Brighton & Hove City Council

Health & Wellbeing Overview & Scrutiny Committee

Title:	**Health & Wellbeing Overview & Scrutiny Committee**
Date:	**23 July 2013**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Rufus (Chair)C Theobald (Deputy Chair), Buckley, Cox, Marsh, Robins, Sykes and Wealls **Co-optees:** Jack Hazelgrove (OPC), Amanda Mortensen (Parent Governor Representative), Marie Ryan (Catholic Schools Service), Susan Thompson (Diocese of Chichester), Youth Council and Healthwatch
Contact:	**Kath Vlcek** 01273 290450 kath.vlcek@brighton-hove.gov.uk

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AGENDA

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To consider

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(b) Declaration of Interest

(c) Declaration of Party Whip, and

(d) Exclusion of Press and Public

80. Minutes of Previous Meeting **3 - 22**

Minutes of previous two HWOSC committees are attached due to omission from last committee agenda pack

81. Chair's Communications

82. Councillor Andrew Wealls - verbal update on Hospital Mortality meeting

83. Annual Public Health Report **23 - 26**

Contact Officer: *Kath Vlcek, Scrutiny Support Officer* *Tel: 01273 290450*

Ward Affected: *All Wards*

84. Joint Health & Wellbeing Strategy **27 - 76**

Contact Officer: *Giles Rossington, Senior Scrutiny Officer* *Tel: 01273 291038*

Ward Affected: *All Wards*

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Contact Officer: *Kath Vlcek, Scrutiny Support Officer* *Tel: 01273 290450*

Ward Affected: *All Wards*

86. Integrated Families: Update **85 - 114**

Contact Officer: *Steve Barton, Lead Commissioner, Children, Youth and Families* *Tel: 29-6105*

Ward Affected: *All Wards*

87. Sussex Community Trust: Foundation Trust Application **115 - 120**

Presentation from Sussex Community Trust; consultation documents will be available at the meeting.

Contact Officer: *Kath Vlcek, Scrutiny Support Officer* *Tel: 01273 290450*

Ward Affected: *All Wards*

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Date of Publication 12 July 2013

Agenda Item 1

To consider the following Procedural Business:

A. Declaration of Substitutes

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

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

B. Declarations of Interest

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Declaration of Party Whip

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

D. Exclusion of Press and Public

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

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

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

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE

4.00pm 23 APRIL 2013

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Rufus (Chair)

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

Other Members present: Co-optees Jack Hazelgrove (OPC); Marie Ryan (Catholic Schools Service); Thomas Soud (Youth Council) and David Watkins (Healthwatch)

PART ONE

60. PROCEDURAL BUSINESS

60.1 There were no substitutes. Apologies were given from co-optees Amanda Mortenson and Susan Thompson.

This was the first meeting for new co-optee Marie Ryan (replacing David Sanders from the Catholic Schools Service). The LINk co-optee's place had ended, as LINk had ended. It has been replaced from Healthwatch, which has a co-optee place on HWOSC. David Watkins attended HWOSC as Healthwatch co-optee.

60.2 There were no declarations of interest

60.3 There was no exclusion of press and public.

61. MINUTES OF THE PREVIOUS MEETING

61.1 There were some changes submitted by the SE Ambulance Trust representative; these changes would be made and the minutes re-circulated to Committee members.

Councillor Theobald wanted the minutes to be amended to show that she had asked for a panel to be held looking at whether there could be a kitchen on the RSCH new development. She felt that it was important that patients had food that was as locally sourced and as fresh as possible. Other members commented that this issue had been discussed by HOSC previously but that Councillor Theobald's suggestion would be noted.

62. CHAIR'S COMMUNICATIONS

62.1 The Chair welcomed the new co-optees to HWOSC.

63. LETTERS FROM MEMBERS OF THE PUBLIC/ COUNCILLORS/ OTHER BODIES

63.1 Ms Jean Calder had submitted a question:

"My mother, who has dementia, was recently admitted to the RSCH with severe dehydration. She had been living in nursing homes. I believe there is a need to increase awareness of the importance of hydration in hospitals and residential care.

Can you ensure that safeguarding protocols at local hospitals are improved so that:

1. *third party complaints about hospital care of vulnerable adults are accepted and investigated and*
2. *if an elderly or vulnerable person is found to be dehydrated, social services are swiftly informed and, if the person arrived from a care or nursing home, appropriate scrutiny bodies are alerted?"*

Ms Calder then asked a supplementary question:

"My mother has lived in three different residential homes. In all 3 I have had concerns associated with hydration and when she went to hospital some of the care provided was in adequate and unsafe. The circumstances are subject to a formal complaint.

Would the Council consider leading a city wide campaign: to raise awareness of the need for hydration in elderly people, especially those with dementia; ensure appropriate training for care and nursing staff; and encourage hospitals and residential care settings to provide water and assist with drinking?

It could be called something like WaterWise or WaterWorks and homes could be accredited."

63.2 The Committee Chair thanked Ms Calder for her question. He said that the Scrutiny Committee was not in a position to give answers to Ms Calder's questions directly but that HWOSC would pass the questions on to the relevant bodies and ensure there was an answer for the next committee, and then take it further if necessary.

The Chair said that he had already had some discussions with Councillor Rob Jarrett, Chair of the Adult Care and Health Committee who was keen for his committee to look into this.

63.3 Mr Watkins said the issue of hydration and care in care homes had been on the LINk/ Healthwatch agenda for some time, and that LINk had carried out a number of reviews and reports which might be relevant. Healthwatch would be happy to take part in any ongoing work into this matter too.

64. UPDATE FROM MATTHEW KERSHAW, CHIEF EXECUTIVE OF BRIGHTON & SUSSEX UNIVERSITY HOSPITALS TRUST (BSUH)

64.1 Matthew Kershaw, the new Chief Executive of Brighton and Sussex University Hospital Trust (BSUH) gave a presentation on the situation with the emergency care system at Royal Sussex County Hospital (RSCH), which had been the subject of media attention recently due to various problems. Mr Kershaw has been in post at BSUH for three weeks, but has 22 years' experience in the health service.

64.2 Mr Kershaw began by saying that the emergency care provision at the hospital is one of his major priorities as it is a serious issue. He appreciated HWOSC inviting him to come and speak about his plans to improve the service.

64.3 Mr Kershaw presented a slide show which explained that RSCH had invited the Emergency Care Intensive Support Team (ECIST) to review the emergency care pathways. HWOSC Members had already had copies of the ECIST reports that followed these reviews.

The review concluded that there were a range of issues that were contributing to the deterioration in performance, but that more patients could be sent home directly from A&E rather than being admitted, that some patients were waiting too long for a bed, and that other patients were staying too long in hospital. The review had led to five workstreams which cut across departments, each led by a clinician. Mr Kershaw said that the work programme would take about six months to complete, but some changes had already come into place, which were having a positive effect on the service provided in the emergency department.

64.4 Mr Kershaw then answered questions from the committee members, along with Dr Christa Beesley of the Clinical Commissioning Group, and Sherree Fagge, Chief Nurse.

64.5 Members asked why there had been a deterioration in services if had changed in the hospital's systems.

Mr Kershaw said that there was no single reason, which is why the five workstreams cut across absolutely everything that the hospital provided. It was fair to say that there had been some particularly difficult days for example when it snowed, which led to higher demand for emergency services but this was not the sole reason for the deterioration in services. People had asked whether the additional regional services such as trauma and vascular services were adding to the decline in services but they are a very small percentage of the services that RSCH provides so he would not say that they added a major pressure.

There may also be issues with how A&E works with wider systems, for example discharge into the community; any delays here can have an impact.

Dr Christa Beesley for the CCG said that she agreed, it was a complex set of reasons for the problems. The CCG has been trying to get a handle on where the problems had started, so the ECIST report was welcome. The problems were ones that could be solved.

64.6 Members asked whether discharge of patients back to areas outside Brighton and Hove always happened quickly enough. Mr Kershaw said that BSUH, commissioners and providers have already carried out work to try and make this happen as quickly as possible. It is in everyone's interest for the process to work as well as possible. If problems do develop, partners will work on a case by case basis to address the situation, reviewing the system where needed. However it should be note that only a small percentage of hospital services are provided to people from out of area, and they are for specialist services.

64.7 Members said that they were shocked at the dramatic decline in the Trust's performance, it slipped by 10% in a short time. There must be more of an explanation for this deterioration. Was it a failure of one service or another?

Mr Kershaw said that there was little that he could add to the previous explanation as it was complex and multi-factoral but in summary, the flow of patients through the hospital and being discharged has slowed and not kept up with the number of patients coming into the hospital. The reason that the flow is not working is not a simple one to establish, it is due to a whole range of reasons which have been outlined. It would not be fair to say that it was a failure of one group or another; hospitals are about large teams working together, and any achievements or failings are for the whole team.

64.8 Members queried the comments in the ECIST report that said that ward rounds were not always carried out on a daily basis. Mr Kershaw clarified that there are daily rounds already, but the ECIST report refers to when a senior review is carried out; this had not always been happening on a daily basis. This will now be addressed.

64.9 Members asked about the Drop In Medical Centre close to the train station. This was open seven days a week, for extended opening hours. Members understood that the medical centre was not allowed to advertise; could this be addressed so that the centre could be used more as an alternative to A&E?

Dr Beesley responded that the medical centre was very well attended, with a high proportion of patients from out of town. The walk-in centre is already promoted as an alternative option to A&E but it also operates as a standard GP practice, and in this instance it is not allowed to advertise any more than any other GP practice.

64.10 Members asked what percentage of patients in A&E could have been treated elsewhere and what is being done to address this?

Dr Beesley said that there are definitely people at A&E who do not need to be there. Estimates are that this ranges between a third and a half of A&E patients. There are a number of processes in place to help address this. Sussex Community Trust has developed a Crisis and rapid response team to minimise A&E admissions, which will offer appointments within four hours, either in a community setting or hospital premises. SPFT has also worked with the CCG to develop a Brighton Urgent response service for people who had an urgent mental health needs, so that people could be seen face to face within 4 hours of referral from a GPs, in a community setting. This service can now also be accessed directly by patients with serious long term mental health problems and their families.

There are certain cases where A&E is definitely the most appropriate place to be, but there are other cases where this is not so. When the 111 service is more established, it is hoped that this will be a good way to direct patients to the most suitable service.

Mr Kershaw commented that there was a definite need to publicise the alternatives to A&E as much as possible.

Dr Beesley said that there was no intention to 'blame' patients for attending A&E unnecessarily but wanted to provide information on how to get to the right place in the medical system; a quick assessment as someone entered A&E could help point people in the direction of the right service.

64.11 Members asked when BSUH Trust has received the ECIST report and what recommendations have already been put into place.

Mr Kershaw said that the Trust had received the report in March, and had developed action plans which addressed every recommendation. Nothing in the report had been ignored. Some changes had already been made outside A&E, whilst in A&E, physiotherapy services have been moved forward in the process to help speed up discharge, the number of consultants has been increased, and other changes have been made. The Trust is committed to making changes sustainably and practically.

Ms Fagge said that nursing staff have a huge part to play, including ward processes and planning for discharge, working with patients and carers. There is Head of Nursing for Discharge, who gives high level input into workstream 5 in particular. Occupational Therapists and physiotherapy staff are also used to help early discharge. There has been an agreed extra investment in A&E nurses, moving from 15 to 18 trained nursing staff and from 5 to 8 untrained nurses.

64.12 Members asked whether Mr Kershaw could take more of an active role in monitoring departments personally. He confirmed that he has been visiting different wards and departments at differing times of the day and night, to see the challenges and the successes, and to meet staff, and he has committed to continue to do this.

64.13 Members also asked that, as the review showed 134 patients who were fit but who had not been discharged, would there be more doctors on duty, to help speed up timely discharge?

Mr Kershaw said that the number of consultants in A&E would be increased, with a move towards 24 hour cover, seven days a week. The hospital is very lucky that it has a motivated and dedicated group of doctors, nurses and support staff so it was important to use their skills properly

64.14 Members queried the financial circumstances that the Trust was in; it had to make significant savings so how could the additional resource be found?

Mr Kershaw said that all NHS bodies were in similar financial situations. Some elements of the action plan would have a positive effect both on patient care and on hospital finances; for example, improving flow in the hospital would be better for patients and for the hospital.

64.15 Members questioned the statement in ECIST's report that the emergency floor was now too small, what was being proposed to address this?

Mr Kershaw said that Level 5, the Emergency Floor was very tight, and changes needed to be made to how departments were arranged on the floor to help treatment and capacity issues. The 3T scheme was also a longer term plan which would help address capacity.

The Healthwatch co-optee said that he had heard concerns about pressure being put onto some patients to feel that they ought to be moving on, and that some elderly patients had said that they had been given the impression that they were nuisances and ought not to be in hospital.

Mr Kershaw said that it was a very valuable point about vulnerable people inadvertently getting the wrong impression. However, based on the staff meetings and visits that he had carried out, Mr Kershaw said that he had been universally impressed with staff commitments to their patients, especially in difficult cases.

Ms Fagge, Chief Nurse, said that she was disappointed that the lady in question had felt pressurised; it showed the importance of planning discharge in a timely and informed way.

Dr Beesley said that the opposite also happened, where patients wanted to leave sooner and could not be discharged. It was hard to balance all the demands but the system should serve the patient.

Dr Beesley also commented that the CCG would be looking for weekly and monthly improvements against the action plan, and there would be regular meetings to assess progress.

64.16 The HWOSC Chair brought this item to a close, concluding that Mr Kershaw had set out a clear action plan which he hoped would deliver concrete results. The next HWOSC would be in June; the Chair would like an update before the next meeting, so that HWOSC could assess progress. This was agreed.

