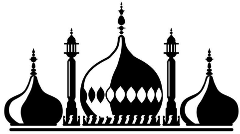
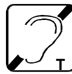


Health & Wellbeing Board

Title:	**Health & Wellbeing Board**
Date:	**11 September 2013**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
	Board Members
Councillors:	Jarrett (Chair), K Norman (Opposition Spokesperson), Meadows (Opposition Spokesperson), Bennett, Bowden, Pissaridou & Shanks
BHCC: CCG Youth Council HealthWatch	Pinaki Ghoshal, Statutory Director of Children's Services Denise D'Souza, Statutory Director of Adult Social Care Dr. Tom Scanlon, Statutory Director of Public Health Dr. Xavier Nalletamby, Clinical Lead Geraldine Hoban, Non-clinical member Hayyan Asif Robert Brown
Contact:	**Caroline De Marco** Democratic Services Officer 01273 291063 caroline.demarco@brighton-hove.gcsx.gov.uk

	The Town Hall has facilities for wheelchair users, including lifts and toilets
	An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter and infra red hearing aids are available for use during the meeting. If you require any further information or assistance, please contact the receptionist on arrival.

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Health & Wellbeing Board

HWB Business Manager

Councillor Jarrett Chair

Lawyer

Democratic Services Officer

Councillor Bowden

Councillor Shanks

Councillor K Norman

Councillor Bennett

Councillor Meadows

Councillor Pissaridou

Statutory Director of Children's Services Pinaki Ghoshal

Statutory Director of Adult Social Care Denise D'Souza

Statutory Director of Public Health Tom Scanlon

Clinical Commissioning Group Xavier Nalletamby

Clinical Commissioning Group Geraldine Hoban

Youth Council

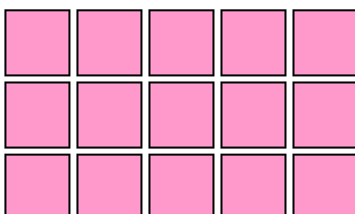
Hayyan Asif

Health Watch Representative Robert Brown

Public Speaker

Member Speaking

Public Seating



Press

AGENDA

PART ONE	Page

13. PROCEDURAL BUSINESS

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

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

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

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

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

14. MINUTES **1 - 12**

Minutes of the meeting held on 12 June 2013 (copy attached).

15. CHAIR'S COMMUNICATIONS

16. PUBLIC INVOLVEMENT **13 - 18**

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

(a) Petitions – to receive any petitions presented to the full council or at the meeting itself (copy attached).
(b) Written Questions – to receive any questions submitted by the due date of 12 noon on the 4 September 2013.
(c) Deputations – to receive any deputations submitted by the due date of 12 noon on the 4 September 2013 (copy attached).

17. ISSUES RAISED BY COUNCILLORS AND MEMBERS OF THE BOARD

To consider the following matters raised by councillors and Members of the Board:

- **(a) Petitions** – to receive any petitions submitted to the full Council or at the meeting itself;
- **(b) Written Questions** – to consider any written questions;
- **(c) Letters** – to consider any letters;
- **(d) Notices of Motion** – to consider any notices of motion

18. NEW ECONOMICS FOUNDATION: A PRESENTATION ON WELLBEING

Juliet Michaelson from the New Economics Foundation to report.

19. SARAH CREAMER, DIRECTOR OF COMMISSIONING AT NHS ENGLAND, SURREY & SUSSEX AREA TEAM TO ADDRESS THE BOARD

20. JOINT HEALTH & WELLBEING STRATEGY SEPTEMBER 2013 — **19 - 128**

Report of Director of Public Health (copy attached).

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

21. JOINT STRATEGIC NEEDS ASSESSMENT UPDATE SEPTEMBER 2013 — **129 - 134**

Report of Director of Public Health (copy attached).

Contact Officer: *Alistair Hill, Kate Gilchrist* *Tel: 01273 296560, Tel: 01273 290457*
Ward Affected: *All Wards*

22. HEALTHWATCH: PROGRESS UPDATE - PRESENTATION — **135 - 142**

Presentation from Jane Viner, Healthwatch Manager (copy attached).

23. INTEGRATED HEALTH, SOCIAL CARE & HOUSING SUPPORT FOR "HOMELESS" PEOPLE — **141 - 162**

Report of Chief Operating Officer, CCG (copy attached).

Contact Officer: *Geraldine Hoban* *Tel: 01273 574863*
Ward Affected: *All Wards*

24. FUNDING TRANSFER FROM NHS ENGLAND TO SOCIAL CARE — **163 - 172**

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

Contact Officer: *Wendy Young* *Tel: 01273 574688*
Ward Affected: *All Wards*

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

The closing date for receipt of public questions and deputations for the next meeting is 12 noon on the fifth working day before the meeting.

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

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

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Date of Publication - Tuesday, 3 September 2013

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING BOARD

5.00pm 12 JUNE 2013

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Jarrett (Chair) Councillor K Norman (Opposition Spokesperson), Meadows (Opposition Spokesperson), Bennett, Bowden, Pissaridou and Shanks (in the Chair from paragraph 8.11)

Other Members present: Jo Lyons, representing the Interim Statutory Director of Children's Services, Denise D'Souza, Statutory Director of Adult Social Care, Dr. Tom Scanlon, Statutory Director of Public Health, Maggie Davies, Clinical Commissioning Group, Geraldine Hoban, Clinical Commissioning Group, Hayyan Asif , Youth Council, Robert Brown, HealthWatch.

PART ONE

1. PROCEDURAL BUSINESS

1A Declarations of Substitute Members

1.1 Maggie Davies, CCG declared she was substituting for Dr Xavier Nalletamby. Jo Lyons, Assistant Director Children's Services (Education & Inclusion) declared that she was substituting for Heather Tomlinson.

1B Declarations of Interests

1.2 Councillor Bowden declared a personal interest in Item 10 - Independent Drugs Commission Report as he was Director of a charity interested in hepatology.

1C Exclusion of the Press and Public

1.3 In accordance with section 100A(4) of the Local Government Act 1972, it was considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to

whether, if members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in section 100I (1) of the said Act.

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

2. MINUTES

2.1 Councillor Meadows referred to paragraph 32.2 relating to a letter on hospital safety. She asked to have a paper on this issue. Councillor Meadows referred to paragraph 37.4 and asked if there had been any progression with regard to provider forums.

2.2 The Chair asked the Health & Wellbeing Board Business Manager to circulate an information note regarding paragraph 32.2. Tom Scanlon reported that the issue of provider forums needed to be discussed with the CCG. He was happy to discuss the matter with Geraldine Hoban.

2.3 Robert Brown referred to paragraph 36.5. He had suggested that Housing Area Panels should be consulted on the JSNA. The Chair replied that there had been a change in the Chair of the Housing Committee. This issue needed to be followed up.

2.4 Councillor Shanks referred to paragraph 35.12 with regard to breast screening. She made the point that since the National Screening Committee policy review, there had been further research which suggested that breast screening was beneficial on an individual basis but not on a population basis. Tom Scanlon said he would follow up with the colleagues who had led the work for the cancer and cancer screening section of the Joint Health and Wellbeing Strategy.

2.5 Hayyan Asif referred to paragraphs 36.7 and 36.8 regarding engagement with the JSNA and asked when this would happen. The Chair replied that there was an item on the JSNA later on the agenda and any major changes would take place next year.

2.6 **RESOLVED -** That the minutes of the meeting held on the 20 March 2013 be approved as a correct record of the proceedings and signed by the Chair.

3. CHAIR'S COMMUNICATIONS

Age Friendly City Project

3.1 The Chair informed members that he would be attending a European event in Dublin to discuss the Age Friendly City Project. The event was accredited by the World Health Programme. He would report back on the event at a future meeting.

Healthwatch

3.2 Robert Brown informed members that Healthwatch Brighton and Hove was currently in the process of being established. There was a development/set up phase until July 2013. A number of ex-LINk volunteers had formed a Transition Group in the interim to carry out some project work and attend meetings such as the HWB. In July, new Healthwatch structures would be in place, and the Transition Group would hand its work over to these new structures. A process for selecting a representative to the Health &

Wellbeing Board would be undertaken. In the meantime Board members were encouraged to sign up to the Healthwatch magazine, so that they could stay in touch with the work Healthwatch was carrying out. The healthwatch website was www.healthwatchbrightonandhove.co.uk

4. PUBLIC INVOLVEMENT

(a) Petitions

4.1 The Chair noted that there were no petitions from members of the public.

(b) Written Questions

4.2 Mr Dave Baker asked the following question:

"Can you assure me that despite the pressure that council budgets are under, that funds allocated to public health in Brighton and Hove will not be diverted to other council activities?

Are you concerned with possible implications that health provision in B&H may be commissioned from firms who are focused on making profits?

The Health and Wellbeing Board is one of the means of ensuring some democratic accountability of the policies of the Brighton and Hove Clinical Commissioning Group. Will the H&WB Board use its influence to restrain the possibility of the CCG privatising our NHS?"

4.3 The Chair gave the following response:

"Central Government funding for local authority public health services is 'ring-fenced' for 13/14 and 14/15, with local authorities required to devote the entirety of the allocations they receive to supporting and promoting the health of the local population. I can therefore confirm that the funds allocated to public health for this period will indeed be used for the purpose of improving public health. It is not possible to discuss Council spending plans beyond 14/15 as detailed budget planning for this period has not yet been undertaken.

The CCG has publicly committed to procuring services which are sustainable and which promote localism. The CCG has further committed to inviting competition to buy services only where necessary and appropriate, viewing the re-tendering of existing contracts as a measure of last resort.

Given these assurances, I am clear that the CCG has no intention to embark on any initiative to 'privatise' local NHS services, nor to favour for-profit providers over other types of provider. I am therefore not concerned that there is the imminent risk of a CCG-driven further privatisation of local NHS services.

However, it is the case that it has been the stated policy of both the current and former Governments to encourage a plurality of providers within the NHS, which explicitly includes for-profit providers as well as NHS trusts, the voluntary and community sector

and not-for-profit providers. I would expect to see the CCG continuing to encourage this plurality of provision within the local health economy."

4.4 Mr Baker asked if the Committee was aware that there were firms advertising NHS Audiology services and that the CCG were commissioning two housing trusts to provide residential care to mental health patients.

4.5 Geraldine Hoban explained that the policy was to open up Audiology services to any qualified provider. Mr Baker may have seen adverts for Spec Savers. The CCG wanted to provide the best quality of care as well as the best value for money. Spec Savers was one of three providers who put in a bid to provide services and the feedback so far was good. The CCG monitored the services very closely and carried out patient surveys. There was no intention to extend any qualified provider to other services.

4.6 In terms of supported accommodation, the CCG had tendered because it wanted better quality supported accommodation. A not for profit organisation had secured the tender and the location remained in the City.

4.7 The Chair stressed that there was no desire to privatise the NHS.

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

(c) Deputations

4.9 The Chair noted that there were no deputations from members of the public.

5. ISSUES RAISED BY COUNCILLORS AND MEMBERS OF THE BOARD

5.1 The Chair noted that there were no petitions, written questions, letters or Notices of Motion from Councillors or members of the Board.

6. PENNY THOMPSON BHCC CHIEF EXECUTIVE TO ADDRESS THE BOARD

6.1 Penny Thompson, Chief Executive, Brighton & Hove City Council introduced herself to the Board. She informed members that she considered the Board to have a very important role in Brighton & Hove and wanted to attend a meeting to see it operating. She asked members to let her know if there was anything she could do to make it work better.

6.2 The Chair remarked that an important role of the Board was a co-ordinating work across all council services and the Chief Executive could assist in that respect.

7. '3T' DEVELOPMENT OF THE ROYAL SUSSEX COUNTY HOSPITAL

7.1 The Board considered a presentation from Matthew Kershaw, BSUH Chief Executive and Duane Passman, Director of 3Ts, Brighton and Sussex University Hospital Trust.

7.2 Mr Passman explained the brief for the 3Ts development. He reported that the Barry Building which had been completed in 1828 would be replaced. Neurosciences would be relocated, a level trauma centre would be established, the cancer centre would be

enhanced and there would be enhanced facilities for teaching and research. The environment would be to the same standard as the children's hospital.

7.3 Members were shown slides of the existing site & plans of the proposed build. The Stage 1 area required to be decanted was 21% of the RSCH site area. Decant sites included the former St Marys Hall School and Brighton General Hospital. The decant period would be from mid 2013 to late 2014. The helipad would be completed between mid 2014 to summer 2015. Stage 1 would be completed by 2018. Stage 2 would be completed by 2021. Stage 3 would be completed by 2022.

7.4 The development would benefit larger numbers of patients each year. 70% of the floor space would be for the people of Brighton & Hove. Members were shown views of the new hospital. There was further information on the Brighton and Sussex University Hospitals website. www.bsuh.nhs.uk

7.5 Robert Brown asked how the hospital would ensure that plans to gear up for the 3T development was not putting services being delivered at risk in terms of effectiveness/quality, particularly given other service pressures at the hospital, and the need to save £30million this year? Mr Brown stressed that the last letter LINk sent to the hospital stated that they did not consider the Trust to be fit for purpose as a trauma centre. Could the hospital cope with the pressures?

7.6 Mr Kershaw explained that it was the hospital's responsibility to ensure services were delivered. With regard to the £30m Cost Improvement Programme, the treasury had asked the trust to demonstrate how it would remain financially viable during the transition. Mr Kershaw was pleased to report that the trust had the right plans in place. There was a need to save £30m as all NHS organisations had to demonstrate financial efficiency and this was what the Trust would do irrespective of the 3Ts development. The 3Ts was not just about delivering highly specialised services. Major trauma services were not required by most patients. The majority of people would use the core services on the new site.

7.7 Mr Passman explained the decant plan. The overwhelming objective was for services on the site to remain on site and remain fully operational whilst building work was carried out. He stressed that although the numbers using the trauma centre were not high, the impact of this service was huge. 450 to 500 cases were expected each year. 350-360 a year were treated at the moment. There was a need to ensure minimum standards were in place.

7.8 Mr Passman stated that the trust had put in place as much as it could in the existing structure to meet standards. He acknowledged that the works would put the hospital under pressure; however major trauma affected a relatively small number of cases.

7.9 Tom Scanlon noted that there had been no detail regarding capacity of district general hospital functions. GPs were concerned that there should be a good district general hospital. He asked about the level of change currently and at the end of the project with regard to this function.

7.10 Mr Passman explained that there would still be some physical capacity on the site during the transition, with regard to district general hospital functions. At the end of the

3Ts, there would be a net extra 100 beds across the trust, some of which would have a district general hospital function.

7.11 Mr Kershaw explained that there would be no reduction in physical capacity. However, the trust was looking to improve emergency care and to decrease acute capacity due to better services in the community.

7.12 Councillor Bowden asked what Plan B would be if the trust were not considered to have a robust plan in place? Mr Kershaw replied that the trust believed it could deliver and had provided information to the treasury. If the plan was not approved by the treasury, Mr Kershaw would reply that the trust currently had a building that did not provide for its patients. Mr Kershaw's personal view was that the trust had a good case. The treasury was rightly asking difficult questions, however the evidence the trust was providing was helping the trust make a good case.

7.13 Geraldine Hoban questioned the affordability around the 3Ts development. She wondered if there was a need to re check the financial assumptions around it. She stressed the need to ensure the case was robust. Were there plans to reassess the financial assumptions?

7.14 Mr Kershaw explained that the case for the 3Ts development had received support from a whole range of individuals. Plans were thorough and he did not want to repeat the process and make a new business case. The plans were being kept under review. Mr Kershaw considered it appropriate to work with the new CCGs. There would be conversations with area teams and financial colleagues in the CCGs.

7.15 The Chair thanked Mr Kershaw and Mr Passman. He hoped that there could be further progress reports in the future. He expected that the Board would have further questions about the shape of services.

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

8. JSNA: UPDATE ON ROLLING PROGRAMME OF NEEDS ASSESSMENTS

8.1 The Board considered a report of the Director of Public Health which explained that since April 2013, local authorities and clinical commissioning groups had equal and explicit obligations to prepare a Joint Strategic Needs Assessment (JSNA). This duty would be discharged by the Health and Wellbeing Board. The Board were asked to approve the planned programme of needs assessments for 2013/14 and note the requirement to produce a pharmaceutical Needs Assessment by March 2015.

8.2 Alistair Hill, Consultant in Public Health reported that priorities for the rolling programme of needs assessments for 2013/4 were set out in paragraph 3.7 in the report. The priorities were Dementia Needs Assessment, Trans Needs Assessment scoping, Homeless Link Health Needs Audit. Preparation to conduct a Pharmaceutical Needs Assessment (PNA) in 2014/15 would also take place.

8.3 Denise D'Souza asked if officers were talking to NHS mental health partners with regards to the Homeless Link Health Needs Audit. The Consultant in Public Health replied that he was liaising with Sussex Partnership Trust NHS Foundation Trust

8.4 Robert Brown asked if individual needs assessments would incorporate a community-asset mapping approach and if so how this would be done. Mr Brown referred to section 4 of the report and stated that this was not community consultation/engagement. It was statutory engagement.

8.5 The Consultant in Public Health explained that the role of asset mapping would be considered within the scope of individual needs assessments. Regarding the comment on engagement, Section 4 of the report had been written in recognition of how the list was drawn up. Officers had not carried out extensive consultation for the topics for this year's programme but had considered the Health and Wellbeing Strategy development, the JSNA and scrutiny reports. The establishment of Healthwatch and the Health & Wellbeing Board as a statutory body on 1 April 2013 would enable discussions on having a wider engagement in this process in future.

8.6 The Chair suggested that there could be further thought as to how to improve community engagement work across the scope of the Health and Wellbeing Board.

8.7 Councillor Bowden asked if a representative from the Clare Project was involved in Trans needs assessment scoping. The Consultant in Public Health explained that he had initially been liaising with the LGBT Health and Inclusion Project whose remit included working with a range of LGBT organisations. The Consultant in Public Health expected groups such as the Clare Project to be engaged in the scoping.

8.8 Hayyan Assif made the point that there was not much included in the report about young people. He asked whether community and voluntary sector organisations for children and young people had contributed to the JSNA? The Consultant in Public Health stated that he was aware that this was the case and could circulate the names of the organisations that had responded to the call for evidence with the minutes. Regarding the list of priorities, he accepted the point regarding children and young people but stressed that the Trans need assessment scoping work would consider young people. Officers were already working with children and young people regarding this issue.

8.9 Geraldine Hoban asked how priority areas were selected. She commented on the recent publication of the Longer Lives data by Public Health England and asked whether Public Health had plans to look at this matter in more depth. The Consultant in Public Health replied that officers would be looking at comparative data. He suggested that the Board could have a presentation on this data if requested.

8.10 At this point in the meeting the Chair announced that he had to leave the meeting as he needed to travel to a conference in Ireland. Councillor Shanks took over as Chair for the remainder of the meeting.

8.11 Jo Lyons reported that Children's Services were launching a toolkit for schools which would look at some of the issues raised.

8.12 Denise D'Souza asked if the Homeless Link Needs Audit would record where people came from i.e. were homeless people being discharged from hospital? The Consultant in Public Health stated that he would make sure that the survey included a question asking if people had recently been discharged from hospital or psychiatric care.

8.13 **RESOLVED** – (1) That the following programme of needs assessments for 2013/14 be approved:
- Dementia needs assessment
- Trans needs assessment scoping
- Homeless Link Health Needs Audit

(2) That the requirement for a Pharmaceutical Needs Assessment by March 2015 be noted.

9. EMOTIONAL HEALTH & WELLBEING (INCLUDING MENTAL HEALTH)

9.1 The Board considered a presentation on the Emotional Health & Wellbeing (including Mental Health) Joint Health & Wellbeing Strategy Priority, from Clare Mitchison, Public Health Specialist (BHCC), Alison Nuttall, Strategic Commissioner CYPT (BHCC) and Anne Foster, Head of Commissioning, Mental Health & Community Care (CCG).

9.2 The presentation set out how improving mental health was a key issue for the City. Members were informed that further work needed to be carried out to ensure mental health had equal priority to physical health. There was a need to develop an explicit local strategy that took a broader approach beyond the mental health and wellbeing services and a need for broader BHCC leadership to help achieve this. The presentation suggested that Brighton & Hove City Council could nominate a senior officer with a responsibility for mental wellbeing within the council, and screen new services and policies (eg mental wellbeing impact assessment) to ensure positive or neutral impact on mental wellbeing for all relevant BHCC decisions.

9.3 Councillor Bowden asked if the strategy would take into account action the government was taking to reduce the financial deficit. Clare Mitchison replied that the recession did have an impact. Suicide prevention work and financial advice work was being carried out.

9.4 Councillor Bowden mentioned a constituent with mental health problems who had been detained in police cells.

9.5 Anne Foster replied that there was a need for a broader strategy approach in relation to mental health. The aim was to divert people out of the courts.

9.6 Councillor Bowden stressed the need for educational training. Staff did not always have the skills to deal with people with mental illness. He stressed that a high proportion of people in prison had mental health problems.

9.7 Alison Nuttall informed members that there was work being carried out to train GPs and staff in GP practices to ensure young people could experience the best environment when visiting their GP. There were also conversations with the police about this issue.

9.8 Robert Brown mentioned that the LINk had written a report on 16-25 year olds, and on self harm in A&E which might be of interest. He would be happy to share the report with the Board. The LINk printed 10,000 bookmarks and had distributed these to young people in the city to help with exam stress and rights when accessing a doctor. The chapter listed a number of strategies in development/need of review. Healthwatch

would be interested in having a conversation about this. Mr Brown asked if the chapter needed a specific outcome on increasing resilience amongst young people.

9.9 Alison Nuttall replied in the affirmative to Mr Brown's questions. Young people steered the project. Services were being developed that would encompass all people from children to adults.

9.10 Hayyan Asif asked what was being done for older people and people with disabilities. He also asked what was being done to help people with exam stress.

9.11 Anne Foster explained that there was a strong community and voluntary sector in Brighton and Hove. Work had been carried out with Adult Care & Health which included older people and the LGBT community. There had been a focus on those at risk.

9.12 Alison Nuttall informed members that the Safer Schools Programme informed officers what young people were doing in schools. Children had access to school counselling. There was also work being carried out in sixth form colleges. The colleges were interested in improving the mental health and wellbeing of their pupils. Clare Mitchison reported that lottery funding had been received for work with young people in schools.

9.13 Tom Scanlon asked if the draft strategy could be in place earlier. Anne Foster replied that work would commence in late summer 2013 and the strategy would be implemented in 2014/15.

9.14 The Chair thanked the officers for their presentation.

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

10. INDEPENDENT DRUGS COMMISSION REPORT

10.1 The Board considered a report of the Director of Public Health which informed members that in 2012 the Safe in the City Partnership established an Independent Drugs Commission to review the current state of drugs problems in the city and the approach being taken by local services to address these issues. The Drugs Commission addressed four key areas and published its final report with recommendations in April 2013. The final report had been received by the Safe in the City Partnership and a plan for the Substance Misuse Programme Board to address the recommendations had been developed.

10.2 The current report asked the Board to note the Independent Commission's report and the actions to date of Safe in the City Partnership in response. The Deputy Director of Public Health presented the report.

10.3 The Chair asked if the drop in deaths was attributable to the use of Naloxone. The Deputy Director of Public Health explained that some information was received when people attended A&E. It was possible that the use of Naloxone had prevented people from dying. However, there were a number of other factors. More people were now receiving effective treatment which will also contribute to reducing drug deaths.

10.4 Robert Brown asked how the Commission considered the impact of drug use on individuals with characteristics protected by the Equality Act 2010. He further asked whether Sussex Partnership Foundation NHS Trust provided information on recommendation 6. Mr Brown asked if specialist youth advice services would be protected from cuts, as they seem vital to this work going forward.

