mandatory, additional and enhanced. Mandatory services are the sight testing service when carried out at a practice. All PCTs must provide for this service and any provider with a contract for mandatory services must provide NHS funded sight tests from a practice. Additional services are laid down in regulations and must be provided by all PCTs. Some providers of additional services may also be providers of mandatory services, but this is not a requirement. The only additional service that has been prescribed in the regulations is mobile services i.e. provision of NHS funded sight tests at day centres, residential care homes and individuals' own homes. Enhanced services are any other primary ophthalmic services commissioned at the discretion of PCTs. to meet what they consider necessary primary ophthalmic services in their areas.

Brighton & Hove PCT has a range of enhanced services:

- Primary Open Angle Glaucoma (P.O.A.G.).
- Age-related macular degeneration (AMD).
- Diabetic Retinopathy.
- Cataract Referral

The regulatory body for optometrists is the College of Optometrists who set exams and provide guidelines for how optometrists operate. Optometrists are

registered with the General Ophthalmic Council (GOC). The PCT reviews local delivery of services and poor performance is dealt with through the PCTs clinical support processes.

**3.2 What has been the take-up of free tests for each year over the past 5 years, identifying those older people who are:**

- **aged 60+ exercising their right to a bi-annual free test;**
- **aged 60 + receiving more frequent free eye tests on the recommendation of their optometrist;**
- **aged 70+ exercising their right to an annual free test;**
- **aged 70 + receiving more frequent free eye tests on the recommendation of their optometrist?**

The PCT does not routinely collect this information and at the time of writing this report, it was not possible to obtain the data requested.

**3.3 How does the city compare nationally, regionally and with comparator cities in respect of free eye testing? (Please provide figures for the same time-frame and for the same categories as requested in 2 above.)**

The PCT does not collect this information and as above, it was not possible to obtain this data.

**3.4 Some older people have said that they feel they have been placed under pressure to purchase spectacles etc. when visiting an optician for their free eye test. Can the PCT detail the steps it takes to ensure that city opticians do not inappropriately use free eye testing sessions to push for sales?"**

Patients have a statutory right to take their prescription wherever they like for dispensing. The PCT were concerned that some older people have reported that they feel they have been placed under pressure to purchase spectacles. No complaints or enquiries through the Patient Advice and Liaison Service have been received about this issue.

**4. Recommendation**

1. Where there are specific concerns about pressure being placed on older people to buy spectacles, these are reported to the PCTs Patient Advice and Liaison Service.
2. The PCT will consider how it can best ensure that people are aware that they can get free eye testing.
3. The PCT will consider what information it needs to collect in relation to sight testing as part of it's contract review process.

| HEALTH OVERVIEW AND SCRUTINY COMMITTEE | **Agenda Item 33**<br>Brighton & Hove City Council |
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| **Subject:** | | **"Healthier People, Excellent Care" – regional implementation of the "Darzi" review of the NHS** |
| **Date of Meeting:** | | **17 September 2008** |
| **Report of:** | | **The Director of Strategy and Governance** |
| **Contact Officer:** | Name: | Giles Rossington Tel: 29-1038 |
| | E-mail: | Giles.rossington@brighton-hove.gov.uk |
| **Wards Affected:** | All | |

**FOR GENERAL RELEASE**

## 1. SUMMARY AND POLICY CONTEXT:

1.1 In order to support the recent national review of NHS healthcare services (the "Darzi" review), regional NHS strategic bodies have been conducting their own reviews of services.

1.2 The South East Coast Review, "Healthier People, Excellent Care", has been co-ordinated by the South East Coast Strategic Health Authority (SHA) with extensive involvement from Primary Care Trusts (PCTs) across the region. Clinicians and managers from NHS provider Trusts have also been included in this process, as have key stakeholders (including representatives of Local Authorities) and members of the public.

1.3 "Healthier People, Excellent Care" sets out a broad vision for regional NHS services over the next 10 or so years, as well as making a series of more specific pledges concerning the development of services in a number of key areas.

1.4 These key areas are: maternity and newborn care; children's health; staying healthy (i.e. "public health"); long term conditions (i.e. "chronic" health problems); acute (hospital) care; mental health; and end of life care;

1.5 A summary of "Healthier People, Excellent Care" is printed in **Appendix 1** to this report. The full SHA report can be downloaded from: www.southeastcoast.nhs.uk/hpec

1.6 "Healthier People, Excellent Care" is a very significant initiative in terms of regional NHS strategic planning; it is expected to provide the basis for the development of NHS services over the next ten years (including initiatives such as the "Fit For the Future" reconfigurations and the development of "World Class Commissioning"). Therefore, although the implementation of many of the specific measures detailed in "Healthier People, Excellent Care" may not be imminent, it is important for members to be familiar with the contents and implications of the review.

## 2. RECOMMENDATIONS:

2.1 To note the contents of the "Healthier People, Excellent Care" review.

## 3. BACKGROUND INFORMATION

3.1 See **Appendix 1** to this report.

## 4. CONSULTATION

4.1 No formal consultation has been undertaken in compiling this report. "Healthier People, Excellent Care" has itself been formulated after extensive consultation with NHS professionals, stakeholders and members of the public. Details of this consultation are included in the body of the "Healthier People, Excellent Care" report.

## 5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are no financial implications arising from this report which is for information only.

Legal Implications:

5.2 "This report is for noting. There are no legal implications to draw to Members attention at this stage."

*Lawyer Consulted: Liz Culpert; date: 04.09.08*

Equalities Implications:

5.3 None directly. "Healthier People, Excellent Care" has been formulated with regard to Equalities issues and this is detailed in the body of the report.

Sustainability Implications:

5.4 None directly. “Healthier People, Excellent Care” has been formulated with regard to Sustainability issues and this is detailed in the body of the report.

Crime & Disorder Implications:

5.5 None directly.

Risk and Opportunity Management Implications:

5.6 None.

Corporate / Citywide Implications:

5.7 The development of NHS healthcare services, as set out in “Healthier People, Excellent Care”, seeks to reduce health inequalities across the region. This accords with the corporate priority to: “reduce inequality by increasing opportunity”. Other elements of the review (in terms of improving the sustainability of the NHS and in terms of general improvements to people’s health and mental wellbeing) accord with the corporate priority to: “protect the environment while growing the economy.”

**SUPPORTING DOCUMENTATION**

**Appendices:**

1. Summary of the “Healthier People, Excellent Care” report.

**Documents in Members’ Rooms:**

None

**Background Documents:**

1. “Healthier People, Excellent Care”: A vision for the South East Coast (full report).

NHS
South East Coast

# Healthier people, **excellent care**

A vision for the South East Coast

## **Summary** document

**Over 4 million people live in the region**

**£6 billion is spent every year on healthcare in Kent, Surrey and Sussex**

**There are 26 local NHS organisations including hospitals, primary care trusts, mental health and community services, an ambulance service and four foundation trusts**

**People are living longer, healthier lives**

**But there is an 18 year difference in how long some people live in the South East Coast**

## What is our vision?

The South East Coast is a vibrant region. More than four million people with different health and care needs live here. We want to make sure everyone gets the best care possible.

Over the past couple of years we've been busy planning better services for mothers-to-be and people needing urgent and emergency care. But there's more to do to help everyone stay healthy and get excellent care when they fall ill.

Professor Lord Darzi, the health minister and respected NHS surgeon, is working with us on these plans. So are many people across the region including doctors, nurses and other healthcare workers.

We can't achieve this goal alone. No one person, group or organisation holds all the answers. We want to hear the views, ideas and experiences of everyone who uses and works in the NHS to help us shape services for the future.

We are not asking you to decide about individual hospitals or services, but about how we can help you stay healthy and get the best care in the coming decade.

This leaflet explains what our vision is and why we need your help. It also tells you where to find more information and how to give us your views.

"How can we help you stay healthy and get the best care in the coming decade?"

## Why change?

The NHS is now busier than ever before, treating more patients more quickly and to higher standards.

*How is this improving NHS services?*

- there are more doctors, nurses and trained staff to treat you
- they can offer you the latest treatments and tests
- your wait for treatment is shorter
- you are seen in cleaner and smarter surroundings that help staff give you better care.

We know demand for services is growing so we need to be sure we can meet your needs and provide excellent care within our budget.

**Our budget has nearly doubled to £6 billion in 2008/09 from £3.6 billion in 2003/04**

**Waiting lists today are less than half of what they were a decade ago**

**97% of patients are seen in less than four hours in A&E now compared to 88% in 2003**

**Deaths from stroke and heart disease have dropped 40% in recent years**

**By December 2008 everyone needing non-urgent care will begin treatment within 18 weeks**


Here are the key issues we think we still need to address together:

- people living across the South East Coast want safer, better quality care
- with more of us living longer our healthcare needs are changing
- not all people in our region have the same health advantages
- we need to make it easier for people to get healthcare where and when they need it including in the evening and at weekends
- hospitals aren't always the best or most convenient place to go for care
- we need more specialist care to make sure those who are most in need are treated by experts
- we need to keep pace with medical advances and the latest technology
- your tax money should be spent wisely.

We've already started planning how we can make maternity, urgent and emergency care better. But we need to do more to make all our services the best they can be. We need to develop services to keep you well, not just treat you when you are sick.

"We need to develop services to keep you well."



## What are the plans?

*We aim to:*

- improve access to health services by making sure you can receive the most appropriate care where and when you need it
- offer high quality services to people with long-term or life-threatening illnesses in safe, clean hospitals, clinics or surgeries
- make sure that every person has an equal chance to stay healthy or get better, especially people who are very vulnerable or have the greatest needs.

In order to make sure our services are the best they can be we have looked at how we can improve them in eight areas:

- Maternity and newborn care
- Children's services
- Staying healthy
- Mental health care
- Acute care
- Planned care
- Long-term conditions
- End of life care

**For each area we are making recommendations for how services and care can be improved:**

## *Maternity and newborn care*

- By 2011 90% of pregnant women will see a midwife within 12 weeks to discuss their individual needs and preferences about how and where to give birth. We will focus in particular on making early contact with women from 'hard to reach' groups
- By 2010 there will be a consultant present on the labour ward for at least 60 hours of every week in every obstetric unit
- By 2010 all women will be individually supported by a healthcare professional throughout their labour and birth

## *Children's services*

- Teams of health and social care givers will co-ordinate care "around the child" by 2011
- There will be special care teams across the South East Coast to help vulnerable young people move easily to adulthood by 2011
- More children's care will be available in the community and outside of hospital.

## *Staying healthy*

- Obese or overweight people will have better access to leisure facilities, one-to-one health advice and support with diets by 2010
- Sexual health clinics will be able to offer appointments within 48 hours and at evenings and weekends
- We will work to reduce the risks to routine and manual smokers, pregnant smokers and their babies and young people by implementing effective tobacco control measures, integrated with high quality stop smoking services.

**"We will make sure you receive the most appropriate care where and when you need it."**

**"We will give you the same high quality of care no matter which part of the health service you first approach"**


## *Mental health care*

- There is no health without mental health: we will reduce the inequalities and social exclusion that are both a cause and effect of mental illness
- There will be effective support at home for people in a mental health crisis and early recognition and treatment for people with first episodes of psychosis
- There will be prompt access to the best psychological therapies in primary and secondary care.

## *Acute care*

- By 2010 people can expect the same outcomes and level of care regardless of which part of the health service they first approach
- By 2010 all appropriate heart attack, stroke and major trauma patients will receive their care from 24/7 specialist units
- There will be close integration of community and social services to support urgent care.

## *Planned care*

- Diagnostic tests in primary care will be available on your local high street
- Everyone will be able to book a GP appointment within 48 hours, if they want to do so
- All diagnostic tests will be performed within 48 hours and all results will be ready within two weeks.


## *Long-term conditions*

- By 2010 health and social care will be jointly planned and purchased for long-term conditions so that people will receive care that is tailored to their needs
- By 2011 90% of patients with long-term conditions will have personal care plans
- By 2012 all patients will receive ongoing support, education and training to help them better manage their own condition.

## *End of life care*

- By 2012 all providers will use recognised standards of best practice including: the Gold Standards Framework, Liverpool care pathway, preferred priorities of care policy
- By 2015 a visiting service to help patients needing pain control for terminal illnesses will be available everywhere
- The NHS in Kent, Surrey and Sussex will work with staff, public and partners to raise awareness of end of life issues.

## What difference will you see in services by 2018?

- There will be no avoidable hospital acquired infections
  - By 2011 there will be no avoidable cases of hospital acquired MRSA
  - and less than 2,000 cases of C. difficile
- By 2010 strokes, heart attacks and major injuries will always be treated in specialist centres
- You will be able to have medical tests to help diagnose and manage your illness on your local high street or at home
- We will turn the tide on the rising numbers of obese people
- Special programmes to help you cope better with long-term conditions such as diabetes will be widely available
- Most dying people will be able to die where they prefer - at home, in a hospital or hospice
- We will reduce the differences in life expectancy seen in the South East Coast area so that all men can expect to live at least 78.6 years and women 82.5 years
- All patients will hold their own medical records.