65. 3T DEVELOPMENT OF ROYAL SUSSEX COUNTY HOSPITAL

65.1 Duane Passman, Director of 3Ts, BSUH, gave committee members a presentation and update on the 3Ts long-term development of the RSCH site.

It was noted that in order to commence the main development, a series of decanting and enabling moves would need to be undertaken which represented just over 20% of the existing hospital site requiring temporary, or permanent relocation.

The first of these moves, the refurbishment of the former St. Mary's Hall school, is underway and will be complete in September 2013.

Professor Passman reminded members that part of the decant project would be the relocation of the nuclear medicine department, which is already in temporary accommodation. Without this (in advance of the move to the main building), it was likely

that the service would have to be closed due to the condition of the existing buildings, which were built as temporary forty years ago.

It was noted that it had been a requirement of the former Strategic Health Authority that all the decant projects (including St. Mary's) could be demonstrated to prove value for money and intrinsic value in their own right.

In design for the new hospital buildings, care will be taken to arrange the new development in a more streamlined way, for example so that wards for general medicine and care of the elderly will be very close to the Emergency Department, where the majority of patients in these care groups are admitted to hospital from.

Professor Passman said that the 3Ts project team has learnt lessons from other hospital development schemes that have been successful in carrying out major developments without affecting other services to ensure that patient access is not affected unduly during the period of the development.

65.2 Professor Passman then answered members' questions.

65.3 Members said that several of the HWOSC committee had sat on the Planning Committee that had given planning permission for the 3Ts development, but they had not appreciated the huge time scale of the development at the time. Was it the case that the government was using delaying tactics?

Professor Passman said that planning approval had been given in January 2012; getting full planning consent had been a pre-requisite of making the business case and being able to progress approvals with the Department of Health and the Treasury. BSUH had anticipated that they would have had final approval from central government in 2012, but they are still providing more information to the decision makers.

It was frustrating that the decision has not yet been made but the prize was still there. The 3Ts scheme was one of the largest publicly funded health schemes in years, looking for £420 million of public money, so BSUH needs to assure their financial sustainability into the future. BSUH did not think that delaying tactics were being used, but that central government was assuring themselves that services were safe, sustainable and high quality and would remain so.

Mr Kershaw said that the clinical case had been accepted, and final assurances were being made. The details would be submitted by the end of May and they expected to hear a response by summer 2013. There has been no relationship between the recent problems in the Trust and a delay in the decision making.

65.4 Members asked for assurances that the development would be covering every necessary health need.

Professor Passman said that they are constantly asked to justify all decisions, and to ensure that they have met all of the needs that they can identify or are required to meet. Technology is always being developed, but having any new equipment will be an improvement on the current provision. It was always the case however, that after a new hospital building is built, within sixty years, everything will be changes at least once.

Parts of the hospital development's plans are to keep a column grid building design so that the space can be as flexible as possible.

65.5 Members asked for assurances that BSUH would not face a Mid-Staffs situation and go into special measures because of poor facilities.

Mr Kershaw said that the Mid Staffs situation occurred because the hospital was clinically and financially unsustainable; this would have happened as the end stage of a large number of monitoring reports etc. In BSUH's case, it is responding to a set of difficult financial challenges, in a similar way to other hospital trusts. It is not the same as being in an administration regime.

65.6 Members asked whether the delay in the start date will mean an ongoing rise in the end costs and a corresponding rise in savings being made.

Professor Passman said that some costs were capital and others revenue costs. He was glad that there had been no real inflation in the £420 million capital cost due to the overall slowdown in the construction sector which meant that there had been no compromise on the quality of the planned facilities. He added that this had not impacted either on the running costs.

65.7 The Chair of the HWOSC brought the item to a conclusion, thanking the Trust for the presentation and saying that HWOSC was committed to and supportive of the proposals. There were understandable concerns with regard to decanting the services, but this was a necessary part of the development and the committee would keep an eye on this as it happened.

66. SEXUAL EXPLOITATION OF CHILDREN: RESPONSE FROM LOCAL CHILDREN'S SAFEGUARDING BOARD

66.1 This item was deferred until the next committee date.

67. AUTISM - SERVICES FOR ADULTS

67.1 Anne Hagan, Head of Commissioning & Partnerships, and Mark Hendriks, Performance and Development Officer, presented a report on progress that had been made against the recommendations made in the scrutiny panel report looking at services for adults with autism.

The panel had been very helpful in informing the council's autism strategy, and significant progress had been made, with a three year action plan being put into place. There were 25 strategic objectives in the report, with a stakeholder group governing the action plan's progress.

The team had just completed the first year, which focussed on improving the diagnostic and care pathway; improvements should be operational in summer 2013.

Work has also been underway to develop an autism champions' network, with autism leads with specialist knowledge present in various services.

Years two and three would focus on transition and the local planning of services. Transition can take a number of forms, with different pathways for different conditions. The Special Educational Needs process was being revised, which will support services for young people up to the age of 25 rather than 18 which was currently the case.

67.2 Jack Norwood from the Adult ADHD Peer Support Group commented that the group was concerned that ADHD was not explicitly mentioned, would the autism strategy reflect the needs of people with ADHD? West Sussex has an ADHD nurse, would anything similar be happening in Brighton and Hove? The Adult ADHD Peer Support Group would like to be involved in any consultation that was taking place.

Ms Hagan said that it would be helpful if she met with Mr Norwood at a separate date, as there may be some risk of people falling between different services.

The Chair of HWOSC thanked Mr Norwood for his comments, and agreed that it would be helpful for Mr Norwood and Ms Hagan to meet to discuss the issues.

67.3 Members then asked questions about the autism report.

Members asked whether training would be mandatory for all staff.

Mr Hendriks said that it was not felt appropriate to make training compulsory, it was about being proportionate to need. The training offer is there and it is down to individual services to access it.

Ms Hagan added that autistic spectrum conditions were briefly mentioned in the equalities training, which was mandatory.

67.4 Members asked whether it would be possible to have details of the number of people who had had specific training. It would be good to try and test the different in people's attitudes following training.

67.5 The Chair invited Mr Steve Harmer-Strange, who had chaired the scrutiny panel, to comment. Mr Harmer-Strange welcomed the update and said that Autism Sussex was working with Jobcentre Plus in East Sussex to make staff autism-aware and help support people with autistic spectrum conditions into employment. He felt that it would be good to test whether there had been any improvements in people's experiences over the next twelve months.

67.6 The Chair said that this was a staged process and recommendations could not be rushed through, as there were many stakeholders involved. He agreed that it would be good for HWOSC to have another update in a year's time. This was agreed.

68. UPDATE ON CURRENT SCRUTINY PANELS

68.1 This was noted.

69. MENTAL HEALTH BEDS UPDATE

69.1 This was noted.

70. WORK PROGRAMME UPDATE

70.1 This was noted.

The meeting concluded at 6.40pm

Chair

Signed

Dated this day of

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE

4.00pm 11 JUNE 2013

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Rufus (Chair)

Also in attendance: Councillor C Theobald (Deputy Chair), Barnett, Buckley, Cox, Marsh, Robins, Sykes

Other Members present: Co-optees Jack Hazelgrove (Older People's Council), David Watkins (Healthwatch), Youth Council

PART ONE

71. PROCEDURAL BUSINESS

71A Substitutes

71.1 Councillor Barnett was substituting for Councillor Wealls. Councillor Theobald stood in as Chair for the start of the meeting as Councillor Rufus was unavoidably delayed.

Apologies had been received from co-optees Amanda Mortenson, Susan Thompson and Marie Ryan.

71B Declarations of Interest

71.2 There were none.

71C Exclusion of Press and Public

71.3 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 material as defined in section 1001(1) of the said Act.

71.4 **RESOLVED –that the press and public be not excluded from the meeting.**

72. CHAIR'S COMMUNICATIONS

72.1 Councillor Theobald, Deputy Chair, chaired the meeting until Councillor Rufus's arrival (delay due to public transport issues)

72.2 The Chair welcomed Councillor Ruth Buckley, who has replaced Councillor Geoffrey Bowden on the HWOSC and thanked Councillor Bowden on behalf of HWOSC for all of his work and input during his time on the committee.

72.3 At the last HWOSC there has been a public question from Jean Calder about hydration in care homes and at the hospital. A response had been circulated to Ms Calder and to all members. Ms Calder had since emailed a response which had been shared with members, and was actively taking related issues up with the Adult Care and Health committee too.

72.4 The GP Quality and performance workshop had been rescheduled to Tuesday 9 July from 9-11. Further information had been emailed around members.

72.5 Adult Social Care have asked to run a workshop with members looking at the options for alternative service models for some ASC provider services. Further information would be sent round when available.

72.6 PUBLIC QUESTION

72.7 HWOSC heard a public question from Mr Terence Rixson, a copy of which is attached to the agenda pack for this committee. The question centred on the development of Healthwatch locally and public involvement.

72.8 Councillor Rufus said that he was unaware of the detail of how Healthwatch had been developed but that Healthwatch was due to come to HWOSC later this year to update the committee on their progress. Healthwatch had been co-opted onto the HWOSC and a co-optee tried to attend at every meeting.

72.9 Mr Watkins, Healthwatch representative, said that his understanding was that Healthwatch was in a period of transition following the demise of LINk. Mr Watkins said that he did not think that Healthwatch officially came into being until May 2014, and that work was being carried out to determine what Healthwatch should look like, before recruiting people to take part. Mr Watkins agreed that it was a frustrating time for members of the public, but explained that the delay was not caused by Brighton and Hove's Healthwatch itself but by the lack of information on what should be happening. He was hopeful that the report later in 2013 would help provide more answers for people including HWOSC members.

72.10 Councillor Rufus said that he would contact the CVSF in his role as Chair of HWOSC to enquire about progress, and would feed back to Mr Rixson when he had received a response. Mr Rixson was welcome to attend the HWOSC where Healthwatch was being discussed.

73. VERBAL UPDATE FROM CLLR MARSH ON PLACE ASSESSMENT

73.1 Councillor Marsh recently took place in a Patient Led Assessment of the Care Environment (PLACE) training session and assessment with RSCH. The assessors visited various areas of the hospital, looking to assess the general environment, decoration, cleanliness and quality of food for patients.

73.2 Councillor Marsh said that she was very pleased to have been part of the assessment process. It felt a very open process; assessors were not barred from visiting any area or asking any questions. She would recommend it to all members; Councillor Theobald was already scheduled to take part in a future assessment.

73.3 Elma Still, Associate Director, Quality, BSUH, responded on behalf of the Hospital Trust, thanking Councillors Marsh and Theobald for taking part. Assessors came from a variety of backgrounds, including patients, carers, and other members of the public. In terms of next steps, the Hospital Trust expected to receive the final PLACE assessment report in August and would be happy to bring it to HWOSC.

74. SEXUAL EXPLOITATION OF CHILDREN: RESPONSE FROM LOCAL CHILDREN'S SAFEGUARDING BOARD

74.1 The Chair began by thanking the Local Safeguarding Children's Board members and colleagues who had attended last committee to present the report. Due to the amount of time given to the A&E item last time, HWOSC did not have time to hear this report so it had been postponed until this committee.

74.2 Howard Baines, Local Safeguarding Children's Board (LSCB) Manager, Rachel Brett (Director of Care & Support Services, Sussex Central YMCA) and Detective Chief Inspector Jeremy Graves, (Head of Crime Brighton and Hove) and chair of the CSE LSCB sub group) presented the report to HWOSC.

74.3 Mr Baines explained that child sexual exploitation (CSE) was high on the LSCB's agenda, and key agencies in the city worked closely together to address the issue. CSE issues also link in with missing children and trafficked children. The LSCB coordinated training programmes for multi-agency staff including school staff and worked with school pupils. The school PSHE curriculum has been updated to include CSE.

CSE is now recognised as a safeguarding issue, which is a complete change from when it was considered to be a sign of promiscuous young people. There has been work to raise police officer awareness about CSE, for example, missing person interviews focus on CSE. The agenda report summarised the initiatives in place in the city.

74.4 Ms Brett gave an overview of the 'What is Sexual Exploitation' (WiSE) project. It began in 2010, following a pan Sussex report 'Tipping the Iceberg' (2007) by Barnardos. WiSE was established using the University of Bedfordshire's ten recommendations for LSCB groups working with CSE.

In Brighton and Hove, following robust evidence gathering, agencies have a good idea of the levels of CSE in the city, and the methods being used by perpetrators. They cannot guarantee that there are no organised crime groups operating in the city but there is no indication that this is the case at present or in the past.

74.5 DCI Graves, who chairs the LSCB subgroup, told members that it was a very well represented group, with approximately thirty members covering a wide range of agencies in attendance. They had a well established process to capture any CSE cases in the city, meeting bi-weekly to share any information about cases. Services are joined up as much as they could be.

74.6 Committee members asked the LSCB representatives questions and comments:

74.7 Members asked about the numbers of children who are affected in Brighton and Hove?

Ms Brett said that at any one time, the WiSE project has about forty young people on their case books, with joint working with other agencies in the city due to capacity issues at WiSE. They have trained over 1000 professionals in identification and screening in CSE, and this has raised the number of referrals to WiSE accordingly. WiSE focus on higher threshold cases, so they hope that people who have been trained will be happy to deal with lower level cases themselves. Feedback has shown that people who have had training feel more confident in contacting WiSE to talk through their concerns and then refer the lower level cases on to the appropriate agencies or deal with it themselves.

The youngest person that WiSE has worked with was twelve; any children younger than this would initially be referred to ACAS, the information would be shared within the fortnightly meeting between Police , ACAS and WiSE in relation to care planning.