10.5 The Deputy Director of Public Health replied that a great deal of work was going on with dual diagnosis. The question on recommendation 6 was an action for the Sussex Partnership Foundation NHS Trust. The Deputy Director of Public Health could not comment on whether youth advice services would be protected from any cuts.

10.6 Councillor Norman remarked that the Independent Drugs Commission Report was clearly intended as something useful and was well intended. However, the authors did not do themselves any favours with the inclusion of a recommendation relating to a consumption room. Councillor Norman hoped that this one recommendation did not lead to long term damage to work on this issue in Brighton and Hove. The recommendation was controversial and Councillor Norman was concerned about the use of the term drug consumption room. There needed to be positive action and not talk of a drug consumption room.

10.7 The Deputy Director of Public Health explained that the remit of the Independent Drug Commission included considering evidence of what is being done elsewhere. Drug consumption rooms were established in many other countries and the terminology was used across Europe. It had been mentioned in a report from Scotland in 2008. Although it may be feasible for a city to have a Drug Consumption Room it is not always considered desirable.

10.8 Councillor Bowden stressed that a fine balance needed to be struck with regards to this issue. He reported that there was terrible deprivation in his ward and that there was drug dealing in a particular tower block. Councillor Bowden spoke of a child who had sustained a needle prick from a discarded syringe. One positive aspect of having a safe environment for drug users was that health workers would be available to help. Councillor Bowden had doubts about the use of methadone which he thought was as addictive as heroin.

10.9 Councillor Norman stated that he was not against the idea of a treatment centre. He felt that there should be safe places where people could have supervision.

10.10 The Chair informed members that she was concerned at the number of women who were not able to look after their children. As a result, the children were taken into care. The Chair stressed that work with work with women with children should be prioritised.

10.11 **RESOLVED** – (1) That the Independent Drugs Commission report (Appendix 1), and the Safe in the City Partnership’s responses to the Drugs Commission report recommendations (as set out at Part 3 of the report) be noted.

(2) That officers be instructed to bring back a further report on the progress of the recommendations of the Independent Drugs Commission to a future HWB meeting.

11. CLINICAL COMMISSIONING GROUP PROSPECTUS

11.1 The Board considered a report of the Director of Public Health which explained that Clinical Commissioning Groups (CCGs) were each required to publish a ‘prospectus’ in 2013. Guidance to CCGs from NHS England defined the prospectus as “a very short guide which explains to your local community what the CCG is, and the ambitions you have for your local population’s health services”. CCGs have considerable latitude in terms of designing local prospectuses.

11.2 NHS England guidance obliged CCGs to obtain the approval of their local Health & Wellbeing Board(s) before publishing their prospectus.

11.3 The draft Brighton & Hove CCG was included as Appendix 1 to the report. Geraldine Hoban presented the report and informed members that the prospectus would eventually be published on the CCG website.

11.4 Denise D’Souza made the point that the word “prospectus” had a different meaning in terms of commissioning. Geraldine Hogan concurred and said she would consider changing the heading to something along the lines of “Guide to the CCG and what we do.”

11.5 Robert Brown suggested that Ms Hoban might want to include something about how the CCG was responding to the Francis Report of the Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust. Geraldine agreed this was a useful suggestion.

11.6 Geraldine Hoban informed members that any further comments could be emailed to her.

11.7 **RESOLVED** – (1) that the comments of HWB members on the CCG prospectus as set out above be noted.

(2) That the publication of the prospectus be endorsed.

12. INTEGRATED CARE PILOT

12.1 The Board had before them a letter from the Department of Health inviting expressions of interest for Health and Social Care Integration “Pioneers”. Members were informed that the Department of Health had called on Local Health Economies to put themselves forward as “pioneers” of integration – ie pilot innovative integrated care solutions involving health and social care and the third sector.

12.2 Members were informed that discussions with key partners in the City suggested that Brighton and Hove would be keen to put itself forward and further discussions with the Council would suggest that integrating support around the needs of homeless people in the City was a priority for all concerned. Therefore the CCG had invited key stakeholders to a meeting on 19th June 2013 where there could be more detailed scoping on what an integrated service might look like across statutory services, primary care and the third sector and obtain partner agencies commitment to being part of this proposal.

12.3 The CCG needed to provide an expression of interest back to the Department of Health by 28th June 2013. One of the criteria was that the CCG had endorsement from the Health and Wellbeing Board to the proposal as an area of focus. Geraldine Hoban stressed that some models of care were not meeting the needs of homeless people and there was a need to think about how to use resources in different ways.

12.4 Denise D'Souza endorsed the proposal and agreed that work needed to be carried out on this issue.

12.5 **RESOLVED** - That the Board endorse the proposal for inclusion in Health and Social Care Integration.

The meeting concluded at 7.36pm

Signed Chair

Dated this day of

HEALTH & WELLBEING BOARD	Agenda Item 16(A) Brighton & Hove City Council

Subject:		**Petitions**		
Date of Meeting:		**11 September 2013**		
Report of:		**Head of Legal and Democratic Services**		
Contact Officer:	**Name:**	**Caroline De Marco**	**Tel:**	**29-1063**
	E-mail:	**caroline.demarco@brighton-hove.gov.uk**		
Key Decision:	**No**			
Wards Affected:	**All**			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 To receive any petitions presented at Council, any petitions submitted directly to Democratic Services or any e-Petition submitted via the council's website.

2. RECOMMENDATIONS:

2.2 That the Committee responds to the petition either by noting it or writing to the petition organiser setting out the Council's views, or where it is considered more appropriate, calls for an officer report on the matter which may give consideration to a range of options, including the following:

- taking the action requested in the petition
- considering the petition at a council meeting
- holding an inquiry into the matter
- undertaking research into the matter
- holding a public meeting
- holding a consultation
- holding a meeting with petitioners
- referring the petition for consideration by the council's Overview and Scrutiny Committee
- calling a referendum

3. PETITIONS

3. (i) Improving Mental Health with Mindfulness

To receive the following e-Petition submitted by John Kapp and signed by 8 people at 2nd September 2013. Petition runs until 10 September 2013.

"We the undersigned call on the Health and Wellbeing Board to empower the Clinical Commissioning Group (CCG) to outsource provision of the Mindfulness Based Cognitive Therapy (MBCT) course to the third sector, so that GPs could prescribe it on a voucher scheme to reduce the waiting time from 20 years to a few weeks."

Deputation concerning the Curing the NHS' Dementia by Mass Commissioning the MBCT Course – Referred from full Council held on 18th July 2013

(Spokesperson) – Mr Kapp

I am a complementary therapist, and a facilitator of the Mindfulness Based Cognitive Therapy (MBCT) 8 week course (1) which is NICE-recommended (2) to improve mental health by teaching people self-help tools by which to better manage their emotions, so they don't need to go to A&E. There are more than 20 facilitators in the third sector of the city (3) providing this course for clients who pay the going rate (£150-370). This course is provided free on the NHS, but the waiting time is 20 years unless you are suicidal. (4) causing health inequalities as the poor can't afford it.

3 years ago, to reduce the waiting time, I created the Social Enterprise Complementary Therapy Company (SECTCo) (5) whose slogan is: 'medication to meditation', and whose mission statement is: 'Give a man a pill, and you mask his symptoms for a day. Teach him mindfulness, and he can heal his life'. To get public sector contracts I sent hundreds of e mails, documents, phone calls, to commissioners. These were not answered, because there was no-one at home who could make a decision, even to say: 'no'. The NHS did turn 65 last week, and decision paralysis is a symptom of dementia. Even Jeremy Hunt says it is sick. My experience proves that **it has dementia**. For the sake of both doctors and patients, we need to cure it. I am the Julia Bailey of Brighton, and pleading for your help now,

The government has done it's part by filling the democratic deficit in health. You are now responsible for public health, and for directing the strategy of the new Clinical Commissioning Group, (CCG). I am therefore calling on you councillors **to play doctor to the CCG** and cure it's demented paralysis by banging heads together. Please set up a 'chemist shop' voucher system by which GPs can prescribe the MBCT course as easily as Prozac. This would boost their morale by restoring their original function as teachers, (6) Then patients could access the course free within a few weeks from the third sector, so wouldn't need to go to A&E. This will fill the disconnect (7) between drugs and talking therapies, and restore patients' trust.

Please do not dismiss this proposal automatically as 'privatisation by the back door'. It is just a way of reducing waiting times for effective treatment, which has had all-party support nationally for more than 7 years. (8). Opening up the market to local complementary therapists would create local jobs and keep the money in the local economy, benefitting our citizens, rather than swelling the profits of drug companies. It will also improve health, reduce inequalities (9) and save taxpayers' money.

First recommendation. The Council authorises the CCG to engage with SECTCo to do 2 pilot trials of the MBCT course for £5,000 (10) and to engage a researcher to evaluate them, and report back to Council in November.
Trial 1. Up to 12 patients referred from a GP surgery in Hove.
Trial 2. Up to 12 sick council staff.

Second recommendation. The Council instructs the CCG to consider this proposal to set up a voucher system for the MBCT course in the city, and report back to the Health and Wellbeing Board (HWB) at its next meeting on 11.9.13.

Councillor Jarrett, Chair of the Health & Wellbeing Board will reply.

Supporting Information:

References

1 Author. I took this MBCT course myself 5 years ago in the voluntary sector in Brighton, paying £185 for it. It transformed my health, so I took the teacher training and have run 7 courses to date, for a total of about 70 students. A researcher conducted a trial last year in which 22 students took part. They increased their positivity score by 20% on average, and the best half of 11 students improved by 30%.

2 The evidence base for the MBCT course

a) **NICE Clinical Guidelines** CG 23, (Dec 2004) and CG 123 (May 2011) for patients who had suffered previous bouts of depression. Other trial results are given below:
b) The trials in 2002 (Teasedale et al) halved the 5 year relapse rate for patients who had suffered 3 previous bouts of depression.
c) It has a 30 years evidence base from more than 500 clinical trials, showing it to be effective in improving mental health for almost anybody, including drug and alcohol addicts, see Breathworks, Manchester (Gary Hennessey) www.breathworks.org.uk
d) It is used by Transport for London, with 20,000 staff, where it has reduced staff absence by 73%.
e) It is being taught in schools, where is improves performance in all areas, and there are moves to get it included in the core curriculum. www.mindfulnessinschools.org
f) A Survey by the Mental Health Foundation showed that 3 out of 4 doctors think that all patients would benefit from mindfulness. www.bemindful.co.uk/mbsr/evidence
g) A recent trial of 15,000 patients shows that talking therapies are better than drugs. (Source: PLOS Medicine, 2013; 10: e1001454)
h) Polls show that 3 out of 4 patients want free complementary therapy on the NHS. (Foundation for Integrated Health, 2009).

3 Third sector provision of the MBCT course
There are 30,000 depressed patients in the city, and potentially they all have the statutory right to a MBCT course under the NHS constitution if their doctor says it is clinically appropriate, as it is a treatment which is NICE-recommended. If all those patients asked their GP for a prescription for this course, and if 20 patients were to be treated together in a class, to deliver their statutory obligation the CCG would need to commission 1,500 courses over say 3 years, say 500 courses pa.
A full time MBCT facilitator can provide up to 25 courses pa, (one course on each day of the week, - 5 per week – on a cycle repeating 5 times per year) so to provide 500 courses pa the CCG would need to commission 20 facilitators.
There are more than 20 MBCT facilitators already teaching this course in the city's third sector, so they could be mobilised to treat patients on GP referral if contracted by public sector commissioners, as proposed. These courses could be provided for £2,500 per course, (10) and £125 per patient treated, which is far cheaper than drugs. The total cost would be £1.25 mpa, which is about 2% of the city's mental health budget of £55 mpa.

4 Waiting times for the MBCT course are given in my paper: 'Co-creating a patient centred NHS' 11 pages, 19.6.13 and www.reginaldkapp.org, section 9.56, and other papers there and on www.sectco.org.uk,

5 Social Enterprise Complementary Therapy Company, (SECTCo) was founded by the author on 4.5.10. It's website is www.sectco.org.uk. Its business plan (written 3 years ago) can be seen on www.reginaldkapp.org, section 9.39, including a list of its 143 complementary therapist founding members in section 5.

6 The word 'doctor' comes from latin 'doctare, to teach,' so prescribing courses would improve their morale. 60% of GPs are in imminent danger of burnout. (Pulse magazine)
7The disconnect between drug and talking therapies
The cause of the NHS's sickness is a disconnect between

- the needs of patients for which they go to the doctor, namely treatments to prevent, heal and cure their sicknesses, and
- the only mass treatments on offer, namely drugs which do not even *claim* to meet those needs, but only mask the symptoms.

Everyone knows that street drugs (like fags and booze) are dangerous and harmful, but to get them you have to spend your own money. Prescription drugs are no less dangerous and harmful, but the commissioning system gives doctors no alternative but to massively overprescribe drugs, giving them away like sweets at a childrens' party, breaking their Hippocratic oath: 'do no harm', as all drugs have harmful side effects.

Last year they wrote a billion monthly prescriptions to about half the population, which means that on average 30 million of us are taking 3 prescription drugs, which are slowly poisoning us with side effects. An inverse care law applies, which shows that the more prescription drugs we collectively take, the worse public health becomes.
To add insult to injury, last year drugs cost us as taxpayers £15 bn, which lined to pockets of private multinational drug companies who have been convicted and fined billions of dollars for putting profits before patients.
This disconnect is the reason why:

- NHS staff morale is at an all time low, as they work for a monstrous system which gives doctors no alternative but to prescribe harmful drugs on demand.
- Patients have lost faith and trust in this monstrous system, which serves no-one but the drugs companies.

Clinical commissioning means that GP commissioners (who see 40 patients per day) have taken the place of PCT managers (who never saw any patients, so never knew whether the treatments worked that they were buying). Patients can ask for MBCT courses, but GPs can only prescribe them if the CCG sets up a system (such as this proposal) to mass-provide them.

8 Privatisation by the back door?

No, it just reduces waiting times, as the Labour government did In 2006 for talking therapy. They opened up the market by recruiting 10,000 therapists from the private sector for Cognitive Behaviour Therapy (CBT) under the Improving Access to Psychological Therapies (IAPT) programme. Two years later they opened up the market for hip and knee replacements to Independent Treatment Centres. These policies were successful and popular, and so would this proposal to open up the market to MBCT facilitators.

9 Reducing health inequalities
The cause of health inequalities.is the rich get the health benefit from complementary therapies which the poor can't afford. This proposal would reduce them by GPs giving patients free vouchers for courses, which they can cash near them. To walk their talk, 'physician heal thyself,' doctors too should access the MBCT course that they prescribe. This new system would produce 3 benefits to public health: reduction of harmful side effects from drugs, effective treatments, less cost to the taxpayer. (4) Our e petition on the council website from Nov 2009 got 445 signatures, and there is another up now from 4.7-10.9.13.

10 Cost implications of these 2 trials SECTCo provides 2.5 hours per week, for 10 days and pay facilitators £1,250 at £50 per hour, and assistants £750 at £30 per hour. Room hire is £500, so our tariff price is £2,500 per course, negotiable.

HEALTH & WELLBEING BOARD	Agenda Item 20 Brighton & Hove City Council

Subject:		**Joint Health & Wellbeing Strategy (Sep 13)**	
Date of Meeting:		**11 September 2013**	
Report of:		**The Director of Public Health**	
Contact Officer:	**Name:**	**Giles Rossington**	**Tel: 29-1038**
	Email:	**Giles.rossington@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The Health & Social Care Act (2012) requires each local Health & Wellbeing Board (HWB) to publish a Joint Health & Wellbeing Strategy (JHWS).

1.2 Brighton & Hove shadow HWB agreed a draft JHWS in September 2012. However, HWBs did not become statutory bodies until April 2013, meaning that the JHWS must also be agreed by the statutory board.

1.3 The strategy that members are here being asked to consider is substantially the same document that was agreed at the September 2012 meeting. However, we have taken the opportunity to:
a) update the strategy where relevant (e.g. with a new section on the Joint Strategic Needs Assessment);
b) reflect consultation and engagement with a range of stakeholders - principally facilitated by the Brighton & Hove Community & Voluntary Sector Forum (CVSF);
c) undertake equalities impact assessment work (an EIA for the JHWS is attached as **Appendix 2** to this report).

1.4 The revised JHWS is included as **Appendix 1** to this report.

2. RECOMMENDATIONS:

2.1 That the Health and Wellbeing Board approve the Joint Health & Wellbeing Strategy set out at **Appendix 1**, and authorise its publication .

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The Health & Social Care Act (2012) obliges each local HWB to publish a JHWS. Neither the legislation nor the statutory guidance concerning the JHWS is particularly prescriptive: in essence, local areas are free to agree their own JHWS, providing the JHWS reflects the major partnership health and wellbeing priorities across the area, proposes plans to improve outcomes in these areas, and is clearly evidence-based.

3.2 Locally, council commissioners and the CCG agreed that the JHWS should be a succinct, evidence-driven document focusing on the core health, public health and social care issues which had the greatest impact on city residents, and where there was a real opportunity to improve outcomes via better partnership working. The draft JHWS (**Appendix 1**) provides more information on the prioritisation process we followed to arrive at a shortlist of highest priority issues, most of which were then adopted as JHWS priorities by the shadow HWB (in May 2012).

3.3 The shadow HWB agreed that the JHWS priorities should be: cancer & cancer screening, smoking, emotional health & wellbeing (inc. mental health), dementia, and healthy weight & good nutrition.

3.4 A JHWS working group made up of senior commissioners from public health, the CCG, BHCC adult social care and BHCC children's services was established to develop the JHWS, with additional input as required from other professionals.

3.5 The period between the shadow HWB agreeing a JHWS draft and the statutory board considering a final draft has allowed us to engage and consult with a number of organisations. These include: local NHS provider trusts, the Supporting People Provider Forum, the Local Strategic Partnership and the Older People's Council. Details of our engagement with the local community and voluntary sector are provided in Section 4 below.

3.6 The final draft of the JHWS presented here to the HWB is substantially the same as the draft agreed by the shadow HWB in September 2012, subject to some minor amendments/additions reflecting comments and suggestions solicited via stakeholder engagement and to the updating of information where necessary.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 Detailed information with regard to community engagement is included in the draft JHWS (**Appendix 1**). In short, however, our engagement with community and voluntary sector organisations was kindly facilitated and led by the Brighton & Hove Community & Voluntary Sector Forum (CVSF). This engagement included several workshop/seminar sessions (both in advance of and subsequent to the development of a draft JHWS) as well as a written survey of CVSF member organisations. The seminar sessions were also attended by a range of social care, public health and CCG commissioners.

4.2 CVSF submitted a detailed response to the JHWS draft. All the CVSF recommendations are well-evidenced and positive, and it is intended that we should implement as many of them as possible. However, the majority of recommendations relate to relatively detailed operational matters rather than high-level strategic planning, and as such are better addressed via individual

commissioning plans rather than the JHWS (both because of the level of detail involved and because they relate to decisions to be taken by officers exercising delegated powers rather than by HWB members). A full response to the CVSF submission will therefore be provided by the JHWS working group (see point 3.4 above) and copied for information to the HWB.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The Joint Health and Wellbeing Strategy informs priorities, budget development and the Medium Term Financial Strategy of the Council, Health and other partners.

Finance Officer Consulted: Anne Silley Date: 29/08/13

Legal Implications:

5.2 Section 196 of the Health and Social Care Act 2012 makes it a duty of the Health & Wellbeing Board to exercise the function of the local authority and its partner clinical commissioning group set out in section 116A of the Local Government and Public Involvement in Health Act 2007. In consequence, the Health & Wellbeing Board for Brighton & Hove is responsible for preparing and publishing a strategy for meeting the needs identified in the relevant Joint Strategic Needs Assessment.

Lawyer Consulted: Oliver Dixon Date: 29/08/13

Equalities Implications:

5.3 An equalities impact assessment has been completed and is attached as **Appendix 2** to this report.

Sustainability Implications:

5.4 Sustainability implications, where applicable, are discussed in the body of the JHWS (**Appendix 1**), particularly in relation to the Healthy Weight & Good Nutrition priority.

Crime & Disorder Implications:

5.5 Crime & Disorder implications, where applicable, are discussed in the body of the JHWS (**Appendix 1**).

Risk and Opportunity Management Implications:

5.6 The JHWS is a significant document in terms of high level partnership planning around health and wellbeing across the city, and the JHWS priorities include some of the biggest current and likely future causes of morbidity and mortality, including cancer, smoking, dementia, mental health and obesity. These conditions pose a very significant risk to city residents, and there is also a very significant opportunity to improve health outcomes by reducing the prevalence of

these conditions, perhaps particularly via prevention and early intervention. However, detailed risk and opportunity management of these issues will be undertaken at an operational/commissioning level.

Public Health Implications:

5.7 Public health implications, where applicable, are discussed in the body of the JHWS (**Appendix 1**).

Corporate / Citywide Implications:

5.8 These are set out in detail in the Inequalities section of the JHWS (**Appendix 1**).

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 The JHWS (**Appendix 1**) provides more information on the JHWS prioritisation process where a range of potential JHWS priorities were discussed and evaluated. A detailed description of the prioritisation process was included in the report “A Proposal for the Development of the JHWS” which was considered by the shadow HWB at its May 2012 meeting.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The Council is required by statute to publish a JHWS which details the highest priority health and wellbeing partnership issues for the local area together with plans to improve outcomes.

SUPPORTING DOCUMENTATION

Appendices:

1. The draft JHWS

2. EIA for the draft JHWS

Documents in Members’ Rooms

None

Background Documents

1. The Health & Social Care Act (2012)

2. Shadow HWB committee report (May 2012): “A Proposal for the Development of the JHWS”.

Brighton & Hove Joint Health & Wellbeing Strategy (JHWS)

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Introduction

What is the Joint Health & Wellbeing Strategy?

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

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

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

The JSNA is not a new initiative, although it is currently undergoing a significant revamp at a national level which is likely to give local areas considerably more freedom to make their JSNA fit with local needs. From April 2013 local HWBs have been responsible for approving and publishing a JSNA for their area.

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

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

Fortunately, Brighton & Hove has a single political authority – the City Council - and one Clinical Commissioning Group responsible for buying the bulk of

NHS services for the whole of the city. There is also a long and successful history of partnership working in Brighton & Hove, with formally shared council/NHS services; close informal partnerships between the council and the NHS; and a thriving strategic partnership structure, with the council, NHS commissioners and providers, city universities, the police, the fire service, voluntary sector organisations and local businesses working together across a variety of themed partnerships.

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

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

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

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

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

Remit of the HWB The core focus of the Brighton & Hove HWB will therefore be on the priorities identified via the JSNA and embodied in the JHWS. However, it is becoming increasingly apparent that Government departments have adopted a maximalist approach to HWBs, effectively assuming that the local HWB is *the* key health and social care partnership for the area, and consequently requiring various plans, strategies and bids for funding/support to be signed off by HWBs. This will require the HWB to take on responsibilities additional to those identified in the JHWS, although the degree and range of these responsibilities is not yet clear.

In addition the development of HWBs gives us an opportunity to involve elected members of the local authority, the CCG and representatives of the public in the work of key city bodies: the programme boards that are responsible for co-ordinating services for issues such as alcohol, healthy weight, tobacco control and our World Health Organisation obligations. Therefore the HWB will also seek to build a relationship with these wellbeing partnership bodies, which will include each programme board 'reporting' regularly to the HWB.