# How can you find out more?

A full explanation of our vision for healthcare is contained in our *Healthier people, excellent care* document. You can get a copy by:

- Downloading it from our website: **www.southeastcoast.nhs.uk/hpec**
- Emailing us at **ournhs@southeastcoast.nhs.uk**
- Or writing to: **FREEPOST Healthier people, excellent care, NHS South East Coast, York House, 18-20 Massetts Road, Horley, Surrey, RH6 7DE.**

## *How can you have a say?*

Your views are important to us. They will help us to check that our ambitions are right for the South East Coast region, and assist us as we plan the implementation of our vision.

This is your opportunity to let us know what you think, and to help shape the future of healthcare in Kent, Surrey and Sussex. **Is it ambitious enough? Will the vision provide you and your family with the healthcare you expect and deserve?**

We have made 24 specific recommendations, covering each of the eight areas of care. Are they the right recommendations? Please read through **Chapter Seven, Making It Happen,** in our main document and consider whether our vision identifies the right means to deliver excellent care. **Is anything missing?**

Finally, tell us whether you think this vision will address health inequalities and help everyone in the South East Coast region become healthier. **Let us know your views by 15th September 2008.**

You can contact us in the following ways:

- Write to us at **FREEPOST Healthier people, excellent care, NHS South East Coast, York House, 18-20 Massetts Road, Horley, Surrey, RH6 7DE.**
- E-mail your thoughts to us at: **ournhs@southeastcoast.nhs.uk**
- Log on to our website for more information and to complete our questionnaire **www.southeastcoast.nhs.uk/hpec**
- Talk directly to us by attending one of our road shows or meetings. Details of these will be on our web site at **www.southeastcoast.nhs.uk/hpec**

**We will review your responses and write a report at the end of September.**

A summary of your views and the next steps will be published on our website in October. NHS South East Coast will then work with the local NHS over the autumn to ensure that together we can deliver this vision.

## *Alternative formats*

If you would like a copy of this summary in another language, or if you would like a copy in Braille, Easy Read, or large text, please contact us at: **Healthier people, excellent care, NHS South East Coast, York House, 18-20 Massetts Road, Horley, Surrey RH6 7DE.** Phone: 01293 778 845

*Russian*

Если вы хотите получить копию этого документа на русском языке, пожалуйста, свяжитесь с нами по указанному выше адресу или телефону.

*Polish*

Jeśli chciałbyś/chciałabyś otrzymać niniejszy dokument w języku polskim, napisz na adres lub zadzwoń pod numer telefonu powyżej.

*Czech*

Pokud byste chtěli kopii tohoto dokumentu v češtině, kontaktujte nás prosím na adrese nebo telefonním čísle uvedeném výše.

*Portuguese*

Se desejar uma cópia deste documento em Português, contacte-nos na morada ou através do número de telefone acima referidos.

*Turkish*

Bu belgenin Türkçe kopyasını isterseniz, lütfen yukarıda belirtilen adres veya telefon numarasını kullanarak bizimle temas kurun.

*Chinese*

欲获得此文件的简体中文版本，请通过上述地址或电话号码与我们联系。

*Arabic*

إذا كنت تود الحصول على نسخة من هذه الوثيقة باللغة العربية، نرجو الاتصال بنا على العنوان أو رقم الهاتف المذكور عاليه.

*Urdu*

اگر آپ کو یہ دستاویز انگریزی میں درکار ہو تو ہم سے اوپر درج کیے ہوئے پتے یا فون نمبر پر رجوع کریں۔

*Bengali*

এই তথ্যসমূহ যদি আপনি বাংলায় পেতে চান তবে অনুগ্রহ করে উপরের ঠিকানা বা ফোন নম্বরে আমাদের সাথে যোগাযোগ করুন ।

*Punjabi*

ਜੇ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੀ ਕਾਪੀ ਪੰਜਾਬੀ ਵਿੱਚ ਲੈਣੀ ਚਾਹੋ, ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਉੱਪਰ ਦਿੱਤੇ ਗਏ ਪਤੇ ਜਾਂ ਫ਼ੋਨ ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ।

| HEALTH OVERVIEW AND SCRUTINY COMMITTEE | **Agenda Item 34**<br>Brighton & Hove City Council |
|---|---|

| | | | | |
|---|---|---|---|---|
| **Subject:** | | **Public Health** | | |
| **Date of Meeting:** | | **17 September 2008** | | |
| **Report of:** | | **The Director of Strategy and Governance** | | |
| **Contact Officer:** | Name: | Giles Rossington | Tel: | 29-1038 |
| | E-mail: | Giles.rossington@brighton-hove.gov.uk | | |
| **Wards Affected:** | All | | | |

**FOR GENERAL RELEASE**

## 1. SUMMARY AND POLICY CONTEXT:

1.1 At its 11 June 2008 meeting the Health Overview & Scrutiny Committee (HOSC) agreed to form a working group to develop ideas for a 2008-2009 HOSC Work Programme. The working group produced a draft Work Programme which was subsequently adopted by the Committee at its 23 July 2008 meeting.

1.2 A key issue identified by the HOSC working group was Public Health. It was decided that the Director of Public Health should be invited to attend a Committee meeting to outline some of the major Public Health challenges facing the city in order to help HOSC members determine which aspects of the Public Health agenda might most valuably be explored in greater depth by the Committee (potentially via an ad hoc Panel).

## 2. RECOMMENDATIONS:

2.1 That members:

(1) note the report and the additional information provided by the Director of Public Health (reprinted in **Appendix 1** to this report);

(2) determine which aspect(s) of the Public Health agenda they might most usefully explore in greater depth (via an ad hoc Panel of the HOSC);

(3) determine the membership of any ad hoc Panel formed to investigate aspects of the Public Health agenda.

## 3. BACKGROUND INFORMATION

3.1 Effective Public Health is widely recognised as a key factor in improving the health of the population and in tackling local and national health inequalities.

3.2 Locally, Public Health is also strongly linked with corporate and city-wide priorities, particularly in terms of the city's economic development.

3.3 Local responsibility for Public Health is shared by Brighton & Hove City Teaching Primary Care Trust (PCT) and the City Council. The Director of Public Health is a joint PCT and Council appointment.

3.4 The Director of Public Health publishes an Annual Report highlighting aspects of the Public Health agenda which he regards as particular priorities. In the normal course of events, it might be deemed appropriate for HOSC to base its work in the Public Health arena on this Annual Report.

3.5 However, the 2008 Annual Report focuses on the health requirements of children and young people; that is, on an area of the Public Health agenda which lies within the remit of the Children & Young People's Overview & Scrutiny Committee (CYPOSC) rather than of the HOSC.

3.6 It has therefore been necessary to seek to identify other aspects of the Public Health agenda which may benefit from the HOSC's examination.

3.7 In determining which aspect(s) of Public Health to focus on, members should bear in mind:

(a) *the restricted scope of ad hoc Panels* - Panels are limited to a maximum of three meetings in public. Some elements of the Public Health agenda might, in consequence, be deemed too broad to be usefully scrutinised via an ad hoc Panel. (If a Panel is established to examine such a broad issue, members may wish to circumscribe its remit so as to ensure that an appropriate focus is maintained.)

(b) *the need to "add value" to the issue being scrutinised*; that is, a successful ad hoc Panel investigation should generally be one which makes a positive practical contribution to the issue being examined. Some elements of Public Health may be of considerable interest without necessarily being open to a great deal of influence at a local level; other

subjects might offer a better opportunity to make truly effective recommendations.

## 4. CONSULTATION

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

## 5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are no direct financial implications to this report, other than in terms of allocating the resources of the Scrutiny team.

Legal Implications:

5.2 "The relevant constitutional restrictions in relation to Overview and Scrutiny work are referred to at paragraph 3.7 of this report. There are no further legal implications to draw to Members' attention."

*Lawyer Consulted: Elizabeth Culpert; Date: 03.09.08*

Equalities Implications:

5.3 There are wide variations in the health of city residents, some of which may meaningfully correlate with gender, ethnicity and/or sexual orientation. Members should therefore be mindful of Equalities issues when determining which aspects of the Public Health agenda to explore and should ensure that Equalities considerations are central to planning the work of any ad hoc Panel.

Sustainability Implications:

5.4 There are no direct sustainability implications to this report.

Crime & Disorder Implications:

5.5 Some aspects of the Public Health agenda (e.g. issues relating to alcohol and/or substance misuse) may have implications for Crime & Disorder.

Risk and Opportunity Management Implications:

5.6 Public Health issues are typically not discrete, but rather correlate strongly with issues such as employment (i.e. people who live healthier lifestyles are more likely to find and retain employment). In consequence, improvements in aspects of Public Health may have a positive impact over and above their direct affect upon the health of city residents and members should be aware of such opportunities.

Corporate / Citywide Implications:

5.7 Improving Public Health is a key factor in “reducing inequality by increasing opportunity”, one of the Council’s corporate priorities.

## SUPPORTING DOCUMENTATION

### Appendices:

1. Additional information supplied by the Director of Public Health.

### Documents in Members’ Rooms:

1. None

### Background Documents:

1. None

# Appendix 1

Public Health and Health Inequality Priorities in Brighton and Hove

Presentation to Health Overview Scrutiny Committee
September 2008

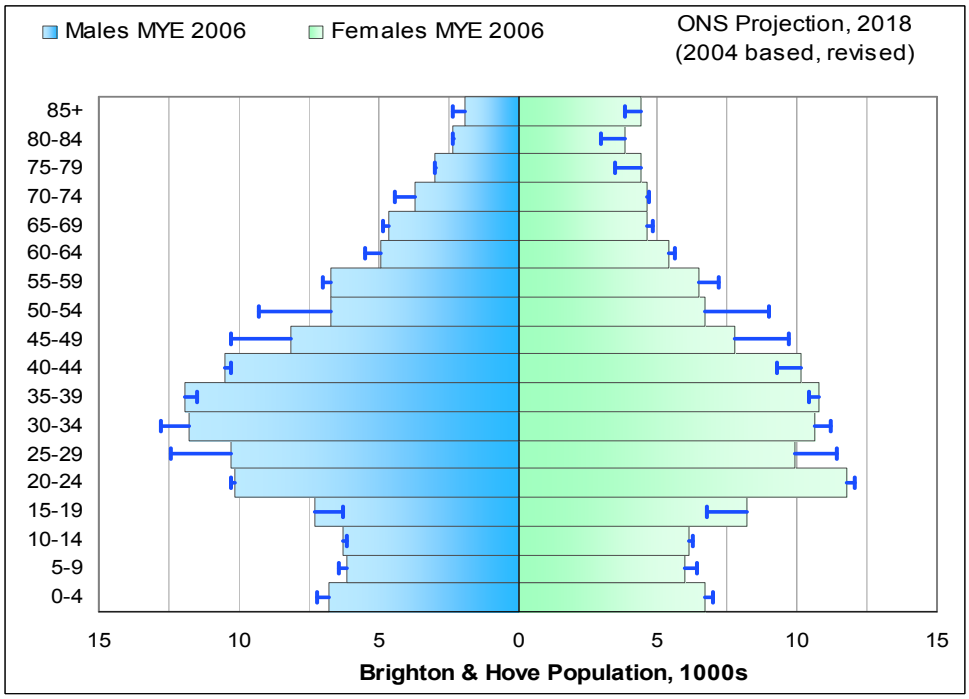
## Introduction

This document presents an overview of the public health and health inequality priorities for Brighton and Hove. The information has been collated from a variety of sources, in particular the Joint Strategic Needs Assessment portfolio which includes the last five Annual Reports of the Director of Public Health. This information has also been used to inform the Strategic Commissioning Plan for 2008-2009 in the context of World Class Commissioning.

## Local demography

In 2006 the Brighton and Hove local authority area had an estimated resident population of 251,400 people. The estimated reconciled PCT population was 260,700. The diagram below shows the age structure of the local resident population in 2006 and the projected changes until 2018.

Figure 1 Population structure of Brighton and Hove 2006 and projected changes by 2018.



Brighton and Hove has an unusual distribution compared with the national picture. There are relatively large numbers of people aged 20 to 44, with relatively fewer children and older people. However, it is important to note that there are relatively more very elderly people, particularly women who are likely to have increased needs for services. During 2007/8 people aged 85 years and above occupied more than one fifth of all hospital inpatient bed days used by PCT residents.

Over the next ten years the population is predicted to increase to 264,600. As the above figure shows the predicted greatest increase will be seen in the 45 to 54 year age group. The population of younger adults will continue to increase, but there will also be increased numbers of younger children. The number of people aged 75 years and above is expected to fall.