74.8 How can councillors be kept informed of what is happening in the city, eg any evidence of CSE crime gangs or other trends?

Graham Bartlett, Chair of LSCB, explained that Councillor Sue Shanks, Chair of the Children and Young People Committee (CYPC) sits on the LSCB and Mr Bartlett attends the CYPC so he is confident that the information is shared appropriately.

Superintendent Graves confirmed that the young people that had been seen so far had come through as individual cases not in clusters; there was no evidence that there had been any CSE criminal gangs operating.

74.9 Some members said that they had doubts over the council's approach to CSE, particularly in the equalities profiling of potential perpetrators. There were a number of factors in Brighton and Hove that meant that CSE gangs could operate here, eg the night time economy, large number of takeaways and amusement arcades, a higher number of runaways coming to the city and so on.

The high profile CSE cases in other cities were largely caused by an unwillingness to upset community cohesion. Some members felt that this was reflected in the cover report for the CSE item, which addressed equalities implications for victims but not the possibility of potential perpetrators being from other equalities groups.

Members would therefore like reassurance that respect for cultural differences would not cloud the LSCB team from carrying out investigations.

Ms Brett said the LSCB was working to look at the night-time economy. From WiSE's perspective, they were not afraid of challenging cultural groups but the fact remained that they had not seen anything of this nature happen to date. If the evidence was there, WiSE and partners would act robustly.

74.10 Members asked whether there had been a formal report of lessons learnt from Rochdale and other areas so far.

Superintendent Graves said that he was not aware that the report had been published but nevertheless, agencies were already working together to share learning, particularly through multi-agency safeguarding hub approaches, where agencies share all of the available information about a particular person.

74.11 Do school governors receive any safeguarding training?

Ms Brett said that there was safeguarding training for governors, which did cover CSE as well. WiSE can also offer bespoke training when requested.

74.12 Members asked how police performed in CSE cases locally.

Ms Brett said that there had been one particular successful prosecution recently, where the victim had learning disabilities. The police worked very well at putting support in for the victim and their family. The case resulted in the perpetrator getting fifteen years in prison.

74.13 What was the approach for tackling online CSE?

Ms Brett said that a member of staff had been trained by Child Exploitation and Online Protection (CEOP) to deliver specific training about online CSE.

74.14 The Healthwatch co-optee said that Healthwatch is able to represent children so they would welcome information about training opportunities. Superintendent Graves said that LSCB did not have a Healthwatch representative at present so they would welcome the input.

74.15 The HWOSC Chair concluded the item; he did not feel that it was necessary to establish a scrutiny panel at present as there was little value that could be added by a panel.

Other members said that they still had some concerns about the potential impact of not tackling perpetrators due to misplaced fear of affecting community cohesion, but they agreed that a panel was not necessary at present.

The Chair agreed to formally contact Councillor Shanks with members' concerns and ask her to raise them with the LSCB. Councillor Shanks' response will be brought back to HWOSC.

75. UPDATE ON 'TALK HEALTH' REPORT

75.1 Debbie Collins from Amaze presented the report. Ms Collins began by giving a huge thanks to HWOSC members for championing the Talk Health report on behalf of the Parents and Carers' Council (PaCC); having the backing of HWOSC had opened doors and given opportunities for dialogue that had not been there before. There has been a wide variation in the reception that Talk Health have had from GP across the city. Some have engaged but some still have a long way to go to fully acknowledge the requirements of a child with special needs.

75.2 There were a few areas of work that still needed further attention, in particular the Children and Adolescent Mental Health Service (CAMHS) which was not engaging with PaCC. Their key contact had left and communication with CAMHS tended to be one-way, with little information coming back to parents. Ms Collins was due to arrange a meeting with CAMHS about how they communicated with parents and carers as it was an issue that has been raised repeatedly.

75.3 Sam Allen, Sussex Partnership Trust, spoke on behalf of CAMHS, apologising for the poor service that PaCC members had experienced and promising to take up the matter with CAMHS colleagues on behalf of PaCC. This was welcomed.

75.4 Ms Collins said that she did not wish to repeat all of the information that was in the report, but welcomed members' questions.

75.5 Members queried what steps were in place to address the abuse of blue badges with regard to the parking scheme at the Royal Alexandra Children's Hospital? How would the road layout be overcome to enable authorised queue jumping?

Ms Collins said that blue badges were checked rigourously. The arrangement in place for blue badge holders to go to the front of the car park queue was only for families who had their children with them. The car park attendant would help the cars pass by where necessary.

75.6 The Healthwatch representative said that they would welcome a parent to sit on Healthwatch.

75.7 The Chair commented that members were still happy to champion the report but given that a large number of the recommendations had already been achieved, it would be a more of a scaled back championing, on the understanding that PaCC will actively contact HWOSC to ask for help where needed.

75.8 Ms Collins agreed this approach would be a helpful one for all parties.

76. A&E AND CAPACITY PRESSURES AT THE ROYAL SUSSEX COUNTY HOSPITAL

76.1 Elma Still, Associate Director, Quality, BSUH, Sherree Fagge, Chief Nurse, BSUH and Geraldine Hoban, Chief Operating Officer, Clinical Commissioning Group (CCG), presented the report updating HWOSC members on progress against the five

workstreams put in place at the emergency department following the ECIST inspection and report.

76.2 Ms Fagge wanted to assure people that the figures circulated related to all emergency services in RSCH including the children's emergency department; everyone was seen in four hours or less. Ms Fagge was aware that adults with special educational needs were flagged up when they attended A&E and will follow up and confirm if this was the case for children.

76.3 There had been local news coverage of the negative Care Quality Commission inspection and report recently; this was not a new inspection but had taken place when the department was in crisis. If the Care Quality Commission inspectors were to return now, the hospital is confident that they would see a very different picture.

76.4 Ms Hoban spoke on behalf of the CCG; they were keeping a close eye on progress at A&E. The summer period tended to have lower demands on emergency services so it was a good time to review pathways of care and discharge arrangements. It was true that the situation had improved at A&E but all parties recognised that there was still a great deal to do.

76.5 Ms Hoban also commented that the CCG had monthly meetings with the Care Quality Commission, reviewing the metrics that they were assessing.

76.6 Members asked why the Care Quality Commission had just come to light, given that the inspection took place in April.

Ms Fagge confirmed that although the assessment was in April, the report had not been published until June. The report focussed on four areas of concern, three of which were about overcrowding in A&E. The fourth area for improvement was staff training; a large piece of work was being organised to address training needs.

76.7 Members said that emergency services were so stretched because the wrong people were using A&E; not everyone who was there needed to be there.

It would also be better to have a separate area for people with drink and drug issues, as these people caused lots of trouble for other attendees. The 111 service had received a lot of poor publicity and was not giving people confidence that it would give appropriate and timely advice.

Ms Fagge said that they had to care for all of the people who came through the doors. However it was true that not everyone who was at A&E should be there. The CCG was currently running a poster campaign to highlight alternatives to A&E including the out of hours service, drop in clinics etc.

There was now a GP on the front door of A&E; they are able to see people straight away and direct them to the most suitable care provider.

Ms Hoban said that there was a dedicated room for people with mental health needs in crisis; this has been very successful at reducing the number of admissions. The CCG

will look at how to address people with drug and alcohol issues, and whether this can be handled in a similar way.

76.8 Members said that they welcomed the campaign to promote alternatives to A&E as long as it did not have the adverse effect of stopping people who should be at A&E from attending.

Ms Hoban said that, when it was fully operational, the 111 service would be the gateway for knowing when A&E was appropriate. Extra investment was going into the 111 service for increased number of staff and clinical services in local call centres.

76.9 Members said that they had felt reassured by Matthew Kershaw's presentation at the last HWOSC and remained reassured by this update. They noted that A&E had accepted that there had been faults and had put in plans to address them. Would it be possible for BSUH and the CCG to consider what other factors might be affecting A&E performance so that HWOSC can put on pressure where necessary. For example, are there delays in adult social care, are some people not used to using GP services etc.

The Chair agreed that it would be good to see detail of all of the determining factors and causes. It was pleasing to see that there was already evidence of progress – as the Hospital Trust had already identified, it would be key to determine whether the positive trend would continue. The report was due to return to HWOSC in September for a further update and review.

77. UPDATE ON DEMENTIA SERVICES

77.1 Anne Foster from the CCG and Simone Lane, Commissioner for Dementia, gave an update report on dementia services in the city. The report and appendices gave an update since the previous report to HWOSC in December 2012.

77.2 Since the report had been written there had been further progress:

The Memory Assessment Service had been launched and would take self referrals from the end of August. The service is provided by a partnership of organisations including the Alzheimer's Society, who will offer care and support post-diagnosis.

The Butterfly Scheme, a carer-led training scheme, is being rolled out across both BSUH sites

The Care Home In-Reach Service has been reviewed and is now funded on a sustainable basis.

77.3 Members asked about the 'This is Me' bag and its contents. Ms Lane said that it was full of the person's key documents including the RCN/and Alzheimer's 'This is me' leaflet which is designed to provide professionals with information about the person with dementia as an individual

77.4 How is work progressing against the National Dementia Strategy?

Ms Foster said that the local plan is in line with the National Dementia Strategy. The establishment of the new Memory Assessment Service was a key milestone as this enables more people to get a diagnosis as early as possible and provides greater opportunity for early intervention and support. The standard in the contract is that there to be no more than a four week wait for an assessment at the Assessment Clinic.

77.5 Members asked whether everyone in certain care homes had dementia.

Ms Foster said that with the number of people with dementia increasing because of an aging population more people with dementia are in mainstream care homes rather than specialist care homes. A key part of the approach to improving care is to ensure it is part of everyone's business. This involves training and development of generic staff such as care home staff as well as providing specialist support example the Care Home In-Reach team.

77.6 Members agreed to note the report, with an update to return to HWOSC in twelve months if needed.

78. MENTAL HEALTH ACUTE BEDS - MAY 2013 UPDATE

78.1 Dr Becky Jarvis gave a brief update on progress with the temporary closure of the mental health beds at Millview.

A number of new staff had been recruited, including care coordinators and additional clinical staff working in the Crisis Resolution Home Treatment Team. In addition a new urgent response service had been in operation since January and a new day service for people with personality disorder opened in May. All of these developments provide opportunity for more care to be provided in the community.

The CCG had recently awarded two new contracts for accommodation support services. These new services will be established later in the year and will help minimise unnecessary long stays in hospital due to accommodation issues.

78.2 It is hoped that by September 2013 the team will be in a position to make a final decision on the closure. Options are: to permanently close the ward; to permanently close the ward with extra investment in services, or to re-open the ward. The clinical team will evaluate all of the data before making their decision and will bring a final report back to HWOSC in due course.

The meeting concluded at 6.15

Signed Chair

Dated this day of

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 83 Brighton & Hove City Council

Subject:		**Annual Public Health Report**	
Date of Meeting:		**23 July 2013**	
Report of:		**Director of Public Health**	
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 Directors of Public Health are required to deliver an annual independent report on the state of local public health. There are no requirements as to the exact content of the report. The joint strategic needs assessment (JSNA) now provides a comprehensive overview of the health needs of the local population. The independent report of the Director of Public Health then has to provide a more in depth view of a particular aspect of health and wellbeing.

1.2 This year the report explores happiness, personal and community wellbeing and how these relate to demographic and lifestyle factors across the city. The report uses census data, as well as data from local health and wellbeing surveys. For adults the report considers the findings from the Health Counts surveys conducted in Brighton and Hove in 1992, 2003 and 2012. For children the report draws on data from the Safe and Well at School surveys.

1.3 The Director of Public Health will make a short presentation on the key findings of the report

2. RECOMMENDATIONS:

2.1 That the report is noted.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 There is a strong case for measuring and seeking to improve happiness and wellbeing. A large scientific body supports the finding that negative emotions can harm health and that it affects the choices in health (smoking, diet, alcohol use, sexual behaviour) that people make.

3.2 National policy now supports the idea that progress should not just be measured on financial measures like gross domestic product (GDP) but include measures of wellbeing.

3.3 Locally policy initiatives like One Planet Living, and aspiration to WHO Age Friendly City status have the potential to improve happiness and wellbeing and thereby improve health.

3.4 The local Clinical Commissioning Group has extended its commissioning framework to include measures of improved wellbeing and social capital.

3.5 Key findings from the recent census show a large increase in the number of BME residents (80% increase) and in those with no religion (73% increase). The number of older people has fallen by 12%.

3.6 Health Counts survey data show that the residents of Brighton & Hove continue to increase their levels of exercise although there is considerable variation by locality, age group, deprivation and by race and religion. Recently retired people show high levels of physical activity. There is some evidence that in recent years the local authority has sought to increase the participation of certain groups who have felt excluded in the past, such as Muslim women.

3.7 There has been little change in the mental wellbeing status of the local adult population over the past 20 years as measured by the Health Counts surveys, although over one third of the population may be vulnerable to poor mental health. Self harm rates have risen in recent years, both in adults and especially in younger people.

3.8 In Brighton & Hove women have higher levels of life satisfaction than men. Older people, who have relatively low levels of feeling worthwhile, are in fact the happiest age group. Social capital is closely related to deprivation. Among ethnic groups local Black and Black British people are more satisfied with life and less anxious. In terms of sexuality, heterosexuals have higher levels of satisfaction, feeling worthwhile and happiness compared to Lesbian, Gay and Bisexual (LGB) groups. Among religious groups Buddhists are more content on many measures of wellbeing while Muslims score low on most indicators of wellbeing and social capital.

3.9 Self-reported health has improved over the last 20 years in the city. In middle age the self-reported health of men falls when compared to women although in retirement there is no gender difference. Residents living in social housing report lower levels of health.