Prioritisation

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

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

This assessment process identified 18 issues with poor scores across several domains – e.g. the issues which have the highest impact upon the local population. Several of these areas related to the 'wider determinants' of health – that is, non-health issues which can be amongst the most important causes of poor health, such as housing, worklessness and child poverty. The shadow HWB decided that it would restrict its focus to core health, public health and

adult and children's social care matters rather than looking directly at these much broader issues, all of which fall within the remit of other city partnerships. Over time the HWB will seek to build relations with these city partnerships, ensuring that there are no gaps between partners; but there are no immediate plans for the HWB to take over responsibility for these wider determinants. For these reasons, the wider determinant JSNA areas were not taken forward as JHWS priorities.

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

The five priorities are:

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

Whilst the benefits of having a really rigorous and objective prioritisation process are clear, it is important that the local HWB is also able to focus on local wellbeing issues that do not necessarily form part of the JHWS. These may be emerging issues, where we do not yet have definitive evidence but where we know there is a major impact. They may also include problems experienced by relatively small groups of people, such that they are never going to be picked up by a population-based prioritisation process, but where there are particularly severe impacts, wholly disproportionate to the numbers of people involved (such as the health needs of rough sleepers). Therefore, although the main focus of the Brighton & Hove HWB will be on the major issues identified via the JHWS process, the HWB reserves the right to engage with other issues, particularly when they have a major impact upon health inequalities across the city.

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

Preceding the JHWS action plans is a brief explanation of the JSNA process and description of the demographic challenges facing Brighton & Hove. Following the action plans is a short section on inequalities, explaining how reducing inequalities is a major driver for this strategy. The draft JHWS ends with a table listing the bodies and partnerships which are chiefly responsible for addressing the high impact issues which are not JHWS priorities, and with a note outlining consultation and engagement on the Strategy to date.
.
Health and wellbeing services are rapidly evolving in reaction to changes in NHS and local authority structures and funding and to changing demographic challenges. In this environment of flux there is an obvious danger that a strategy becomes a snapshot of services at a particular time, which quickly goes out of date. We trust that this will not be the case with the JHWS. The strategy will be posted on the Council's website, and key elements of the JHWS (including links to city strategic partnerships responsible for key elements of wellbeing, and to the development of equalities work around the JHWS priorities) will be 'dynamic' – being updated periodically to reflect changes to partnership structures, new data etc. The HWB will also regularly review progress against the JHWS targets, holding council and CCG commissioners to account to ensure that the promised improvements to services are actually followed through.

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

Finally, the JHWS prioritisation process is intended to be evidence-based and objective (although we freely acknowledge that it is a work in progress). In seeking to identify the highest impact issues with the most potential to improve outcomes through better partnership working, we did not set out with any preconceptions about the issues we wanted in the JHWS, and we could in theory have ended up with a list of priorities which had little in common with each other. However, it quickly became apparent that the priorities chosen share some very significant common properties, and that improving outcomes in each area may involve some similar strategies: encouraging people to take a little more responsibility for their own lives, and to take a little more interest in the lives of their families, friends and neighbours; enabling local communities to be more supportive of people with health or social care needs; working together to create a city where everyone, but particularly our most vulnerable citizens, feels supported to live safe, secure lives.

Joint Strategic Needs Assessment (JSNA) in Brighton and Hove

The JSNA is an ongoing process that provides a comprehensive analysis of current and future needs of local people to inform commissioning of services that will improve outcomes and reduce inequalities. To do this, needs assessments gather together local data, evidence from the public, patients, service users and professionals, plus a review of research and best practice.

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

- An annual JSNA summary, which gives a high level overview of Brighton & Hove's population, and its health and wellbeing needs;
- A rolling programme of comprehensive needs assessments for the city;
- Brighton & Hove Local Information Service (BHLIS), which is a health data and information resource for those living and working in Brighton & Hove.

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

The population of Brighton & Hove

The latest mid year population estimates for 2011 show there are 273,000 people resident in the city and this is predicted to increase to 291,000 by 2030. Our population differs in distinctive ways to that of the South East and England. There is a much higher proportion of people aged 16-64 years, with lower proportions of children and older people aged 65-74. However, a similar proportion of the population are aged 85 years or over in Brighton & Hove as in England (2.2% of the population) and this group is likely to need more services.

Some key population groups within the city include:

- **Gender** – The 2011 Census indicated a fairly even proportion of male and female residents. However, the Census did not quantify the trans population and the 2013 Brighton & Hove Trans Equality Scrutiny Panel concluded that there is not a reliable local or national estimate of the size of the trans population.
- **Black and Minority Ethnic (BME) groups -** The most recent population estimates (2011) show that 80.5% of the city's population are White British and 19.5% are from a BME group. This is a lower proportion than England (20.2%), but higher than the South East (14.8%).

- **LGB** - Estimates suggest that there may be 40,000 people from Lesbian, Gay, Bisexual (LGB) communities living in Brighton & Hove, around 15% of the city's population.
- **Carers** - 9% of the population (approximately 24,000 people) identify themselves as carers.
- **Migrants** - the city is a common destination for migrants from outside the UK, 2010 figures show that 15% of the city's population was born abroad.
- **Students** - there has been an increase in the numbers of students in the city to more than 35,200 in 2011/12. This is approximately 13% of the total population. Many students choose to stay on after university.
- **Military veterans** – an estimated 17,400 military veterans live in the city. A veteran is anyone who has served in Her Majesty's Armed Forces at any time, irrespective of length of service.

Life expectancy, healthy life expectancy and inequalities

Life expectancy in Brighton & Hove is 77.7 years for males and 83.2 for females. Whilst females in the city can expect to live on average six months longer than nationally, life expectancy for males is almost one year lower. Healthy life expectancy is 67.9 years for males and 72.9 years for females meaning that, on average, around 10 years of life is spent in ill health.

As has been seen nationally, whilst mortality rates in the city are falling in all groups, they are falling at a faster rate in the wealthiest 20% of the population meaning inequalities are widening. The gap in life expectancy between the most and least deprived people in the city is now over 10 years for males and over 6 years for females and similar inequalities also exist in healthy life expectancy.

Highest impact health and wellbeing issues

For the 2012 JSNA we aimed to systematically identify the impact of different factors on the health and wellbeing of the city's population. This fed into the prioritisation process for the Joint Health and Wellbeing Strategy. The issues with the greatest impact on health and wellbeing in the city, mapped across the life course, are:

Wider determinants which have the greatest impact on health & wellbeing

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

High impact social issues

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

Specific conditions

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

Wider determinants of health

The health and wellbeing of our population is greatly influenced by a wide variety of social, economic and environmental factors and action to address these wider determinants is the most effective way to make improvements in health outcomes. This section sets out some of the issues that are considered key to Brighton & Hove.

Child poverty: National data for 2010 suggests that approximately one in five children in Brighton & Hove live in poverty which is similar to the national average and to levels in some other nearby cities. However, it is significantly

higher than the South East Coast average which has the lowest regional rate in the country.

Employment and unemployment: In 2012 the employment rate in the city was 71% of people of working age, which is similar to the national rate but lower than the South East Coast. In total there are estimated to be 11,800 unemployed people in the city.

Education: In 2012 56.4% of pupils achieved 5 A*-C grades including English and Maths in Brighton & Hove (compared with 59.4% for England). However, provisional figures for 2013 suggest that local performance improved to 62% (final confirmed local data and comparative data for England will be published in 2014).

Housing and homelessness: Housing pressures have seen homelessness increase by nearly 40% over the last three years with the most common reasons being eviction by parents, family or friends (38%) and loss of private rented accommodation (30%). A third of the city's housing stock (up to 40,000 homes) is considered to be non-decent with the vast majority (92%) being in the private sector; 42.5% of all vulnerable households in the private sector are living in non-decent accommodation

Fuel poverty: In 2011, 12.2% (14,500) of households in the city were estimated to be fuel poor (defined as a household needing to spend more than 10% of its income to maintain an adequate level of warmth). People living in cold homes during the winter months are at increased risk of ill health and death. In Brighton & Hove from 2008-11 there was an average of 135 'excess winter deaths' per year (equivalent to a similar rate to the South East but slightly higher than England).

Improving Health

This section summarises the key health and wellbeing issues currently facing Brighton & Hove including health related behaviours and specific conditions that contribute to both early mortality and reduced quality of life.

Alcohol: 18% of adults in the city are believed to engage in increasing or higher risk drinking. Rates of alcohol-related A&E attendance and hospital admissions have increased in recent years, and in the recent Big Alcohol Debate, 36% of respondents were worried about the effect alcohol has on people in the city. In addition, the city faces challenges from substance misuse and there were 1,582 clients in drug treatment during 2012. A third of this client group had been in treatment for over four years.

Healthy weight: Overweight and obesity are major risk factors for diseases such as Type 2 diabetes, cancer and coronary heart disease. In terms of children in the city, in 2011/12, 15% of Year 6 pupils in the city were obese which is lower than England at 19% while almost 8% of reception children were obese which is also lower than England at 9.5%. For adults, data suggest that in Brighton & Hove, 20% of adults are obese compared to 24% nationally, and an estimated 3% are morbidly obese which is similar to national levels.

In terms of healthy eating, the 2012 Health Profile for Brighton & Hove indicates that 30% of adults are eating a healthy diet, which is similar to the England average of 29% and between 2003 and 2012 there was a significant increase in the proportion of residents eating 5 portions of fruit and vegetables a day – from 43% to 52%.

Domestic and sexual violence: In 2012/13, almost three and a half thousand domestic violence incidents were reported to the police in Brighton & Hove, a slight increase from the previous year. There were also 373 police recorded sexual offences, an increase of 12% compared with the previous year although these figures are likely to be underestimates since many people do not report such violence to the police.

Emotional health and wellbeing: Nationally one in ten children aged 5-16 years are thought to have a mental health problem which would equate to nearly 4,000 children in Brighton & Hove. In adults, 13% have a common mental health disorder while 1% have a more severe disorder. Both of these figures are higher than across the country as a whole. Despite this, local surveys have suggested that a large proportion of people are emotionally well with over 70% of adults indicating that they are happy with their lives and feel that the things they do are worthwhile.

Smoking: In Brighton & Hove, prevalence of smoking is 23% which is higher than the national figure of 20%. On average there are 381 smoking related deaths per year in Brighton & Hove, which again is higher than the national average. However, the city did have a significantly higher rate of successful quitters in NHS Stop Smoking Services than the England average.

Disability: People with physical and sensory disabilities are more likely to suffer discrimination, poor access to some health services and worse employment prospects, each of which can impact negatively on health. It is estimated that in Brighton & Hove in 2012 there were almost 17,000 people aged 18-64 with a moderate or severe physical disability, approximately 3,500 people with a moderate or severe visual impairment and approximately 23,000 people with a hearing impairment.

Specific health issues

Cancer and screening access: Mortality from all cancers in people under 75 years of age is significantly higher in Brighton & Hove than England and the South East. There are three NHS cancer screening programmes in England: breast, cervical and bowel. In Brighton & Hove, screening uptake rates are generally lower than both regional and national figures.

HIV/AIDS: In 2011 Brighton & Hove had the ninth highest HIV prevalence in England at 7.6 per 1,000 15-59 year olds compared with 1.7 in England as a whole. This was the highest prevalence anywhere outside of London. Brighton & Hove also has the highest rates of common sexually transmitted infections outside London.

Diabetes: The prevalence of diabetes is increasing nationally due to increased obesity, an aging population and increasing numbers of South Asian people, who are at greater risk of developing diabetes. In Brighton &

Hove numbers have also increased with 3.3% of people aged 17 years or over registered with GPs having diabetes in 2012 compared with 2.9% in 2008.

Coronary heart disease: In 2011/12 2.3% of all patients registered with GPs in the City had coronary heart disease. Despite reductions over recent decades, it remains the most common cause of death nationally and in Brighton & Hove. It was the main cause of death for 218 people in Brighton & Hove in 2011 which was approximately 10% of all deaths with rates higher in the most deprived areas.

Influenza immunisation: Influenza is a highly contagious viral infection that can cause serious illness and death, especially in vulnerable groups including very young and elderly people. Immunisation is available for people in these groups including everyone over the age of 65. In 2012/13, uptake in Brighton & Hove among those eligible was just under 70%, which is a slight decrease from the previous year and lower than England as a whole and the national target of 75%.

Dementia: It is estimated that there are currently almost three thousand people aged 65 years or over with dementia in Brighton & Hove and in 2011 it was the main cause of death for 112 people, approximately 5% of all deaths.

Musculoskeletal conditions: Musculoskeletal conditions include a range of conditions including back pain, shoulder pain, hip and knee pain which can limit mobility in older people and make them vulnerable to falls. In each year it is estimated that about 40% of the adult population have low back pain, 5% have hip pain and 60% of over 65s severe knee pain.

Cancer and Access to Cancer Screening

A Cancer

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

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

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

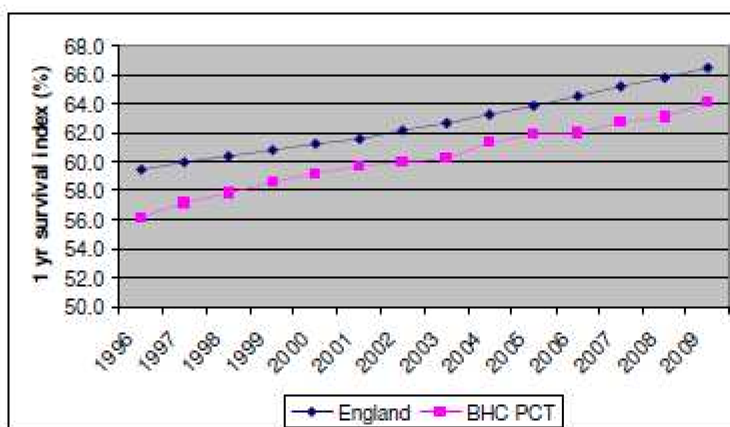
Incidence and mortality from cancer is considerably higher amongst the more deprived groups, largely due to lifestyle factors, such as higher smoking rates. The mortality gap between the poorest groups and the most affluent appears to be widening.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What we can do to make a difference

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

The lifestyle issues associated with cancer are very similar to those related to heart disease or diabetes. Major campaigns are in hand to identify and support people whose risks are high - e.g. NHS Health Checks, and referral to specific services - such as Stop Smoking or weight management. Many agencies are engaged in helping people exercise, manage weight or reduce alcohol consumption, and this work needs to continue and be strengthened. With the move of responsibility for this area over to Brighton and Hove City Council, additional efforts will need to be made to ensure a seamless and coordinated approach across agencies.

There is a cancer health promotion team based within Sussex Community Trust, currently focussing on improving uptake of screening, and this service will be reviewed to see if it's remit can be widened.

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

The local Brighton &Hove lung cancer awareness campaign continues to be active. The Sussex Cancer Network (SCN) has now been disbanded, and the area wide overview is now held the South East Coast Cancer Strategic Clinical Network (SCN), as part of the changes under the Health and Social Care Act. Ensuring strong engagement with the SCN to help focus its work on these areas is important.

Maintain continued implementation of former Sussex Cancer Network's delivery plans

The former Sussex Cancer Network identified a number of specific goals to help tackle other local issues:

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

The responsibility for continued delivery of these actions has now passed to the NHS England Area Team, and it will be important to ensure full engagement of NHS England in the Boards strategic plans.

Work was previously set in train to review variations in cancer referrals from GP practices and explore what further measures can be developed to support GPs to achieve appropriate early diagnosis.

With the support of Macmillan, a primary care GP and nursing lead have been appointed by the CCG,. to support the coordination of primary care cancer management across Brighton and Hove The intention is to focus on early intervention and preventative measures as well as supporting people living with cancer post-treatment.

Outcomes

From the Public Health Outcomes Framework:

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

From the NHS Outcomes Framework:

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

B Cancer Screening

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

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

In 2010/11:

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

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

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

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

Bowel cancer screening up-take rates appear to be increasing although final 2011/12 data is not yet available.

Since 2005-06, the PCT has commissioned a cancer health promotion team - employed by Sussex Community Trust - to increase cancer screening rates. A service specification is in place identifying where efforts should be targeted. This service will be reviewed and ways explored to widen its remit and maximise its effectiveness

The responsibility for commissioning cancer screening programmes has passed to NHS England Area team, and it will be important to ensure full engagement of NHS England in the Board's strategic plans. However, there remains a degree of uncertainty about different agencies roles in encouraging increased screening uptake.

What we can do to make a difference

Bowel cancer

- Publicise the bowel cancer screening programme and encourage people to participate; once people have done so once, the data shows that they are much more likely to do so again.

- Increase up-take particularly amongst men, minority ethnic groups and people living in the more deprived areas of the city where up-take rates tend to be lower.
- Work to reduce endoscopy waiting times, allowing us to extend the offer of bowel screening to people aged over 70 (up to 75).

Breast

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

Cervical

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

All programmes

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

Plan for improvement including key actions

- Work with NHS England to explore options for increasing screening up-take for the three NHS cancer screening programmes
- Evaluate and review the health promotion service provided by Sussex Community Trust
- Work with NHS England to set local improvement targets for the next three years and monitor annually focusing on those populations and groups, and GP practices, where rates are lowest

Outcomes

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

Emotional Health and Wellbeing (including Mental Health)

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

- The government's strategy, *No Health without Mental Health* defines wellbeing as 'a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.'[1]

- A national survey carried out by the Office for National Statistics shows that some groups report higher levels of self-reported wellbeing.[2] These include people who are employed, live with a partner/spouse, are in good health, or are aged under 35 or over 55 years.

- One in four people experience a mental health problem at some point in their lives.

- One in 10 children between 5 and 16 has a mental health problem.[3]

- The cost of mental ill health to the economy in England for adults has been estimated at £105 billion. This includes the cost in terms of sickness absence or unemployment.

- Where young people experience significant mental health needs they may miss time in education and risk poorer educational outcomes.

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

- Mental illness still carries considerable stigma.

Brighton and Hove

- The first local data from the ONS subjective wellbeing survey were published in July 2012.[4] Brighton and Hove residents reported higher average levels of happiness than the national average:

[1] HM Government. No health without mental health: A Cross-Government Mental Health Outcomes strategy for People of all Ages. London, 2011.
[2] Office for National Statistics. First Annual ONS Experimental Subjective Well-being Results. July 2012.
[3] No Health without Mental Health, as above.
[4] Office for National Statistics. First Annual Report on Measuring National Well-being Release. London, 2012.

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

- The City Tracker survey[5] shows a high level of satisfaction with Brighton and Hove, and the local area, as a place to live particularly amongst 25 – 34 year olds.

- Despite higher levels of self-reported wellbeing across the city, local prevalence of mental illness continues to be generally higher than the average for England for both common mental health problems, such as anxiety and depression and severe mental illness, such as schizophrenia or bipolar disorder.

- If 10% of those aged 5 – 16 have a mental health problem, this would equate to 3,199 children and young people in Brighton and Hove.

- Over the last 5 years, the number of children and young people presenting at the Accident and Emergency Department of the Royal Sussex County Hospital with serious self harm has increased significantly from 63 per year in 2009 to 91 per year in 2011 and with high numbers predicted for 2012[6]. For adults the numbers of A&E attendances and admissions related to self-harm are also very high.[7] Between 1 April 2011 and 31 March 2012, there were 1703 attendances related to self-harm: the highest number of attendances is from those under 30 years old.[8]

Inequalities

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

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

- Some groups within the population have a higher risk of developing mental ill-health: homeless people, offenders, certain BME groups, LGB people, veterans, looked after children, transgender people, gypsies and travellers, vulnerable migrants, victims of violence, people approaching the end of life, bereaved people, people with a dual

[5] Brighton and Hove City Council. City tracker survey, 2012.
[6] Reporting from Social Work Team, Brighton and Sussex University Hospitals.
[7] Public Health Observatories. Brighton and Hove health profile. 2012.
[8] HES data.

diagnosis or complex needs, and people with learning disabilities have all been identified as at higher risk[9].
Brighton and Hove has relatively high proportions of some of these groups including homeless, LGB and transgender people. The Count Me in Too survey found that 79% of the city's LGBT population reported some form of mental health difficulties.

- Recent data on local hospital admissions for mental ill-health do not reflect previous findings that rates were higher than expected among BME groups; nationally, BME groups are more likely to be diagnosed with a mental illness than those who are White British, with new psychosis diagnoses up to seven times higher in Black Caribbean groups. [10]

- Brighton and Hove has high numbers of looked after children and child protection cases .Numbers of Looked after children in 2012 was above statistical neighbours and considerably above the England average [11]On average approximately 85 Looked After Children (LAC) are referred to Child and Adolescent Mental Health Services (CAMHS) each year - this is 5% of the total CAMHS population. This is a disproportionate reflection of the number of LAC in the total child population (approximately 1% as of May 2012) and demonstrates the higher propensity of LAC for mental health issues[12].

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

<u>What we are doing well already</u>

Recognition of the role and value of the community and voluntary sector is a strong theme, both in preventive and treatment services, across all ages.

1. Promoting wellbeing working in partnership with the local community and voluntary sector:

During 2012, NHS Brighton and Hove and Brighton and Hove City council consulted on proposals to redesign community mental health support services via the Commissioning Prospectus and have commissioned a new range of services to start in April 2013 including employment support, and targeted out-reach support for the most vulnerable and at risk groups in Brighton & Hove.
Emotional wellbeing has been included in the One Planet Living Health and Happiness action plan.

[9] HM Government. No health without mental health: implementation framework. London: July 2012.
[10] Raleigh VS, Irons R, Hawe E, et al. Ethnic variations in the experience of mental health service users in England: results of a national patient survey programme. Br J Psychiatry. 2007;191:304-312.
[11] http://media.education.gov.uk/assets/files/xls/l/la%20summary.xls
[12] CAMHS monitoring data

A programme of mental health promotion services is commissioned from the voluntary and community sector by the public health team (value approximately £100,000).
A small grants scheme to support local mental health promotion projects was established in 2012. So far 19 proposals have been funded across the city ranging from allotment groups to art and photography.
World Mental Health Day and World Suicide Prevention Day are both celebrated annually.
Children's centres and parenting programmes (e.g. Triple P) promote resilience and early help.
Right Here project for young people 16 – 25 focuses on resilience building and prevention of the escalation of mental health issues.

2. Support and treatment for those with emerging or existing mental health problems:

A new Wellbeing Service has been developed to provide access to psychological therapies in a range of primary care and community settings. Access to the service has been widened through a new option of self-referral.
The supported accommodation pathway has been redesigned – making more flexible use of resources and targeting resources more effectively to those with the most complex needs.
A single point of access to tiers 2 and 3 CAMHS[13] has been established.
A 14-25 service has been developed to bridge the gap between CAMHS and adult services.
Provision of duty service and urgent care for CAMHS services.
A strategy is in development to promote effective liaison between social care team and CAMHS when young people present at A&E with self harming behaviours.
The care pathway for responding to adults with urgent mental health needs has been redesigned. In January 2013 the Brighton Urgent Response Service was launched which provides an improved 24/7 crisis response service for adults with mental health needs. The new arrangements will be evaluated during 2013.

Where are the gaps?

- Both the adult mental health commissioning strategy and the mental health promotion strategy are in need of review and update and a

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

commissioning strategy for children and young people needs development.
- We have information about self reported wellbeing from the national ONS survey for the whole city, but need further work on the Health Counts survey to understand the distribution of emotional wellbeing across different neighbourhoods, communities of interest and demographic groups.
- Treatment services for people with complex needs or dual diagnosis need review to ensure better coordination.
- Better understanding of the profile of self harm in the city and improved awareness of the issues and appropriate responses within universal and specialist services.
- Waiting times for psychological services are still too long.