With regard to the different subpopulations within the city a recent review of inequalities in the city reported (OCSI 2007):

- 15% of the city's residents were born outside England, well above national and regional levels.
- The population of Black and minority ethnic (BME) groups is estimated to have increased by 35% between 2001 and 2004 (compared to 13% nationally)
- 20% of all births in 2005 were to mothers born outside the UK
- the city ranks among the 10% of local authorities for migrant worker registrations
- a growing Lesbian, Gay, Bisexual and Transgender (LGBT) population (latest estimate,35,000)

Sections of the LBGT community are at increased risk of mental illness and sexually transmitted infections including HIV and are more likely to be smokers and to drink above the recommended "safe levels" of alcohol.

At the time of the 2001 census 94.2% of the Brighton and Hove population were from white groups compared with 91% nationally. More recent estimates produced for 2005 suggest that the local picture is changing (Table 1).

Table1 Estimated ethnic composition of Brighton and Hove 2005

| | **2001** | | **2005** | | **% change** |
|---|---|---|---|---|---|
| All Groups | 247.3 | 100 % | 249.8 | 100 % | 1.0% |
| White: British | 218.1 | 88 % | 213.2 | 85 % | -2.2% |
| White: Irish | 4.0 | 1.6 % | 3.8 | 1.5 % | -4.2% |
| White: Other White | 11.4 | 4.6 % | 12.5 | 5.0 % | 9.6% |
| Mixed | 4.7 | 1.9 % | 5.4 | 2.2 % | 14.7% |
| Asian | 4.5 | 1.8 | 6.9 | 2.8 | 54.7% |

| | | % | | % | |
|---|---|---|---|---|---|
| Black | 2.0 | 0.8 % | 3.7 | 1.5 % | 86.7% |
| Chinese | 1.2 | 0.5 % | 2.2 | 0.9 % | 77.6% |
| Other | 1.5 | 0.6 % | 2.1 | 0.8 % | 41.2% |

Source ONS

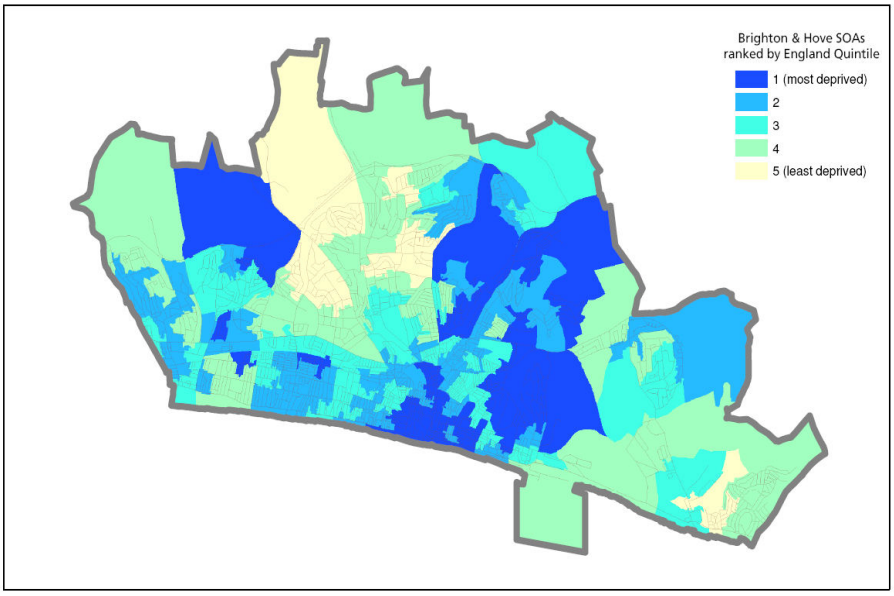
These changes are important as different ethnic groups experience different disease patterns. For example Asians as well as Black Africans and Caribbeans are at increased risk of cardiovascular disease and diabetes.

**The broader determinants of health**

Many different factors influence health. It has been estimated that the NHS can only contribute 8% to any increase in life expectancy (SECSHA Health Inequality Strategy) and that other factors, the broader determinants of health, such as education, employment and housing have a greater impact. Some of the major socio-economic problems in the city are the levels of young people not in education, employment or training, sections of the population with low skills, the number of people claiming incapacity benefit and high numbers of children both in lone parent households and in households with no working adults (OCSI 2007).

Inequalities exist cross the city both within population sub groups such as people from different ethnic groups and people living with disabilities, as well as between neighbourhoods. The Index of Multiple Deprivation 2007 identifies Brighton and Hove as the 79th most deprived authority in England (out of 354), with 9% of all Super Output Areas in the City falling within the 10% most deprived SOAs in England and 8 SOAs falling in the 5% most deprived. Map 1 shows that most of the deprived areas are in the East of the city. However, the majority of people suffering disadvantage in the city do not live in the most deprived 20% of SOAs.

Map 1 Brighton and Hove Super Output Areas deprivation ranking from IMD 2007



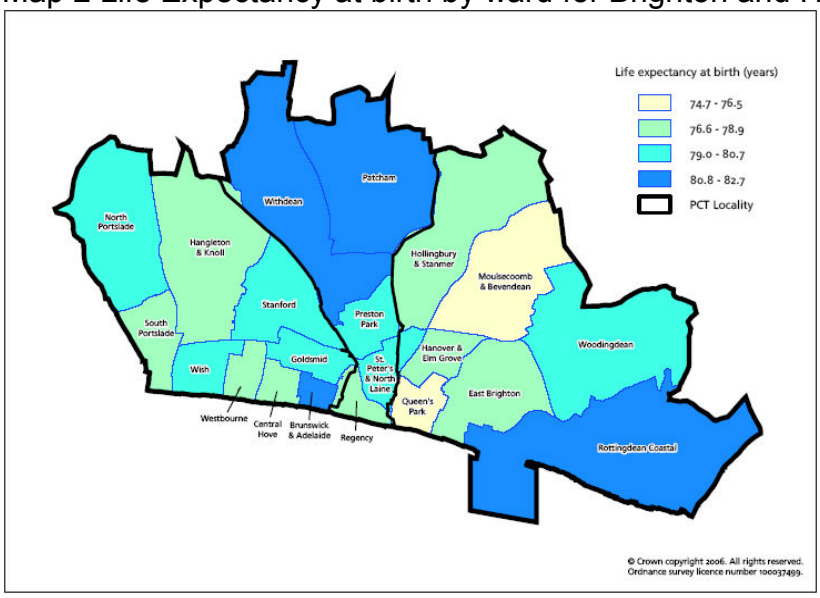



Source: Office of National Statistics, 2007

**Life Expectancy**

There is a national health inequality target for Life Expectancy. Life expectancy at birth is a useful global measure of population health and illustrates the inequalities across the city. The average life expectancy at birth for males in Brighton and Hove in 2004/2006 was 76.3 years compared with 77.3 years for England. For females the life expectancies were 81.8 years and 81.6 years respectively. The average life expectancy for Brighton males in 1999/2001 was 74.6 years and for females 80.5 years. However as the map below demonstrates there are variations in life expectancy between the different wards across the city. Comparison with the map above clearly links life expectancy with deprivation.

Map 2 Life Expectancy at birth by ward for Brighton and Hove 2003-5



Source BHCPCT Public Health

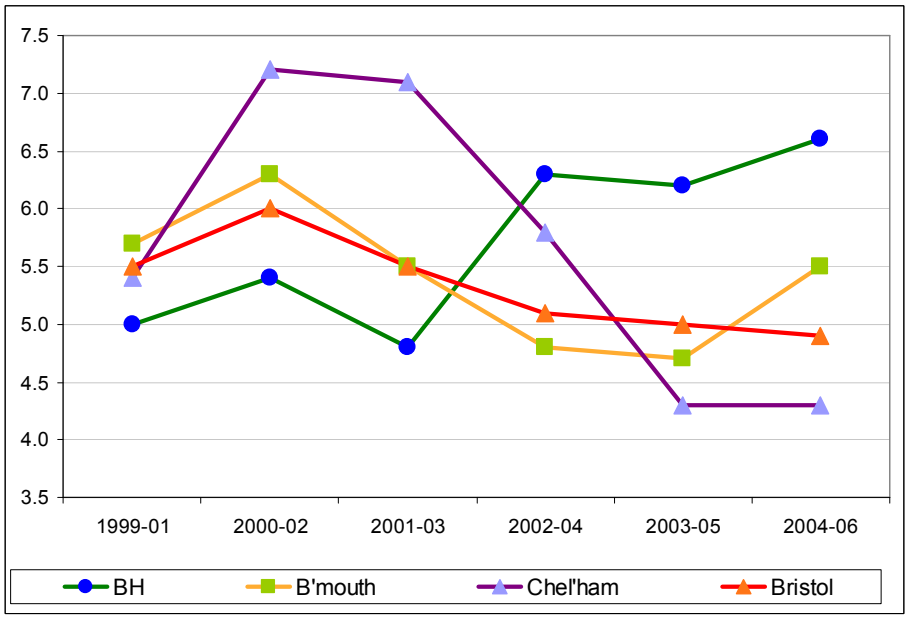
The Department of Health (DH 2007) has identified the key interventions for reducing the gap in life expectancy between the most and least disadvantaged PCTs. These are relevant to reducing health inequalities within Brighton and Hove. The interventions to consider include:

- greatly increasing the capacity of smoking cessation clinics
- increasing the coverage of effective therapies for secondary prevention of cardiovascular diseases in people aged under 75 years
- primary prevention of cardiovascular disease in people of all ages with hypertension through treatment with antihypertensives and statins.
- the early detection of cancer
- reducing mortality from respiratory diseases
- reducing mortality from alcohol related diseases
- reducing infant mortality.

**Infant and Child Health**

Like life expectancy infant mortality is a measure of a population's overall health. Unlike life expectancy the actual annual number of deaths upon which the rates are based are relatively very few. This has implications for making comparisons between different areas within the same local authority. The figures below compare the trend in infant mortality for the city between 1999/2001 and 2004/06 with the trends for those cities considered to be similar to Brighton and Hove by the Office for National Statistics.

Figure 2 Infant mortality rates 1999/01 to 2004/6 for Brighton and Hove compared with ONS comparator areas.



In general the majority of neonatal deaths are due to immaturity, congenital anomalies and intrapartum asphyxia, anoxia or trauma. Over two-fifths of post-neonatal deaths are due to congenital anomalies and sudden infant deaths. Because of the small number of deaths the causes of death also vary from year to year. In 2005 of the 18 infant deaths 15 were aged under 28 days and seven of the infant deaths were due to extreme immaturity compared with one death in 2004. Regarding Sudden Infant deaths there was one in 2004 and none in 2005. Low birth-weight is an important factor regarding perinatal death. Smoking during pregnancy is more frequent amongst women from lower socio-economic groups and is a contributory factor to low birth weight. The highest rates of low and very low birth-weight babies in Brighton and Hove are seen in the more deprived parts of the city.

Breastfeeding and vaccinations protect children from infectious diseases and other conditions. Breastfeeding initiation rates across the city are high, but the number of babies being breastfed at 6 weeks has been much lower but appears to be improving. The most recent data for the first three months of 2008 showed a breastfeeding rate at 6 weeks of 64%. Across the city the maternal breastfeeding rates between health visiting teams vary from 19% to 60%. This may be due to demographic and cultural factors in the population or differences in expectation or practice.

Childhood immunisation rates in Brighton and Hove are below the national rates. The table below compares the rates of vaccination for selected vaccines at certain ages. Each percentage point represents approximately 30 vaccinated children. Vaccination rates tend to be lower amongst children from more socioeconomically deprived families. Locally it is also considered that the large natural health movement has an impact on uptake.

Table 2

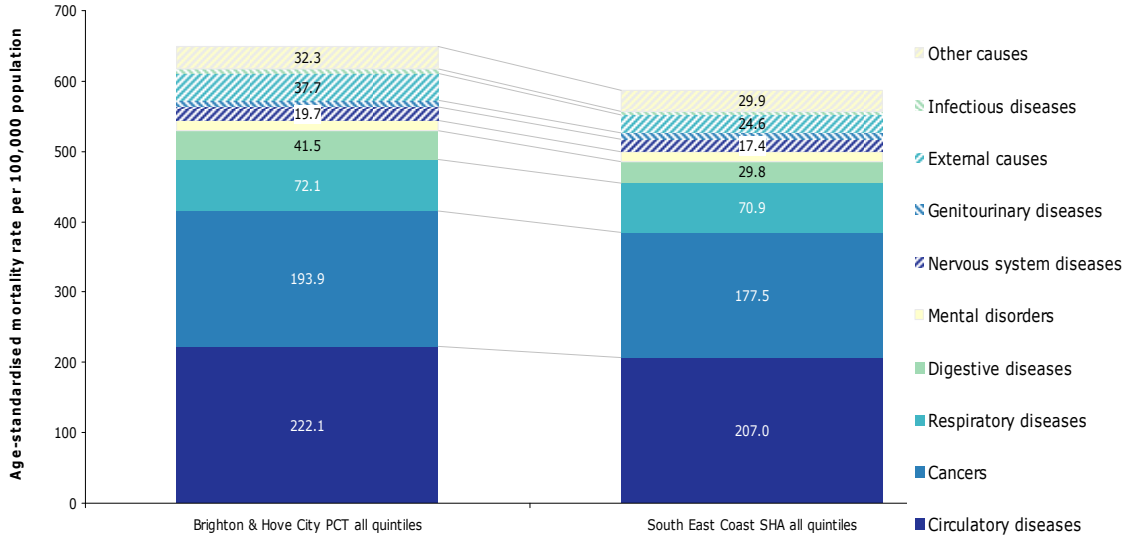
| Vaccine | Age | BHCPCT | England |
|---|---|---|---|
| DTaP/IPVB/Hib | % immunised by their first birthday | 88 | 91 |
| MMR | % immunised by their second birthday | 79 | 85 |
| DTaP/IPV Booster | % immunised by their fifth birthday | 71 | 79 |

In 2005/6 23% of five year olds in Brighton and Hove had active dental decay. This is better than the national figure of 33% but slightly above the SHA rate of 22%. There is however a clear association between increased incidence of dental caries and socio-economic disadvantage. The treatment of diseases of the oral cavity is the most frequent cause of hospital admission for local children, as any dental work requiring general anaesthesia must be carried out in hospital.