3.10 The overwhelming majority of young people are happy. Levels of happiness are lower however in certain groups: Chinese children, LGB and unsure children and children who are bullied or excluded.

3.11 Smoking rates continue to fall in adults and children and smoking remains strongly associated with deprivation. People who have never smoked are happiest.

3.12 Alcohol use among children (11 – 16 year olds) is falling and those children who use alcohol report lower levels of happiness and wellbeing. The level of drug use among children has remained stable over the past few years, but its use is also associated with lower levels of happiness and wellbeing.

3.13 Among adults in Brighton & Hove levels of unsafe drinking in men have fallen over the last 10 years (from 27% to 18%) while the figure has remained stable in women (17%). Among women, the highest levels of unsafe drinking are to be found in middle aged women while among men, the recently retired report the highest levels of unsafe drinking. A local student survey finds that most students drink safely or do not drink, however there is a significant minority of students who when they do drink, drink to get drunk.

3.14 Drug-related deaths have fallen substantially over the past 10 years from 67 deaths in 2000 to 20 in 2011. More people are entering into a programme of recovery. There is emerging information on club drugs that suggests that these drugs may be more dangerous than many young people think. Both drug use and high volume alcohol use are associated with lower levels of happiness and wellbeing.

3.15 Rates of sexually transmitted infections are high in Brighton & Hove – the third highest outside of London. Unsafe sexual activity is associated with alcohol and drug use. People who reported having one sexual partner in the previous year recorded the highest levels of happiness.

3.16 Progress in addressing inequalities over the last ten years has been mixed with large health inequalities regarding those at risk of depression, smokers and those with limiting long-term illness. Obesity is increasingly associated with deprivation. High risk drinking is as likely among the more affluent.

3.17 The report recommends that there is greater consideration of happiness, and personal and community wellbeing, in their own right, and well as markers for health.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 The report reflects contributions from the Clinical Commissioning Group, City Council staff as well as colleagues in the universities and in the third sector. The report's content will be discussed at local health strategic partnerships.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The costs of the report are covered from the city council's ring fenced public health grant. For the last 8 years the print and production costs of the report has remained within the budget of £10,000.

Legal Implications:

5.2 The report does not carry any legal implications with regard to implementation.

Equalities Implications:

5.3 The report draws attention to the considerable inequalities that exist within Brighton & Hove. These are addressed in the main body of the report.

Sustainability Implications:

5.4 The addressing of issues of social capital and lifestyle requires a long-term consistent and sustainable approach.

Crime & Disorder Implications:

5.5 Crime and disorder are significant factors in terms of social capital, particularly in relation to their association with drug and alcohol use. This is addressed in the main body of the report.

Risk and Opportunity Management Implications:

5.6 None

Public Health Implications:

5.7 These are covered in the main body of the report.

Corporate / Citywide Implications:

5.8 The report is consistent with the City Council values as set out in the Corporate Plan. Many of the targets and milestones set out in the City Council Corporate Plan are consistent with improving lifestyles and boosting social capital as recommended in the report.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 There is a statutory requirement to publish an annual report and therefore no alternative options available.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The independent Annual Public Health Report is published by the Director of Public Health and is put before the council and partner organisations for their information and consideration.

SUPPORTING DOCUMENTATION

Appendices:
None

Documents in Members' Rooms
None, although copies of the annual report have been sent to all councillors.

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 84 Brighton & Hove City Council

Subject:		**Joint Health & Wellbeing Strategy (JHWS)**
Date of Meeting:		**23 July 2013**
Report of:		**Head of Law/Monitoring Officer**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 29-1038**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The Health & Social Care Act (2012) requires all upper-tier local authorities to establish partnership Health & Wellbeing Boards (HWB). One of the main duties of each HWB is to publish a local Joint Health & Wellbeing Strategy (JHWS). This report provides general information on the JHWS as well as details of the Brighton & Hove JHWS priorities and the assessment process that generated them.

1.2 **Appendix 1** to this report contains the draft JHWS, provisionally endorsed by the Shadow HWB in September 2012, and due to be signed off by the statutory HWB in September 2013.

2. RECOMMENDATIONS:

2.1 That HWOSC members consider and comment on the information contained in this report.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 **National Context.** The Health & Social Care Act (2012) requires every local area with a Health & Wellbeing Board (HWB) to publish a Joint Health & Wellbeing Strategy (JHWS) identifying the major health and wellbeing challenges for the local population and detailing plans to improve outcomes in these key areas. Guidance around the JHWS is very non-prescriptive, with local areas largely free to design a JHWS that suits their needs. However, it is recommended that the JHWS focuses on a relatively few high priority issues rather than attempting to describe the totality of health and wellbeing needs across the local area. It is also intended that the JHWS be a 'high-level' document, describing the strategic picture rather than delving into operational details.

3.1.1 Once agreed by the local HWB, the JHWS will influence strategic commissioning of relevant health, public health, adult and children's social care *and* allied services across the local area. Clinical Commissioning Groups (CCG) are obliged to ensure that their commissioning plans accord with the JHWS, and can be referred to NHS England if the local HWB feels that this is not the case. There is a parallel pathway for the HWB to refer local authority commissioning plans to the Council. More information on the statutory guidance for the JHWS is available here: https://s3-eu-west-1.amazonaws.com/media.dh.gov.uk/network/18/files/2013/03/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-20131.pdf

3.2 **Local Context.** Locally, it was agreed that we should use the data collected via the Joint Strategic Needs Assessment (JSNA) process to inform the Brighton & Hove JHWS. We therefore divided the JSNA data into 82 themed areas and a team of officers from public health, the community sector and from the council's adult social care, children's services, scrutiny, policy, and communities & equalities teams 'scored' each area against a matrix of public health outcomes (e.g. the impact of each issue in terms of life expectancy; in terms of healthy life years; its impact on equalities groups; local performance against national averages/comparators/national targets; trend of performance etc). From this prioritisation process we identified a long list of 20 or so JSNA areas with multiple 'red' scores – the highest priority health and wellbeing issues for the city.

3.2.1 A second assessment process saw us further 'score' each long-listed issue, seeking to determine whether the matter was a core partnership issue or more properly the responsibility of a single organisation; whether the issue was already being dealt with by a city strategic partnership; whether there had been a good deal of recent work on the matter etc. The intention here was to identify those issues where the HWB as a partnership could add most value, and to exclude those issues where we would simply be duplicating work already being undertaken by other bodies. To this end we excluded 'wider determinant' issues – i.e. non-health or social care matters which nonetheless impact upon health and wellbeing such as housing quality, employment or child poverty. All of these issues are currently the responsibility of partnership bodies under the aegis of the Local Strategic Partnership (details of this are included in the draft JHWS). We also excluded issues where there has been a good deal of recent work and where robust partnership structures are in place (e.g. alcohol in terms of the Intelligent Commissioning pilot on alcohol, the Big Alcohol Debate, the establishment of a city Alcohol Programme Board etc). Further, we excluded issues which were clearly the main responsibility of one commissioning body (e.g. diabetes or musculoskeletal conditions which are predominantly CCG matters).

3.2.2 Following this second round of assessment a shortlist of six highest priority issues were presented to the Shadow HWB for possible inclusion in the JHWS. The SHWB agreed to include five of these in the JHWS (the sixth, flu vaccination was rejected as being essentially an operational issue for the CCG and Public Health).

3.3 JHWS Priorities. The JHWS priorities are:

- Dementia
- Cancer & access to cancer screening
- Emotional health & wellbeing (inc. mental health)
- Healthy weight & good nutrition
- Smoking

3.3.1 The JHWS outlines the key challenges in each of these areas, includes an action plan for service improvement, and suggests some ways we might measure improvement in each area. The JHWS is a high-level document outlining strategic intentions and is not intended to include details on operational issues or outcomes-monitoring – more detailed work, particularly in terms of outcomes measures will be undertaken for each of the priorities via the relevant commissioning strategies. Progress in implementing the JHWS priority action plans will be regularly reported to the HWB.

3.4 More information on the prioritisation process, the JHWS priorities, and on the links between the JHWS and the citywide commitment to reduce health inequalities is included in the draft JHWS attached as **Appendix 1** to this report.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 Community sector organisations took part in the JSNA prioritisation process. We further engaged with the sector around our initial plans for the JHWS (including running workshop sessions attended by 30+ local CVS organisations).

4.2 We have consulted CVSF on the draft JHWS, attending two workshop sessions on JHWS priorities organised by CVSF. CVSF has produced a written response to the draft JHWS, incorporating the views of 80+ local CVS organisations, and this response has informed the drafting of the JHWS due to be presented to the September 2013 HWB for endorsement. (The CVSF response to the JHWS is incredibly useful and we are committed to delivering as many of their ideas as possible. Since the JHWS is a high-level document, it may be that we address CVSF concerns via the detailed commissioning plans and strategies that sit beneath the JHWS rather than via the JHWS itself.)

5. FINANCIAL & OTHER IMPLICATIONS:

<u>Financial Implications:</u>

5.1 None to this report for information

Legal Implications:

5.2 None to this report for information

Equalities Implications:

5.3 None directly. The JHWS report for endorsement to September 2013 HWB will include a full EIA with links to individual EIAs for each of the JHWS priority areas.

Sustainability Implications:

5.4 None to this report for information

Crime & Disorder Implications:

5.5 None to this report for information

Risk and Opportunity Management Implications:

5.6 None to this report for information

Public Health Implications:

5.7 None to this report for information

Corporate / Citywide Implications:

5.8 None to this report for information

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 None. This is a report for information

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 This report is for noting.

SUPPORTING DOCUMENTATION

Appendices:

1. The draft Joint Health & Wellbeing Strategy (JHWS)

Documents in Members' Rooms

None

Background Documents

1. The Health & Wellbeing Act (2012)

2. Statutory Guidance on the JHWS (DH 2013)

Appendix 1

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

Contents

Introduction

What is the Joint Health & Wellbeing Strategy?

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

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

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

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

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

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

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

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

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

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

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

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

Prioritisation

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

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

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

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

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

The five priorities are:

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

The Contents of this Report

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

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

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

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

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

Joint Strategic Needs Assessment in Brighton and Hove

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

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

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

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

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

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

The population of Brighton and Hove

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

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

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

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

Key population groups in the city:

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

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

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

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

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

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

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

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

Life expectancy, healthy life expectancy and inequalities

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

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

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

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

Highest impact health and wellbeing issues

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

Wider determinants which have the greatest impact on health & wellbeing

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

High impact social issues

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

Further information

www.bhlis.org/jsna2012

Cancer and Access to Cancer Screening

A Cancer

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

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

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

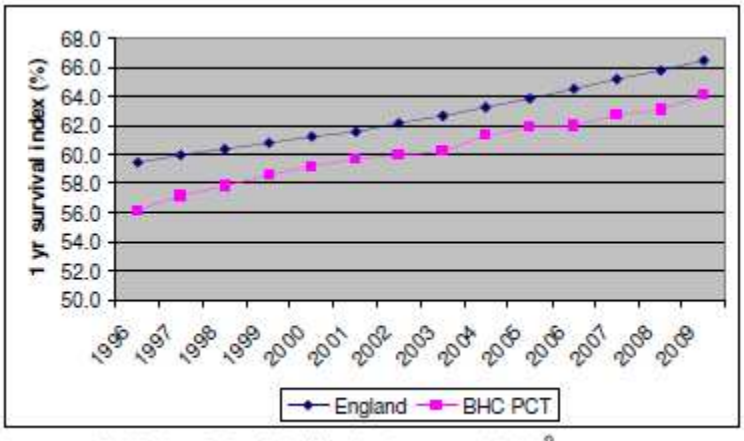
Incidence and mortality from cancer is considerably higher amongst the more deprived groups, largely due to lifestyle factors, such as higher smoking rates. The mortality gap between the poorest groups and the most affluent appears to be widening.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What we can do to make a difference

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

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

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

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

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

Support implementation of Sussex Cancer Network's delivery plans

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

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

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

Outcomes

From the Public Health Outcomes Framework:

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

From the NHS Outcomes Framework:

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

B Cancer Screening

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

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

In 2010/11:

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

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

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

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

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

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

What we can do to make a difference

<u>Bowel cancer</u>

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

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

Breast

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

Cervical

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

All programmes

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

Plan for improvement including key actions

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

Outcomes

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

Emotional Health and Wellbeing (including Mental Health)

What is the issue/ why is it important 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.'[10]

- A national survey carried out by the Office for National Statistics shows that some groups report higher levels of self-reported wellbeing.[11] 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.[12]

- 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.

<u>Brighton and Hove</u>

- The first local data from the ONS subjective wellbeing survey were published in July 2012.[13] Brighton and Hove residents reported higher average levels of happiness than the national average:

[10] HM Government. No health without mental health: A Cross-Government Mental Health Outcomes strategy for People of all Ages. London, 2011.
[11] Office for National Statistics. First Annual ONS Experimental Subjective Well-being Results. July 2012.
[12] No Health without Mental Health, as above.
[13] 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[14] 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[15]. For adults the numbers of A&E attendances and admissions related to self-harm are also very high.[16] 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.[17]

<u>Inequalities</u>

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

[14] Brighton and Hove City Council. City tracker survey, 2012.
[15] Reporting from Social Work Team, Brighton and Sussex University Hospitals.
[16] Public Health Observatories. Brighton and Hove health profile. 2012.
[17] HES data.

diagnosis or complex needs, and people with learning disabilities have all been identified as at higher risk[18].
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.

- Brighton and Hove appears to follow the national trend with BME groups having twice the national rate of mental health hospital admissions along with lower uptake of primary care mental health services[19].

- 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 [20]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[21].

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

What we are doing well already

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.