What we can do to make a difference

- Start to think about emotional health and wellbeing in a different way – as part of everyone's business and as important as physical health.
- Continue to shift the balance of spend between prevention and treatment and focus more on providing support to build resilience and maintain mental wellbeing.
- Take a city-wide approach to improving the wider determinants for good mental health including:
    - Encourage greater uptake of physical activities;
    - Promote mental health and wellbeing in the workplace;
    - Promote mental health and wellbeing in schools, including a focus on the problem of bullying and its impact upon wellbeing;
    - Ensure that the Stronger Families Stronger Communities Partnership addresses issues of mental health and wellbeing as they relate to the city's most vulnerable families.
- Develop more holistic care and treatment for both adults and young people with dual needs – both mental health and alcohol/substance misuse.
- Work across a care pathway to ensure more effective transition from children & young people's services to adult services. Develop more effective links across adult and children's commissioning and services so that the issues of parental mental health, including in the antenatal and post natal phases, are well understood and the impact on child development minimised.
- Ensure emotional health and mental health wellbeing is integrated as far as possible into service provision rather than being separately provided in a medical model by "specialist mental health" service providers.
- Extend access to psychological therapies providing evidence based earlier treatment and support to more people.
- Continue to engage service users in service developments.

Plans for improvement including key actions

- Map current activity and plans in Brighton and Hove against the recommended actions in the implementation framework for No Health without Mental Health.
- Develop an all-ages mental health and wellbeing commissioning strategy.
- Engage local people about happiness and wellbeing, focusing on the 'Five Ways':
  - Connect – with the people around you, family, friends and neighbours;
  - Be active – go for a walk or a run, do the gardening, play a game;
  - Take notice – be curious and aware of the world around you;
  - Keep learning – learn a new recipe or a new language, set yourself a challenge;
  - Give – do something nice for someone else, volunteer, join a community group.

Outcomes

- Improved ONS subjective wellbeing scores (PHOF)
- Better emotional well-being of looked after children (PHOF)
- Reduced hospital admissions for self-harm (PHOF)
- Increased employment for people with a mental illness(PHOF & NHSOF)/ proportion of adults in contact with secondary mental health services in paid employment (ASCOF)
- Reduction in proportion of people in prison with mental illness (PHOF)
- Increased settled accommodation for people with mental illness (PHOF)/ proportion of adults in contact with secondary mental health services living independently without the need for support (ASCOF)
- Improving outcomes for planned procedures – psychological therapies (NHSOF)
- Reduction in premature death for people with serious mental illness - under 75 mortality rate (PHOF)/ under 75 mortality rate in people with serious mental illness (NHSOF)
- Reduction in the suicide rate (PHOF)
- Patient experience of community mental health services (NHSOF)

Dementia

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

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

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

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

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

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

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

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

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

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

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

Good quality early diagnosis and intervention for all

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

Improved quality of care in general hospitals

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

Living well with dementia in care homes

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

Reduced use of antipsychotic medication

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

Other developments

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

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

What can we do to make a difference?

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

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

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

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

Needs Assessment
Currently there is limited information about people with dementia in the city, and it is based mostly on national estimates. There is no joint strategic needs assessment for dementia. A needs assessment would assist in commissioning plans going forward, and the rolling programme of JSNA needs assessments for 2013-14 includes a commitment to a dementia needs assessment.

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

Plan for improvement including key actions

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

Outcomes

How will we measure success?

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

Healthy Weight and Good Nutrition

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

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

What are we doing well already?

- The local prevalence of overweight and obesity in children aged 10-11 years is below the national prevalence..

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

nutrition) both for Local Authority's premises and NHS Trusts (including Meals on Wheels, care homes, school meals); reducing food waste; and expanding land used for growing food.

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

- Promoting the Workplace Wellbeing Charter to all local businesses.

What are the gaps?

- The current specialist weight management service is very limited and results in people being actively considered for bariatric surgery when alternative intensive support may have a similar successful outcome.
- There is a gap in the pathway for the weight management programme delivered in primary care for patients with co-morbidities associated with overweight and obesity.
- There are currently no community weight management services and/or sufficient health promotion of healthy weight, good nutrition and physical activities for young people aged 13-25 years..
- There are currently no reliable local data on adult obesity.
- Low levels of satisfaction in the community with local sports facilities.
- Low provision of physical activities in some local neighbourhoods – therefore people have to travel to leisure centres/other locations.
- Availability and use of local produce by local organisations to provide healthy meals for the local population.

What can we do to make a difference?

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

- Work more closely with local communities to identify their needs and priorities in relation to weight issues and develop services that respond to these needs.
- Identify the needs of young people aged 13-15 years in relation to weight issues.
- Engagement at a local level from large retailers/supermarkets who have signed up to the national Public Health Responsibility Deal food pledges. In particular engaging local supermarket chains in proximity of schools in the city to promote healthier choices for children.
- Engagement from local take-away outlets in proximity of schools to influence food preparations (for e.g. salt content; use of trans-fats etc).

- Develop community assets to encourage the provision of neighbourhood based physical activities and food production e.g. allotments and gardens. Schools could be the hub for a community.
- Improve the quality of food served to people by public organisations- using local produce whenever possible.
- Continue to support a Healthy Settings Programme which promotes healthy eating and physical activity in early years settings, schools and Further Education colleges.
- Improve the quantity and quality of local leisure and sports facilities.
- Work with local employers to make sure the workplace charter is actually being delivered.

Plan for improvement including key actions:

- Establish the Healthy Weight Programme Board to provide the framework to bring together a wide range of organisations from the voluntary, public and private sectors (in particular food retailers).The Board's Action Plan outlines four separate domains with a series of actions for each of the partners, the funding sources and key performance indicators. The key objective is to strengthen local action to promote healthy weight and to prevent overweight and obesity through a life course approach and to address obesity through appropriate treatment and support.
- Ensure the development of a comprehensive weight management service for children and adults from primary through to tertiary care.
- Development and evaluation of the local GP Champions project for young people aged 13-25 years. The aim of the project is to engage young people in the development of health promotion services relating to healthy weight, good nutrition and an active lifestyle.
- Develop a network of Community Health Champions to work directly with the community to encourage greater participation and access to services including physical activities by specific groups including older people and people with learning disabilities.
- To consider the further development of schools as community hubs for promoting physical activity and healthy eating and support schools to achieve outcomes for children under the healthy weight priorities within the healthy settings programme. This will include greater engagement with parents and pupils through the increased provision of school based healthy lifestyles programmes outside school hours.
- To further develop the partnership with local leisure centre providers to increase local community participation.
- Strengthen the ongoing work with the local economic partnership to promote healthy eating and active lifestyles to employees via the workplace.
- To use education initiatives to promote healthy and sustainable food choices and the skills to cook, including for those in care support roles.
- To improve the information for people, particularly vulnerable people, about the importance of good nutrition for health and wellbeing as well as the healthy eating options available in their local area.

- Increase the number of overweight and obese children referred to community weight management services, through closer working with primary care.

- Ensure local community weight management services include cognitive behaviour skills to address the emotional issues linked to weight issues.

Outcomes

- Public Health Outcomes framework includes:
    - Excess weight in 4-5 and 10-11 year olds
    - Excess weight in adults.
    - Proportion of physically active and inactive adults
- Reduction in prevalence of overweight/obese children from the National Child Measurement Programme dataset for children aged 10-11 years.
- Increase the proportion of children and young people achieving the Chief Medical Officer's recommendation for levels of physical activity including an increase in school based activity.
- Reduction in the prevalence of adults who are overweight or obese (estimated until the national data set is put in place).
- Increase the proportion of adults doing at least 30 minutes of moderate physical activity per week.
- An increase in the number of community assets linked to physical activity, cooking skills and healthy eating.

Smoking

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

- Smoking is the greatest cause of health inequalities and premature mortality. Smoking rates are much higher amongst routine and manual workers and amongst people from some ethnic groups.
- Estimated that 23% of the Brighton and Hove population smoke compared with 20% for England
- 85% of year 7 to 9 pupils report never smoking compared with 50% of year 10 and 11 pupils.
- On average a lifelong smoker will lose ten years of their life.
- The three most common causes of death from smoking are lung cancer, chronic obstructive pulmonary disease and cardiovascular disease.

What are we doing already?

- The Brighton and Hove Tobacco Control Alliance has been established with multiagency representation. The Alliance has an action plan with four main areas: helping communities to stop smoking; maintaining and promoting smoke free environments; tackling cheap and illegal tobacco; stopping the inflow of young people recruited as smokers..
- Smoking cessation services are the most cost-effective life saving intervention provided by the NHS. The local stop smoking specialist service co-ordinates the local smoking cessation services and provides training and support for the intermediate services in primary care (general practices and pharmacies). Over the last ten years local smoking cessation services have helped around 30,000 people to try and stop smoking. In 2012/13 the stop smoking services helped 2,042 people to successfully quit.
- The specialist service provides stop smoking sessions in the most deprived neighbourhoods, and through workplaces helps smokers who are routine and manual workers to quit. There is a well established service within the hospital.
- Working with pregnant women. All pregnant women are now routinely screened with carbon monoxide monitors.
- Working with schools to reduce the number of young people starting smoking and to help those who smoke to quit.
- Linking in with national events such as “No smoking Day.”

What are the gaps?

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

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

What can we do to make a difference?

- Working with the Brighton and Hove Community Development Team and the local community to reduce the local smoking prevalence.
- Working with the community to understand the needs of all ethnic groups for smoking cessation services.
- Working with environmental health and licensing to use their regular and routine contact with restaurant staff and taxi drivers to reach smokers not accessing services. Link with the GMB union to access manual workers.
- Support work in schools to ensure smoke free sites, effective tobacco education and delivery of or referral to smoking cessation services as part of the Healthy Schools programme.
- Work with parents who smoke to help them understand the issues for their children, and to help them to quit.
- Patients who smoke and who are being referred for surgery should be seen by the stop smoking service to enhance their post-operative recovery.
- Encourage general practices to refer patients being considered for smoking cessation treatment to their own practice based intermediate services to improve clinical effectiveness.
- Further communication work including local websites and the use of viral media. Develop a local communications strategy for our local population, to include the promotion of stop smoking services.
- Promote no smoking in outside areas such as play areas, outside schools and on the beach.
- Support young people in youth settings, colleges and universities to stop smoking.

Plan for improvement including key actions

- Work with CVSF/community engagement team to explore a community asset based approach to reducing smoking.
- Work with local ethnic communities and groups to develop suitable services.
- Develop a plan for promoting no smoking in certain outdoor areas.
- Support the review and development of effective tobacco education, as part of drug, alcohol and tobacco education in schools and Healthy Schools.
- Ensure secondary school staff are able to refer students to smoking cessation services or can deliver smoking cessation sessions in school.

Outcomes

- Reduction in smoking prevalence as per the Public Health outcomes framework:
    - Smoking prevalence – adults (over 18s)
    - Smoking prevalence – 15 year olds
    - Smoking status at time of delivery.
- Reduction in the SAWSS based smoking prevalence data on children and young people:
    - Percentage of young people who have never smoked at ages 11-14 and 14-16 years.
- Increased number of smokers from different ethnic groups being seen by the Stop Smoking team.

Inequalities

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

The Joint Health and Wellbeing Strategy is a key part of addressing local inequalities and the factors that influence them. The Health and Wellbeing Board will consider the impact of inequalities on the health and wellbeing of the city's population and also link with those partnerships with responsibility for directly tackling the wider determinants of health. In addition to work being undertaken by the HWB, the CCG is developing a new primary care development strategy which will contribute to reducing health inequalities through a strategic approach to reduce exception reporting and a premature mortality audit.

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

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

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

The Review provides a framework for approaching inequalities within Brighton and Hove. Tacking Inequality is one of the three priorities in the council's

corporate plan for 2011-2015, and is also a duty of the Clinical Commissioning Group. The two other priorities in the council's corporate plan: engaging people who live and work in the city and creating a more sustainable city are also important to addressing inequalities.

Marmot recommendations and the relevant local high-level partnerships.

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

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

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

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

Youth Joint Commissioning Board

SEN partnership board</td><td colspan="2">Learning disability strategy and partnership group
Centre for Independent Living
Carers Group*</td></tr>
<tr><th colspan="5">Specific conditions</th></tr>
<tr><th></th><th>Children</th><th>Young people</th><th>“Adults”</th><th>Older people</th></tr>
<tr><td>Cancer and access to screening</td><td>South East Coast Strategic Clinical network for cancer</td><td>South East Coast Strategic Clinical network for cancer</td><td colspan="2">South East Coast Strategic Clinical network for cancer
Individual screening steering groups for breast, bowel and cervical cancer.</td></tr>
<tr><td>HIV & AIDS</td><td></td><td colspan="3">Sussex HIV Network
Sexual health programme board</td></tr>
<tr><td>Musculoskeletal</td><td></td><td colspan="3">Ongoing Sussex-wide review group</td></tr>
<tr><td>Diabetes</td><td colspan="4">Diabetes Clinical Reference Group</td></tr>
</table>

Coronary Heart Disease			SEC Strategic Clinical Cardiovascular Network	
Flu immunisations	Local Immunisation & Vaccination Committee	Seasonal flu group		
Dementia				Sussex-wide Dementia Partnership Brighton & Hove Dementia Strategy Implementation Group Carers Strategy Group
Wider determinants				
	Children	**Young people**	**“Adults”**	**Older people**
Child poverty	Child poverty strategy and task group			
Education	The Learning Partnership Secondary Schools Partnership Healthy Settings Programme Panel Behaviour and attendance partnership Stronger families stronger communities programme board		Adult Learning Group	
Employment /Unemployment	Economic Partnership City Employment & Skills Steering Group Employer Engagement Group			
Housing	Strategic Housing Partnership.			
Fuel poverty	Overseen by Strategic Housing Partnership			

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

Engagement and Consultation

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

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

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

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

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

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

- Participation in a July 2012 workshop event organised by CVSF – explaining and debating the JSNA and JHWS with CVSF members.

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

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

Subsequent to this engagement, a draft JHWS was endorsed by the shadow HWB in September 2012. This draft was shared with a number of bodies, including local NHS providers. In particular, there was an extensive piece of engagement with local community and voluntary sector organisations, facilitated by the Brighton & Hove Community & Voluntary Sector Forum (CVSF). More than 80 CVSF member organisations attended themed workshops with the relevant JHWC commissioners on the JHWS priorities or responded to survey questions about the JHWS.

The eventual product of this engagement was a detailed sector response to the draft JHWS, which included many valuable suggestions for improving outcomes across the JHWS priority areas. Where possible, CVSF recommendations have been incorporated into the final strategy. However, the JHWS is intended as a high-level document, and many of the suggestions we received are focused upon operational matters rather than strategic ones. In consequence, in the majority of instances a response to/implantation of

CVSF recommendations will be via specific commissioning plans and strategies rather than the JHWS.

We would like to thank CVSF for all the work they have done in this respect. A detailed response to CVSF recommendations, including information on how each recommendation will be advanced, will be compiled and circulated in due course.

Appendix 2

Equalities Impact Assessments for the Health and Wellbeing Board priority areas

What are Equality Impact Assessments (EIAs)?

Public sector bodies need to be able to evidence that they have given due regard to the impact and potential impact on all people with 'protected characteristics' in shaping policy, in delivering services and in relation to their own employees.

'Protected characteristics' are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation. They also include marriage and civil partnership but only in relation to eliminating discrimination.

The following principles, drawn from case law, explain what is essential in order for the Public Sector Equality Duty to be fulfilled.

Public bodies should ensure:

Knowledge – everyone who works for the council and other statutory bodies must be aware of our Equality Duties and apply them appropriately in their work

Real consideration – you must consider the aims of the Equality Duty as an integral part of your decision-making process. The Duty is not about box-ticking; it must be done properly, with rigour and an open mind so that it influences your final decision.

Sufficient Information- you must consider what information you have and what further information is needed to give proper consideration to the Equality Duty

Proper Record Keeping – we must keep records of the process of considering the Equality Duty and the impacts on protected groups. This encourages transparency and the proper completion of Equality Duties. If we don't keep records then it may be more difficult for us to evidence that we have fulfilled our equality duties.

Review – we must have regard to the aims of the Duty not only when a policy is developed and decided upon but also when it is implemented and reviewed. The Equality Duty is a continuing duty.

EIAs are about making services better for everyone and value for money; getting services right first time.

The Health and Wellbeing Board – Priority Areas

Through its Joint Health and Wellbeing Strategy (JHWS), the Health and Wellbeing Board has chosen five priority areas on which to focus the Board's work.

Detailed information on how the priority areas were chosen can be found in the introduction to the Joint Health and Wellbeing Strategy document. In terms of equality impacts, the themed data used in the prioritisation process was considered under a number of criteria including the impact on particular groups including protected characteristic groups, and on their impact on inequalities.

The Brighton and Hove Local Information Service (BHLIS) website has more detail about the Joint Strategic Needs Assessment which was used to inform the HWB in choosing their priorities (http://www.bhlis.org/jsna2012). This link includes a detailed impact matrix, showing the impacts on affected equalities groups where known.

The five priorities for the HWB are:

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

Each of these areas has its own Equalities Impact Assessment (EIA). This document's purpose is to pull the EIAs together into one place and to provide a link to each EIA.

The HWB has not been directly involved in any of the EIAs for the priority areas. However the expectation is that the HWB members will use the EIAs to review service delivery, policy and make recommendations for the next steps in service development. The EIAs should be reviewed annually as a matter of good practice.

The Equality Impact Assessments

This section links to each Equality Impact Assessment (attached at the end of the document), details which agency is responsible for the EIA and when it was completed.

- **cancer and access to cancer screening (Enclosure 1)**

to follow

- **dementia (Enclosure 2)**

  The Dementia Action Plan; written by the Clinical Commissioning Group, November 2011.

  Anticipated outcomes include:

- Initiation of a new Memory Assessment Service
- Recommissioning of Care Home In each Team
- Completion of EOL and dementia care pathway
- Dementia champion for the Royal Sussex County Hospital

Service commences June 2013, with pathway to be completed by December 2013.

The Plan is for 2 years and the CCG joint commissioner for Dementia in conjunction with the Dementia Implement Group will be responsible for its continued delivery.

- **emotional health and wellbeing (including mental health) (Enclosure 3)**

  The Emotional Health and Wellbeing EIA was written by Brighton & Hove City Council, August 2013

- Despite higher levels of self-reported wellbeing across the city, local prevalence of mental illness continues to be generally higher than the average for England for both common mental health problems, such as anxiety and depression and severe mental illness, such as schizophrenia or bipolar disorder.

- The chapter sets out an intention to develop an all age emotional health and wellbeing strategy; a further EIA will need completing when the strategy is completed, The aim of the strategy will be to promote improved emotional health and wellbeing for the whole population and to offer timely and appropriate mental health interventions for children and adults in a range of settings, taking account of all equalities issues.

- **healthy weight and good nutrition (Enclosure 4)**

  Strategy written by Public Health, Brighton and Hove City Council. Completed in July 2013

- In Brighton and Hove an estimated 43,632 adults are obese and 6,500 are morbidly obese. An estimated 14,000 children and young people

aged 2-19 years are overweight or obese. This is predicted to increase to 16,400 by 2020.
- Obesity is strongly correlated with inequalities and deprivation.
- The estimated annual cost to the NHS in the city related to overweight and obesity was £78.1 million in 2010. This is predicted to increase to £85 million by 2015.
- Excess weight is a major risk factor for diseases such as type 2 diabetes, cancer and heart disease.

The action plan and strategy aim to promote healthy weight and healthy lifestyles for the whole population and to offer weight management programmes and services to overweight and obese children and adults in a range of settings

- **smoking (Enclosure 5)**

  Reducing Health Inequalities through Tobacco Control and Joint Health & Wellbeing Strategy; written by Public Health, Brighton and Hove City Council, January 2013.

  The BHTCA acts to reduce health inequalities caused by smoking. Smoking is a local priority for the Brighton & Hove City Council Health & Wellbeing Strategy .

  Smoking is the primary cause of premature death.
  The principal beneficiaries are-
  - Young people and others who are not recruited to smoking
  - City residents who quit.
  - Benefits for communities and families who live in areas of high smoking prevalence.
  -

  The Brighton & Hove Tobacco Control Alliance has been established with multiagency representation which will-
- Helping communities to stop smoking
- Maintaining & Promoting Smokefree environments
- Tackling cheap and illicit tobacco
- Stopping the inflow of young people as smokers.

Enclosure 2 – Dementia EIA/ Action Plan

Name of Function - Dementia Action Plan

Date of Equality Impact Analysis –November 2011

Name and position of person completing the EIA – Katie Hirst, Commissioning [Clinical Commissioning Group]

Sources of information used to complete EIA- Input from GP clinical leads and secondary care clinicians, contract monitoring data, information from Public Health .

Names of stakeholder groups or numbers of individuals involved and the protected characteristic communities they represent

- Sussex Partnership Foundation Trust
- Brighton and Hove City Council
- Sussex Community NHS Trust
- Brighton and Sussex University Hospital Trust
- Alzheimer's Society
- Age Concern
- MIND
- The Martlets Hospice
- People with dementia and carers via the Alzheimer's Society

Anticipated positive impact for each relevant group

- Initiation of a new Memory Assessment Service
- Recommissioning of Care Home Inreach Team team
- Completion of EOL and dementia care pathway
- Dementia champion for the Royal Sussex County Hospital

Evidence that this impact has been delivered

- Service commences 1st June 2013
- Redesigned service starts April 1203.
- Pathway to be completed by Dec 2013.
- Post holder operational

Anticipated negative impact for each relevant group – none identified

Evidence this impact has been mitigated – N/A

Where evidence of positive or negative impact has not been collected please indicate how this evidence will be collected – none identified

Outstanding actions from the EIA - including timescale for delivery and responsible individual -

The Plan is for 2 years and the CCG joint commissioner for Dementia in conjunction with the Dementia Implement Group will be responsible for continued delivery of the plan

Enclosure 3 – Emotional Health and Wellbeing EIA

Title of EIA	Emotional health and wellbeing Health and Wellbeing Strategy Priority. The strategy is currently in draft form.	**Ref No.**	
Delivery / Resource / Finance Unit or Intelligent Commissioning name	Joint strategy across CCG , BHCC children's commissioning and public health (delivery through range of local statutory and CVS organisations)		
Aim of policy or scope of service	Despite higher levels of self-reported wellbeing across the city, local prevalence of mental illness continues to be generally higher than the average for England for both common mental health problems, such as anxiety and depression and severe mental illness, such as schizophrenia or bipolar disorder. The chapter in the health and wellbeing strategy sets out an intention to develop an all age emotional health and wellbeing strategy and further EIA will need completing when the strategy is completed, The aim of the strategy will be to promote improved emotional health and wellbeing for the whole population and to offer timely and appropriate mental health interventions for children and adults in a range of settings The strategy will take due account of all equalities issues herewith		

2. Record of data/engagement; impacts identified; and potential actions to meet the Duties.

	Data[1] that you have	Community engagement exercises or mechanisms[2]	Impacts identified from analysis (actual and potential)[3]	Potential actions to advance equality of opportunity, eliminate discrimination, and foster good relations (You will prioritise these below)
Consider: • How to avoid, reduce or minimise negative impact (if you identify unlawful discrimination, including victimisation and harassment, you must stop the action and take advice immediately). • How to promote equality of opportunity. This means the need to: – Remove or minimise disadvantages suffered by equality groups – Take steps to meet the needs of equality groups – Encourage equality groups to participate in public life or any other activity where participation is disproportionately low – Consider if there is a need to treat disabled people differently, including more favourable treatment where necessary • How to foster good relations between people who share a protected characteristic and those who do not. This means: – Tackle prejudice – Promote understanding				
Community Cohesion (what must happen in all communities to enable different groups of people to get on well together.)	Focus on developing services in the community and via for example primary care, schools. . Developing greater focus on promotion of emotional wellbeing and raising awareness and reducing stigma.	The draft JHWS, including the Emotional health and wellbeing priority, was discussed with the CVSF, and consulted on via the council's portal in 2012 and at focus groups in 2013	Poor mental health retains a stigma and ongoing work needed to reduce this	We have information about self reported wellbeing from the national ONS survey for the whole city, but need further work on the Health Counts survey to understand the distribution of emotional wellbeing across

[1] 'Data' may be monitoring, customer feedback, equalities monitoring, survey responses…
[2] These may be ongoing links that you have with community and voluntary groups, service-user groups, staff forums; or one-off engagement sessions you have run.
[3] If data or engagements are missing and you can not define impacts then your action will be to take steps to collect the missing information.