**Major causes of death for all ages**

The figure below shows the main causes of death within Brighton and Hove and compares the rates with those for the SHA as a whole. It clearly shows that the commonest causes of death, cancers, circulatory diseases, respiratory diseases and digestive diseases (which includes liver diseases) are similar but that the Brighton rates are higher for all disease groupings.

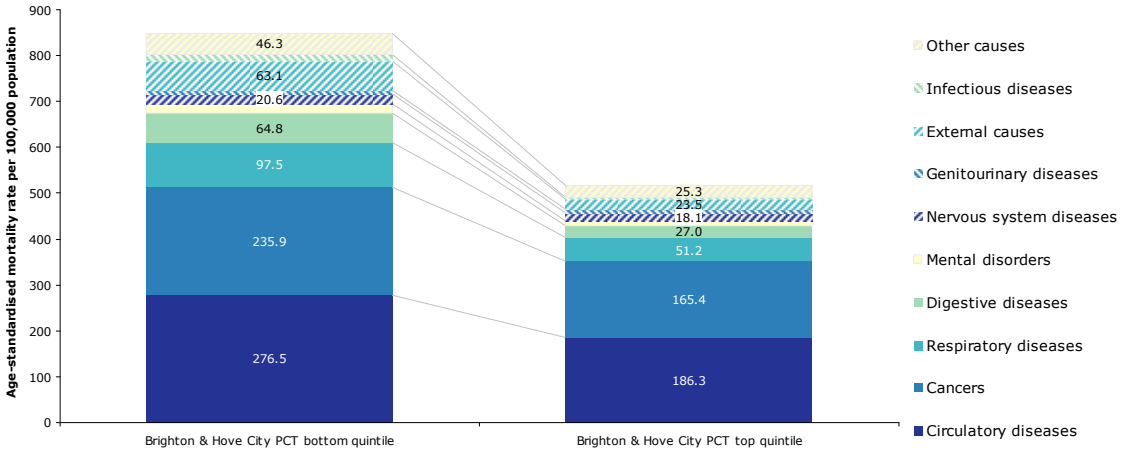
Figure 3 Mortality rate per 100,000 population for the total population of BHCPCT compared with the total population of SEC SHA 2002-6




Source SEPHO Toolkit

The figure below compares the death rates for BHCPCT for 2002-6 for the least deprived quintile of the city's population with the most deprived quintile. Again the commonest causes of death are similar but the rates are clearly much greater in the most deprived quintile.

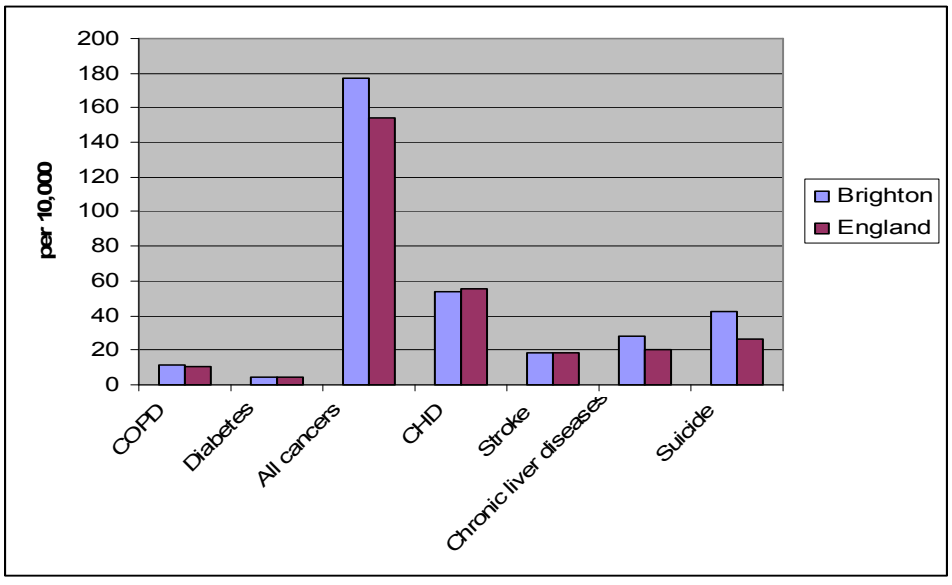
Figure 4 Mortality rate per 100,000 population for the least and most deprived quintiles in BHCPCT 2002-6




Source SEPHO Toolkit

The chart below shows that the same conditions also have the greatest years of life lost, though for suicide and injury undetermined the Brighton rate is relatively much higher than the national one.

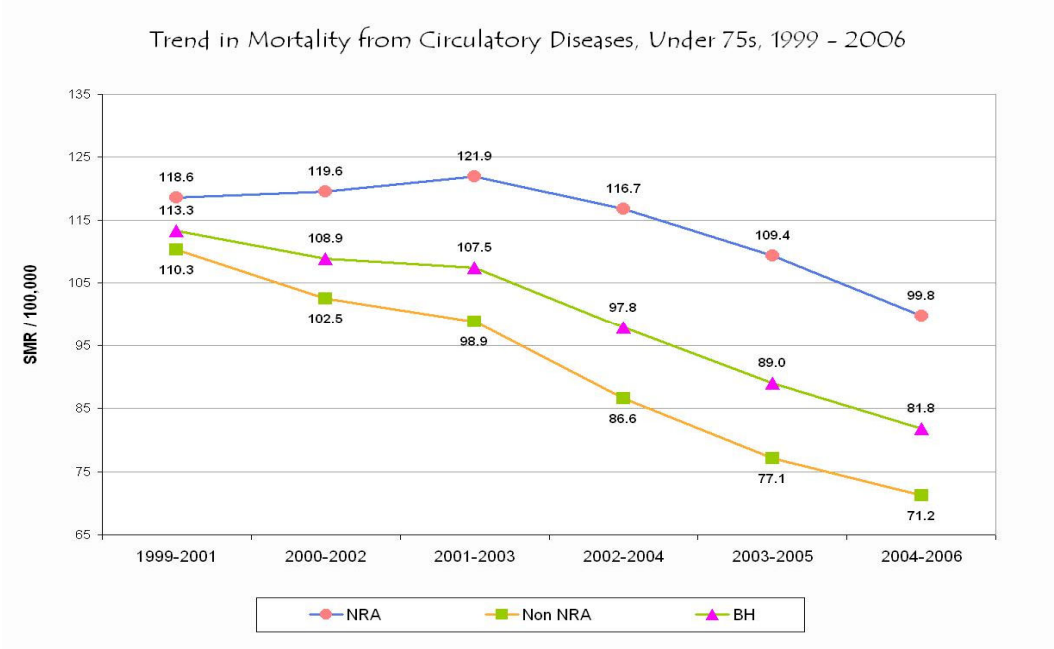
Figure 5 Years of Life Lost per 10,000 population under 75 years for Brighton and Hove and for England 2004-6

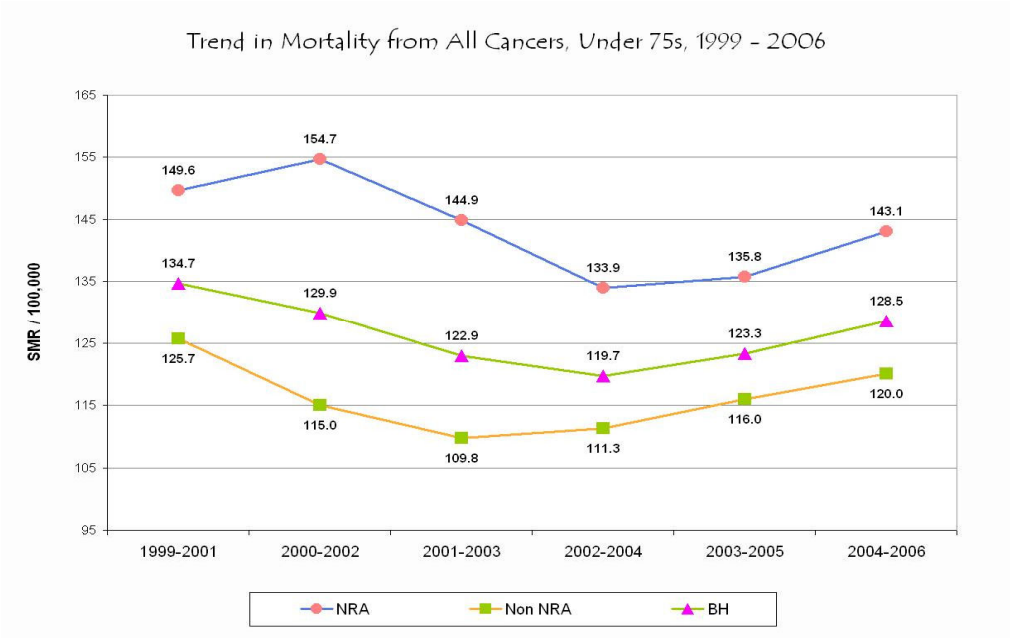



Source: NCHOD

**Major causes of death and Health Inequalities**

Figure 6 and 7 below show that for the two major killers the recent trend for deaths from circulatory diseases in people aged under 75 years in Brighton and Hove has been downwards whereas for cancers the recent trend is upwards. In addition the rates are higher in those areas of the city which received neighbourhood renewal funding (NRA) and the gap compared with the rest of the city is not reducing.




The recent increase in cancer is being investigated further. The most common cancers showing a significant increase in absolute numbers in recent years are lung and breast cancer, but the trend is not straightforward. Of the 165 male deaths in 2006 in people aged under 75 years, 44 were from lung cancer compared with 35 in 2004 and 47 in 2001. There were 138 female deaths under 75 years in 2006 of which 33 were from lung cancer and 26 from breast cancer. This compares with 23 and 21 in 2004 and 20 and 34 in 2001 respectively. The mortality rate per 100,000 females under 75 years from breast cancer has also fluctuated from 29.9 in 2001 to 18.5 in 2004 and 30.2 in 2007. For males and females combined the rates for lung cancer had

been steadily increasing from 2003 to 2006, but the rate fell slightly in 2007. A similar pattern has been seen for male but not for female deaths.

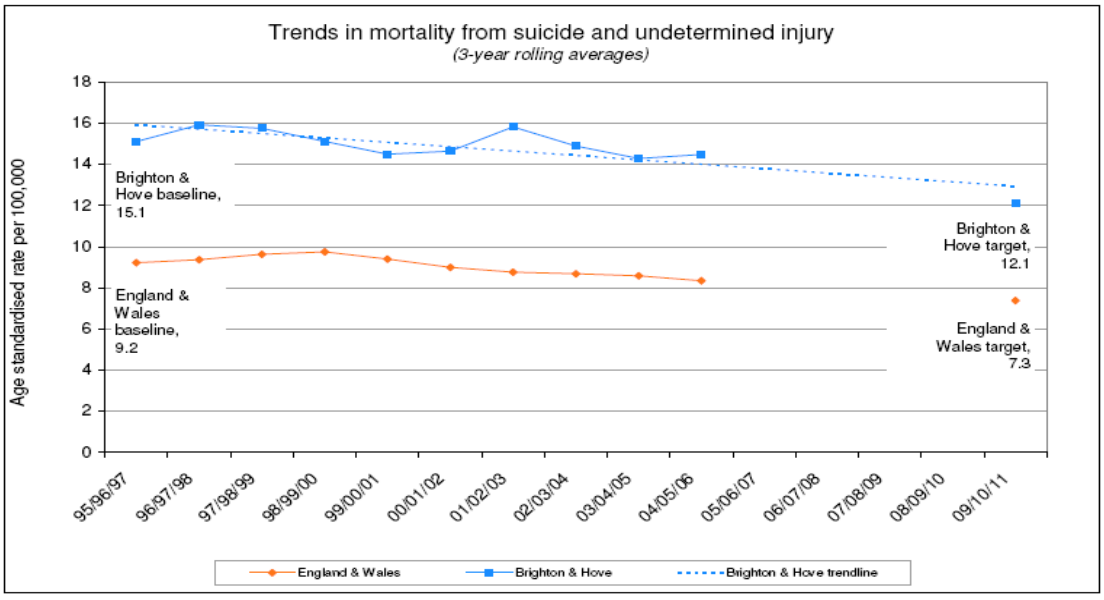
**Mental health and substance misuse**

Brighton and Hove has a high Mental Health Needs Index score together with a large number of people at increased risk of mental health problems. Based on national survey work 25,000 people in Brighton and Hove aged 16 to 65 suffer from a neurotic disorder at any one time. The most common disorder is mixed anxiety and depression. There are also estimated to be 2000 people with bipolar disorder and 600 with schizophrenia. Schizophrenia is both the most common cause of hospital admission and the condition with the longest average length of stay.