[18] HM Government. No health without mental health: implementation framework. London: July 2012.
[19] Hazel Henderson. Black and minority ethnic health needs analysis ,Brighton and Hove City PCT, 2008.
[20] http://media.education.gov.uk/assets/files/xls/l/la%20summary.xls
[21] 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[22] 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.

<u>Where are the gaps?</u>

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

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

Improved quality of care in general hospitals

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

Living well with dementia in care homes

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

Reduced use of antipsychotic medication

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

Other developments

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

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

What can we do to make a difference?

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

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

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

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

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

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

Plan for improvement including key actions

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

Outcomes

How will we measure success?

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

Healthy Weight and Good Nutrition

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

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

What are we doing well already?

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

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

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

- Promoting the Workplace Wellbeing Charter to all local businesses.

What are the gaps?

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

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

What can we do to make a difference?

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

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

Plan for improvement including key actions:

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

Outcomes

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

Smoking

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

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

What are we doing already?

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

What are the gaps?

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

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

What can we do to make a difference?

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

Plan for improvement including key actions

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

Outcomes

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

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

Inequalities

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

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

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

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

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

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

Marmot recommendations and the relevant local high-level partnerships.

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

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

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

Social issues				
	Children	**Young people**	**"Adults"**	**Older people**
Alcohol	Alcohol programme board Safe in the City Partnership Board			
		Youth Joint Commissioning Board		
Healthy weight and good nutrition	Physical activity steering group Transport Partnership			
Domestic and sexual violence	Domestic violence working group			
Mental health and emotional wellbeing	Emotional Health & Wellbeing Partnership Board (up to25yrs)		Mental health Clinical Reference Group Suicide prevention group (18+yrs)	
Smoking	Tobacco Control Alliance			
Disability	Disabled children's strategic partnership board Youth Joint Commissioning Board Transition forum		Learning disability strategy and partnership group Centre for Independent Living Carers Group*	
Specific conditions				
	Children	**Young people**	**"Adults"**	**Older people**
Cancer and access to screening	Sussex Cancer Network	Sussex Cancer Network	Sussex Cancer Network Individual cancer screening steering groups for breast, bowel and cervical cancer.	
HIV & AIDS		Sussex HIV Network Sexual Health Clinical Reference Group		
Musculoskeletal		Ongoing Sussex-wide review group		
Diabetes	Diabetes Clinical Reference Group			
Coronary Heart Disease			Sussex Cardiac Network	
Flu immunisations	Local Immunisation & Vaccination	Seasonal flu group		

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

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

Engagement and Consultation

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

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

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

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

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

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

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

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

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

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

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 85 Brighton & Hove City Council

Subject:		**Dual Diagnosis**	
Date of Meeting:		**23 July 2013**	
Report of:		**Monitoring Officer**	
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The purpose of this paper is to update the HWOSC on progress and future plans to improve local services and response to those with a dual diagnosis.

2. RECOMMENDATIONS:

2.1 The HWOSC is asked to note progress so far and the proposal to develop a more integrated model of care for Dual Diagnosis.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The term Dual Diagnosis describes the co-existence of mental health problems and problematic use of substances including drug and alcohol. However it is recognised that “dual diagnosis” is not a diagnosis in itself and the term “complex needs” may be a more appropriate term to use.

3.2 In 2012 a Joint Strategic Needs Assessment for Dual Diagnosis was completed and it highlighted the fact that: “Services for mental health and substance misuse in Brighton and Hove operate entirely separately, and the impact is felt across the system” (JSNA 2012). This separation of services can result in people being excluded from services, being bounced between services as individuals’ needs fail to meet existing service thresholds or falling through the net of care.

3.3 A Multiagency Dual Diagnosis Steering Group was established to strengthen the collaborative response to Dual Diagnosis and to take forward the recommendations of the Joint Strategic Needs Assessment report.

3.4 More details of the steering group’s work can be found in **Appendix 1.**

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 Engagement and consultation on the re-commissioning of substance misuse services will commence in summer 2013.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this cover report for information.

Legal Implications:

5.2 None to this cover report for information.

Equalities Implications:

5.3 None to this cover report for information.

Sustainability Implications:

5.4 None to this cover report for information.

Crime & Disorder Implications:

5.5 None to this cover report for information.

Risk and Opportunity Management Implications:

5.6 None to this cover report for information.

Public Health Implications:

5.7 Brighton and Hove Clinical Commissioning Group and Brighton and Hove City Council have identified improving the dual diagnosis care pathway as a key strategic priority for 2013-14. A lack of integrated service provision can result in high use of inappropriate services and poorer health outcomes including high levels of self-harm and suicide.

Corporate / Citywide Implications:

5.8 Reducing health inequalities and long standing public health issues is a key aim of the corporate priority to reduce inequalities.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S)

6.1 None

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 To keep HWOSC members updated with progress made by the Steering Group.

SUPPORTING DOCUMENTATION

Appendices:

1. Report from CCG

2.

Documents in Members' Rooms

1. None

2.

Health and Wellbeing Overview Scrutiny Committee

Dual Diagnosis Update

23rd July 2013

1. Purpose of the paper

The purpose of this paper is to update the HWOSC on both current progress and future plans to improve local services and response to those with a Dual Diagnosis.

2. Background

2.1 Brighton and Hove Clinical Commissioning Group and Brighton and Hove City Council have identified improving the dual diagnosis care pathway as a key strategic priority for 2013-14.

2.2 Mental health and substance misuse problems frequently coincide and the relationship is complex. Substance misuse is usual rather than exceptional for people with serious mental illness but co-morbidity can occur at any level of severity and is not just confined to those with serious mental illness.

2.3 The term Dual Diagnosis describes the co-existence of mental health problems and problematic use of substances including drug and alcohol. However it is recognised that "dual diagnosis" is not a diagnosis in itself and the term "complex needs" may be a more appropriate term to use.

2.4 National guidance and best practice is that "mainstreaming" is the key means of delivering care for people with **serious mental illness** and this means that overall care should be provided by mental health services, supported by substance misuse colleagues.

2.5 Conversely best practice is that the care of people with substance misuse problems with **mild to moderate mental health conditions** such as anxiety and depression be managed by substance misuse services and supported by mental health services.

2.6 In 2012 a Joint Strategic Needs Assessment for Dual Diagnosis was completed and it highlighted the fact that: "Services for mental health and substance misuse in Brighton and Hove operate entirely separately, and the impact is felt across the system" (JSNA 2012). This separation of services can result in people being excluded from services, being bounced between services as individuals' needs fail to meet existing service thresholds or falling through the net of care.

2.7 A lack of integrated service provision can result in high use of inappropriate services and poorer health outcomes including high levels of self-harm and suicide.

3. Summary of current progress

3.1 A Multiagency Dual Diagnosis Steering Group has been established to strengthen the collaborative response to Dual Diagnosis and to take forward the recommendations of the Joint Strategic Needs Assessment report.

3.2 The steering group has wide representation across the statutory and voluntary sector and includes: mental health, substance misuse, housing, criminal justice services (police and probation), primary care and wellbeing representation.

3.3 The Steering Group has developed a Multiagency Action Plan to take forward the recommendations of the Joint Strategic Needs Assessment report. Key developments to date are:

3.3.1 Definition of dual diagnosis

The steering group has adopted a broad definition of Dual Diagnosis, in line with the Joint Strategic Needs Assessment recommendation, so as to address the spectrum of Dual Diagnosis needs from those with mild to moderate mental health needs with problematic substance misuse to those with serious mental illness and problematic substance misuse. This is to ensure that people are not excluded from support, and that services work collaboratively to ensure an effective, appropriate and timely response to Dual Diagnosis.

3.3.2 Improved identification of Dual Diagnosis needs

The Multiagency Steering Group has developed a Universal Screening Tool to assist frontline staff, across agencies, to screen for Dual Diagnosis and to inform the assessment process. The tool is supported by a directory of support services to assist care navigation and signposting.

This Universal Screening tool will be piloted from July to September 2013. Frontline staff will receive joint training from the specialist Mental Health and Substance Misuse services on Dual Diagnosis and use of the screening tool. The tool will be evaluated in October 2013, it is hoped that it can then be rolled out for wider use from October 2013.

3.3.3 Assessment and management of Dual Diagnosis

Sussex Partnership Mental Health Trust, have in line with national guidance and best practice assumed lead responsibility for people with serious mental illness and a substance misuse problem. This principle is the foundation of the Sussex Partnership Foundation Trust Dual Diagnosis strategy which was launched in 2011.

Significant work has been done to support the development of shared assessment and care planning across mental health and substance misuse services.

A jointly developed shared care plan with commissioners and service users is currently being piloted by Sussex Partnership Foundation Trust across mental health and substance misuse services. This tool will be fully evaluated in September 2013.

3.3.4 Accommodation with Support

3.3.4.1 The need for more accommodation with support for those with complex needs, including Dual Diagnosis, was highlighted in both the Multi-agency Review of Mental Health Accommodation with Support 11/12 and the Dual Diagnosis Joint Strategic Needs Assessment 2012.

3.3.4.2 The findings of the Multi-agency review of Mental Health Accommodation with Support 11/12 resulted in a number of actions in relation to Dual Diagnosis including: a review of the West Pier hostel and a joint procurement for additional units of mental health accommodation with support.

3.3.4.3 On-going investment was secured for the West Pier which enabled the service to redesign and provide additional capacity for people with mental health, including Dual Diagnosis. The West Pier now has a total of 25 beds for mental health including dual diagnosis.

3.3.4.4. A recent joint procurement for Mental Health Accommodation with Support has resulted in the commissioning of an increased number of units for mental health, and a strengthened focus on those with complex needs including Dual Diagnosis.

The procurement covered four tiers of accommodation support:

- Accommodation with Support for High Support Needs
- Accommodation with Support for Medium Support Needs
- Floating Accommodation Support (within peoples own homes) and
- Tenancy Support services

The procurement has resulted in the successful commissioning of 120 units of support, of which a hundred are new and additional capacity for the city. The new services will start from February 2014 and will be monitored to ensure that services and accommodation pathways are flexible and appropriate to those with complex needs including Dual Diagnosis.

4. Future integrated care model for Dual Diagnosis

4.1 Whilst efforts so far have gone some way to strengthen partnership and joint working across mental health and substance misuse services a more integrated approach for those with a **serious mental illness** and problematic substance use is still required.

4.2 The Local Authority and the Clinical Commissioning Group have begun to scope how mental health and substance misuse services could be better aligned or integrated. Work has begun by mapping current services and the interfaces and overlaps between these services. This will help identify the substance misuse resource that could be integrated into mental health services.

4.3 The outcome of this work will be fully considered within the current re-commissioning plans for substance misuse services, led by the Local Authority and Public Health.

4.4 Engagement and consultation on the re-commissioning of substance misuse services will commence this summer, with a procurement process initiated in January 2014 for start of new services from April 2015.

4.5 For those with more **mild to moderate mental health issues** with substance misuse issues, work will continue via the Multiagency Steering Group to ensure that treatment and interventions are accessible and effective, and that care is streamlined and joined up where appropriate.

5. Summary and recommendation

The Multiagency Steering Group will continue to oversee and monitor progress against the Dual Diagnosis Multiagency Action Plan and promote a whole system collaborative response to Dual Diagnosis.

6. Recommendation

The HWOSC is asked to note progress so far and the proposal to develop a more integrated model of care for Dual Diagnosis. It is recommended that a further update is presented to the HWOSC in June 2014.

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 86 Brighton & Hove City Council

Subject:		**Stronger Families Stronger Communities**
Date of Meeting:		**23 July 2013**
Report of:		**Pinaki Ghoshal Director of Children's Service**
Contact Officer:	**Name:**	**Steve Barton Assistant Director Stronger Families Youth and Communities Tel: 29-2105**
	Email:	**Steve.barton@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The purpose of this report is to provide an overview of progress on the Stronger Families Stronger Communities (SFSC) programme and to seek feedback from the committee.

1.2 SFSC is Brighton and Hove's response to the national Troubled Families Programme which aims to 'turnaround' the lives of 120,000 families by the end of this Parliament. The council has agreed a target with the Troubled Families Unit (TFU) to work with 675 families or households (i.e. individuals without dependant children) between April 2012 and March 2015.

1.3 The previous HWOSC report (titled 'Troubled Families Initiative') and the minutes of that meeting are attached for information.

2. RECOMMENDATIONS:

2.1 That the Committee note the comments of the report.

2.2 That the Committee identify issues for the SFSC programme to take forward.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The national programme and our local programme have a shared hypothesis – that new approaches to improving the resilience, capacity and independence of families and households facing multiple disadvantages will improve outcomes for those families and significantly reduce public sector expenditure. Achieving and demonstrating that improvement and reduction is the strategic purpose of SFSC, rather than just drawing down short term Payment by Results (PBR) funding.

The council and its partners can, potentially claim PBR funding for 563 families/households with 112 receiving support from other parallel programmes such as 'Progress' (delivered by Skills Training UK, selected by the Department of Work and Pensions to deliver the European Social Fund Programme for

families with multiple problems). The maximum PBR funding over 3 years is 2.2m which is the government's estimate of 40% of the cost of working with this cohort.

SFSC is therefore pursuing a twin track strategy to:

- Deliver a multi-agency/cross sector Family Coaching service to families and households eligible for the SFSC programme
- Use evidence from that service to act as a catalyst for whole systems change

3.2.1 The programme reports to the Director of Children's Services, is accountable to the Executive Leadership Team and the Policy and Resources Committee and is managed by the Assistant Director for Stronger Families Youth and Communities. There are four levels of governance and operational management:

- Partnership Board: senior partners - policy and strategy
- Programme Board: the management team - strategy and operations
- Delivery Board: multi-agency triage and delivery
- Management Information Group: performance reporting and analysis

3.2.2 A family or household must meet 2 of the first 3 criteria set out in Appendix 1 to be eligible for the programme. Criterion 4 is our local filter to prioritise allocation.