	Participation in World mental health day. Social connectedness is in itself protective for mental wellbeing.			different neighbourhoods, communities of interest and demographic groups.
Age (people of all ages)	Taking the Brighton & Hove population of 5-16 year olds to be approximately 38,198[4] and using the mental health strategy data of one in 10 children experiencing mental health problems, this would equate to 3,819 children & young people in the city with mental ill-health. Most mental health problems start in childhood & adolescence & the majority of severe & enduring mental illnesses are diagnosed by the age of 18.Adolescence is a vulnerable time for the emergence of emotional ill	Service user groups in adult mental health services. Amaze is the parent participation organisation locally. Representation of parent carers and service users on key strategy groups and partnerships. CVSF have contributed to consultation on the HWS chapter. Safe and Well at schools survey asks specific mental health questions of school age children and has been extended to include students at 6th form colleges Mind is commissioned to deliver mental health	Lack of an all age mental health strategy increases likelihood of their being 'gaps' between areas of provision for different age ranges. Developing this strategy will help mitigate this	Teen to adult personal advisers support young people aged 14-25 who find it difficult to access services. Right Here (a partner with the local authority) supports young people aged 16-25 via resilience building activities and volunteering opportunities. Development of all age mental health strategy. Increased focus on improved transitions from child to adult services. Specific ongoing developments for young people eg online counselling

[4] Office for National Statistics Mid year estimates 2010

	health issues. Self reported wellbeing in the Health Counts survey showed that respondents aged 65-74 years were most happy: 78% for men and 77% for women. However, respondents aged over 75 years were least likely to feel that things in their life were worthwhile (65%). An older people's needs assessment (2008) found the mental health problems affecting the greatest number of older people in the city are dementia and depression. Applying national prevalence to the local population suggests that there are around 3,100 with depression and 1,000 with severe depression.	advocacy and participation for children and young people		

Disability (a person is disabled if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities[5])	People with autism or Asperger syndrome are particularly vulnerable to mental health problems such as anxiety & depression, especially in late adolescence & early adult life.[6] This is an area of concern in the city and is a key aspect of the Special Educational Needs strategy. People with physical health problems, especially long term conditions, are more vulnerable to depression and anxiety. Analysis from the Compass database (the voluntary register for children & young people with disabilities in the city) shows that as of 1st June 2013	Currently there is no specific engagement with adults with a disability. AHA group for children and YAP.	Ensure that services are appropriately promoted and accessible to those with disability.	Increased data on those with disabilities and their mental wellbeing- including from Health counts data

[5] The definition includes: sensory impairments, impairments with fluctuating or recurring effects, progressive, organ specific, developmental, learning difficulties, mental health conditions and mental illnesses, produced by injury to the body or brain. Persons with cancer, multiple sclerosis or HIV infection are all now deemed to be disabled persons from the point of diagnosis.

[6] Tantam D. Prestwood S. (A mind of one's own: a guide to the special difficulties and needs of the more able person with autism or Asperger syndrome. 3rd ed. London: National Autistic Society; 1999.

[7] Amaze analysis conducted for the JSNA in June 2013.

	26% of children & young people with an up-to-date record on the register are known to have received support from CAMHS over the past two years.[7] Long term ill health and in particular pain are contributors to being at risk of suicide			
Gender reassignment (a transsexual person is someone who proposes to, starts or has completed a process to change his or her gender. A person does not need to be under medical supervision to be protected)	An additional survey of a small number of trans young people[8] indicates that this cohort or particularly vulnerable to mental health issues	No specific mechanism in place due to lack of data. Awaiting information from trans needs assessment	No data.	Once available the data will be analysed and plans will be put in place accordingly.
Pregnancy and maternity (protection is during pregnancy and any statutory maternity leave to which the woman is entitled)	Women vulnerable to post natal depression or with other mental health problems before or after childbirth can access a specialist perinatal mental health service. All			

[8] Allsorts Youth Project (2013) Allsorts Trans* Survey Report, Quarter 4 Jan-March 2013

	mothers screened for mental health issues by midwives and health visitors . Family nurse partnership works intensively with first time mothers under 19 years. Young mothers are at greater risk of developing post natal depression.			
Race (this includes ethnic or national origins, colour or nationality, including refugees and migrants; and Gypsies and Travellers)	Across England, BME groups are more likely to be diagnosed with a mental illness than those who are White British, with new psychosis diagnoses up to seven times higher in Black Caribbean groups. [9] Local hospital admissions data do not reflect previous findings that rates were higher than expected among BME groups, however. In the Health Counts survey, there was no significant difference in	Service user groups in adult mental health services. Amaze is the parent participation organisation locally. Representation of parent carers and service users on key strategy groups and partnerships. CVSF have contributed to consultation on the HWS chapter. Safe and Well at schools survey asks specific mental health questions of school age children and has been extended to	The service specifications require providers to ensure that services are delivered in a culturally sensitive manner and are tailored accordingly.	

[9] Raleigh VS, Irons R, Hawe E, et al. Ethnic variations in the experience of mental health service users in England: results of a national patient survey programme. Br J Psychiatry. 2007;191:304-312.

	any of the self reported wellbeing measures for BME respondents. However, respondents with Mixed ethnicity showed significantly worse results for satisfaction (54%), happiness yesterday (57%) and for being less anxious (41% in the less anxious category).	include students at 6th form colleges Active engagement with community groups at the BMECP. Psychosocial support services for the BME community are currently being commissioned, following consultation.		
Religion or belief (religion includes any religion with a clear structure and belief system. Belief means any religious or philosophical belief. The Act also covers lack of religion or belief.)	In the Health Counts survey there were no significant differences by religion in self reported wellbeing. Buddhists were most likely to be satisfied with their lives (88%), feel that life was worthwhile (94%) and were most happy (82%). By contrast, Muslim residents reported lower levels of satisfaction with life (55%), were significantly less likely to feel that the things they did in life were worthwhile	No specific data collected.	Current approaches take into account faiths and cultures.	Further work is required to identify needs.

	(57%), were less happy with their lives (54%), and were also significantly less likely to have low levels of anxiety (40%).			
Sex (both men and women are covered under the Act)	More men than women are admitted to hospital overall for mental illness: 64% of people admitted are men.[10] Females are significantly more likely to have to have medium to high satisfaction with life and to feel the things they do are worthwhile. Males however are significantly more likely to have had very low or low levels of anxiety on the previous day. There was little difference in how happy people felt on the previous day by gender (2012 Health Counts survey). Young females are more likely than males to	Service user groups in adult mental health services. Amaze is the parent participation organisation locally. Representation of parent carers and service users on key strategy groups and partnerships. CVSF have contributed to consultation on the HWS chapter. Safe and Well at schools survey asks specific mental health questions of school age children and has been extended to include students at 6th form colleges	Participation contract awarded to specifically target young men.	Suicide prevention group focuses on the most at risk groups

[10] Sussex Foundation Partnership NHS Trust data for Brighton and Hove residents (2012-13).

	present to A&E with serious self harm. Of the young people under 18 presenting to A&E with serious self harm in 2012, 88% were female. Men are three times more likely to die by suicide than women and men aged 35-49 are most at risk (local audit of Coroner's records). Safe and Well at school data (2012) indicates that girls are much more likely to experience feeling anxious / worried often or sometimes than boys (57% compared to 39% with boys). Girls are also more likely to feel very sad / depressed (32% compared to 21% with boys) or lonely / isolated (25% compared to 18% with boys). Boys are more likely to experience feeling very			

	angry often or sometimes (33% compared to 29% with girls) and marginally more likely to feel out of control (21% compared to 20% with girls).			
Sexual orientation (the Act protects bisexual, gay, heterosexual and lesbian people)	Brighton and Hove has a significant proportion of young people who would describe themselves as LGBT. Surveys undertaken by Allsorts, a local support project, reflect the increased vulnerability of this group to mental health issues. SAWSS : Across all categories of negative mood the trend with sexual orientation appears to be that LGB students are more likely to experience them than unsure respondents and unsure students are more likely to experience them then heterosexual students. The largest	Service user groups in adult mental health services. Amaze is the parent participation organisation locally. Representation of parent carers and service users on key strategy groups and partnerships. CVSF have contributed to consultation on the HWS chapter. Safe and Well at schools survey asks specific mental health questions of school age children and has been extended to include students at 6th form colleges Direct consultation via Allsorts	No data currently available.	Health Count analysis.

	differences between heterosexual and LGB students in SAWSS dats is on hurting or harming yourself (7% heterosexual and 46% LGB) followed by suicidal thoughts (7% heterosexual and 44% LGB) and spending time a lot of time alone (18% heterosexual and 49% LGB). The Count Me in Too survey found that 79% of the city's LGBT population reported some form of mental health difficulties. For the Health Counts survey, heterosexual respondents were more likely to be more satisfied with their life, feel the things the do are worthwhile, have higher levels of happiness and be less anxious than LGB and			

	unsure respondents. There were no significantly different results for any LGBU group.			
Marriage and civil partnership (only in relation to due regard to the need to eliminate discrimination)	The 2012 Brighton & Hove Health Counts survey showed that the risk of depression is significantly higher in people who area single, divorced or separated. This reflects national ONS survey data which shows higher levels of self reported wellbeing among those who are married, in a civil partnership or cohabiting.			
Other relevant groups eg: Carers, people experiencing domestic violence, substance misusers, homeless people, looked after children etc	Of the referrals to Tier 3 CAMHS in the period January-September 2012 102 were known to social services. The England average score for emotional and behavioural health (SDQ scores)of looked after children is 13.8	Service user groups in adult mental health services. Amaze is the parent participation organisation locally. Representation of parent carers and service users on key strategy groups and partnerships. CVSF have	The supported accommodation pathway has been redesigned – making more flexible use of resources and targeting resources more effectively to those with the most complex needs.	

	and the Brighton and Hove average is 14.8 (2012) with 0-13 being deemed normal, 14-16 being borderline for concern and 17+ being cause for concern Some groups within the population have a higher risk of developing mental ill-health: homeless people, offenders, certain BME groups, LGB people, veterans, looked after children, transgender people, gypsies and travellers, vulnerable migrants, victims of violence, people approaching the end of life, bereaved people, people with a dual diagnosis or complex needs, and people with learning	contributed to consultation on the HWS chapter. Safe and Well at schools survey asks specific mental health questions of school age children and has been extended to include students at 6th form colleges		

[11] HM Government. No health without mental health: implementation framework. London: July 2012.

	disabilities have all been identified as at higher risk[11]. Brighton and Hove has relatively high proportions of some of these groups including homeless, LGB and transgender people. The 2012 Health Counts survey showed that the risk of depression in significantly higher among more deprived groups. Respondents who own their own homes did significantly better across all measures, and those who are employed significantly higher for satisfaction with life and feeling the things they do are worthwhile. However, those who rent from a housing association or local authority or council fare significantly worse across all four measures. There was no significant			

	difference in levels of happiness and wellbeing for carers.			

Healthy Weight and Good Nutrition EIA

1. Front sheet

Title of EIA	Healthy Weight and Good Nutrition Action Plan and Joint Health and Wellbeing Strategy Priority. The strategy is currently in draft form.	**Ref No.**	
Delivery / Resource / Finance Unit or Intelligent Commissioning name	Public Health		
Aim of policy or scope of service	• In Brighton and Hove an estimated 43,632 adults are obese and 6,500 are morbidly obese. An estimated 14,000 children and young people aged 2-19 years are overweight or obese. This is predicted to increase to 16,400 by 2020. • Obesity is strongly correlated with inequalities and deprivation. • The estimated annual cost to the NHS in the city related to overweight and obesity was £78.1 million in 2010. This is predicted to increase to £85 million by 2015. • Excess weight is a major risk factor for diseases such as type 2 diabetes, cancer and heart disease. The action plan and strategy aim to promote healthy weight and healthy lifestyles for the whole population and to offer weight management programmes and services to overweight and obese children and adults in a range of settings.		

2. Record of data/engagement; impacts identified; and potential actions to meet the Duties.

	Data[12] that you have	Community engagement exercises or mechanisms[13]	Impacts identified from analysis (actual and potential)[14]	Potential actions to advance equality of opportunity, eliminate discrimination, and foster good relations (You will prioritise these below)
Consider: • How to avoid, reduce or minimise negative impact (if you identify unlawful discrimination, including victimisation and harassment, you must stop the action and take advice immediately). • How to promote equality of opportunity. This means the need to: – Remove or minimise disadvantages suffered by equality groups – Take steps to meet the needs of equality groups – Encourage equality groups to participate in public life or any other activity where participation is disproportionately low – Consider if there is a need to treat disabled people differently, including more favourable treatment where necessary • How to foster good relations between people who share a protected characteristic and those who do not. This means: – Tackle prejudice – Promote understanding				

[12] 'Data' may be monitoring, customer feedback, equalities monitoring, survey responses…
[13] These may be ongoing links that you have with community and voluntary groups, service-user groups, staff forums; or one-off engagement sessions you have run.
[14] If data or engagements are missing and you can not define impacts then your action will be to take steps to collect the missing information.

Community Cohesion (what must happen in all communities to enable different groups of people to get on well together.)	Programmes provided in community settings such as community centres, schools and local leisure facilities. Population level data are available from the 2012 Health Count Survey. This is self-reported height and weight for adults and is available by protected characteristic groups. Locally commissioned programmes have collected data on the protected characteristics of service users and since 2012 have been using the city council's equality monitoring framework. Information from the National Child Measurement	Citywide consultation and stakeholder interviews included within physical activity needs assessment. Focus groups with community weight management service users were completed in May 2013. The findings informed the service specification in particular providing more post programme support. Local Active Travel Forum brings together a wide range of community groups and service providers. The draft JHWS, including the Healthy Weight priority, was discussed with the CVSF, and consulted on via the council's portal in 2012.	The JSNA identified specific groups as needing further engagement to increase participation and access for a range of population groups. Older people, particularly the vulnerable, socially isolated and people at risk of falls. People with disabilities, both physical and learning; the consensus was that not enough is currently being done, particularly in university and youth settings. LGBT community, specific groups were people with disabilities, older more isolated people and young LGBT men.	The Healthy Weight Programme Board brings together a wide range of organisations from the voluntary, public and private sectors. The Board's Action Plan outlines four separate domains with a series of actions for each of the partners, the funding sources and key performance indicators. The key objective is to strengthen local action to prevent overweight and obesity through a life course approach and to address obesity through appropriate treatment and support. The Board will oversee the delivery of the JHWS priority for Healthy

	programme demonstrates that children from the more socio-economically deprived areas of the city are more likely to be overweight or obese. The contracts with providers stipulate the need for targeted work in areas of socio-economic inequality.			Weight and Good Nutrition. The JHWS Healthy Weight and Good Nutrition Priority was presented and discussed at the CVSF network in January 2013. the comments and suggestions from the CVSF network were integrated in the JHWS Healthy Weight and Good nutrition section.
Age (people of all ages)	The National Child Measurement Programme (NCMP) measures children aged 4-5 years and 10-11 years every year. 2011/2012 NCMP data shows that 19% of children in Reception	The parents of children with an unhealthy weight are contacted by a health professional before they receive the result by post and offered support and access to services.	Parents of very overweight children contacted directly by the School Nurse Team reported that they welcome the opportunity to discuss their child needs and receive advice accordingly.	Plans to increase participation of children and young people from the most socio-economically deprived parts of the city. Results from the Health Count Survey will inform further actions

	Year (4-5 years) were overweight or obese. 30% of children in Year 6 (10-11 years) were overweight or obese. There is no regular or reliable local data on the prevalence of adult obesity (a national issue). Data from the Health Survey 2011 estimates 22% of adults are obese. Data is collected on the age of service users attending local weight management services. Information is available from the Health Count Survey. Adults of all ages can be referred into local services by their GP or people can self-refer.	The Food Partnership is running focus groups for clients attending community and individual weight management programmes to improve access and participation. People who are overweight or obese can discuss their needs with primary care or other health care professionals.	Because of morbidity associated with obesity, people of all ages should receive advice and support from the health service.	for adults.

Disability (a person is disabled if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities[15])	National data shows that those with a disability or mobility issues are more likely to be overweight or obese. Locally ongoing work with children who have special and complex needs- e.g. work with individual children who are not suited to community group programmes such as MEND through the child weight management clinic at Seaside View. Adults are also able to attend a 1:1 clinic if they prefer this to group sessions. Some information on	Currently there is no specific engagement with adults with a disability, although some adults with mobility issues participated in the focus groups led by the Food Partnership.	Ensure that community services are appropriately promoted and accessible to those with disability.	Adults with disabilities can be referred to local weight management services. Data is now being provided which will indicate if further work is required.

[15] The definition includes: sensory impairments, impairments with fluctuating or recurring effects, progressive, organ specific, developmental, learning difficulties, mental health conditions and mental illnesses, produced by injury to the body or brain. Persons with cancer, multiple sclerosis or HIV infection are all now deemed to be disabled persons from the point of diagnosis.

	adults is available through the Health Count Survey: Those with a limiting long-term illness or disability (39%) were significantly less likely than all respondents (53%) to be a healthy weight. The figure for those without a disability was 58% were a healthy weight.			
Gender reassignment (a transsexual person is someone who proposes to, starts or has completed a process to change his or her gender. A person does not need to be under medical supervision to be protected)	The Health Count Survey shows that 9 of the 16 trans respondents giving self reported heights and weights were a healthy weight – a similar proportion to all respondents. As regard to service uptake, data is only starting to be collected.	No specific mechanism in place due to lack of data.	No data.	Once available the data will be analysed and plans will be put in place accordingly.

Pregnancy and maternity (protection is during pregnancy and any statutory maternity leave to which the woman is entitled)	All pregnant women booking with BSUHT are weighed and offered dietetics advice to maintain a healthy weight during pregnancy. This is based on NICE guidance.	Discussed at the Maternity Service Liaison Group which is a user led forum.	Not all women to the Shape Up post pregnancy community programme chose to attend.	Further work is required to improve uptake of that Shape-Up post pregnancy service.
Race (this includes ethnic or national origins, colour or nationality, including refugees and migrants; and Gypsies and Travellers)	National data shows that children from black Caribbean background were more likely to be overweight and obese. Locally from the NCMP there is no significant difference between ethnic groups for children in Reception. However for children in Year 6, Asian, Asian British and Black or Black British children have an increase prevalence of obesity (but only the Asian	The Food Partnership actively engages with community groups at the BMECP, including parents.	The service specifications require providers to ensure that services are delivered in a culturally sensitive manner and are tailored accordingly. The JSNA Physical Activity shows that BME groups lack targeted sports and physical activity provision. In particular: Muslim women; those with a disability; those prone to clinical obesity and small clusters of	Continued communication of results with parents and service providers.

	category is statistically significant). For adults the Health Count Survey shows that there was some difference in being a health weight between BME respondents (59%) and White British respondents (52%) though neither group were significantly less likely to be of a healthy weight than all other survey respondents.		people where language is the key barrier to participation.	
Religion or belief (religion includes any religion with a clear structure and belief system. Belief means any religious or philosophical belief. The Act also covers lack of religion or belief.)	Further to the comment above related to ethnicity, no routine data collected. No data on children religion is collected through the NCMP but data is available for adults from the Health Count Survey. Respondents	No specific data collected.	Current approaches take into account faiths and cultures are regard diet and exercise.	Further work is required to identify needs. This will begin with the Health Count results.

	to the survey with no religion (58%) were significantly more likely to be a healthy weight. Christians were less likely (47%) though not significantly so and those with a religion other than Christian (54%) were similar to all respondents (53%).			
Sex (both men and women are covered under the Act)	National data shows prevalence by gender. Locally gender data is collected by providers. Population data from the Health Count Survey shows that adult male respondents (47%) are significant less likely to be a healthy weight than female respondents (59%) in Brighton and Hove.	As above (see age section).	JSNA physical activity identified the need to increase participation and access for girls and young women, students; adult women and parents. Men are more reluctant than women to attend mixed community groups and services and can be seen on a 1 to 1 basis or in men only groups.	Monitoring of prevalence and uptake of services.

	This is similar to the national picture. Adult males are less likely to be a healthy weight in all age groups.			
Sexual orientation (the Act protects bisexual, gay, heterosexual and lesbian people)	There is no national data available. Local data is available from Health Count Survey and indicates that heterosexual respondents (45%) and LGB, unsure and other respondents (47%) were as likely to be of healthy weight, the small difference was not statistically different. Data only recently being collected by providers locally.	If the Health Count identifies a need for further work with these groups then this will be pursued through existing engagement mechanisms.	No data currently available.	Health Count analysis.
Marriage and civil partnership (only in relation to due regard to the need to eliminate	There is no national data available. Local data from the Health Count Survey shows that are no statistically			

discrimination)	significant differences in healthy weight by marital status.			
Other relevant groups eg: Carers, people experiencing domestic violence, substance misusers, homeless people, looked after children etc	For Looked After children they are routinely included in the NCMP. Data on some of the groups is included in the Health Count Survey. Carers (42%) are significantly less likely to be a healthy weight than all respondents.			

3. Prioritised Actions:

NB: you should also highlight here if there is potential for cumulative impact across the service or for a specific group.

Action	Timeframe	Lead officer	Evidence of progress	Success measure
• Analysis and interpretation of Health Count Survey	**June 2013**	**Kate Gilchrist**	**Presentation at the Healthy Weight Programme Board in July 2013**	**Data used to inform equality monitoring and access to services.**
• Analysis and interpretation of service providers monitoring returns	**6 monthly evaluation reports**	**Lydie Lawrence**	**Evaluation inform service commissioning**	**Increased access to services, service effective and positive health outcomes.**
• Ensure the development of a comprehensive weight management service for children and adults from primary through to tertiary care.	**June-December 2013**	**Lydie Lawrence**	**Procurement service specification to P&R Committee on 11th July 2013**	**New contract in place by 1st April 2014.**
• Plans to increase participation of children and young people from the most socio-economically deprived parts of the city. • Results from the Health Count Survey will inform further actions for adults	**April 2013-April 2014**	**Lydie Lawrence**	**Support to GP practices to refer children to service (advice on how to deal with sensitive issue of weight with families and use of BMI charts for boys and for girls).**	**Increased referrals of children to Healthy Weight Referral Services.**

• To build on the work with the local community to identify and develop local venues for healthy weight and good nutrition linked programmes.	**April 2013- April 2014**	**David Brindley**	**Audit of existing prevention activities in the community.**	**Increased provision and access in local venues.**
• To further develop the partnership with local leisure centre providers to increase local community participation.	**April 2013- April 2014**	**David Brindley**	**Work with local leisure providers through exercise referrals and free swimming.**	**Increased local community participation**
• To promote healthy eating and active lifestyles to employees via the workplace.	**April 2013 -**	**David Brindley**	**Healthy choice awards in public sector catering and restaurants.** **Global Corporate Challenge in Local Authority**	**Healthy Eating promoted in Brighton and Hove City Council and NHS workplace**
• To improve the information for people, particularly vulnerable people, about healthy eating options available in their local area.	**April 2014**	**Lydie Lawrence**	**Embedded in the Community Weight Management service specification for procurement.**	**Increased access to service and advice for vulnerable people**
				.