An older people's mental health needs assessment carried out in Brighton and Hove in 2004 found that the two types of mental health problems which affect older people the most are dementia and depression. Applying national prevalence rates to the local population suggests that within the city there are over approximately 3,100-3,200 people aged 65 years and above with dementia. Of these approximately one third will suffer from severe dementia. It is estimated that 10-15% of all older people suffer from depressive symptoms.

As figure 8 shows the suicide rate in Brighton and Hove is much higher than the national average. A local suicide audit of deaths in 2003-5 (based on 119 deaths) showed that 87% of people had had a primary diagnosis of mental illness (of these, 45% had depression, 25% had alcohol/substance dependence), 67% were males, 76% were either single, divorced /separated or widowed, 88% were heterosexual, 51% were aged between 18-44 years and 94% were white.

Figure 8 Mortality rate from suicide and undetermined injury for Brighton and Hove and for England and Wales 1995/7 to 2004/6



Deaths from suicide in people under the age of 20 years are rare: there were 14 suicides in total among 15-19 year olds between 1987 and 2003. However, the number of children with mental health needs is significant. The Children and Young People's Trust estimate that there are over 3000 local children with moderately severe problems and over 800 with complex mental health needs. Mental health issues are more likely amongst children who are looked after, adopted, on the child protection register, have learning difficulties, have suffered traumatic life events or are young offenders. Drug use amongst 11-15 year olds has reduced between 2001 and 2006.

Brighton has relatively high numbers of adult problem drug users including injecting drug-users. Table 3 shows the annual number of drug related deaths in the city. Although not all parts of the country report to the national programme Brighton still has a relatively high proportion of the national total. Heroin or Morphine and alcohol were implicated in a significant number of the deaths.

**Table 3 Number of drug related deaths in Brighton & Hove and in England and Wales 2000-2006**

| | No of Deaths in England and Wales* | Brighton & Hove No of Deaths | Brighton & Hove Rate per 100,000 |
|---|---|---|---|
| 2000 | 1319 | 67 | 32.56 |
| 2001 | 1774 | 59 | 28.51 |
| 2002 | 1684 | 56 | 26.85 |
| 2003 | 1659 | 53 | 25.30 |
| 2004 | 1472 | 47 | 22.32 |
| 2005 | 1382 | 51 | 24.22 |
| 2006 | n/a | 38 | 17.8 |

(Source : National Programme on Substance Abuse Deaths) * Not all jurisdictions report to the database.

Alcohol misuse including binge drinking is a substantial and growing problem in Brighton and Hove, particularly for men. In 2006 SEPHO ranked Brighton and Hove as the 11th highest of the 67 Local Authorities in the South East for alcohol related hospital admissions. Based on data from 2001-3 Brighton had the second highest alcohol specific death rate for males of all Local authorities in England. For females Brighton and Hove was ranked 62nd. Between the periods 1991/97 and 1998/2004 alcohol specific death rates for men almost doubled whereas in women the death rates were unchanged. Brighton and Hove is also in the top quintile for alcohol related recorded crimes, violent offences and sexual offences. A 2007 systematic review by the National Institute for Mental Health in England found an increased relative risk of alcohol dependence in lesbian, gay and bisexual groups at least 1.5 times higher than the heterosexual population. The relative risk for substance misuse was also increased.

## Chronic Disease and Morbidity

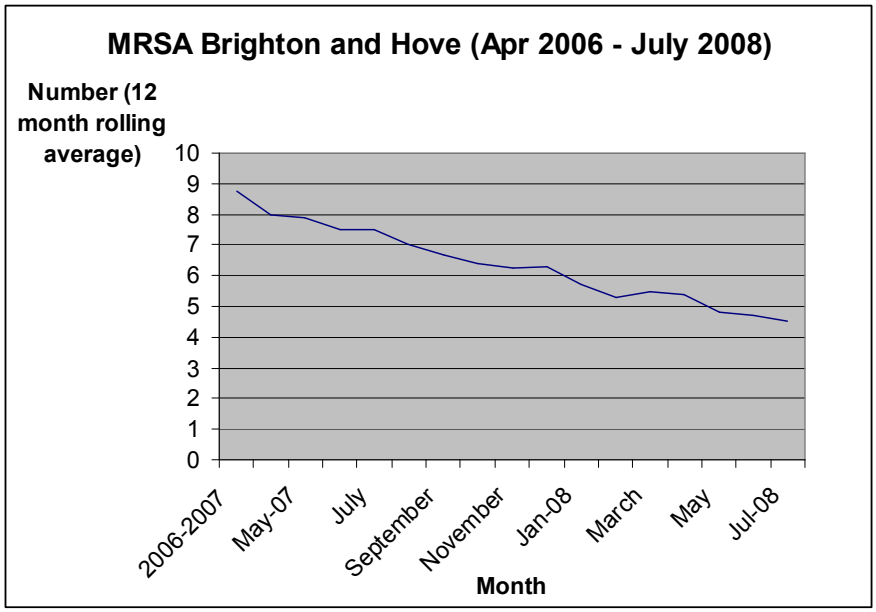
Although a poor indicator of morbidity for some conditions hospital admissions provide some insight to the diseases experienced by the local population. In total in 2007/8 BHCPCT residents spent over 76,000 days as hospital inpatients. This does not include day cases. As the table below shows the majority of hospital bed days are used by people aged 65 years and above.

Table 4 Percentage of total bed days by age and type of admission 2007/8.

| Age (years) | Type of admission | | |
|---|---|---|---|
| | Elective | Emergency | All |
| <65 | 44.9% | 41.6% | 42.1% |
| 65+ | 55.1% | 58.4% | 57.9% |
| 75+ | 30.8% | 46.3% | 44.1% |
| 85+ | 5.1% | 23.1% | 20.5% |

Health care acquired infection, and MRSA and Clostridium difficile (CD) in particular, has become a significant issue in recent years. A great deal of work has been undertaken across the local health economy to address this. The high rates of MRSA infection (bacteraemias) have been falling steadily since 2006 and the monthly average (based on 12 month rolling averages) has fallen from 8.75 in April 2006 to 4.5 in July 2008.

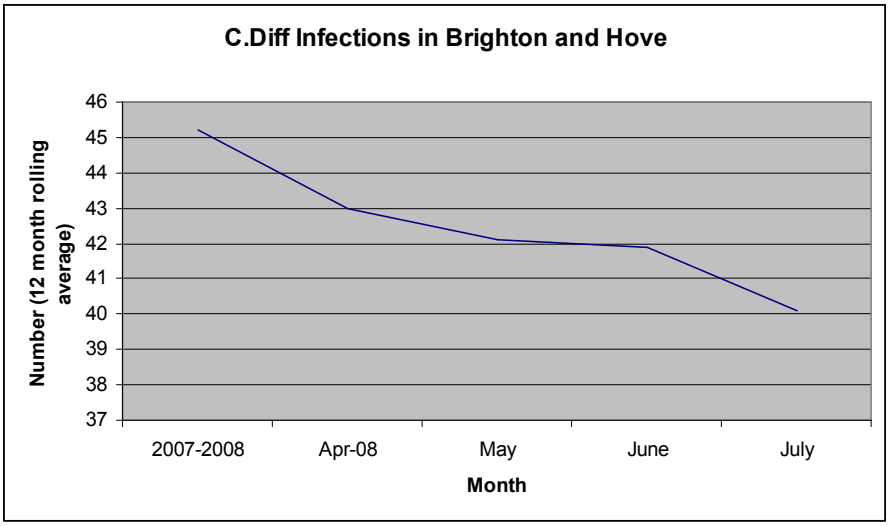
Figure 9 MRSA Bacteraemias in Brighton and Hove, 12 month rolling average




The 2007/8 rate of CD cases in the local community was 14 per 10,000 people, based on 345 cases, which was above the SHA average of 10.4. The PCT target for 2008/9 is for a total of 272 cases falling to 125 in 2010/11.

Figure 10 shows the 12 month rolling average figure from when data first became available (April 2007). While the numbers of infections are higher than MRSA and data recording does not go back as far, there is a suggestion of a similar trend with a reducing rate of infection. Several new initiatives around deep cleaning, a C.Diff ward and a new antibiotic policy across primary and secondary care should have further impact on reducing infection rates.

Figure 10 C.Diff infections in Brighton and Hove, 12 month rolling average




The table below describes by locality within the PCT the prevalence, mortality and admission data for different chronic conditions experienced by local residents. There are some data quality issues about the primary care data from the Quality and Outcomes Framework used to estimate prevalence. The true prevalence is likely to be greater than that presented.

As the table shows the highest mortality rates for cancer and coronary heart disease were in the east locality. This is in keeping with the higher levels of deprivation seen in that part of the city and is likely to reflect increased smoking levels and other variations in lifestyle. The table also clearly shows that the number of hospital admissions for conditions such as diabetes and asthma were relatively few in comparison with the number of people with the condition.

Table 5 Crude prevalence, mortality and admission data for chronic diseases by locality. Data from years 2004 to 2007

| **Condition** | **Locality** | **QOF 2006-7** | | **SMR 2004-6** | **Admissions 2005-7** | |
|---|---|---|---|---|---|---|
| | | | | | **Emergency** | **Elective** |
| | | **Disease Register Size** (No) | **Crude prevalence** (Rate /1000) | (Rate / 100,000) | Avg No. per Yr | Avg No. per Yr |

| | | | | | | |
|---|---|---|---|---|---|---|
| Bronchitis, emphysema and other COPD | Central | 689 | 6.9 | 4.0 | 6 | 1 |
| | East | 1,182 | 12.8 | 15.9 | 9 | 2 |
| | West | 1,041 | 10.4 | 15.5 | 14 | 1 |
| | *BH* | *2,912* | *9.9* | *13.1* | *29* | *4* |
| Asthma | Central | 5,335 | 53.3 | * | 61 | 0 |
| | East | 5,312 | 57.3 | * | 126 | 2 |
| | West | 5,456 | 54.6 | * | 96 | 1 |
| | *BH* | *16,103* | *55.0* | *1.4 (all ages)* | *283* | *3* |
| CHD | Central | 2,009 | 20.1 | 26.9 | 94 | 12 |
| | East | 2,583 | 27.9 | 68.6 | 221 | 28 |
| | West | 2,700 | 27.0 | 45.2 | 210 | 28 |
| | *BH* | *7,292* | *24.9* | *47.1* | *525* | *68* |
| Heart Failure | Central | 456 | 4.6 | * | 34 | 2 |
| | East | 554 | 6.0 | * | 84 | 4 |
| | West | 563 | 5.6 | * | 96 | 5 |
| | *BH* | *1,573* | *5.4* | 5.7 | *215* | *11* |
| Stroke | Central | 997 | 10.0 | 7.3 | 86 | 7 |
| | East | 1,141 | 12.3 | 14.3 | 158 | 9 |
| | West | 1,420 | 14.2 | 20.1 | 178 | 11 |
| | *BH* | *3,558* | *12.2* | *15.2* | *421* | *27* |
| Cancer | Central | 676 | 6.7 | 83.6 | 127 | 597 |
| | East | 854 | 9.2 | 152.3 | 234 | 960 |
| | West | 829 | 8.3 | 129.5 | 245 | 1,150 |
| | BH | 2,359 | 8.1 | 128.9 | *606* | *2,706* |
| Diabetes | Central | 2,203 | 0.0 | * | 39 | 22 |
| | East | 2,728 | 0.0 | * | 83 | 50 |
| | West | 2,908 | 0.0 | * | 79 | 43 |
| | *BH* | *7,839* | *0.0* | *3.7* | *202* | *114* |