3.2.3 Line management of the city's successful Family Intervention Project (FIP) was moved from Community Safety to Children's Services in order to provide a tried and tested platform for the new team. Forward funding from the government's PBR scheme has been used to recruit additional Family Coaches. An innovative partnership arrangement means that six of the new coaches have a lead role with key partners. In return each partner is seconding a member of staff into the ITF, significantly increasing capacity, demonstrating tangible partnership and creating a multi-agency approach (Family Coaching) across the Police, Probation, Adult Social Care, the Children in Need Team, Housing and the Youth Offending Service. In total there are 29.5 (FTE) Family Coaches management and administrative posts in the ITF.

Close partnership with the Community and Voluntary Sector has enabled us to contract with CRI, following a competitive tendering process, for them to deliver 45 family interventions and introduce a scheme for other voluntary agencies to claim results payments when they have worked successfully with families.

3.5. Our most significant intervention is Family Coaching alongside a group work programme and community initiatives. Based on the success of our local FIP and national evidence published by the TFU which describes the five core elements of effective family intervention as:

- A dedicated worker, dedicated to a family
- Practical 'hands on' support
- A persistent, assertive and challenging approach
- Considering the family as a whole – gathering the intelligence
- Common purpose and agreed action

In Brighton and Hove Family Coaching is provided at four levels:

- Intensive: allocated to ITF, working intensively with families
- Support: : allocated to ITF, supporting families and professionals
- Mentoring: ITF provide support to lead agency/professional network
- Monitoring: Lead Agency hold case and ITF monitors progress

3.6. At the time of writing 226 families have engaged on the programme and we have closed 19 cases after Family Coach interventions. The TFU is very satisfied with our progress. We have claimed our full year 1 PBR funding and are eligible for the full year 2 funding. The SFSC Performance Report for July 2013 is attached as Appendix 3.

3.7. The SFSC Programme Board is responsible for collating evidence to support our participation in or leadership of initiatives to act as a catalyst for whole systems change. This includes:
Connecting to relevant city wide, corporate and children's services priorities and development including:

City-wide:

- Presentation to City Management Board 16th April as part of a discussion about community budgets focusing on vulnerable adults; presentation to the Safe in the City Partnership (9th July) focusing on partnership working to address anti-social behaviour
- Representing B&H statutory sector agencies on the Core Group for Pan Sussex Lottery Bid for services for vulnerable adults

Corporate:

- membership of Financial Inclusion, Welfare Reform and Neighborhood Governance boards and/or working groups
- implementation of Patchwork (an application to allow front line workers from different agencies to share information about the families and individuals they are working with)

Children's Services:

- to strengthen integration and a single children's service approach we have created a new service area – Stronger Families Youth and Communities comprising: SFSC; Value for Money; the Youth Offending Service; the Council's Youth Service; the Youth Employability Service; and the Clermont Family Assessment Centre
- the ITF pathway and triage process is part of an initial proposal to create a Single Early Help Pathway, building on the Common Assessment Framework and dovetailing with discussions to establish a Multi-agency Safeguarding Hub (MASH) for Brighton and Hove and supporting the design of a city wide Early Help Strategy.

SFSC information systems generate data to provide weekly case-work reports, a quarterly performance report (Appendix 2) and enable claims to the TFU for payment by result funding. Strategically this data also supports:

- A Savings Calculations Framework. Based on a national prototype developed by Greater Manchester and the Department of Communities and Local Government. The framework has been agreed by the SFSC Board and is providing projections to support future budget planning.
- Local evaluation (focusing on service user feedback) and participation in the national evaluation programme

SFSC is involved in a range of change initiatives of which the following are particularly relevant to the Health and Well Being agenda:

- Services for vulnerable adults especially those who are parents: we have convened an informal working group of adult and children social care and health staff to examine the complex interface between services. The second

session on July 15th shared information about different pathways, thresholds and services and considered how best to support key developments including:

- Meeting the requirements of the Family Justice Review and new Public Law Outline – and therefore the early identification and assessment of cases, including where more than one child has been the subject of care proceedings
- Consolidating short term funding from adult social care and health/public health to provide specialist support (mental health, substance misuse and domestic violence) to the children's services Advice, Contact and Assessment Service and, potentially establishment of a MASH and/or a Single Early Help Pathway.
- Improving pathways and joint commissioning across children's and housing services including a new pathway for 16+ advice and accommodation

- Joint approach to a cohort of vulnerable young people: we are part of an emerging project between the council's Pupil Referral Unit federation, Public Health, the council's Youth Service and the Youth Offending Service to develop a programme of activities to support individual care plans/interventions for young people involved in or at risk of being involved in anti-social behaviour and who are known to 'Operation Blower' and the above services.

- Employment and advice services: one of the most challenging SFSC targets and a major challenge for the city SFSC is part of a number of initiatives including:

- Secondment of a full time staff member from Job Centre Plus to the ITF
- New opportunities between ITF, Job Centre Plus and the Youth Employability Service (YES) facilitated by the creation of Stronger Families Youth and Communities in Children's Services
- Transfer of the lead for the implementation of new approach to Youth Information Advice and Counseling Services to YES following a review led by the Children's Commissioning Team

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 SFSC is one of three projects forming a Co-production Pilot funded by the Local Strategic Partnership and run by the Community and Voluntary Sector Forum which focuses on the development of community engagement and consultation.

4.2 SFSC's local evaluation programme is focussing on service user and community engagement to complement the national evaluation programme.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The Stronger families, Stronger Communities initiative is underpinned by grant from the Department of Communities and local government. The grant is split between an 'attachment fee' paid in advance based on the number of families that the local authority will work with, a payment by results element, paid when the success criteria has been met and an amount to cover management costs. The estimated costs of an intervention with a family is £10,000 and the grant is

based on 40% of this cost with an expectation that local authorities and their partners will fund the remaining 60%.

In 2012/13 the grant received was £704,000 of which £100,000 related to the management element and £2,400 claimed against the payment by results criteria. Of this £591,000 has been carried forward to 2013/14. The attachment fee for 2013/14 is £676,800 and has already been received along with the £100,000 management element.

In addition to the grant the Council funds the Integrated Team for Families at £450,000 per annum and there are contributions (annually for three years) of £36,000 from the Youth Offending Service, Children's Social work teams and the Housing and Adult social care Directorates. Also there is in-kind contributions from the Probation and Police services.

The estimated costs for the initial three years of the project are c£3.7m and work is currently underway to ascertain the estimated level of savings generated. It is difficult at this stage to accurately project the level of savings achievable as very few cases have been closed and therefore there is not enough evidence with which to extrapolate the likely level of success of the project.

Finance Officer Consulted: *David Ellis* *Date: 12/07/2013*

Legal Implications:

5.2 The SFSC programme will assist the council in delivering a number of statutory duties across different service areas, including the duty under S17 of the Children Act 1989 to "safeguard and promote the welfare of children within their area who are in need; and so far as is reasonably consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs", as well as the duties under Children Act 2004 of a number of agencies to promote the wellbeing of children.

Lawyer Consulted: *Natasha Watson* *Date: 12/07/2013*

Equalities Implications:

5.3 An Equalities Impact Assessment is in final draft. The findings have not been included in this report.

Sustainability Implications:

5.4 A sustainability assessment is being completed.

Crime & Disorder Implications:

5.5 Issues of Crime and Disorder are central to the programme and are one of the three determining eligibility criteria. The Assistant Director responsible for the programme sits on the Safe in the City Partnership Board and is also responsible for the Youth Offending Service.

Risk and Opportunity Management Implications:

5.6 These are set out in the Stronger Families Youth and Communities Business Plan for 2013/14 and are based on a workshop, focussing on SFSC with the council Risk Manager.

Public Health Implications:

5.7 This is dealt with in the body of the report.

Corporate / Citywide Implications:

5.8 This is dealt with in the body of the report.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Different arrangements were considered for the location and line management of the SFSC programme.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The recommendations reflect the Committee's request for an update following an initial presentation in December 2012.

SUPPORTING DOCUMENTATION

Appendices:

1. **Appendix 1**

Criteria 1. Crime/anti-social behaviour (ASB)

- Households with 1 or more under 18-year-old with a proven offence in the last 12 months
- Households where there is persistent anti-social behaviour (please consider likelihood of this behaviour reoccurring and/or impact on victims)

Criteria 2. Education (family affected by at least one child engaging in truancy or exclusion from school)

- Has been subject to permanent exclusion?
- There has been three or more fixed school exclusions across the last 3 consecutive terms
- Is in a Pupil Referral Unit or alternative provision because they have previously been excluded
- Is not on a school roll
- A child has had 15% unauthorised absences or more from school across the last 3 consecutive terms

Criteria 3. Work

- Has an adult on DWP out of work benefits (Employment and Support Allowance, Incapacity Benefit, Carer's Allowance, Income Support and/or Jobseekers Allowance, Severe Disablement Allowance)

Criteria 4. (Applies to families with children and households without dependant children)

- Families with children subject to a Family CAF, Child in Need or Child Protection Plan and/or where a child(ren) are at risk of entering the care system
- Families or households causing high cost to public services including frequent police call outs or arrests, or where there is an adult currently serving a custodial sentence or subject to probation supervision (community order or license)
- Families or households where there are significant underlying health problems including emotional and mental health problems; drug and alcohol misuse; long term health issues; health problems caused by domestic violence; under 18 conceptions
- Families or households where there is an adult on an Adult Safeguarding Plan

Appendix 2:

Stronger Families, Stronger Communities Performance Report July 2013

All figures are cumulative i.e. 01/04/2012 to 29/06/13

Headline Data

1.1 Overall Targets (3 year programme)

Eligible Cases identified to date	**546**	**81%**
Total number of families engaged on programme to date	**226**	**33%**
(Number of cases currently OPEN)	**(207)**	
(Number of cases to date CLOSED)	**(19)**	

1.2 Benchmark Data – Comparison (Troubled Families Unit 31/03/2013)

Area	Total number of Families	Number of families identified	No. of families worked with	% of families worked with	No. of families turned round at Jan 2013	% of families turned around
BHCC	675	526	183	**27%**	3	**0%**
National Average				**30%**		**1%**

1.3 Progress against Local Targets 2013 – Detail

Results	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Families Identified	439	491	526	534	540	546						
Target	250	250	250	335	335	335	419	419	419	563	563	563
Percentage	175.6 %	196.4 %	210.4 %	159.6 %	161.4 %	163%						
Families Engaged	70	83	183	187	190	226						
Targets	100	150	180	208	236	265	293	321	363	405	448	490
Percentage	70.0%	55.3%	101.7 %	89.8%	80.4%	85.7%						

1.4 Engaged Cases Type

	End Jun 13
ITF Intensive	**58**
ITF Supported	**78**
ITF Mentoring	**11**

CVS Supported	
ITF Monitoring	**79**
Total	**226**

	Jun 13 Actual	June 13 %	Profile %
Intensive	**58**	**26%**	**15%**
Supported	**78**	**35%**	**52%**
Mentoring	**11**	**4%**	**20%**
Monitoring	**79**	**35%**	**13%**
Total	**226**	**100%**	**100%**

1.5 Eligibility Criteria / Case Mix Breakdown

	%	No. of cases
Crime/ASB, Education and Worklessness	25	57
Crime/ASB and Worklessness Only	15	33
Crime/ASB and Education Only	12	28
Education and Worklessness Only	48	108
		226

1.6 Coached cases worked to date (Cases at Intensive or Supported level)

ITF Core Family Coaches		**66**
Seconded coaches		**29**
Seconded Children's Social Care Coaches	4	
Seconded Housing Coaches	5	
Seconded Police Coach	2	
Seconded Probation Coaches	12	
Seconded Youth Offending Coaches	6	
Specialist coaches		**40**
Specialist Adult Social Care Coach	7	
Specialist Children's Social Care Coach	14	
Specialist Housing Coach	7	
Specialist Police Coaches	5	
Specialist Youth Crime Coaches	7	
CAF Mentor		**1**
Total		**136**

2. Families Identification and Triage Process

Total number of potentially eligible cases identified through Data Matching (P1)	447
Total number of eligible referrals received from professionals (P2)	168
(Of which, those families that had already been identified via data)	(- 69)

Total number of potentially eligible families identified	**546**

Pre-Investigation	170
Investigation	38
Triaged (eligibility confirmed) and Pending Allocation	97
Allocated but not yet confirmed open	16
Open	207
Closed	19
	(546)

Triage Process:

Cases Triaged to date (Mixture of P1 and P2 cases)	418
Accepted onto programme	309
Further Investigation required	23
Confirmed Not Eligible at Triage	86

3. Case Closure and Success Rate

Total number of cases closed to date	**19**
No claim	8
Claims for Category 1a (Crime, ASB and Education) ONLY	3
Claims for Category 1b (Progress to Employment) ONLY	3
Claims for Category 1a AND Category 1b	4
Claims for Category 2 (Continuous Employment)	1

Analysis of Success To Date

Total possible potential claim from 19 closed cases	**£15200**	**(19*£800)**
Total success to date	£6400	**42.11% success rate**
Actual PbR Monies to claim to date	**£5333**	(£6400*5/6ths)

5. Case Characteristics

The information below relates to the total caseload of 227 cases worked with to date, 724 individuals. Only individuals resident in the main family household have been included.