Reducing Health Inequalities through Tobacco Control Equality Impact Assessment

<table>
<tr><td>Title of EIA</td><td>Brighton & Hove Tobacco Alliance (BHTCA)
Reducing Health Inequalities through Tobacco Control and Joint Health & Wellbeing Strategy</td><td>Ref No.</td><td></td></tr>
<tr><td>Delivery / Resource / Finance Unit or Intelligent Commissioning name</td><td colspan="3">Planning & Public Protection : Regulatory Services</td></tr>
<tr><td>Aim of policy or scope of service</td><td colspan="3">The BHTCA acts to reduce health inequalities caused by smoking.
Smoking is a local priority for the Brighton & Hove City Council Health & Wellbeing Strategy .
Smoking is the primary cause of premature death.
The principal beneficiaries are-
Young people and others who are not recruited to smoking
City residents who quit.
Benefits for communities and families who live in areas of high smoking prevalence.
The Brighton & Hove Tobacco Control Alliance has been established with multiagency representation which will-
Helping communities to stop smoking
Maintaining & Promoting Smokefree environments
Tackling cheap and illicit tobacco
Stopping the inflow of young people as smokers.</td></tr>
</table>

2. Record of data/engagement; impacts identified; and potential actions to meet the Duties.

	Data[16] that you have	**Community engagement exercises or mechanisms[17]**	**Impacts identified from analysis (actual and potential)[18]**	**Potential actions to advance equality of opportunity, eliminate discrimination, and foster good relations** (You will prioritise these below)

Consider:

- How to avoid, reduce or minimise negative impact (if you identify unlawful discrimination, including victimisation and harassment, you must stop the action and take advice immediately).
- How to promote equality of opportunity. This means the need to:
  - Remove or minimise disadvantages suffered by equality groups
  - Take steps to meet the needs of equality groups
  - Encourage equality groups to participate in public life or any other activity where participation is disproportionately low
  - Consider if there is a need to treat disabled people differently, including more favourable treatment where necessary
- How to foster good relations between people who share a protected characteristic and those who do not. This means:
  - Tackle prejudice
  - Promote understanding

[16] 'Data' may be monitoring, customer feedback, equalities monitoring, survey responses…
[17] These may be ongoing links that you have with community and voluntary groups, service-user groups, staff forums; or one-off engagement sessions you have run.
[18] If data or engagement are missing and you can not define impacts then your action will be to take steps to collect the missing information.

Community Cohesion (what must happen in all communities to enable different groups of people to get on well together.)	National smoking prevalence : 20% The Health Counts 2012 shows Brighton & Hove prevalence : 23.1% in some areas in the City eg Moulsecomb and Bevendean the smoking prevalence is 30-34% and in Withdean and Hove Park the prevalence is low 11-16% According to the Integrated Household Survey in all areas in England the smoking prevalence in Brighton & Hove is 22.9% for 2011/12. The stop smoking service works with anybody who wants to quit smoking	Neighbourhood Forums/LATS/NR Stop Smoking service. Health Trainers, Health Check Nurses, Health Service. GMB. Coptic Church. Taxi Forum. Target R & M groups. Local Community assets. BMECP	Smoke free homes. Smoke free vehicles. Smoke free leisure areas. 4 week quitters	Comparison of referrals to quitters – socio economic groups, ethnic groups. Public Health Outcomes Framework Tobacco Control Profiles(Public Health Observatories) Health Counts 2012 Integrated Survey

Age (people of all ages)	Health Counts Survey 2012 shows that there is no significant difference in smoking prevalence between males and females (males 25%),(females 22%). In Brighton & Hove prevalence in men increases between 18-24 years and 25-34 years which reaches 35%.At the age of 75 years or over for males and females smoking prevalence is at its lowest point 5% for males and 10% for females Nationally 21% of adult men and 19% of adult women are smokers Two thirds of smokers start smoking before age 18 years The 2012 SAWSS shows	Schools/Youth Centres/Community Centres/Local community assets /	Reduce under 16s trying smoking for the first time. Reduced smoking prevalence in Adults Tackling cheap & illicit tobacco	Test purchase operations. UAS training. Healthy Schools – PSHE. Quarterly data from Stop Smoking Service Health Counts Survey SAWS Survey

	that KS3 84% responded that they had never smoked not even a puff compared to 9.4% tried smoking once or twice. Also 25.5% of respondents had smoked more than 40 cigarettes in the last 7 days. KS4- 49.6% never smoked 7.4% have smoked more than 40 cigarettes KS2 96.9% have never tried a cigarette			
Disability (a person is disabled if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out	Causes of disability : cancer, COPD, CVD. Sussex Partnership Foundation Trust is developing 2013/14 a Physical Health	Retirement groups Day Centres Older People's Council Workers Forums Alzheimer's Society Amaze Fed Centre for	Reduce smoking prevalence and health inequalities	Introduction of new monitoring form will capture this information April 2013- Specialist Stop Smoking Service

normal day-to-day activities[19])	CQUIN and stop smoking is part of this. Staff will be trained to deliver stop smoking interventions to their clients	Independent Living Sussex Partnership Foundation Trust BSUH		Monitoring forms from Sussex Partnership Foundation Trust
Gender reassignment (a transsexual person is someone who proposes to, starts or has completed a process to change his or her gender. A person does not need to be under medical supervision to be protected)	No data ?	LGBT Workers Forum Spectrum THT	Reduce smoking prevalence	Introduction of new monitoring form April 2013-Specialist Stop Smoking Service
Pregnancy and maternity (protection is during pregnancy and any statutory maternity leave to which the woman is entitled)	Reduce smoking during pregnancy to 11 % by 2015 measured at time of giving birth. Smoking at time of delivery 2011/12 in Brighton & Hove is	Maternal Health Steering Group Midwives Health visitors Children Centres	Reduced number of pregnant women smoking Reduce the risk of secondhand smoke Reduce the number of women smoking at time of delivery	Data collection from the monitoring forms Routine screening of pregnant women Tobacco control profiles Public Health Outcomes Framework

[19] The definition includes: sensory impairments, impairments with fluctuating or recurring effects, progressive, organ specific, developmental, learning difficulties, mental health conditions and mental illnesses, produced by injury to the body or brain. Persons with cancer, multiple sclerosis or HIV infection are all now deemed to be disabled persons from the point of diagnosis.

	7.6% 2011/12- 73 pregnant women recorded as stopping smoking at 4 weeks during pregnancy.			BSUH
Race (this includes ethnic or national origins, colour or nationality, including refugees and migrants; and Gypsies and Travellers)	Brighton & Hove 4 week quit data 2011/12 shows 7 mixed race 12 Asian/ Asian British 15 black/black British 12 other ethnic group attended stop smoking services Health Counts 2012 survey shows that there is no difference in smoking prevalence between BME respondents (23%) and white respondents (23%).Smoking prevalence in Brighton & Hove in	BME Workers Forums BME Community Partnership (www.bmecp.org.uk) CIMB Taxi Forum Coptic Church	Reduce smoking prevalence. Joint Health & Wellbeing Strategy	Introduction of new monitoring form April 2013-Specialist Stop Smoking Service Health Counts Survey Domain1 Tobacco Control action plan

	mixed ethnic groups is (32%) though this difference is not significant.			
Religion or belief (religion includes any religion with a clear structure and belief system. Belief means any religious or philosophical belief. The Act also covers lack of religion or belief.)	The Health Counts Survey states that there is no significant difference in smoking prevalence by religion, though it is higher in those with no religion (27%)	Church, Mosque and Temple groups BMECP	Reduce smoking prevalence	Introduction of new monitoring form April 2013-Specialist Stop Smoking Service Health Counts Survey
Sex (both men and women are covered under the Act)	This is described in section Ages above.	Same as section ages	Reduce smoking prevalence Tackle cheap and illicit tobacco	Brighton & Hove Stop Smoking Service currently collect this data
Sexual orientation (the Act protects bisexual, gay, heterosexual and lesbian people)	Health Counts survey 2012 shows LGB and unsure respondents (30%) more likely to say they smoke than heterosexuals (22%) Highest smoking	Stonewall Spectrum LGB Workers Forum	Reduce smoking prevalence	Introduction of new monitoring form April 2013-Specialist Stop Smoking Service Health counts survey

	prevalence is seen amongst bisexuals (40%) significantly higher than for all respondents			
Marriage and civil partnership (only in relation to due regard to the need to eliminate discrimination)	Health Counts Survey 2012 shows that single people are more likely to smoke (33%) Those in a civil partnership or living as a couple significantly less likely (18%) No significant difference in those who are widowed as a couple (16%) and those who are separated or divorced (25%)	LGB Worker s Forum Stonewall	Reduce smoking prevalence	This data is captured on the Health Counts Survey

Other relevant groups eg: Carers, people experiencing domestic violence, substance misusers, homeless people, looked after children etc	The Health Counts Survey 2012 shows no significant difference in smoking prevalence between carers (24%) and all respondents	Carers' Forum Carers' Centre	Reduce smoking prevalence	Introduction of new monitoring form April 2013-Specialist Stop Smoking Service Health counts survey

3. Prioritised Actions:

NB: you should also highlight here if there is potential for <u>cumulative</u> impact across the service or for a specific group.

Action	Timeframe	Lead officer	Evidence of progress	Success measure
Develop SDG action plans	2013/14	Sue Venables	Stop Smoking Service	Reduce smoking prevalence Reduce health inequalities
SDG1) Helping communities to stop smoking. SDG2) Maintaining and promoting smoke SDG3) free environments. SDG4) Tackling cheap and illicit tobacco. Stopping the inflow of young people Recruited.		Sue Venables		(Reduced prevalence ((young people). (4 week or 1 year (quitters. (Smoking status of (pregnant women at (time of delivery.
Based on Health count results				
Data from Gold Standard monitoring form				

Signing of EIA:-

Lead Equality Impact Assessment Officer:	**Sue Venables** **Tim Nichols**	**Date: 15.01.13**
Head of Service Delivery Unit	**Martin Randall**	**Date:**
Lead Commissioner (if required):	**Peter Wilkinson**	**Date:**

Equalities Impact Assessment Publication Template

Name of review:	Brighton & Hove Tobacco Alliance (BHTCA) Reducing Health Inequalities through Tobacco Control
Period of review:	Continuous – from setting up Tobacco Alliance in December 2010 and ongoing
Date review signed off by Head of Unit / Lead Commissioner:	15.01.13
Scope of the review:	Reducing Health Inequalities through Tobacco Control
Review team:	Susan Venables/Jean Cranford/Tim Nichols
Relevant data and research:	Discussion with South East Region colleagues from other Las and TCA's, published data (Association of Public Health Observatories, Department of Health, Action on Smoking & Health (ASH), Primary Care Trust, Stop Smoking service)

Consultation: indicate who was consulted and how they were consulted	Tobacco Alliance and Strategic Domain Group members, citizens of Brighton & Hove via Stop Smoking Services and via various campaigns e.g Stoptober, National stop smoking day events, BHCC & PCT staff via face to face contact, taxi drivers in B&H via the taxi forum
Assessment of impact, outcomes and key follow-up actions:	No negative impacts identified.
Name and contact details of lead officer responsible for follow-up action:	Susan Venables, Tobacco Control Co-ordinator susan.venables@brighton-hove.gov.uk 01273 293927
For further information on the assessment contact:	Susan Venables, Tobacco Control Co-ordinator susan.venables@brighton-hove.gov.uk 01273 293927

HEALTH AND WELLBEING BOARD	Agenda Item 21 Brighton & Hove City Council

Subject:		**Joint Strategic Needs Assessment Summary 2013**	
Date of Meeting:		**11 September 2013**	
Report of:		**Director of Public Health**	
Contact Officer:	**Name:**	**Kate Gilchrist**	**Tel: 29-0457**
	Email:	**Kate.gilchrist@brighton-hove.gcsx.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 From April 2013, local authorities and clinical commissioning groups have equal and explicit obligations to prepare a Joint Strategic Needs Assessment (JSNA). This duty to be discharged by the Health and Wellbeing Board. The purpose of this item is to ask the ***Board to note the publication of the JSNA summary for 2013.*** The plan for the 2013 summary update was approved by the shadow Board in March 2013. The JSNA 2013 has been updated in line with this plan. The easy read summary is being published as part of the Joint Health and Wellbeing Strategy.

2. RECOMMENDATIONS:

2.1 That the Board notes the 2013 JSNA summary for publication on BHLIS.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

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

3.2 The Local Government & Public Involvement in Health Act (2007) placed a duty on local authorities & Primary Care Trusts to work in partnership & produce a JSNA. Under the the Health & Social Care Act 2012, responsibility for preparing the JSNA will be exercised by the Health and Wellbeing Board from April 2013. The guidance signals an enhanced role for JSNAs to support effective commissioning for health, care & public health as well as influencing the wider determinants that influence health & wellbeing, such as housing & education.

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

- Each year, a JSNA summary, giving an high level overview of Brighton & Hove‘s population, & its health & wellbeing needs is published. It is intended

to inform the development of strategic planning & identification of local priorities.

- A rolling programme of comprehensive needs assessments. Themes may relate to specific issues e.g. adults with Autistic Spectrum Conditions, or population groups e.g. children & young people. Needs assessments are publically available & include recommendations to inform commissioning.
- BHLIS (www.bhlis.org) is the Strategic Partnership data & information resource for those living & working in Brighton & Hove. It provides local data on the population of the city which underpins needs assessments.

3.4 Since August 2009, a city needs assessment steering group has overseen the programme of needs assessments. In 2011 membership includes the Community & Voluntary Sector Forum (CVSF), Sussex Police & the two universities, in addition to the existing members from the city council, Clinical Commissioning Group & LINks (now HealthWatch).

3.5 The JSNA summary structure is informed by the NHS, Public Health and Social Care outcomes frameworks & the forthcoming Child Health Outcomes Strategy; The Marmot report, which advocated adopting a “life course approach”; & the 2012 consultation. For the 2012 refresh we have produced a series of summaries grouped under key outcomes. Building on previous years most of the sections will be co-authored by a member of the Public Health team & a relevant lead in Adult Social Care, Children’s Services, the Community & Voluntary Sector, or other statutory partners.

3.6 At the March 2013 meeting, the shadow Board approved the following option for the update:

3.6.1 Option 2: Update the summary and strengthen evidence in the areas identified in the action plan, but do not repeat the assessment of high impact health and wellbeing issues conducted in 2012 or hold a formal consultation. This option involved the following activities to strengthen the evidence in the JSNA:

- Sections reviewed and updated
- Recommendations updated and action from previous year added
- New data from the 2011 Census and the 2012 Health Counts survey incorporated into the summary
- A call for evidence from the community and voluntary sector
- An easy read summary of the JSNA produced
- A review of assets approach to JSNA in other areas

3.7 **The JSNA 2013 has been updated in line with this plan. The easy read summary is being published as part of the Joint Health and Wellbeing Strategy.**

4. COMMUNITY ENGAGEMENT AND CONSULTATION

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

4.2 It was agreed by the shadow Board in March 2013 that the 2013 summary update had no formal consultation period.

4.3 However, a call for evidence from the Community and Voluntary Sector has been undertaken. We asked for evidence on the needs and assets of those who live and access services in the city. This evidence could be qualitative, quantitative or a mixture of both, and ideally should have been evaluated. To help address areas where we had limited evidence, we especially welcomed evidence around equalities groups and voice of the public.

4.4 The call for evidence ran from April to May 2013 and included 1:1 sessions being available for organisations to discuss their evidence and how it might be included in the JSNA, with the Head of Public Health Intelligence and a Research and Analysis Specialist.

4.5 There were 14 submissions, from 12 organisations, listed below. All but one submission were able to be included in the JSNA, at least in part.

- The Parent Carers Council
- Friends, Families and Travellers
- Age UK Brighton & Hove
- Sussex Beacon
- mASCot
- Sussex Interpreting Services
- Allsorts Youth Project
- Carers Centre
- Community Transport Brighton & Hove Ltd
- Brighton Women's Centre
- BMEYPP

HealthWatch's role in future needs assessment summaries is to be discussed at the September City Needs Assessment Steering Group, now that the HealthWatch manager is in place.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The resources required to develop the summary were met within the public health budget for 2013/14.

Finance Officer Consulted: Anne Silley Date: 27/08/13

Legal Implications:

5.2 The statutory duty imposed upon local authorities and clinical commissioning groups to co-operate with one another in preparing a JSNA is set out in section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by the Health and Social Care Act 2012. Under section 196 of the 2012 Act, responsibility for fulfilling the duty imposed by section 116 of the 2007 Act lies with the Health and Wellbeing Board (HWB) for the area in question. The terms of reference for the Brighton & Hove HWB include the delgated function of approving and publishing the JSNA for the city.

Lawyer Consulted: Oliver Dixon Date: 29/08/13

Equalities Implications:

5.3 The City Needs Assessment Steering Group, including equalities leads for BHCC & NHS Brighton & Hove, has strengthened the city needs assessment guidance to include equalities strands. Strategies using the evidence in the needs assessment will require an EIA. The summary identifies local inequalities in terms of equalities groups; geography & socioeconomic status. Each report section has inequalities clearly evidenced. In addition, there are sections which bring together the key needs of each group. The inclusion of Census and Health Counts data in 2013 has strengthened the equalities evidence within the JSNA.

Sustainability Implications:

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

Crime & Disorder Implications:

5.5 None

Risk and Opportunity Management Implications:

5.6 None

Public Health Implications:

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

Corporate / Citywide Implications:

5.8 This supports the city's duty for the City Council and CCGs to work in partnership and produce a JSNA.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 None

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 From April 2013 it is a statutory duty for Local Authorities and CCGs to produce JSNA. It is a core function of the Health and Wellbeing Board to approve the JSNA process from April 2013.

SUPPORTING DOCUMENTATION

Appendices:

None

Documents in Members' Rooms

None

Background Documents

1. Department of Health. Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. March 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf
2. The 2012 JSNA Summary is available at www.bhlis.org//jsna2012

HEALTHWATCH BRIGHTON AND HOVE

Date: 11th September 2013

Meeting: Health & Wellbeing Board

Healthwatch Lead: Jane Viner – Healthwatch Manager (Maternity Cover)
Tel: 01273 810234 Email: jane@cvsetorforum.org.uk

Title/Subject Matter: Healthwatch Update

Purpose of the Report

The purpose of this report is to give background information about Healthwatch, an update regarding the development of Healthwatch Brighton and Hove.

Background Information

What is Healthwatch?

The Health and Social Care Act 2013 makes provision for the establishment of Healthwatch a new consumer champion.

Healthwatch operates on two levels: at a national level through Healthwatch England and at a local level through Healthwatch organisations. As in other areas Healthwatch Brighton and Hove was established in April 2013.

Healthwatch's are independent organisations. Their aim is to give service users and communities a stronger voice to influence and challenge how health and social care services are provided within local areas. They replace Local Involvement Networks (LINks) which were established in 2008 and will carry on their work, with the addition of new functions and powers.

Healthwatch will have credibility and public trust through being responsive and acting on concerns when things go wrong, and operating effectively and efficiently, with the objective of improving the public experiences of health and social care in Brighton and Hove.

Healthwatch Brighton and Hove, in line with national guidance, undertakes the following functions:

Influencing
To shape the planning and delivery of NHS, public health and adult and children's care services. This will include scrutinising the quality of services, particularly in response to public concern, holding them to account, representing the voice of the public and patients, contributing to the work of the Health and Wellbeing Board, contributing to the Joint Strategic Needs Assessment (JSNA) and working in partnership with commissioners of NHS, public health and adult and children's social care services.

Local Healthwatch can escalate matters to the overview and scrutiny committee of a local authority where they feel it necessary to do so. The overview and scrutiny committee must acknowledge receipt and keep Healthwatch informed of any action they take.

Signposting
To help people to make choices about their care by providing evidence based information about local services and supporting patients and the public to choose the most appropriate service.

Advising
To empower and enable individuals to speak out, including supporting them to access NHS complaints advocacy services.

Powers

Local Healthwatch has:

- powers to request information from commissioners and providers of health and social care and expect a response within 20 working days.
- make reports and recommendations and expect a response within 20 working days.
- enter and view premises where publically funded health or social care is provided with the exception of children's social care services.
- have a seat on the local statutory health and wellbeing board, actively participating in local decision making.

- refer matters to the local Health Scrutiny Committee.

Healthwatch Brighton and Hove

Brighton and Hove City Council has responsibility for commissioning the local Healthwatch service. It has awarded the contract to develop Healthwatch to the Brighton and Hove Community and Voluntary Sector Forum (CVSF). CVSF (www.cvsectorforum.org.uk). The independent Complaints and Advocacy Service (ICAS) is provided by Impetus (www.bh-impetus.org) who lead a partnership of local advocacy providers.

The Healthwatch Brighton and Hove team are based at the CVSF's offices but will travel widely across the city, where they will support information points and signposting activities.

The governance arrangements for Healthwatch Brighton and Hove will include an overarching Governing Body that will be made up of members of the public, service users, independent Engagement / Advocacy organisations and will need to be able to represent the diverse communities of the city.

Whilst CVSF is responsible for delivering the Healthwatch contract, the Healthwatch Brighton and Hove Governing Body will be the autonomous body that drives and oversees the work and ensures that Healthwatch is accountable to the public and its stakeholders.

There will be working arrangements between the CVSF's Trustee Board and Healthwatch Brighton and Hove Board, to ensure clear lines of responsibility, independence and accountability. CVSF will employ staff to support the work of Healthwatch, and have responsibility for financial management, insurance and contract compliance.

From April 2014 Healthwatch Brighton and Hove will be an independent entity with its own legal form. The final form will have governance structures in place including: a membership, a governing body or board or management committee, a chair of the governing body or board, an annual report (which the Health and Social Care Act 2012 requires to be sent to the NHS Commissioning Board, relevant Clinical Commissioning Groups and Healthwatch England) and annual accounts.

Further information can be found here:

Healthwatch England www.healthwatch.co.uk

Healthwatch Brighton and Hove www.healthwatchbrightonandhove.co.uk

healthwatch
Brighton and Hove

Development Phases 2013 - 2014

Phase 1> Transition - April - July 2013

- Helpline set-up
- Monthly Magazine established
- Healthwatch website development
- Intelligence data base developed
- Hospital Pilot project launched
- Transition project work undertaken
- Interim Representation
- Public Engagement work undertaken
- Volunteer Strategy developed
- Relationships established with Community Spokes
- Relationships established with Commissioners and Providers
-

As part of its approach to setting up Healthwatch Brighton and Hove CVSF committed to continuing to work closely with the volunteers involved in the Brighton and Hove LINk to ensure that their experience and expertise informed the work undertaken by Healthwatch Brighton and Hove during the set up period whilst new mechanisms for engaging with and involving patients, residents and new volunteers were being developed. The Healthwatch Transition Group stopped operating on 31st July 2013.

Phase 2> Mobilisation - August – October 2013

- Staff and Volunteer recruitment
- Paid Independent Chairperson (open recruitment process)
- Shadow Governing Body Member recruitment (open recruitment process)
- Healthwatch Representative's recruitment
- Launching Healthwatch Brighton and Hove
- Developing the Work Programme
- Developing a Communication and Engagement Strategy
- Establishing engagement mechanisms with Community Spokes
- Agreeing a Memorandum of Understanding for work with commissioners and providers

Healthwatch Brighton and Hove will be recruiting an Independent Chairperson and Members to a Shadow Governing Body. The shadow governing body will be responsible for deciding the type of independent organisation that Healthwatch will become.
As well as undertaking its core functions, Healthwatch Brighton and Hove will be implementing the volunteering strategy, volunteer support programme, and volunteering roles. We aim to start recruiting to these roles in September 2013.