* numbers too small to provide meaningful rate

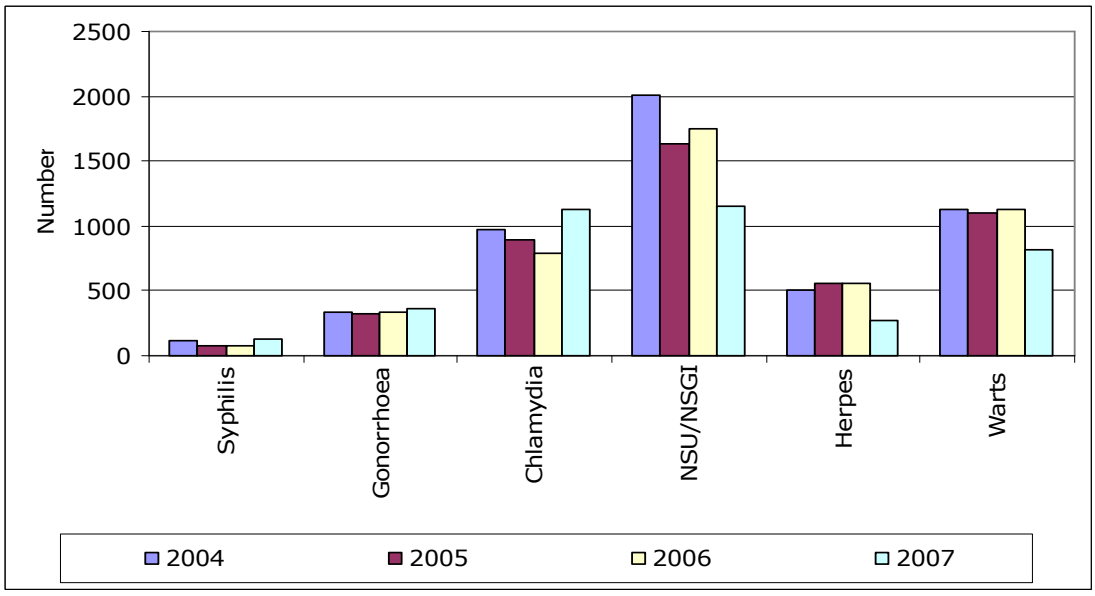
**Sexual health**

Brighton and Hove has high rates of sexually transmitted infections (STIs), people living with HIV, teenage pregnancy and terminations of pregnancy. It is currently difficult to obtain resident based information about STIs but overall contacts at the main Genito-Urinary Medicine (GUM) clinic in Brighton and Hove remain very high and are increasing year on year. In March 2008 the GUM clinic achieved the national target of offering everyone an appointment to be seen within 48 hours of contacting the service.

Brighton and Hove has high rates of the commonest sexually transmitted infections such as chlamydia but also has very high rates of gonorrhoea and syphilis when compared with national rates. However, unlike the national picture the rates of gonorrhoea cases have not fallen in recent years (Figure

11). The majority of these infections are amongst men who have sex with men.

**Figure 11 Number of new contacts seen at Brighton GUM clinic by sexually transmitted infection 2004 – 2007**




Source BHCPCT/KC60

During 2007/8 the local chlamydia screening programme screened 4,348 people aged 15-24 year of which 3640, almost 10% of the target population, were eligible for inclusion under the national target. Of the 3640 tests 259 (7%) were positive results. Approximately three quarters of all the tests done and of the positive results were amongst females. The target for 2008/9 is 6355 screening tests completed, which is equivalent to 17% of the target population. A new Local Enhanced Service for primary care including pharmacists is being developed to further increase uptake of the programme. In addition all chlamydia tests carried out, not just those in the screening programme, will be included unless they took place at the GUM clinic.

Brighton has very high rates of people living with HIV compared with the other PCTs in the region. In December 2006 there were 1121 identified people in Brighton and Hove living with HIV, 1019 of whom were males. The total figure for both sexes has been increasing rapidly; in December 2005 it was 1000, and for 2001 it was 633.

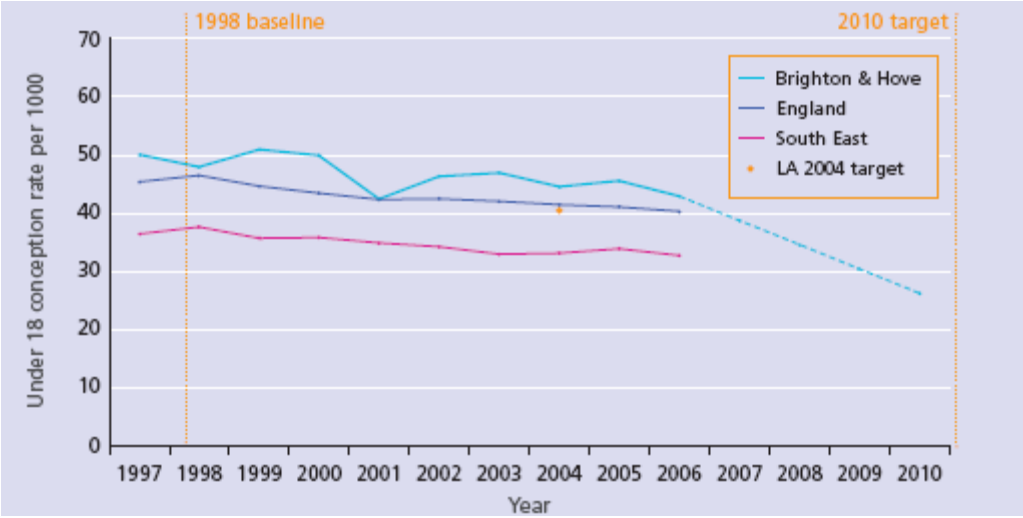
It is estimated that one third of gay men infected with HIV do not know their diagnosis. This is important not only from a prevention perspective but also for ensuring correct monitoring of disease markers to allow treatment to be started as soon as it is required.

As Figure 12 shows the teenage pregnancy rates in Brighton and Hove are above the national average. To achieve the local 2010 target of a 45% reduction will require a significant sustained fall in the rate. It has fallen

10.5% since 1998. The highest rates in the city are seen in the most disadvantaged areas and there is a clear link with educational achievement. In 2004-6 57% of teenage conceptions in Brighton and Hove resulted in abortion compared with 48% nationally.

In the 2007 Health Related Behaviour Survey 45% of boys and 62% of girls knew where they could get free condoms. This compared with 42% and 63% respectively in 2004 and 52% and 63% respectively nationally in 2006. Half the local secondary schools and all the sixth form colleges currently have outreach sexual health and contraceptive service provided by the school nurse team.

Figure 12 Teenage pregnancy rates for Brighton and Hove compared with the rates for England and the South East 1998-2006 (three year rolling average).




Source ONS

Brighton has rates of terminations of pregnancy above the national average for women of all ages. In 2007 the rate per 1000 women resident in Brighton and Hove was 23 for all ages and 22 for women under 18 compared with a national rate of 19 and 20 respectively. The comparable SHA figures were 18 and 17 respectively.

**Lifestyle and prevention**

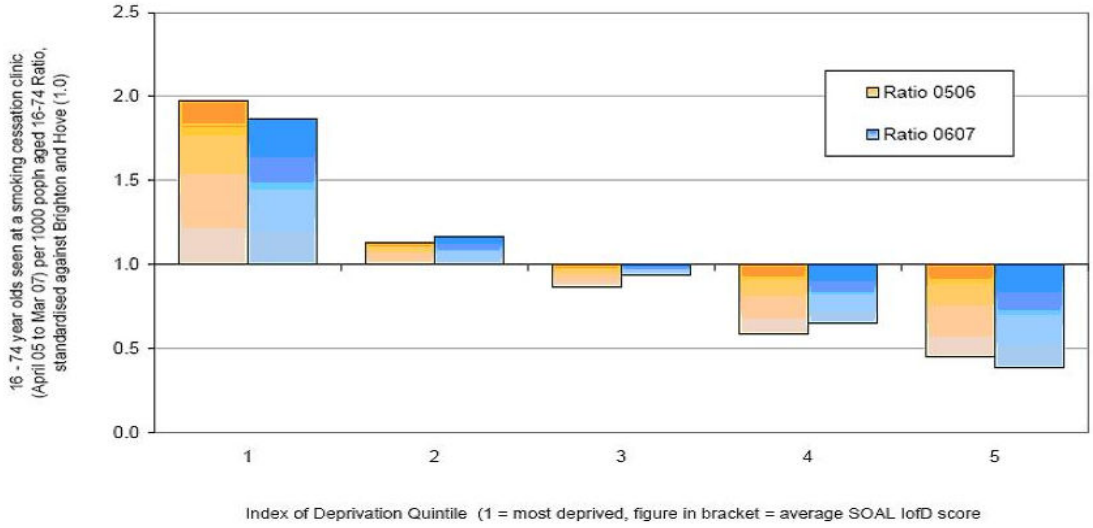
The individual factors influencing the variation in morbidity and mortality can be considered as being either unavoidable such as age, gender and ethnicity or avoidable such as smoking, excessive alcohol consumption, diet, sedentary lifestyle etc. The ability to make healthier choices is influenced by personal circumstances and the broader determinants of health. The latest lifestyle survey of the Brighton and Hove adult population was in 2003.

Smoking is the greatest cause of health inequalities and premature death. In the 2003 survey the number of daily smokers had fallen to 20% from 27% in

1992 with approximately 7% more people being occasional smokers. However, amongst people living in the more deprived parts of the city rates of nearly 50% were recorded from a different household survey at that time. During 2006/8 the local smoking cessation service helped over 4,000 people to quit smoking. However, in 2008/9 there appears to be a reduction in the number of referrals to the service, and the service is planning how it should respond to this change.

One of the possible disadvantages of providing a specialist smoking cessation service is that it may inadvertently widen inequalities as people living in more affluent parts of the city take up the service more readily than those living elsewhere. The figure below shows that in recent years this has not been the case locally and that the specialist service has seen more patients from the more deprived parts of the city.

Figure 13 Referrals to the specialist smoking cessation service per 1000 population by deprivation quintile.




The Health Related Behaviour Survey (HRBS) of 14 -15 year olds in 2007 found that 15% of boys and 25% of girls had smoked at least one cigarette in the previous week. The national figures were 13% and 20% respectively.

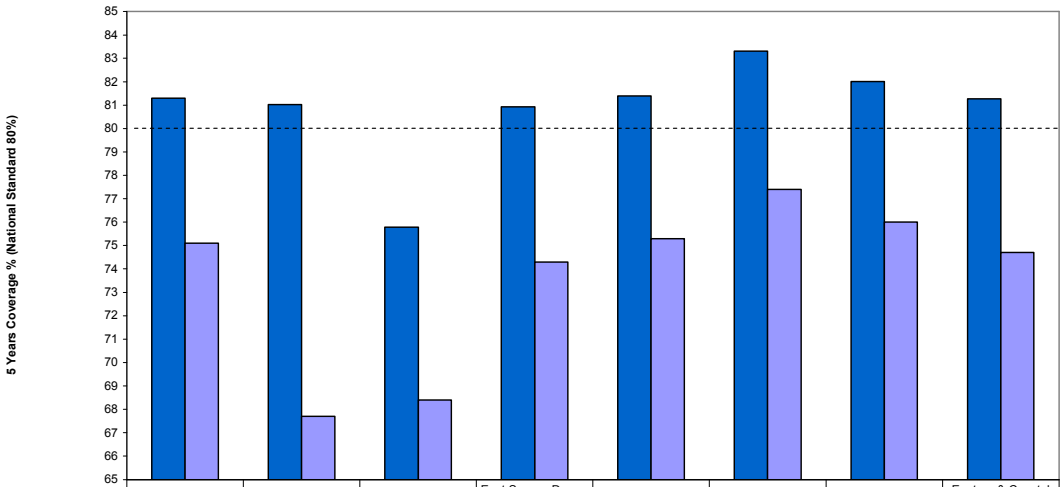
Nationally it is estimated that approximately one in four adults drink above "safe drinking levels". This equates to more than 50,000 adults in Brighton and Hove. Over the period 1992 to 2003 the percentage of adult men consuming above safe levels increased from 165 to 27%. For women the increase was from 8% to 17%. The HRBS found that drinking amongst young people is on the increase with 13% of boys in 2007 reporting drinking at least 14 units of alcohol in the last week compared with 10% in 2004. The figures for girls were 9% and 6% respectively.

Obesity is an increasing concern both for adults and children. Being overweight or obese increases the risk of diabetes, hypertension, heart disease and cancer amongst other diseases. It is estimated that nationally,

without effective action, one fifth of children aged two to ten and one third of adults will be obese by 2010. There is only limited valid local information about obesity. Modelled estimates suggest that in 2005 20.2% of adults in Brighton and Hove were obese. Local data in 2006/7 found 30.2% of year six children were overweight or obese which is similar to the SHA and national picture. Encouragingly the HRBS found that the eating habits of children aged 10-14 are improving as are the levels of physical activity.