General Information

Age – By Individual		
Under 5	43	5.9 %
5 – 12	145	20%
13-16	211	29.1%
17-18	45	6.2%
18+	264	36.5%

(DOB Unknown)	16	(2.3%)

Ethnicity – By Individual		
White British	590	81.5%
Asian or Asian British – Pakistani	2	0.3%
Asian or Asian British – Bangladeshi	4	0.6%
Other (Middle Eastern / Arab)	14	1.9%
Black or Black British – African	5	0.7%
Mixed White and Black African	13	1.8%
Mixed White and Black Caribbean	6	0.8%
Other Mixed	4	0.6%
White Irish	4	0.6%
White Other	8	1.1 %
(Ethnicity Unknown)	74	(10.2 %)

Gender – By Individual		
Male	327	45.2%
Female	397	54.8%

Housing – By Family		
Social Housing – BHCC	118	52%
Social Housing – Housing Association / RSL	42	18.5%
Private Rented Sector	32	14.1%
Temporary / Emergency Housing	11	4.8%
Private Ownership	4	1.8%
Other	1	0.4
Information not known	19	8.4%

Lone Parent Families – By Family *(information has not been collected to date in Monitoring cases)* Of which Female lone parent Of which Male lone parent	102/151	67.5% 92.9% 7.1%

Benefits cap

15 of the total 226 cases **(6.6%)** are currently affected by the Benefits Cap, with amounts varying between £23 and £323 per week.

Schools Information

School Name	Number of Pupils in ITF Cases
Alternative Centre for Education	21
BACA	27
Benfield Primary	6
Bevendean Primary	6
Blatchington Mill	10
Brighton and Hove Pupil Referral Unit	16
Carden Primary	9
Cardinal Newman	15

Carlton Hill Primary	3
Cedar Centre	8
Coldean Primary	5
Coombe Road Primary	7
Dorothy Stringer	13
Downs Park	2
Elm Grove Primary	1
Fairlight Primary	6
Goldstone Primary	6
Hangleton Infant	2
Hangleton Junior	5
Hertford Infant	2
Hertford Junior	2
Hove Park	37
Longhill High	41
Moulsecoomb Primary	13
PACA	12
Patcham High	15
Patcham House	2
Patcham Junior	2
Peter Gladwin Primary	1
Rudyard Kipling Primary	6
Somerhill Junior	2
St Bartholomew's CE Primary	3
St John the Baptist RC Primary	1
St Joseph's RC Primary	1
St Luke's Primary	4
St Mark's CE Primary	7
St Nicolas CE Junior	4
Stanford Junior	1
The Connected Hub	16
Varndean	34
West Blatchington Primary	5
West Hove Junior	1
Whitehawk Primary	11
Woodingdean Primary	3
Grand Total	**394**

314 **(79.7%)** of the pupils are eligible for Free School Meals.

54 **(13.7%)** have a Statement of Special Educational Needs, with a further 218 **(55.3%)** having a status of either School Action or School Action Plus.

All Education data is correct as of the Schools Census on 21st January 2013.

Other Family Issues

Additional information was collected this month to support the work around the Savings Calculation Framework.

This information was received via Coaches in the Integrated Team for Families, through direct contact with the families themselves. As such there are some issues around disclosure and quality of information, particularly as many of the cases in question were very new at the time of the analysis, and coaches may not yet have developed relationships with the families to the level needed to fully collect this information. The figures in this section should therefore be treated as indicative rather than exact.

The most prevalent issue is Adult Mental health with Family Coaches reporting **32**% of adults within coached cases as having some sort of mental health issue, whether formally diagnosed, reported by another case worker or self reported by the client. 38% of these were reported as being Service Users.

Domestic Violence is also a significant issue, with **18%** of clients reported as experiencing DV at the start of the intervention, and **47%** reported as having experienced DV in the past.

Of those currently experiencing DV, child-to-parent DV is by far most prevalent accounting for 78% of cases. Previously experienced DV is more likely to have been reported as being from a partner, with this accounting for 64% of those cases.

Substance misuse issues are more prevalent than alocohol misuse issues, with **13%** of adults reported as having an alcohol misuse issue and **9%** with a substance misuse issue.

Documents in Members' Rooms

None

Background Documents

None

HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE	**Agenda Item 48** Brighton & Hove City Council

Subject:		**Stronger Families, Stronger Communities Programme**		
Date of Meeting:		**18 December 2012**		
Report of:		**Heather Tomlinson**		
Contact Officer:	**Name:**	**Steve Barton**	**Tel:**	**296105**
	E-mail:	**Steve.barton@brighton-hove.gov.uk**		
Wards Affected:	**All**			

FOR GENERAL RELEASE

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1.1 Stronger Families, Stronger Communities (SFSC) is Brighton and Hove's response to the national Troubled Families Programme which aims to 'turnaround' the lives of 120,000 families by the end of this Parliament. The council has agreed a target with the Troubled Families Unit (TFU) - to work with 675 families or households (i.e. individuals without dependant children) between April 2012 and March 2015.

1.2 The council can therefore claim Payment by Results (PBR) funding for 563 families/households with 112 receiving support from the parallel 'Progress Programme' (delivered by Skills Training UK, selected by the Department of Work and Pensions to deliver the European Social Fund Programme for families with multiple problems). The maximum PBR funding over 3 years is 2.2m which is the government's estimate of 40% of the cost of working with this cohort.

1.3 The national programme and our local programme have a shared hypothesis - that new approaches to improving the resilience, capacity and independence of families and households facing multiple disadvantage will improve outcomes for those families and significantly reduce public sector expenditure. Achieving and demonstrating that improvement and reduction is the strategic purpose of SFSC, rather than just drawing down short term PBR funding.

1.4 SFSC is therefore pursuing a twin track strategy:

- Urgently to establish delivery arrangements
- Providing evidence and acting as a catalyst for whole systems change

2. RECOMMENDATIONS:

2.1 That the Committee notes the SFSC aims and objectives and the progress made in establishing the programme

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Background:

SFSC is based on the work of a multi-agency Working Group established in November 2011 to review the city's response to families facing multiple disadvantage. The SFSC Lead Commissioner/Coordinator came into post on 1st August.

3.2 Governance, eligibility, project management, vision and strategy:

The multi-agency Partnership Board agreed governance arrangements i.e.

- Partnership Board: senior managers/commissioners – policy, strategy joint commissioning and co-production
- Programme Board: the management team – strategy, operations, impact
- Delivery Board: integrated management and delivery systems - identification, triage and allocation and supervision of case work
- Management Information Group: data systems and sharing, performance reporting and analysis

(See Appendix 1 for Membership)

The Partnership Board agreed the 4th local criteria which, with the 3 national PBR criteria determines eligibility for the programme (Appendix 2). Brighton and Hove is one of only a few local authority areas that includes both families with children and vulnerable adults in households without dependant children.

A draft vision and strategy is attached as Appendix 3 and provides a succinct statement of purpose and a baseline for evaluating impact and outcomes.

3.3. Engagement and Communication:

Programme Board officers are members of, have met with, presented to or submitted reports to: the Local Strategic Partnership; Public Service Board; Safe in the City Partnership Board; Community Safety Forum; Shadow Health and Well Being Board; Community and Voluntary Sector Forum; Learning Partnership; Head Teachers Business Conference; Sussex Court Liaison and Diversion Scheme; Integrated Offender Management Group; Joint Commissioning Board for Services for Young People; the Core Group for a Sussex partnership bid for Big Lottery Funding for adults with complex and multiple needs; Sussex Partnership Foundation Trust; the Domestic Violence Commissioning Group; the Alcohol Programme Board; the Substance Misuse Programme Board; the Neighborhood Governance Board; the Financial Inclusion Working Group; Information Governance Group; the School Governors Forum; the Behavior and Attendance Partnership; the Local Safeguarding Children's Board;

We are scheduled to attend: the Children's Service Committee. There are a series of meetings scheduled with Head Teachers and local schools clusters. The SFSC Programme is one 3 projects that form a Co-Production Pilot led by the Community and Voluntary Sector Forum and funded by the city's Public Service Board.

3.4. Delivery:

The council has moved line management of the Family Intervention Project from Community Safety to SFSC to provide an evidence-based platform for a new Integrated Team for Families (ITF).

Forward funding from the government's PBR scheme has been used to recruit additional Family Coaches. An innovative partnership arrangement, devised by a multi-agency working group, means six new coaches will have a lead role with key partners. In return each partner is seconding a member of staff into the ITF significantly increasing capacity, demonstrating partnership and creating an integrated multi-agency approach across the Police, Probation, Adult Social Care, the Children in Need Team, Housing and the Youth Offending Service.

Our year 1 target is to engage with a total of 225 families/households -187 through SFSC and 38 through the Progress Programme. The Delivery Board has is establishing a service pathway i.e.

- Identification: sharing data/professional referrals to identify families
- Investigation: confirmation of eligibility & summary of current support
- Triage: first determination of likely service level
- Engagement: initial visit to gain consent/agree action plan
- Delivery: intervention/support/monitoring
- Outcomes: closure, step-down provision or escalation

Triage is the first key decision point where a multi-agency group identifies, prioritises and decides likely level of service i.e.

- Intensive: allocated to ITF, working intensively with families
- Support: allocated to ITF, supporting families and professionals
- Mentoring: ITF provide support to lead agency/professional network; or
- Monitoring: Lead Agency hold case and ITF monitor progress and ensure appropriate data is collected

(See Appendix 4)

Following successful engagement a plan will be drawn up with the family and any professionals already involved. Assessment and case management arrangements will be based on the Common Assessment Framework and Team Around the Child processes and will, whenever necessary dovetail with case management systems of partners e.g. Children in Need Plans.

We have 35 cases allocated or pending allocation and 30 open 'legacy' cases.

3.5. Strategy:

Programme Board members are taking forward a wide range of initiatives to jointly commissioning and/or develop integrated partnership and delivery arrangements including:

- Through membership of the Alcohol Programme Board, the Substance Misuse Programme Board and the Domestic Violence Commissioners Group
- discussions with the council's school improvement team and head teachers to involve schools e.g. on-site triage/planning meetings in respect of all eligible children on roll
- co-producing a commissioning framework so that community and voluntary sector organisations, with the capacity to deliver 'whole-family' interventions, are part of the programme
- representing the council and local statutory partners on the Core Group developing a Big Lottery Bid for services to adults with complex and multiple needs across Brighton and Hove, Eastbourne and Hastings
- participating in the development of the Integrated Offender Management strategy
- agreeing with Sussex Partnership Foundation Trust pathways into support from specialist mental health services

The Programme Board has limited capacity and is therefore targeting key strategic issues that directly relate to families and households facing or at risk of multiple disadvantage. For example through membership of the council's Financial Inclusion and Neighborhood Governance Boards and by championing the implementation of the Patchwork Application (which will enable front line practitioners quickly to contact those professionals already involved with families) which is playing a key role in developing our understanding of the information sharing and systems agenda that underpins much of this work.

A central purpose of the programme is to collate information about eligible families and households - their lives, experiences and aspirations, and the issues and challenges they face with the support and enforcement agencies that know them. And, on the basis of that evidence and with our partners to identify and address issues, barriers and opportunities to promote whole systems change.

The programme has a particular responsibility to consider the needs facing families and households at risk of becoming eligible for the programme. For example the programme is part of a meeting between children's social care and housing to consider the impact of changes to welfare and other benefits on homelessness and levels of accommodation need in relation to the council's overlapping statutory responsibilities.

Our critical strategic priority is to develop a local response to the central hypothesis of the programme i.e. that a new approach to improving the resilience, capacity and independence of families and households facing multiple deprivation will improve outcomes for those families and significantly reduce public sector expenditure. An outline proposal will be presented the SFSC Partnership Board in December based on:

- the successful Children's Services Value for Money Programme
- a 'cost-calculator' format developed by a consortium of authorities in Greater Manchester (and validated by the DCLG)
- the outcomes of the second phase of the national Communities Budget projects – all of which are addressing families in multiple disadvantage

4. CONSULTATION

4.1 From its inception the SFSC Programme has reflected the engagement and partnership priorities set out in the council's Corporate Plan, the City's Sustainable Community Strategy and the strategies and plans that underpin them.

4.2 Those priorities are demonstrated by the programme's governance arrangements and communication and engagement activity including participation in the Co-Production Pilot led by the Co immunity and Voluntary Sector Forum.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1.

Financial Implications:

The Stronger Families, Stronger Communities programme is financed by a mixture of new external funding and use of current existing resources. The council has bid for external funding delivered through a payment by results mechanism which is split between an upfront 'attachment fee' totalling £1.4m over three years and a results based element of up to £0.8m, dependant on the level of success. In addition to this current council resources of £0.6m per annum have been identified to support the programme. The strategy is designed to deliver savings across a range of organisations including BHCC and the success of this will be monitored and reported as part of the children's services VFM programme.

Finance Officer Consulted: David Ellis *Date: 15/11/12*

5.2

Legal Implications:

The context of the SFSC programme is set out in the body of the report. In providing services aimed at a cohort of families experiencing multiple disadvantage the programmes will assist the authority in meeting its statutory duties to families in need under Children Act 1989, it will promote the outcomes for children contained in the Children Act 2004 under which public agencies must co-operate, and it will assist the authority in meeting the overarching duties under the equalities legislation. Adults in need of community care services are entitled to assessment and identification of relevant services and this agenda should also promote the capacity to fulfil that statutory duty.

Lawyer Consulted: Natasha Watson *Date:20.11.12*

5.3.

Equalities Implications:

The purpose of the SFSC programme is to target and support a cohort of families and households in the city experiencing multiple disadvantage, which often includes the impact of overlapping inequalities issues. As well as working with families and individuals, to improve their well being and outcomes, the programme is charged with promoting whole systems change.