Healthwatch Brighton and Hove will be formerly launched, and this will be an opportunity for the public, Healthwatch volunteers and associates to engage in prioritising the feed-back received about local health and social care services in the development of the new work plan.

Phase 3> Implementation – November – March 2014

- Developing the Legal Structure for the new Independent Governing Body.
- Influencing the key health and social care commissioners and providers.
- Providing information to help people make choices about the services they use.
- Listening to people views, concerns and suggestions about services and using that information to help shape and improve them.
- Researching, carrying out Enter and View, writing reports and making recommendations.
- Producing an Annual Report.

During this phase the new Shadow Governing Body will agree its legal form, this will be an open and transparent structure for making decisions and Enabling local people to influence what it does (e.g. internal processes, work prioritisation, recommendations, impact analysis) and acts in accordance with the Nolan principles of standards in public life.

Phase 4> Independence- April 2014 – Onwards

- April 2014 – Healthwatch Contract Transferred from CVSF to the new Independent Governing Body.

From April 2014 Healthwatch Brighton and Hove will be an independent entity with its own legal form. The final form will have governance structures in place including: a membership, a governing body or board or management committee, a chair of the governing body or board, an annual report (which the Health and Social Care Act 2012 requires to be sent to the

NHS England, relevant Clinical Commissioning Groups and Healthwatch England) and annual accounts.

HEALTH & WELLBEING BOARD	Agenda Item 23 Brighton & Hove City Council

Subject:		**Integrated health, social care and housing support for “homeless” people**	
Date of Meeting:		**11 September 2013**	
Report of:		**Geraldine Hoban, Chief Operating Officer, Brighton and Hove Clinical Commissioning Group**	
Contact Officer:	**Name:**	**Geraldine Hoban**	**Tel: 574863**
	Email:	**Geraldine.Hoban@nhs.net**	
Key Decision:	**No**		
Ward(s) affected:		**All**	

FOR GENERAL RELEASE.

1. SUMMARY AND POLICY CONTEXT:

1.1 Brighton and Hove has a significant and growing number of people who could be called “homeless” ie living in temporary accommodation, hostels, squats, on friend’s sofas or sleeping rough.

1.2 Despite a good range of services existing in the City, our models of care and service delivery too often do not meet the needs of this very vulnerable community as evidence by their poorer health outcomes and use of emergency/crisis services.

1.3 A recent call by the Department of Health to explore innovative ways of delivering better outcomes for people through more integrated health and social care led to an expression of interest being submitted by partners in the City. The submission proposes the delivery of integrated health, social care and housing advice to this group of “homeless” people through a co-located multi-disciplinary team (MDT).

1.4 The Health and Wellbeing Board was informed of the intention to bid at its meeting in June and members agreed that this was a worthwhile project.

1.5 The Department of Health has since informed the CCG as the lead organisation that the proposal was not successful. Whilst feedback on the bid was very positive, they did not feel that the pilot would have the broader population impact required of the national pioneer sites.

1.6 There is, however, from earlier discussions with partner agencies, a real willingness to implement a local integrated service along the lines of the model proposed.

1.7 It is therefore recommended that despite not achieving national pioneer status the City proceed with a programme to deliver an integrated service and set up the necessary governance arrangements to oversee implementation.

2. RECOMMENDATIONS:

2.1 That the Health and Wellbeing Board –

2.1.1 Note the detailed expression of interest in becoming a national pioneer site for integrating health, social care and housing support and the Department of Health's response;

2.1.2 Endorse the intention of partner agencies to implement the integrated model described in Appendix 1;

2.1.3 Approve the setting up of a multi-agency Programme Board to oversee implementation of the integrated care model;

2.1.4 Provide oversight of the Programme Board on an ongoing basis.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 There is an increasing national push for greater integration between health and social care as a way of driving more person centred and efficient services.

3.2 Health and Wellbeing Boards will increasingly be mandated to provide the oversight for local integration and pooled budgets.

3.3 The Department of Health, in collaboration with other partners such as the Association of Directors of Adult Social Care, NICE, Public Health England etc has called on local areas to submit an expression of interest should they wish to pilot innovation in integrated care. The national programme will provide tailored support to pioneer sites in return for disseminating and promoting lessons learned for wider adoption across the country.

3.4 Locally key partners were very keen to put themselves forward as a pioneer site. Stakeholder meetings were held with key partners across the City including the range of healthcare providers, social services, housing and third sector. The resulting proposal focuses on the development of an integrated, co-located primary care led multi-disciplinary team to provide health, social care and housing support to homeless people.

3.5 An expression of interest was submitted to the Department of Health on 28th July, a copy of which is attached at Appendix 1 to this paper.

3.6 Communication was received from the Department of Health in August providing feedback on the bid but concluding that it had not been successful. It was considered to be “a good collaborative bid, which aligns with local strategies and population priorities. The application demonstrated positive health and wellbeing board support and examples of integrated responses to need”. However, “Whilst there was a clear plan, the Panel considered that there was little evidence or detail around cost benefits and were unsure whether there is sufficient population for desired impact at the scale required to be a national pioneer”. The full response from the Department of Health is attached as Appendix 2.

3.7 However, despite not being awarded pioneer status, partner agencies in the City are keen to implement an integrated service along the lines of the model proposed. This is clearly a very needy population who could be better served by working in a more integrated way.

3.8 The cost of the service would be met within existing resources – ie a re-engineering of the model of delivery rather than investment in a new service. Some element of pump priming may be needed to initiate the new service and small amounts of non-recurrent funding will be sought to enable this.

3.9 The CCG will provide the project management resource required to support implementation.

3.10 In order to oversee the implementation of this model it is suggested that a Programme Board be established comprised of key partner agencies. Each organisation would be accountable through its own governance arrangements but the programme of implementation would be overseen by the Health and Wellbeing Board.

3.11 This Programme Board would align with current and emerging strategic planning groups around integration of health, housing and social care but would focus specifically on the implementation of the integrated MDT.

4. CONSULTATION COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 A range of stakeholder organisations were involved in formulating the expression of interest.

4.2 Greater community engagement and service user involvement in particular will be a key part of phase I of the project.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The integrated service is expected to reconfigure existing resource within a new model of delivery. Evidence from elsewhere would suggest that a more integrated service delivers efficiencies in other parts of the health or social care system but this has not been quantified locally as yet. This will be a key part of phase 1 of the Programme and reflected in both the Council and Health budget strategies and medium term plans.

Finance Officer Consulted: *Anne Silley* *Date: 02/09/13*

Legal Implications:

5.2 The recommendations at paragraph 2 above are consistent with the Health & Wellbeing Board's terms of reference, under which it may promote integration and joint working in health and social care issues across Brighton & Hove in order to improve the health and wellbeing of the city's population.

Lawyer Consulted: *Oliver Dixon* *Date: 30/08/13*

Equalities Implications:

5.3 An EIA has not been carried out on the expression of interest given the tight timescale for submission but will be a key part of the programme as it progresses.

Sustainability Implications:

5.4 None identified.

Crime & Disorder Implications:

5.5 This initiative is aimed at better supporting vulnerable 'homeless' people, a group which is over-represented both as the perpetrators of crime & disorder and as the victims of crime. The initiative should therefore help reduce crime & disorder, although no precise targets/outcome measures have been identified at this stage.

Risk and Opportunity Management Implications:

5.6 Although the group of vulnerable 'homeless' people is still relatively small (albeit growing rapidly), it has a disproportionate and statistically significant impact upon demands for health and care services; on crime, anti-social behaviour and noise nuisance; on housing-associated problems etc. There is therefore both a significant risk in not better targeting support for this group of people, and potential benefits to be accrued from doing so, across a wide range of services. Detailed risk/opportunity assessment and mitigation would be undertaken by the Programme Board.

Public Health Implications:

5.7 The 2012 JSNA evidenced that the single homeless population have poor health outcomes (including mental ill-health, drug & alcohol dependency, physical health problems) and make disproportionate use of high cost unplanned healthcare. National evidence from different sources shows that, of deaths that occur in hostels or while registered with homelessness services, the average age at death is low (about 40-44 years). Patients registered with Brighton Homeless Healthcare had high A&E attendance rates, emergency admission and readmission rates and low rates of planned inpatient admissions. Additional evidence will be provided by the Homeless Link Health Audit which is being

conducted in hostels and other settings as part of the JSNA programme (as approved by the Health and Wellbeing Board). More effective commissioning and service provision has the potential to improve outcomes and reduce costs.

Corporate / Citywide Implications:

5.8 “Tackling Inequality” is one of the Council’s key priorities, and the group of vulnerable ‘homeless’ people are amongst the most disadvantaged in the city. Therefore, any actions which improve outcomes for this client will help deliver the corporate objective.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Given the failure of the pioneer bid, partners could have abandoned plans to better integrate services for this client group. However it is clear that there is a pressing need to work more closely to support vulnerable ‘homeless’ people, hence the recommendations within this report.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 Brighton and Hove has a large and growing number of “homeless” people with extremely poor health outcomes.

7.2.1 Despite a significant amount of resource directed at our homeless community and some examples of excellent practice we do not have a strategic or fully joined up approach to the planning or delivery of services to our most vulnerable community.

7.2.2 Establishing a co-located MDT which integrates the whole range of health, social care and housing support will help develop a more comprehensive and joined up service for homeless people in the City.

7.2.3 Establishing a Programme Board to implement the model, overseen by the Health and Wellbeing Board will strengthen the mechanism for delivery and accountability for this key programme of work.

SUPPORTING DOCUMENTATION

Appendices:

1. Submission of Interest in Being a Pioneer Site for Integrated Health, Social Care and Housing Support in Brighton and Hove.

2. Response from the DH regarding Brighton and Hove's Expression of Interest in being a Pioneer Site for Integration

Documents in Members' Rooms

None

Background Documents

None

Appendix 1:

Integrating Health, Social Care and Housing Support for Homeless People in Brighton & Hove

Expression of Interest to be a Pioneer Site

June 2013

A Collaborative Submission by:

Brighton and Hove Clinical Commissioning Group, the City Council, Community and Voluntary Sector Forum, Brighton & Sussex University Hospitals Trust, Sussex Community Trust, Sussex Partnership Foundation Trust and Morley Street Homeless Practice

1. INTRODUCTION

Brighton and Hove CCG, in partnership with the City Council, Public Health, the Third Sector, Primary Care, Community Healthcare, Mental Health and Substance Misuse Services and Secondary Healthcare providers are keen to pioneer a person centred model of health, social care and housing support to homeless people in the City. This expression of interest has been endorsed by our Health and Wellbeing Board at its meeting on 12th June 2013.

We have chosen this cohort of individuals as they are some of our most vulnerable individuals, often with a combination of physical ill-health with mental illness and substance misuse (drug and alcohol), complex health needs and premature death. The City is seeing a year on year rise in homelessness. Homeless people are more likely to use A&E, spend time in hospital and to be heavy users of mental health and substance misuse services. Despite some beacons of good local practice and innovation there has never been a strong enough focus on a multi-agency personalised joined up approach in the City. We are aware that some of our current services can operate within rigid boundaries – geographical, cultural, organisational, systemic and legal frameworks – and therefore prevent homeless people from accessing the healthcare and support they require.

We would use the opportunity of becoming a Pioneer site (and the support it would offer) as a lever to engage stakeholders and homeless people in this programme of work. We would establish an overarching strategic board for Health, Social Care and Housing and other partners including the Police, Probation Services and Third Sector in the City to oversee the pilot, establish a multidisciplinary integrated support team co-located with city centre homeless services, develop integrated pathways into and out of other key service areas, and identify and trial a range of integrated solutions to key priority areas. We would embed evidence based best practice and personalisation in all areas of service delivery and share the learning locally and nationally.

2. DEFINITION OF HOMELESSNESS

For the purpose of this proposal we have defined homelessness as:

- People in temporary accommodation;
- Hostel occupants;
- Hidden homeless i.e. people in ‘squats’ or ‘sofa surfers’; and
- Rough sleepers.

3. HOMELESSNESS IN OUR CITY

Brighton and Hove is a city with a population of about 275,000 living in 121, 540 households. Located between the South Downs and the sea, about 53 miles from London, the City is renowned as a “party” town with a vibrant arts and leisure scene. The City has significant pockets of deprivation and high levels of mental health/substance misuse needs compared to other areas in the South East.

The City has a challenging picture regarding housing stock with:

- Low levels of home ownership or social housing;
- 9th highest private rented sector in England;
- One of the largest stocks of houses in Multiple Occupancy in England;
- Steady increase in average rental costs – well above the Housing Benefit Local Housing Allowance;

The combination of high levels of need, pressure on accommodation and the impact of the economic downturn/welfare reform has meant our City is witnessing an increasing level of homelessness, well above the national level.

Since 2003/04 the most common reason for homelessness in the city is due to eviction by parents, family or friends (32.3% in 2009/10). Together with loss of private accommodation (31.8%) it accounts for almost two thirds of homelessness in the city in 2009/10. A further 25 households were accepted due to domestic violence (6.8% of all homelessness acceptances).

In Brighton and Hove more than half of all homelessness acceptances involve families with children, or a member of the household who is pregnant, although homelessness acceptances in these groups are lower than the national average. Homelessness in Brighton and Hove during 2009/10 due to physical disability is over two times higher than the England average and due to mental illness is over three times higher (BHCC Housing Statistical Bulletin, 2009/10).36 A large proportion of homeless young people are not in education, employment or training and care leavers are over-represented.

There has been a sharp increase in the number of recorded rough sleepers in the City. In November 2011 the official rough sleeper street count was 37, up from 14 the previous year. This is an increase of more than 160% compared with a national increase of 23%. CRI – an organisation who provide services to this group locally, worked with 732 rough sleepers (sleeping on the streets or in insecure temporary accommodation) in 2011/12 – an increase of 24% on the previous year.

Current monitoring data suggests that rough sleepers in Brighton and Hove are 90-95% male, predominantly aged between 30 and 45 years and 20% are non-British nationals, with those who are from other countries mainly being from Eastern Europe.

The growing number of homeless in our City is a challenge for the health and wellbeing of a very vulnerable group of people, as well as placing an unprecedented pressure on health, housing support services and other statutory partners.

4. THE NEEDS OF HOMELESS PEOPLE

We know from local and national evidence that homeless people have significantly worse health than the general public, for example:

- 80% of homeless people have one or more physical health need. For over half, this represents a chronic health problem.

- 70% of homeless people have at least one mental health problem[1].
- Depression and anxiety are five times as common as with the general population.
- Mortality rates for coronary heart disease are 12 times greater for patients registered with our homeless practice compared to the 2nd highest rate.
- Rough sleepers experience TB at 200 times that of the known rate among the general population.[2]
- A third of rough sleepers have attempted suicide.
- The average age of death of a homeless person is estimated to be 43-47[3]
- A&E attendances are five times higher in our homeless population than the local average. 40% of homeless people will have used A&E in the past six months, and nearly a third will have been admitted to hospital as an inpatient.[4]
- Hospital readmission rates (at 28 days after discharge) are twice as high as the local average.
- When rough sleepers attend hospital, they average seven A&E attendances per patient, nearly 10 appointments per patient for outpatients, and nearly three inpatient admissions per patient. They also present with more co-morbidity – one in five who had contact with hospitals had three or more diseases.
- Planned in-patient admissions are a third lower than the local average.
- Rough sleepers face a number of attitudinal and structural barriers to accessing healthcare. These include discrimination by health professionals, difficulty in registering with a GP, a lack of knowledge of services, a lack of continuity of care, and cost. Fear of stigmatisation and health as a low priority are also significant barriers.

5. CURRENT SERVICE PROVISION

There is a significant amount of support available to homeless people in the City and some excellent examples of innovative practice.

- A General Practice dedicated to homeless people exists in the city. This has been established for over 10 years and has a list size of approximately 1000. This practice offers all the services a normal GP surgery would, and was set up to address the particular health concerns faced by homeless persons. It works closely with the services mentioned below, but is currently unable to offer outreach.
- Integrated Primary Care Teams (district nursing, specialist nursing and therapy support) working around clusters of GP Practices are beginning to provide in-reach to hostels providing follow up care after hospital discharge; palliative care; monitoring of complex multiple chronic conditions and providing ongoing support. This is a rapidly increasingly complex caseload which requires specialist expertise and knowledge from case managers and advanced practitioners.

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[1] Homeless Link, The Health and Wellbeing of people who are homeless: findings from a national audit,(2010) www.homeless.org.uk/health-needs-audit

[2] See Inclusion Health: Evidence Pack (March 2010) www.cabinetoffice.gov.uk/media/346574/inclusion-health-evidencepack.pdf

[3] Crisis, Homelessness: a silent killer (2011). This study looks at the mortality of single homeless people which includes those sleeping rough, in hostels and in other hidden homeless situations. This should not be confused with life expectancy figures.

[4] Homeless Link, The Health and Wellbeing of people who are homeless

- A year long randomised clinical trial has been undertaken by the Pathway based at our local acute hospital – Brighton and Sussex University Hospital Trust (BSUH). The trial investigates the effects of a specific GP led homeless team within the hospital on outcomes for patient including levels of satisfaction, length of hospital stay and re-admission rates. One benefit of the trial has been the instigation of a weekly patient centred MDT attended by primary, secondary and community healthcare professionals, social workers, housing workers, hotel managers, third sector organisation, street outreach workers and medical students and the ability to work across providers and follow patients back to the community.
- A mental Health Homeless Team provided by Sussex Partnership Foundation Trust (SPFT) who works specifically with service users who are street homeless and in temporary accommodation. This is a multi-disciplinary team in conjunction with the City Council; the team works closely with other statutory and community and voluntary sector providers across the City to meet the needs of this challenging and hard to engage client group.
- A member of SPFT staff is seconded to the Council's Temporary Accommodation and Allocations Team in order to source appropriate placements within residential, temporary and supported accommodation for service users known to adult mental health services. This role is also key in facilitating timely and safe discharges from acute in-patient settings.
- Psychiatric liaison services are provided within BSUH 24 hours a day. This service works closely with all acute medical in-patient services particularly those in the integrated hospital discharge team and A&E.
- SPFT provide an integrated substance misuse service in Brighton and Hove in partnership with Crime Reduction Initiative (CRI). This is an assessment, treatment and care coordination service. Both drug and alcohol services are provided to the BSUH A&E department as part of this service. Interventions including counselling, prescribing, harm minimisation, group work, rehabilitation with a substantial focus on recovery, peer and user involvement.
- Substance misuse services have lead nurses and recovery mentors allocated to each of the hostels in the City.
- There is a variety of innovative Third sector support services provided for homeless people in the city. The Community and Voluntary Sector Forum (CVSF) the local umbrella body for the third sector, has over 350 community groups and voluntary organisations within its membership. A number of their members provide support services to homeless people. Some of the services include:
- Brighton Housing Trust: First Base Day Centre which offers a range of services to support people who are sleeping rough or insecurely housed in the city to get off the streets, and start realising their aspirations through work, learning and leisure and find a place the can call home. Some of the services include a healthy lifestyles project, promotional and awareness of sexual health, a CV and employment service, heritage and cultural activities, and a catering social enterprise company: www.bht.org.uk/services/first-base-day-centre
- Clocktower Sanctuary: which provides a drop-in and referral centre for homeless young people aged 16 to 25. The sanctuary offers a friendly space, food and drink, access to computers and the internet, signposting to housing, health, education, employment and social services, as well as practical and emotional support to help young people get their lives back on track: www.theclocktowersanctuary.org.uk

- Friends First Trust: Provides supported housing and move-on housing to single homeless people: www.friendsfirst.org.uk
- Brighton Soup Run: Volunteers serve hot soup, bread, and tea to anyone who needs it seven days a week on Marine Drive in Brighton and by the Peace Statue on the Brighton/Hove border. It provides a lifeline to homeless and vulnerable people across Brighton and Hove.
- St Johns Ambulance Homeless service: Works to improve access to primary health care services for homeless and vulnerable people across Sussex. Delivers practical training for professionals and homeless people, and works from primary health care units in the community, Brighton and Hastings: www.sussex.sja.org.uk
- Sussex Nightstop: Arranges temporary accommodation on a night by night basis for young people at risk of homelessness, in the homes of trained volunteers: www.sussexnightstop.org.uk
- A range of supported housing for vulnerable single homeless men and women provided by organisations such as Brighton YMCA, www.brightonymca.co.uk Southdowns Housing www.southdownhousing.org etc
- A report into the role and contribution of churches in the city, written in 2011, identified that there were 12 outreach projects, 9 drop-ins, and 2 supported housing schemes run by churches, most that are not part of the CVSF membership.
- Housing services in the City commission a range of assertive outreach support, recovery mentors, relocation work; 'No Second Night Out' pilots; alcohol nurse; severe weather emergency responses and have demonstrated positive outcomes for clients such as increasing contact with GPs, helping clients to access detox support, hostels and private rented sector accommodation and hospital and residential care, reducing antisocial behaviour and helping clients to reconnect with family.

As Phase I of the Pilot we would look to conduct a thorough mapping exercise to both quantify and cost the level of support in existence across the City and to better understand the strengths and gaps in current service provision and identify opportunities for further integration/streamlining service models.

6. PROPOSED MODEL OF CARE

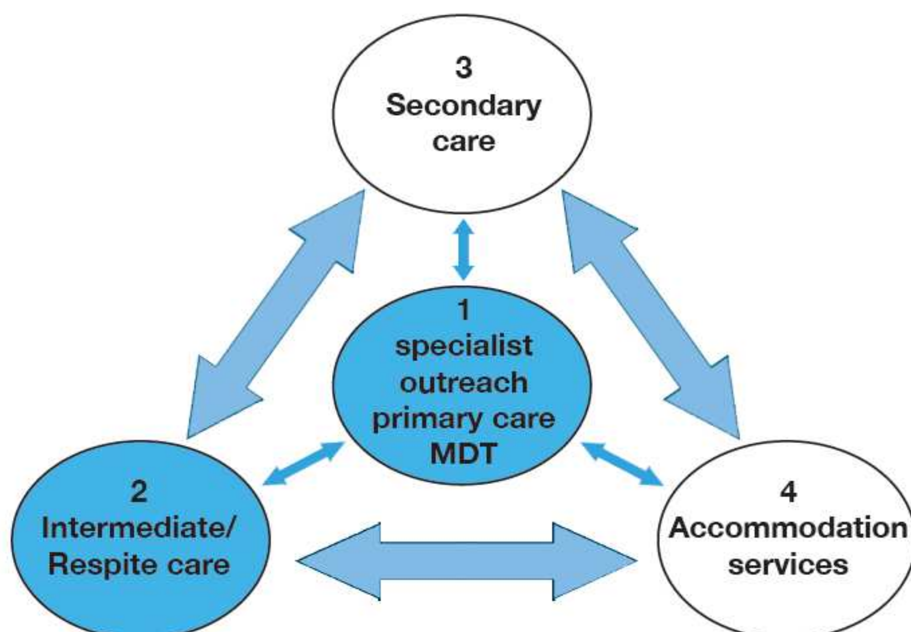
Our aim is to provide a high quality primary care focused model of support for homeless people in the City, shifting the focus from crisis management to preventative, proactive care, service co-ordination and case management. This will not only provide a better quality intervention and health outcome for the person concerned but these models have been shown to be cost effective to the health economy including reducing hospital admissions and in-patient stays[5]. Additionally, targeted health interventions for homeless people have been shown to reduce the amount of time that people are homeless.

The integrated model of care we are proposing therefore is evidence based and the one recommended by the Faculty of Homeless Health[6].