The uptake of prevention programmes, such as those addressing the issues outlined above, tends to be greater amongst people from higher socioeconomic groups. This is demonstrated locally by the PCT's cervical cancer screening programme. Overall coverage has been falling over recent years and is now below the national target of 80% (Figure 14). The coverage is particularly low for the 25-34 age group, which is a national issue. However, for all ages local coverage is lowest in the more disadvantaged parts of the city.

Figure 14 Cervical screening coverage for 2006-7 by % target population for BHCPCT and other PCTs within SECSHA.




| | Surrey | West Sussex | Brighton & Hove City | East Sussex Downs & Weald | Hastings & Rother | West Kent | Medway | Eastern & Coastal Kent |
|---|---|---|---|---|---|---|---|---|
| 5 year coverage | 81.3 | 81.0 | 75.8 | 80.9 | 81.4 | 83.3 | 82.0 | 81.3 |
| 3.5 year coverage | 75.1 | 67.7 | 68.4 | 74.3 | 75.3 | 77.4 | 76.0 | 74.7 |

Breast screening coverage has also fallen in recent years. Between 2005/6 and 2006/7 the percentage of women aged 53 to 64 being screened within 36 months fell from 77.1% to 70.1%. The screening service has been unable to recruit adequate numbers of staff to maintain the 36 month screening interval for women. The service is due to move to new premises with modern digital technology in the autumn of 2008 and it is anticipated that this will help to resolve the organisational issues and allow the coverage to return to above national target levels.

**Summary**

Brighton and Hove PCT is one of the most deprived PCTs in the South East. This together with a relatively large proportion of younger adults results in a population with significant health needs and inequalities. Particular challenges are the low immunisation rates of children, high teenage pregnancy rates, high rates of sexually transmitted infections, high levels of alcohol and drug related morbidity and mortality, increasing cancer mortality and widening inequalities for cancer and cardiovascular diseases. Encouraging healthy lifestyles through reducing smoking and hazardous and harmful drinking together with promoting exercise and healthy eating will help to address some of these issues. Although the population is relatively young by national standards the older population still has the greatest impact on inpatient hospital services.

**Key References**


- Department of Health (2007). Tackling Health inequalities: 2004-6 data and policy update for the 2010 National target. London.
- Joint Strategic Needs Assessment Portfolio2008
- Scanlon T (2006). Commissioning for Health; Annual Report of the Director of Public Health. Brighton and Hove.
- Scanlon T (2007). A Focus on Performance; Annual Report of the Director of Public Health . Brighton and Hove.
- Scanlon T (2008). Brighten Up! Growing Up in Brighton & Hove. Annual Report of the Director of Public Health.
- OCSI (2007) Developing Appropriate Strategies for Reducing Inequality in Brighton and Hove.
- SECSHA (2007) NHS South East Coast: Health Inequality Strategy.

| HEALTH OVERVIEW AND SCRUTINY COMMITTEE | Agenda Item 35<br>Brighton & Hove City Council |
|---|---|

| | | | | |
|---|---|---|---|---|
| **Subject:** | | **The draft City Strategic Commissioning Plan: update on consultation** | | |
| **Date of Meeting:** | | **17 September 2008** | | |
| **Report of:** | | **The Director of Strategy and Governance** | | |
| **Contact Officer:** | Name: | Giles Rossington | Tel: | 29-1038 |
| | E-mail: | Giles.Rossington@brighton-hove.gov.uk | | |
| **Wards Affected:** | All | | | |

**FOR GENERAL RELEASE**

## 1. SUMMARY AND POLICY CONTEXT:

1.1 Brighton & Hove City Teaching Primary Care Trust (PCT) referred a draft of the City Strategic Commissioning Plan to the Health Overview & Scrutiny Committee (HOSC) for consideration at the 16.01.08 HOSC meeting.

1.2 HOSC members were asked to comment on the contents of the draft Plan and to approve the PCT's proposals for public and stakeholder consultation in relation to further development of the Plan and in relation to the development of the "World Class Commissioning" agenda.

1.3 Much of this consultation has now been undertaken and a final draft of the City Strategic Commissioning Plan has been produced. (Copies of the Plan are available on request.)

## 2. RECOMMENDATIONS:

2.1 That members:

(1) note this report and the additional information provided by the PCT (**Appendix 1** and **Appendix 2)**;

(2) note that a final draft of the Strategic Commissioning Plan has now been submitted to the South East Coast Strategic Health Authority (SHA);

(3) note the PCT's selection of key health outcomes which will determine the local focus of the World Class Commissioning initiative (following consultation with stakeholders and members of the public as detailed in **Appendix 1**).

## 3. BACKGROUND INFORMATION

3.1 The City Strategic Commissioning Plan is authored by Brighton & Hove City Teaching Primary Care Trust (PCT) in partnership with the City Council. The Plan outlines the background to the commissioning of city health (and some social care) services, and describes how changes to the commissioning strategy will seek to improve the health and well-being of Brighton & Hove residents over the next three years.

3.2 The Health Overview & Scrutiny Committee (HOSC) examined an earlier draft of the City Strategic Commissioning Plan at its 16.01.08 meeting. The HOSC resolved:

"(1) That the draft Strategic Commissioning plan be noted and a HOSC Working Group established to examine aspects of the Plan in more detail;

(2) That the Committee agrees that Brighton & Hove Primary Care Trust has made adequate provision to consult the local public and stakeholders with regard to the City Strategic Commissioning Plan."

3.3 A HOSC Working Group was subsequently established and reported back to the Committee on 23.04.08 (see Item 80 on the 23.04.08 HOSC agenda).

3.4 The remit of the Working Group was, in essence, to use the draft Strategic Commissioning Plan as a resource for identifying areas of concern in terms of citywide healthcare performance and planning which might then be added to the HOSC Work Programme. Members of the

Working Group did identify a number of areas of concern and these were incorporated into a report on a recommended HOSC Work Programme (Item 81 on the 23.04.08 HOSC agenda). A number of these topics were subsequently included in the HOSC 2008/2009 Work Programme (Item 23 on the 23.07.08 HOSC agenda).

3.5 When initially considering the draft City Strategic Commissioning Plan, members were also asked to come to a view on whether the PCT had adequately consulted the public and stakeholders in regard to its commissioning strategies, both in terms of completed consultations and in terms of plans for further engagement.

3.6 Members did determine that the PCT's consultation strategy was satisfactory. The further consultation that the PCT promised at the 16.01.08 HOSC meeting has now largely been undertaken (details of this are provided in the appendices to this report).

3.7 Elements of the Strategic Commissioning Plan have been amended in response to public and stakeholder comments. Although some of these amendments may be significant, the final draft of the Plan is not materially different from the draft considered by the HOSC Working Group.

3.8 Members are therefore not being asked to reconsider the Strategic Commissioning Plan in its entirety, but rather to note that the consultative process which members approved at their 16.01.08 has been undertaken as agreed, and that the final draft of the Plan is the result of this consultative process.

3.9 "World Class Commissioning" is an NHS initiative to improve healthcare by more closely linking the commissioning process with health outcomes and by sharing local commissioning expertise and best practice across the NHS. Current and future NHS strategic planning, both on a local and a national level, will increasingly be informed by the World Class Commissioning agenda.

## 4. CONSULTATION

4.1 No formal consultation has been undertaken in relation to the preparation of this report. However, the draft City Strategic Commissioning Plan has been formulated after extensive consultation with stakeholders and members of the public. The Appendices to this report detail the public and stakeholder consultation carried out by the PCT.

## 5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are no financial implications to this report (which members are asked to note).

Legal Implications:

5.2 There are no legal issues for the Council arising from the recommendations to HOSC in this report.

*Lawyer Consulted: Elizabeth Culbert; Date: 15/08/08*

Equalities Implications:

5.3 There are no such direct implications to this report. However, the Strategic Commissioning Plan itself has been formulated with regard to equalities issues. When previously considering the Plan, HOSC members were satisfied that the PCT's proposals for public and stakeholder engagement were such that they encouraged the involvement of all sections of the community. Members may wish to check that the PCT's actual public engagement has been in accordance with these plans.

Sustainability Implications:

5.4 There are no direct sustainability implications to this report.

Crime & Disorder Implications:

5.5 There are no direct crime and disorder implications to this report.

Risk and Opportunity Management Implications:

5.6 None have been identified

Corporate / Citywide Implications:

5.7 The City Strategic Commissioning Plan is a key element in the development of city health and social care services.

## SUPPORTING DOCUMENTATION

### Appendices:

1. **Appendix 1**: details of the PCT's public and stakeholder consultation;
   **Appendix 2**: detailed feedback from consultative events organised by the PCT

### Documents in Members' Rooms:

There are none.

### Background Documents:

1. The City Strategic Commissioning Plan (final draft).

Brighton and Hove City NHS
Teaching Primary Care Trust

| | |
|---|---|
| **Report to:** | **Brighton & Hove Health Overview and Scrutiny Committee** |
| **Date:** | **17th September 2008** |
| **Regarding:** | **Strategic Commissioning Plan - Update** |

## 1. Introduction

This paper provides information on:

1. the range of stakeholder engagement undertaken by the PCT as part of the development of the PCTs Strategic Commissioning Plan
2. update on the Strategic Commissioning Plan
3. priority health outcomes selected by the PCT

## 2. Stakeholder engagement

The attached summary details the range of engagement activities carried out by the PCT to inform the Strategic Commissioning Plan. In addition to these activities, the PCT held a stakeholder event in February 2008 to consider how it should engage with stakeholders in the development and commissioning of health services for the city. This event attended by 80 stakeholders, together with an independent review of the PCTs engagement and communication activities will enable a refresh of the PCTs engagement plan.

A large stakeholder event was held in July 2008 (copy of results attached) which brought together 200 stakeholders from the voluntary sector; NHS organisations; City Council; private sector; not for profit organisations and members of patient / ptient representative groups to discuss the key strategic themes and related initiatives linked to agreed health outcomes.

Two further events will take place in September. One with primary care providers (GPs; Practice Nurses) on 25th September and a second event for all stakeholders on 30th September. Both events will be an opportunity to discuss the PCTs Strategic Commissioning Plan.

## 3. Strategic Commissioning Plan (SCP)

The PCT submitted the Strategic Commissioning Plan to the Strategic Health Authority on 9th September (attached). The SCP will continue to undergo further development and refinement. There will be the opportunity to consider and reflect the feedback and comments received from mid September to early October. The final SCP will be considered by the PCTs Board in October prior to submission to the Strategic Health Authority by the 31st October 2008.

## 4. Selection of Priority Health Outcomes

As part of World Class Commissioning the PCT is required to submit 10 outcome measures by which the PCT will be assessed.

The outcome assessment measures the PCT on two national targets and eight locally chosen targets. The locally chosen outcomes allow the PCT to reflect local health priorities.

When selecting the outcome measures the PCT must consider:

- Health needs of the population
- Priorities identified in the strategic plan

Although the World Class Commissioning Assurance Framework gives 54 measures from which to choose, where the list does not provide an appropriate metric to reflect the PCT Strategic Priorities PCT's are encouraged to provide their own. In these circumstances the PCT will be required to supply a robust data set against which their performance can be measured.

The two national targets are:

- Health inequalities measured through the average IMD score
- Life Expectancy measured through life expectancy at time of birth, years

Following the stakeholder consultation event in July, a series of discussions and reflection the PCT has selected the 8 local targets which will be central to the PCT's strategic plan and supporting targeted initiatives.

The WCC Outcome measures selected for the Assurance Framework assessment are:

- Hypertension prevalence
- Proportion of women aged 53-64 offered screening for breast cancer
- MRSA rate per 10,000 bed days
- Percentage of all deaths that occur at home
- Rate of alcohol related admissions per 100,000 population
- Percentage of Delayed Transfers of care per 1000,00 population
- Under 18 conception rates per 1000 females aged 15-17

In order to provide a full reflection of the PCT priorities one measure have been identified locally and not from within the core WCC Outcomes Measures:

- Childhood Obesity

The outcome measures reflect the priorities determined in the PCT's strategic plan have been selected against the core criteria set by the SHA, national guidance as well as local prioritisation criteria. The measures will challenge and test the PCT performance and the PCT will need to demonstrate movement towards a rate of improvement (towards excellence) over the 3 year time period of the plan.

# Appendix 2

**BRIGHTON AND HOVE CITY TEACHING PCT**

**WORLD CLASS COMMISSIONING**

**Patient and public engagement activities to support Strategic Commissioning Plan initiatives**

| Initiative | Engagement to date |
|---|---|
| Teenage pregnancy initiative | Strategy developed and overseen by a multi agency group involving key stakeholders including teenage parents. |
| Childhood obesity initiative | Development of strategy overseen by multi-agency childhood obesity strategy group involving all key stakeholders<br>During the consultation phase( December 2007 - February 2008) the strategy was disseminated widely to elicit comment – sought advice from LA communications group re who to consult with<br>Presented strategy to the Healthy City Partnership, the Children and Young People's Trust senior management team and the Primary Care Trust's executive team. |
| Prevention and secondary prevention of coronary heart disease | GP workshop on prevention of CVD<br>PCT working group on establishment of a Locally Enhanced scheme for general practice to develop at-risk registers, using these to identify those who would benefit from interventions<br>Practice Based Commissioning locality meetings on incentive scheme for reducing lifestyle risks<br>Collation of views from primary care on the barriers to improving registration of those at risk |
| Improving the performance and coverage of screening services - breast | Initiative outstanding |
| Prevention of admission pathway (including STAN) | Service providers including BSUHT, SDH, Local Authority partners and Practice based Commissioners have all been consulted on the relevant parts of the overall pathway.<br>A selected group of service user representatives on the 2/07/08 were part of a broad initial consultation on the pathway.<br>Further consultation will be undertaken with both stakeholders and service users to determine service development and inform subsequent evaluation. |
| Short Term Services Review | In the development of the project initiation document a range of key stakeholders have been consulted ,LHE DTOC Directors meeting, BSUHT, BHCC including Older peoples Steering group, SDH and PCT Chair and Relevant Executive leads. Final plan will be subject to scrutiny by relevant bodies including HOSCE and Cabinet structure and will be presented to the PCT PMO and PEC. |
| MRSA infection rates | Initiative outstanding |

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| Alcohol initiative (Mental Health) | Stakeholders have been involved through the DAAT alcohol strategy sub-group. The sub- group consists of senior managers from the Police, Children and Young People's Trust, Probation Service, Community Safety,Primary Care Trust, Sussex Partnership Trust, Supporting People, and representatives from voluntary sector and patients. The initiative has developed through this group and through research conducted by the Police and Health professionals detailing the impact of harmful drinking. |
| Alcohol initiative (Public health) | Engagement through alcohol strategy process established by the DAAT Alcohol Strategy sub-group, consisting of senior local Police Officers, Children and Young People's Trust, Probation Service, Community Safety, Primary Care Trust, Sussex Partnership Trust, Supporting People, Health Trainers, primary care LGBT communities, CRI, voluntary sector and patient representatives.<br><br>Safe Space has wide engagement and is well supported by the Police. It is a partnership between Hove YMCA, Red Cross, Brighton & Hove PCT, Sussex Police, St Paul's Church and Brighton & Hove Drug & Alcohol Action Team (through Communities Against Drugs) and Legal & General. |
| End of Life Care strategy | Consultation with the Citizens panel October 2006<br><br>Public event with stakeholders October 2006<br><br>GPs and other clinicians were consulted in 2006 in preparation for a local strategy |

Other initiatives (not directly linked to priority outcomes)

| **Initiative** | |
|---|---|
| Maternity services | Review of maternity services (June – August 2008).<br>Focus groups and individual meetings with parents focussing on those groups who are less engaged.<br>Review of the Maternity Services Liaison Committee (a parent led group looking at maternity services in Brighton and Hove) to ensure greater representation from across the city. |
| Smoking cessation | The stop smoking service and tobacco control alliance has been established since 2000, and have continued to involve patients, the public, stakeholder groups, trading standards, environmental health, South Downs NHS Trust, GPs, Pharmacies, private and public sector organisations across the city and the Healthy City Partnership. |
| Bowel cancer initiative | A multiagency group led by the Sussex Cancer Network has been leading the introduction of the programme.<br>There is ongoing involvement by patients in all areas of cancer care including a group specifically looking at bowel cancer. The Health Promotion subgroup also includes patients. |
| Children and Adolescent Mental HealthServices (CAMHS initiative | All Stakeholder are involved in the Pathfinder programme which is testing evidence based practice in 12 schools across the city and then rolling this best practice out to other schools.<br>There is both local and national evaluation which involves children; young people; parent/carers and teachers.<br>Strategic review of CAMHS and CAMHS commissioning Strategy in 2007 identified the need to respond more quickly and more effectively to crises following consultation with young people and families. |
| Development of an Integrated Urgent Care Centre | The rationale for the project sits within the Brighton and Hove City PCT strategies for Unscheduled Care and Chronic Disease Management which were subject to extensive consultation with stakeholders across the LHE. This initiative was further developed during specific consultation with stakeholders to shape urgent care priorities for the strategic plan at a city wide consultation event on 2/7/2008. |
| Effective referral management | PBC leaders and GP colleagues drove the development of the Gateway Management function. BICS is now owned by primary care and its triage function managed and delivered by local GPs.<br>The proposal to develop a gateway management function was discussed with the local Health Overview and Scrutiny Committee in January 2008 who considered that the PCT had made adequate arrangements to consult with stakeholders and the general public. The proposal was also discussed at the Patient and Public Involvement Forum. |
| Timely access and choice | 18 week national policy was developed following extensive national consultation with patient and public groups. |

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| | PCTs 18 Week Programme Board includes patent representatives within its membership<br><br>PCT has led a national pilot on patient and public participation on 18 weeks and this work has been extended. |
| Effective pathways | Initiative outstanding |
| Improving access to psychological therapies | Increased investment in this area will facilitate the employment of an additional 29 wte psychological therapists to deliver the increased number of interventions. |
| Suicide initiative | Initiative outstanding |
| Improved/Increased access to primary care services | Yearly patient surveys by GPs<br><br>Citizens panel looked at the development of a GP led health centre and a further survey is planned for 2008. Continued engagement with GPs, Local Medical committee. |
| Improved quality of primary care services | Patient surveys, pilot programme to develop the use of an IT based solution to gain real time patient experience (Dr Foster Patient Tracker system).<br><br>Local Pharmacy survey. |
| Long Term – Stroke/ABI, dementia, physical disability, diabetes) | <u>Stroke</u><br><br>Stroke steering group includes stroke association<br><br>Neuro-rehabilitation service user consultation (May-July 2008)<br><br>Developing with Sussex stroke leads model for ongoing user consultation/engagement<br><br><u>Dementia</u><br><br>Locally, extensive consultation was undertaken for the development of the original Local Health Economy Older People with Mental Health strategy. Additional consultation will take place with stakeholders as part of the refresh of this strategy in 2008/09.<br><br>A recent event with Local Health Economy stakeholders 2/7/08 helped to shape the overall priorities for the PCT's Strategic Commissioning plan and within this the key areas for focus within long term conditions. A follow up stakeholder event will be held in September 08.<br><br>Extensive consultation with Local Health Economy stakeholders, including service providers, service users and carers was held for the development of the recent Older People's Strategy. This identified key principles for the development of older people's services across the city, including the promotion of healthy aging; supporting independence; providing more responsive and accessible care and supporting more people at home. These principles will be reflected within the refresh of the OPMH strategy.<br><br><u>Diabetes</u><br><br>The community diabetes business case has been subject to comprehensive review and signoff by patients and clinicians, who are represented on the Diabetes Clinical Reference Group |

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| | (CRG).<br>The model has been approved by the CRG, in which there has been patient representation. There are ongoing meetings with local patient groups who are receiving regular updates.<br><br><u>Physical disability</u><br>Physical disability steering group – cross representational membership including Federation of disabled people<br>Discussion and attendance at Disability Equality Scheme service users group.<br>Carers events |
| Increasing access to level II sexual health services in primary care | Service was developed in conjunction with BSUH<br>BSUH provide governance and support<br>Primary care have been engaged through practice based commissioning locality meetings and through the STIF and HIVed courses.<br>Patients are offered this service through GUM booking system and through primary care. |
| Increasing uptake of chlamydia screening programme | BSUH are engaged through contract negotiation.<br>Chlamydia screening office are involved in regular steering group and ad hoc meetings<br>Primary care are involved through practice based commissioning meetings and through development of locally enhanced service for chlamydia screening in primary care (general practice and community pharmacy)<br>Voluntary sector providers are involved through service level agreement negotiations and performance monitoring<br>Chlamydia screening is a regular agenda item for the clinical reference group for sexual health.<br>Patient and public involvement is undertaken by the chlamydia screening office directly |
| Increasing access to long acting reversible contraception (LARC) | Service has been developed in response to high levels of patient demand |

<u>Underpinning engagement activities</u>

The PCT works to a Public and Patient Engagement Policy which includes a process for both engaging and consulting the public which includes:

- Part funding (with the City Council and the Police) of the Citizen's Panel
- Clinical Reference/Discussion Groups – condition or care path way groups of patients; clinicians; managers and voluntary sector organisations
- HUB (Health User Bank) - city wide group of patients, carers and the public who

have expressed an interest in being involved in the development of local healthcare services.

- Expert Patients Programme -- PCT run programme supporting self management for those living with long term health conditions.

- Patient satisfaction - The PCT has recently contracted with the Picker Institute and Dr Fosters to provide hand held 'patient tracker systems'. These devices enable health organisations to ask patients in a range of settings for their views (about cleanliness; food; attitudes of staff; treatment regimes etc).

- Gateway organisations - The PCT funds a number of organisations to consult on behalf of the PCT and help the PCT engage with traditionally excluded or marginalised groups. Current funding includes:

    - Black & Ethnic Minority Community Partnership (BMECP)
    - Spectrum (LGBT Community organisation)
    - Federation of Disabled People
    - Consumer Consultancy (people with a mental health issues)
    - Speakout (people with a learning difficulty)
    - Pensioners Forum (older people)
    - Nova Scarman Trust (work with neighbourhood renewal areas)
    - Maternity Services Liaison Committee
    - MIND (people with a mental health issues)
    - Parents Forum (part funded by the PCT)

- Compact - An agreement made between the public bodies in the city, communities and the voluntary sector about how we work together.

# Agenda Item 37

**HOSC Draft Work Programme 2008/2009**

| Issue | Date to be considered | Referred By? | Overview & Scrutiny Activity | Progress and Date | Outcomes and Monitoring |
|---|---|---|---|---|---|
| Sussex Partnership Trust: changes to B&H services (inc. reconfiguration of Mill View hospital) | 23 July 2008 | SPT | Monitor progress of changes/determine whether planned changes constitute "significant variations in service" | Report: 28.11.07 23.07.08 | Debated at 23.07.08 HOSC. Regular updates agreed with SPT |
| Sussex Partnership Trust: increased access to "talking therapies" | 23 July 2008 | | Overview | | See above |
| Mental Health: personalisation of care agenda | 23 July 2008 | Director of ASC and Housing | Overview (possibility of more HOSC involvement throughout the year) | | See above |
| Sussex Partnership Trust: Foundation Trust application | 23 July 2008 | SPT | Monitor progress of FT application | Reports: 25.07.07 28.11.07 23.07.08 | See above |
| Eye Testing for over 60s | 17 September | OPC (public question) | Update on free eye testing for over 60s | | |

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|---|---|---|---|---|---|
| **Issue** | **Date to be considered** | **Referred By?** | **Overview & Scrutiny Activity** | **Progress and Date** | **Outcomes and Monitoring** |
| "Healthier people, Excellent care" (Darzi Review) | 17 September | SHA | Overview of SE aspects of national review of NHS services (Darzi review) | | |
| Public Health | 17 September | | Overview of B&H public health (to inform more detailed work throughout the year). | | |
| Sussex Orthopaedic Treatment Centre (SOTC) | 05 November | | Monitoring performance of SOTC | Report: 29.11.06 | |
| LINk: 6 monthly review of progress in establishing a B&H LINk | 05 November | | Monitor progress of LINk contract. | | |
| PCT Communication Strategy | 05 November | PCT | Update on PCT's consultation strategy | | |
| Healthcare Commission (HCC) Annual Health Check (audit of NHS Trust performance) | 21 January | | Overview compliance of local NHS Trusts with HCC standards | Annual issue | |

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| **Issue** | **Date to be considered** | **Referred By?** | **Overview & Scrutiny Activity** | **Progress and Date** | **Outcomes and Monitoring** |
| Dentistry: performance of B&H dental contract | 21 January | Local Dental Committee | Monitor B&H performance in year 2 of new national dental contract | | |
| South Downs Health Trust: Strategic Direction Review | 21 January | SD | Update on SD strategic direction | | |
| Crohns and Colitis | TBC | OPC | To be determined | | |
| Scrutiny of Section 75 arrangements | TBC | | To be determined | | |
| PCT Communications Strategy | TBC | PCT | HOSC to comment on refresh of PCT strategy | | |
| "3Ts" development of RSCH | TBC | BSUHT | HOSC to comment on 3Ts re-development of RSCH site (esp. on consultation plans) | | |
| Maternity: report back on PCT maternity consultation | TBC | PCT | Analyse consultation feed-back (to possibly inform more detailed work by HOSC) | | |
| GP-Led Health Centre | TBC | PCT | Update on award of contract | | |

| Issue | Date to be considered | Referred By? | Overview & Scrutiny Activity | Progress and Date | Outcomes and Monitoring |
|---|---|---|---|---|---|
| Mental Health Act | TBC | SPT | Implications of new Mental Health Act | | |
| Community Care | TBC | | Develop ways of dealing with services moving from acute to community sector | | |