[5] St Mungos (2010), Homelessness, it makes you sick: www.mungos.org/campaigns/momelessness_it-makes-you-sick/

[6] The Faculty for Homeless Health - Pathway (2011) Standards for Commissioners and service providers. www.londonpathway.org.uk/uploads/homess health standards.pdf

Figure 1 - Integrated approach to commissioning of homeless health services.



Our model will offer a single point of access with a common assessment framework. Care will be integrated horizontally through the establishment of a co-located primary care led MDT with patient centred care planning at the heart of the model and continuity of care across service provision, namely: primary care, community nursing and therapy services, mental health, substance misuse and alcohol services, social services, learning disability services, third sector and housing support. We would ensure vertical integration with secondary care through clear integrated pathways of care and a model of in-reach and strengthen our Intermediate /Respite Care in order to avert unnecessary secondary care admission, prevent inappropriate hospital discharge and emergency re-admission and organise onward care and resettlement.

Peer support will be integral to the model of care we are proposing. There are currently some excellent examples of homeless peer support in the City including Care navigators at BSUH, and CRI peer mentoring with rough sleepers. The Pathway approach includes peer care navigators (who have personal experience of homelessness) working as an integral part of the team who support patients on the wards and then continue to support them after discharge from hospital.

The integrated service will work in a psychologically informed way by ensuring appropriate training and development for all staff working in the MDT and across integrated pathways to respond effectively to people with psychological needs and longstanding emotional problems. Working with SPFT we will ensure that there is appropriate training for staff in the MDT and across pathways of care which address issues such as dual diagnosis, harm minimisation and motivational interviewing. Integrating physical and mental health needs across all areas of service provision is a priority for the CCG and we would use the learning from this pilot and share good practice across other services.

We would also want to ensure sexual violence, assault and exploitation is explicitly addressed as part of this Pilot as we know that these issues impact heavily on those who are insecurely

housed or homeless, and further reduces their access to health services. We would link to local projects doing work on this issue, such as work with young people: http://www.sussexcentralymca.org.uk/information_advice_support/_wise_project; the local rape crisis centre: Survivors Network http://www.survivorsnetwork.org.uk and local support groups for domestic violence: www.riseuk.org.uk

The City has signed the Armed Forces Covenant and we will ensure the needs of veterans are explicitly addressed in this Pilot. A liaison post for homeless ex-military personnel is currently being commissioned in conjunction with the Ministry of Defence and will be a key link for the MDT.

We are keen to explore the opportunities for greater personalisation and increased choice within this Pilot. The initial mapping exercise will enable us to quantify more clearly current service provision and finances. A key focus of the programme will be to explore the options for pooled funding and piloting personalised budgets.

All partner agencies are committed to co-locating staff within a newly established MDT and working within a whole system governance framework. We have a history of successful integrating of service provision in the City which we can draw on including multidisciplinary Hospital Rapid Discharge Team at the front door of A&E comprising Social Workers, Therapy and Nursing staff, Integrated Primary Care Teams (nursing, therapy, and social workers) configured around clusters of GP Practices and integrated health and social care services in adult mental health, dementia services and substance misuse.

7. ENGAGEMENT WITH SERVICE USERS

Our ethos is to fully engage service users at all levels during this Pilot.

Lead by service users, we will create a series of meaningful statements about care against which we will monitor the quality and impact of our Integrated Pilot.

Whilst we will ensure service users are part of the overarching governance as well as the operational management of the Pilot, we would also like, as part of the support from the national programme to look at more innovative and meaningful ways in which we can fully embed service users in planning, delivery and evaluation.

8. EXPECTED OUTCOMES

We would work closely with our partner agencies in the City wide Strategic Board to refine the expected outcomes from the Pilot. Some initial areas of thinking include:

- Reduction in the numbers of rough sleepers.
- Reduction in the breakdowns in temporary accommodation
- Reduced length of stay in acute beds – mental health and hospital.
- Reduced emergency admissions for people classed as homeless.
- Reduced emergency re-admissions for people classed as homeless.

- Improved user satisfaction with service provision.
- Increased number of homeless people registered with a GP.
- Increased number of homeless people registered with a long-term condition, receiving case management and regular reviews.
- Improved measures of social re-ablement such as education and training/back to work etc.

9. IDENTIFYING FINANCIAL EFFICIENCES FOR RE-INVESTMENT

National and international evidence suggests that more proactive and integrated services for homeless people can reduce their use of urgent care services.
There were in excess of 200 emergency admissions of homeless people to our local hospital over the 12 month duration of the project. Whilst data from our local research project is not available until later in the year, other Pathway sites have demonstrated a 30% reduction in length of stay for this cohort of patients and significant reduction in re-admissions. We will look to fully estimate the impact of our integrated approach on urgent care as well as other services drawing on the evidence from elsewhere once the service and financial mapping exercise has been completed.

10. PLAN FOR DELIVERING THE INTEGRATED VISION

In pulling together this expression of interest we have obtained the full sign up of partner agencies in reconfiguring existing resource within an integrated model of care.

In order to deliver the integrated vision we envisage the Pilot having three distinct phases.

Phase I where we will establish the governance arrangements and engage further and in more detail with the wider stakeholder group including Ambulance services, Third Sector Providers, Sussex Police, Community Safety Team, Probation Services, Academic organisations etc to map current services, describe barriers to access and identify good practice and innovation already in existence. During this phase we will actively engage with homeless people and will to work closely with them to inform service redesign. We will develop a narrative with homeless service users as per National Voices which sets the direction and vision for the MDT.

Phase II will see the establishment of the co-located MDT, development of the single assessment framework and integrating pathways of care with other key service providers.

Phase III will involve the piloting of innovate practices such as personal health budgets, peer support mechanisms and other areas as defined on a rolling basis.

We will look to embed evaluation and reflective practice at all levels of project delivery. Our intention is to continually evaluate our approach and the outcomes of pilots rolling out the integration concept to other parts of the local system. We will share the learning as to what

has worked and what has not worked locally and nationally via relevant learning networks, websites, conferences etc.

We are linked into the National Pathway and the Faculty for Homeless and Inclusion Health are interested in highlighting and sharing any learning that comes out of the Pioneer Site.

Futurehealth Brighton is a social enterprise run by local GPs who are looking at innovation and integration of services from the perspective of primary care. They have expressed an interest in working with us through the different phases of the project. They would also be able to offer links with Brighton's Community and University Partnership Program and other academic institutions that have expertise in evaluation, as this is a key theme of the integration vision.

Phase I	July – Dec 2013	Initiate City Wide Strategic Planning Board to oversee implementation of Pilot. Recruit senior project management resource to oversee programme of work. Map current service provision and expenditure across all partner agencies. Conduct stakeholder engagement to further understand strengths and weaknesses of current configuration. Develop specification and project plan for implementation of the MDT. Agree and embed structures for patient engagement Secure location for hosting MDT.
Phase II	Jan-Dec 2014	Establish MDT and co-locate staff. Define and roll out case management processes. Develop and roll out common assessment framework Continue to identify good practice, identify gaps and feed into rolling Programme Plan.
Phase III	Jan 2015 onwards	Roll out of pilot projects such as personal budgets; peer support mechanisms, models of palliative care etc Ongoing review and reflective learning to be built into operational model and governance structures.

11. Summary and Conclusion

Brighton and Hove is a city with a large and growing number of homeless people who have extremely poor health outcomes. Despite a significant amount of resource directed at our homeless population and some excellent examples of innovation in the City – particularly in relation to third sector provision, primary care support and local research – we do not have a strategic or joined up approach to supporting our most vulnerable community.

Our proposal is to establish a primary care led MDT integrating the whole range of health, social care and housing support to homeless people building on the good practice which currently

exists in pockets across the City and develop seamless pathways of care into and out of other key services.

We aim to test a variety of innovative pilots such as peer support mechanisms, service user engagement, models of palliative care and personal budgets for homeless people in the city.

A senior City-wide Partnership Board would be established to oversee the Pilot and ensure a more joined up approach to the strategic planning and operational delivery of services for this client group.

Our links to national organisations and academic institutions will help us to evaluate the impact of our model and disseminate the learning/good practice on a wide scale.

The following evidence has been considered in pulling this bid together.

Innovation/ evidence	Brief description
Personalisation Guidance for the Homeless sector (2012) Pilots (4 parts of the country)	• Early stages of development within the homelessness sector. • Homelessness services are embracing the new approach in a variety of innovative ways within existing services such as reviewing current delivery, while some have been funded directly to carry out individual budget pilots • The majority of pilots within the homelessness sector have focused on responses to outreach in specific relation to the target of ending rough sleeping by 2012. • The pilots have being extremely successful in re-housing entrenched rough sleepers across the country, and learning from these pilots will be vital for how the sector approaches personalisation in the future. • Implementing personalisation can take many forms, for example looking at areas of the project where choice is limited to clients such as shift patterns and key workers, meals and activities. http://homeless.org.uk/sites/default/files/How%20to%20personalise%20your%20service%20-%20Final.pdf **http://www.jrf.org.uk/sites/files/jrf/supporting-rough-sleepers-summary.pdf**
Integrated care pilots	A pilot offering integrated care for homeless people with the aim of reducing mortality and morbidity, and reducing acute secondary healthcare usage among its clients. Using a band 7 nurse, care coordinator and GP (once a week) reductions seen in secondary care usage. http://www.mungos.org/services/recovery_from_homelessness/homeless_intermediate_care_pilot_project/
Single point of access and assessment to	Multiple exclusion homelessness. Access to assessment is the key to accessing the resources that allow for outcome based and individualised responses. More importantly, access to a shared or common assessment framework is vital if we are to prevent a 'retrench to silos' where each service sector evolves its own approach to personalisation meaning that people end up with multiple budgets, one for health, one for care and one for housing support http://www.kcl.ac.uk/sspp/kpi/scwru/pubs/2011/cornesetal2011homelessnesssummary.pdf
Improving hospital admissions and discharge. E.g. Pathways	Hospitals, local authority housing teams and voluntary sector organisations should work together to agree a clear process from admission through to discharge to ensure homeless patients are discharged with somewhere to go and with support in place for their on-going care. This process should start on admission to hospital. Pathway at BSUH (2011) http://homeless.org.uk/sites/default/files/HOSPITAL_ADMISSION_AND_DISCHARGE._REPORTdoc.pdf http://www.londonpathway.org.uk/uploads/Pathway_draft_BSUH_Homeless_needs_assessment.pdf
The	The psychologically informed environment (PIE) can be created in a service such

psychologically informed environment (PIE)	as a hostel or day centre where the social environment makes people feel emotionally safe. A PIE is an approach rather than a place, its an 'enabling environment'. PIEs can be developed within existing commissioned services, wherever appropriate training and development enables staff to respond effectively to people with psychological needs and longstanding emotional problems.http://www.southampton.ac.uk/assets/imported/transforms/peripheralblock/UsefulDownloads_Download/A6FD3BB1EB2A449987C12DFF91EF3F73/Good%20practice%20guide%20%20%20Psychologically%20informed%20services%20for%20homeless%20people%20.pdf
Role for adult social care for the homeless	Specialist homeless post in Adult social care resulted in • Improved communication between ASC and hostel staff • Better understanding of role and remit of ASC for hostel staff • Continuity resulting in a more joined up way of working and better outcomes for clients • Proactive working leading to early interventions for clients • http://homeless.org.uk/ASC-specialist-social-work-post-hostel-residents
Peer support for homeless toolkit and Promoting Access to Health Services (PATHS) project	Toolkit- Peer support for homeless this includes peer health education, Peer health promotion, peer health advocacy, peer involvement in commissioning. The PATHS project provides volunteers who can go with patients to their appointments, helping them to remember the time and day, find the their way there and back, and to feel confident enough to deal with new health staff http://homeless.org.uk/sites/default/files/HomelessHealth_PeerActivityToolkit_0.pdf http://www.oxhop.org.uk/getinvolved/paths.html
Pathways - Standard for commissioners and service providers- Faculty of homeless health.	– Integrated approach to commissioning homeless health and services – Horizontal - patient centred care planning and continuity of care across service provision – Vertical integration- Compassion, communication and continuity of care between primary, secondary and community care. – Standards for commissioners – Outcome measures http://www.londonpathway.org.uk/uploads/homeless_health_standards.pdf
Service user involvement, engagement and empowerment	Person centred coordinated care where by the individuals needs are fully assessed and are given timely readily understood information and are supported to make informed choices and to be actively involved in their care planning to help them to reach their goals and desired outcomes. They will have coordinated MDT care that will support them in making decisions about their care and the personal health/social care budgets available to them to obtain their goals. Ensuring a smooth transition into other services once outcomes have been realised. http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf **Using the Narrative developed for us by National Voices will be developed for homeless people.**

2: Appendix 2 - Response from DH on Expression of Interest

From: Pioneers [mailto:pioneers@dh.gsi.gov.uk]
Sent: 09 August 2013 16:31
To: Hoban Geraldine (NHS BRIGHTON AND HOVE CCG)
Subject: Expression of interest to become a Pioneer

By email
Geraldine Hoban

9 August 2013

Expression of interest to become a Pioneer – 006-South Brighton

Dear Colleague,

Thank you for expressing an interest in becoming a pioneer in health and social care integration.

Over 100 expressions of interest were received, clearly indicating a very high level of commitment to service improvement, meeting the challenge of designing coordinated services around the needs of patients and service users. Many of the expressions of interest were of a high quality.

Unfortunately your application has not been shortlisted for further consideration, but we would like to ensure you benefit from the wider programme of support we are putting in place. We were impressed with the range of ambitious plans and initiatives already underway and are therefore very keen for you to remain involved and to be part of a network of support, sharing the learning taking place in your area.

The Panel's decision is final, but in order to help you further refine your plans for integrated care and support, the Panel has provided the following feedback on your application:

The Panel considered that this was a good collaborative bid, which aligns with local strategies and population priorities. The application demonstrated positive health and wellbeing board support and examples of integrated responses to need. Whilst there was a clear plan, the Panel considered that there was little evidence or detail around cost benefits and were unsure whether there is sufficient population for desired impact at the scale required to be a national pioneer.

Through reviewing the applications we have a clearer picture of what localities need from the Integrated Care and Support Collaborative in order to enable and empower integration locally. Over the coming months, we will develop the support programme that localities need. The pioneers, when selected, will be a key part of that programme, sharing the lessons from their experiences for wider adoption.

Your details have been passed to NHS Improving Quality (NHSIQ), which is hosting the Integration Care and Support Exchange (ICASE) and will be developing a range of approaches to ensure that the learning from Pioneers is widely shared and further developed. As an area that has expressed interest in this programme of work, NHS IQ will keep you informed of these learning and development opportunities, which we encourage you to engage with over the coming months. As a first step, based on the feedback we have received from local areas, and recognising the need for pace, we have commissioned the production of a toolkit to support business planning and delivery locally. Please let us know if you would be willing to contribute to developing this.

The expectation is that all localities will make progress in planning and delivering better integrated care and support over the coming years, irrespective of whether they are a part of the pioneers programme, supported in particular by the recently announced Integration Transformation Fund that will be shared between the NHS and local authorities. We encourage you to share the proposals within your pioneer application with local partners, as local planning in relation to this Fund gets underway. Further details on the Integration Transformation Fund will be published shortly.

The national partners thank you for sharing through your application, a description of your work to take forward integrated care and support. This information is very valuable to us as we continue the on-going process of ensuring that policy at national level supports innovation locally. As a result, colleagues may be in touch in the coming weeks to discuss elements of your application in more detail.

Yours Sincerely,

The Integrated Care and Support Pioneer Team
Part of the National Integrated Care and Support Collaboration
2N15 Quarry House, Quarry Hill, Leeds, LS2 7UE

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HEALTH & WELLBEING BOARD	Agenda Item 24 Brighton & Hove City Council

Subject:		**NHS Funding Transfer to Adult Social Care**	
Date of Meeting:		**11th September 2013**	
Report of:		**Geraldine Hoban, Chief Operating Officer, CCG** **Denise D'Souza, Executive Director, Adult Social Care**	
Contact Officer:	**Name:**	**Wendy Young** **Anne Hagan**	**Tel: 01273 574688**
	Email:	**Wendy.young5@nhs.net** **Anne.hagan@brighton-hove.gcsx.gov.uk**	
Key Decision:	**No**		
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The purpose of this paper is to seek approval from the Health and Wellbeing Board for the proposed plans developed jointly for the use of funding streams to support health and social care joint working.

1.2 In previous years this allocation has been passed by Primary Care Trusts to local authorities. In 2013/14 it was announced that the funding transfer to local authorities will be carried out by the NHS Commissioning Board and that the sign off of local proposals should be by Health and Wellbeing Boards.

1.3 The allocation for 2013/14 in Brighton and Hove is **£4,397,579**.

1.4 It is a condition of the transfer that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. The funding must be used to support adult social care services in each local authority, which also has a health benefit.

2. RECOMMENDATIONS:

2.1 That Health and Wellbeing Board agree the proposed use of the allocation as set out in section 3.5 and sign the Section 256 agreement between the local authority and NHS England appended to this report

2.2 That Health and Wellbeing Board is provided with regular updates on how the funding is being used locally against the overall programme of adult social care expenditure and the overall outcomes against the plan, in order to assure itself that the conditions for the funding transfer are being met.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 In the 2011/12 Operating Framework for the NHS in England, the Department set out that PCTs would receive allocations totalling £648 million in 2011/12 and £622 million in 2012/13 to support adult social care. For 2013/14, the funding transfer to local authorities will be carried out by the NHS Commissioning Board. The allocation for Brighton and Hove is **£4,397,579**[1].

3.2 The 2013/14 funding must be used to support adult social care services in each local authority, which also has a health benefit. It is a condition of the transfer that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment.

3.3 The guidance also suggests that the proposals:

- must have regard to the Joint Strategic Needs Assessment for the local population, and existing commissioning plans for both health and social care
- must be able to demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer
- may be used to support new or existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment.

3.4 This is the third year of this allocation and a joint plan has been developed by Brighton and Hove Clinical Commissioning Group and Adult Social Care. The plan includes:

- a continuation of existing services such as early supported discharge and rapid response services
- spending on adult social care to maintain essential services
- investments in new services such as additional staffing for bed based intermediate care services, and
- a joint winter contingency the proposals for which will be jointly agreed by health and social care and used to provide additional investment in core services to mitigate winter pressures.

[1] In 2015/16 a larger £3.8 billion pooled Integration Transformation Fund will be developed to support local integration of health and care services. This fund will sit with Local Authorities and plans for use of this fund will be presented to Health and Wellbeing Boards for approval.

3.5 The following table sets out the proposed use of the funding allocation:

Analysis of the adult social care funding in 2013-14 for transfer to local authorities		
Service Areas- 'Purchase of social care'	***Local Detail (£'000)***	***TOTAL AMOUNT (£'000)***
Integrated crisis and rapid response services • Winter contingency	300	300
Maintaining eligibility criteria	2,264	2,264
Re-ablement services • Additional home care for ICS • Making I@H non chargeable (part year) • Care Manager in I@H (part year)	100 60 18	178
Bed-based intermediate care services • Knoll House	187	187
Early supported hospital discharge schemes	176	176
Mental health services • Mental health alignment to IPCT's (part year)	50	50
Other preventative services • Continuation of ASC plans from 11/12:Retention & extension of preventive services • Coordinating role to maximise the impact of prevention • Carers support posts	300 50 50	400
Other social care (please specify) • Improved integrated assessment capacity – hospital and community case management with extended hours • Retention of a Resource Centre & transformation of short term services (CCG & ASC)	272 640	912
TOTAL ALLOCATION: £4,397,579 **(*Total figure of £4,467,000 is full year effect therefore any shortfall will be met from slippage against some projects or from contingency budget)**		***£4,467**

4. CONSULTATION

4.1 This report details the proposed plans developed jointly for the use of funding streams to support health and social care joint working. If there are any changes to the services proposed, they would be subject to their own service consultation process.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 Financial Implications:
The funding allocation of £4,395,579 will be released from NHS England on receipt of the signed Section 256 agreement. Expenditure against this allocation will be monitored through the budget monitoring processes.

Finance Officer Consulted: Name Anne Silley Date: 28/08/13

5.2 Legal Implications:

The statutory requirement for transfer of funding and the associated condition of the transfer that the local authority agrees with its local health partners how the funding is best used within social care is described in the body of this Report. The Health and Wellbeing Board is required to approve proposals for the application of transferred funds. In doing so the Health and Well Being Board should have regard to the Guidance recommendations set out at 3.3. There are no other specific legal or Human Rights Act implications arising from this Report.

Lawyer Consulted: Name Sandra O'Brien Date: 28/08/13

Equalities Implications:

5.3 The funding arrangements are expected to have a positive equalities impact by ensuring access to services that are appropriate to meet health & social care needs. As and when changes are proposed to services, a full Equalities Impact Assessment is undertaken

Sustainability Implications:

5.4 The funding arrangements will ensure better use of resources and continued collaborative working.

Crime & Disorder Implications:

5.5 There are no crime & disorder implications

Risk and Opportunity Management Implications:

5.6 Collaborative commissioning and funding arrangements will enable the city to benefit from more integrated and efficient services,

Public Health Implications:

5.7 The funding agreements proposed reflect the city's commitment to preventive and reablement services and health & well being in the city.

Corporate / Citywide Implications:

5.8 The NHS funding transfer of funding form the NHS to Adult Social Care reflects the continued commitment to collaboration and partnership working.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Detailed consideration was given to how the funding should be spent and the options detailed fit the strategic priorities.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 National guidance on the allocation process for 2013/14 requires that the Health and Wellbeing Board approves the plans and is able to report on use of the allocation to NHS England.

SUPPORTING DOCUMENTATION

Appendix 1
Section 256 Agreement

Background Documents
None.

Appendix 1

Memorandum of agreement Section 256 transfer

Ref No: **Funding Transfer from NHS to social care – 2013/14**

Title of Scheme: **Brighton & Hove Social Care Allocation 2013/14**

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money on the National Health Service?

    - A continuation of existing services such as early supported discharge and rapid response services will avoid hospital admission, and enable more timely discharge.
    - Spending on adult social care to maintain essential services to avoid hospital admission and promote timely discharge.
    - Investments in new services (such as additional staffing for bed based short term care services) will ensure that people receive rehab services, move through short term services in a timely and maintain their independence.
    - A winter contingency plan will be jointly agreed by health and social care and used to provide additional investment in core services to mitigate winter pressures

2. Description of scheme (in the case of revenue transfers, please specify the services for which money is being transferred).

    The plan includes:

    - a continuation of existing services such as early supported discharge and rapid response services
    - spending on essential adult social care services
    - investments in new services such as additional staffing for bed based intermediate care services, and

- a joint winter contingency the proposals for which will be jointly agreed by health and social care and used to provide additional investment in core services to mitigate winter pressures.

Financial details (and timescales)

3. Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed).

Year(s)	Amount	Revenue
2013-14	£4,397,579	Revenue

4. Please state the evidence you will use to indicate that the purposes described at questions 1 and 2 have been secured.

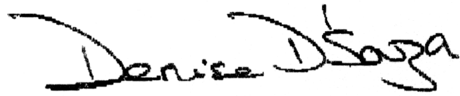
The Health and Wellbeing Board will be provided with regular updates on how the funding is being used locally against the overall programme of adult social care expenditure and the overall outcomes against the plan, in order to assure itself that the conditions for the funding transfer are being met.

Signed for CCG :

Christa Beesley
Accountable Officer
Brighton and Hove Clinical Commissioning Group

Date: 30.08.13

Signed for BHCC:



Denise D'Souza
Executive Director, Adult Social Care
Brighton & Hove City Council
Date: 30/08/13