5.4

Sustainability Implications:
The programme seeks to improve the resilience, capacity and independence of families and households facing multiple deprivation to improve outcomes for those families and significantly reduce public sector expenditure. The sustainability of the programme, and/or of the key interventions it uses will depend on successful identification of those efficiencies.

5.5

Crime & Disorder Implications:
Anti-social behaviour and criminal activity are integral to the national and local eligibility criteria for the programme. The ITF is based upon the successful Family Intervention Project, which was part of national programme targeting anti-social behaviour. In addition the Police, Probation and Youth Offending Service are seconding staff into the programme to support the development of integrated approaches to addressing crime and disorder. The Lead Commissioner is also a member of the Safe in the City Partnership.

5.6

Risk & Opportunity Management Implications:
The SFSC Programme Board maintains a risk register. The programme is working with the council's Internal Audit to manage process and risk in respect of PBR claims to the national Troubled Families Unit. The above report sets out a range of opportunities the programme is exploring with partners.

5.7

Corporate / Citywide Implications:

The above report describes how the SFSC programme will support corporate and city wide priorities, plans and service developments.

SUPPORTING DOCUMENTATION

Appendices:

Appendix 1: Membership of Governance Groups

Appendix 2: SFSC Eligibility Criteria

Appendix 3: SFSC Draft Vision/Strategy

Appendix 4: Levels of Service Offered by ITF

Appendix 1: Membership of Governance Groups

Partnership Board:

Steve Barton, Lead Commissioner Stronger Families Stronger Communities, B&HCC (Chair)

Andy Porter, Deputy Director Social Inclusion, Sussex Partnership NHS

Gail Grey, CEO, Women's Refuge / RISE

Debbie Corbridge, ITF Manager, B&HCC

Denise D'Souza, Director of Adult Social Services, Lead Commissioner ASC and Health B&HCC

Heather Tomlinson, Interim Director of Children's Services, BHCC

Geraldine Hoban, Chief Operating Officer, Brighton and Hove Transitional Consortium PCT

Joanne Matthews, Strategic Commissioner for Adults and Older People, PCT

James Dougan/Rosalind Turner, Head of Children and Families, B&HCC

Jo Lyons, Lead Commissioner - Schools, Skills & Learning, B&HCC

Laura Williams, Communications Development and Lead Officer, CVSF

Leighe Rogers, Offender Management Director, Sussex Probation

Linda Beanlands, Commissioner - Community Safety, B&HCC

Louise Hoten, Head of Finance - Business Engagement / CYPT & Environment B&HCC

Mark Rist, CMgr FCMI GIFireE , T/Area Manager, Borough Commander, Brighton & Hove, ESFRS

Nick Hibberd, Head of Housing & Social Inclusion, B&HCC

Nicky Cambridge, People & Place Co-ordinator / Communities & Equalities Commissioning, B&HCC

Paul Brewer, Head of Performance, Performance Team, B&HCC

Peter Wilkinson, Public Health Consultant, PCT

Rima Desai: VFM Programme Lead, Strategic Commissioner, B&HCC

Simon Nelson, Temporary Superintendent, Public Protection Teams and Joint Delivery, Sussex Police

Valerie Pearce, Head of City Services, B&HCC

Programme Management Board

Steve Barton, Lead Commissioner Stronger Families Stronger Communities, B&HCC (Chair)

Debbie Corbridge, ITF Manager, B&HCC

Ellen Jones, Head Of Service - Integrated Area Working - Schools & Communities

Paul Brewer, Head of Performance, Performance Team, B&HCC

Rima Desai: VFM Programme Lead, Strategic Commissioner, B&HCC

Sarah Colombo: Child Poverty/CVS, Childcare Strategy Manager - Information & Workforce Development

Sue Boiling: Service Manager, Agency Placement Team/VFM

Delivery Partnership

Anna Gianfrancesco, Service Manager, Youth Offending Service, B&HCC

Bruce Mathews, Chief Inspector, Sussex Police

Debbie Corbridge, ITF Manager, B&HCC

Deborah Parr, ITF Monitoring and Performance Officer, B&HCC

Emma Gilbert, Social Inclusion & Involvement Manager, B&HCC

Fay Roberts, Family Intervention Project Operational Manager, B&HCC

Lucy Anderson, Operations Manager, Skills Training

Martin Edwards, Senior Probation Officer, Sussex Probation

Mat Thomas, ITF Operational Manager, B&HCC

Peter Castleton, Community Safety Manager (Casework), B&HCC

Richard Cattell, Senior Social Worker, B&HCC

Richard Hakin, Operational Social Work Service Manager, Children In Need, B&HCC

Richard Jordan-Penswick, Tenancy Manager, Anti-Social Behaviour Housing Team, B&HCC

Steve Barton, Lead Commissioner Stronger Families Stronger Communities, B&HCC

Steve Springett, Family Intervention Project Operational Manager, B&HCC

Management Information and Infrastructure Group

Paul Brewer, Head of Performance, Performance Team, B&HCC (Chair)

Rima Desai: VFM Programme Lead, Strategic Commissioner, B&HCC

Kim Bowler, Performance & Business Manager, Youth Offending Service, B&HCC

Deborah Parr, ITF Monitoring & Performance Officer, B&HCC

Daniel Elliott, Education Performance Analyst, B&HCC

TBA, ASB Data Specialist

TBA, Corporate ICT representative (in phase 2)

TBA, CVS representative (in phase 2)

Appendix 2: SFSC Eligibility Criteria

The family, individual or household would need to meet 2 of the first 3 criteria to be eligible for the Stronger Families Stronger Communities Programme. Criteria 4 will help to prioritise allocation.

Criteria 1. Crime/anti-social behaviour (ASB)

a. Households with 1 or more under 18-year-old with a proven offence in the last 12 months

b. Households where there is persistent anti-social behaviour (please consider likelihood of this behaviour reoccurring and/or impact on victims)

Criteria 2. Education (family affected by at least one child engaging in truancy or exclusion from school)

a. Has been subject to permanent exclusion?

b. There has been three or more fixed school exclusions across the last 3 consecutive terms

c. Is in a Pupil Referral Unit or alternative provision because they have previously been excluded

d. Is not on a school roll

e. A child has had 15% unauthorised absences or more from school across the last 3 consecutive terms

Criteria 3. Work

Has an adult on DWP out of work benefits *(Employment and Support Allowance, Incapacity Benefit, Carer's Allowance, Income Support and/or Jobseekers Allowance, Severe Disablement Allowance)*

Criteria 4. Brighton & Hove Local Priorities (applies to families with children and households without dependant children)

a. Families with children subject to a Family CAF, Child in Need or Child Protection Plan and/or where a child(ren) are at risk of entering the care system

b. Families *or* households causing high cost to public services including frequent police call outs or arrests, or where there is an adult currently serving a custodial sentence or subject to probation supervision (community order or license)

c. Families *or* households where there are significant underlying health problems including emotional and mental health problems; drug and alcohol misuse; long term health issues; health problems caused by domestic violence; under 18 conceptions

d. Families *or* households where there is an adult on an Adult Safeguarding Plan

Appendix 3: SFSC Draft Vision/Strategy:

Vision:

An integrated policy, commissioning, delivery programme that supports:

- The council's Corporate Plan**:** tackling inequality; promoting engagement; and achieving value for money
- The city's Sustainable Community Strategy and: the strategic priorities of the Learning Partnership; the Safe in the City Partnership; the City Employment and Skills Plan; and the Local Safeguarding Children's Board.

Values and Principles:

- Partnership and co-production
- Outcome led and evidence based
- Reflexive –partnership, commissioning and casework will be respectful, honest, challenging, assertive, authoritative , persistent, supportive and compassionate

Strategy:

- To co-produce a programme of strategic, community and individual interventions that improves resilience and outcomes for families and households facing multiple deprivation
- To monitor the impact of interventions to reduce costs, invest in early help and preventive services, promote public sector innovation and build social capital

Objectives:

- Commission and deliver evidence based interventions and build flexible professional systems which enable mainstream services to meet the needs of families and households facing multiple deprivation
- Negotiate whole systems change and prevention strategies based on the evidence and experience of families and households eligible for the programme, identifying and resolving issues impeding the effectiveness and value for money of local services for families facing, or at risk of multiple deprivation

Workstreams:

Delivery:

- Establish a multi-agency Integrated Team for Families to provide whole family/multi-professional interventions and support to eligible families
- Jointly commission and/or integrate other whole family and/or specialist services and build shared information and/or case management systems, especially with schools and colleges, the NHS and community and voluntary sector organisations

Whole Systems Change:

- Be a catalyst for whole systems change, recognising that 'A plethora of front line initiatives for change does not necessarily add up to a transformed system'(NHS Institute for Innovation and Improvement)
- Through the SFSC Partnership Board nnegotiate a pragmatic change strategy based on the experiences of families and households on the programme

Appendix 4: Levels of Service Offered by ITF

INTEGRATED TEAM FOR FAMILIES

Level of Services offered by ITF

Intensive: Allocated to ITF, working intensively with families
Support: Allocated to ITF, supporting families and professionals
Mentoring: ITF provide support to lead agency/professional network
Monitoring: Lead Agency hold case and ITF monitor progress and ensure appropriate data is collected

Each level of service is determined by the Stronger Families Stronger Communities (SFSC) Programme eligibility criteria and outcome targets, aiming to deliver interventions that enable families or individuals to meet the goals in the Family Action Plan and:

Reduce anti social and offending behaviour through a mixture of support, diversionary activities and where necessary, through enforcement based intervention

Improve school attendance and reduce school exclusions for school-aged children

Address adult worklessness

Address issues affecting the safety and well being of families and children, and vulnerable households without dependent children including:

- Issues identified by a Family CAF, Child in Need or Child Protection Plan and/or where a child(ren) are at risk of entering the care system
- Where families *or* households are causing high cost to public services including frequent police call outs or arrests, or where there is an adult currently serving a custodial sentence or subject to probation supervision (community order or license)
- Families *or* households where there are significant underlying health problems including emotional and mental health problems; drug and alcohol misuse; long term health issues; health problems caused by domestic violence; under 18 conceptions
- Families *or* households where there is an adult on an Adult Safeguarding Plan

INTENSIVE

Family Coaches will be working with families that meet the ITF criteria and have entrenched, multigenerational and significant barriers to achieving positive outcomes.

If the family is not engaged with social care the Family Coach will be the lead professional responsible for case management decisions and partnership working to design and deliver effective interventions.

Working assertively with families, ensuring regular contact through home visits, one to one, and wider family work to deliver intensive support with around 6-8 hours of contact per week.

Where social care are involved with the family the Family Coach will take the lead in providing interventions and monitoring progress against PbR targets whilst working seamlessly alongside processes of child safeguarding, including reporting to, and attendance at, Child Protection Conferences, Core Groups and Child in Need Network Meetings.

The Family Coach will be leading on Family CAF implementation with families that meet the SFSC criteria who fall below the social work threshold.

SUPPORT

Family Coaches will be working with families with multiple disadvantages that meet the ITF criteria and where there are some barriers to achieving positive outcomes.

They will support the Lead Professional/Team around the Family or social worker on making case decisions and partnership working that designs and delivers effective interventions to enable families or individuals meet the goals in the Family Action Plan.

Working assertively with families, ensuring contact through home visits, one to one, and wider family work to deliver support, with around 2-4 hours of contact per week.

Working seamlessly alongside processes of child safeguarding, including reporting to, and where necessary attendance at, Child Protection Conferences, Core Groups, Network Meetings and Team Around the Family Meetings.

Where there is not a Team Around the Family in place, initiate and take a lead in the Family CAF implementation with families with multiple disadvantages who fall below the social work threshold.

MENTORING

Supporting professionals *(that are working with families who meet the ITF criteria)* with any aspect of the Family CAF process particularly focussing on partnership working that designs and delivers effective interventions that enable families or individuals meet the goals in the Family Action Plan

This may include, for example, the completion of a Family CAF Assessment, identifying relevant professionals, negotiating a Family CAF plan or support with facilitating a 'Team around the Family' meeting.

MONITORING

The Family Coach will liaise with the Lead Professional, other Team Around the Family members or Social Worker and collect information required to evidence progress made against ITF targets.

48.1 Mat Thomas from the Stronger Families, Stronger Communities (SFSC) Team presented the report. The SFSC Team was Brighton & Hove City Council's approach to central Government's Troubled Families agenda.

48.2 Brighton & Hove City Council has been asked to turn around 675 families in the city, to make them more able to cope. The approach is a 'Payment by Results' one, which gives local authorities a percentage payment for engaging families and producing results, which is split in different ways over the three year life of the programme.

48.3 The service is delivered by Family Coaches, who can spend up to 10 hours per week with a family. Coaches have a very small caseload, with no more than five families per coach, and they deliver a very intensive service. There are 24 FTE staff and a partnership board.

48.4 The family doesn't necessarily need to have a young person in it to qualify for intervention, there are certain criteria that are looked for: school attendance below 85%, anti social behaviour or youth offending, and or a history of worklessness.

The family must have two out of three of the above criteria to be eligible; many will have all three.

48.5 In order to receive Payment by Results, strict results need to be achieved, for example, all children in the family must have an over 85% school attendance for three terms, or anti social behaviour should be reduced by at least 60%.

48.6 Questions and comments included:

How does the approach differ from the family intervention project work?

The team works with the whole family, targeting specific areas as needed. The team is trying to work with slightly less priority cases in order to address their behaviour before it escalates. The Family Coach agrees the approach with the family, eg discussing what is reasonable and sharing outcomes.

How are families identified?

There are a number of ways, mainly through professionals identifying eg the school or social worker. The team then holds a team meeting to decide which families to take forward.

48.7 The Chair thanked Mr Thomas for his presentation and asked for an update in six months or so, with a cost benefit analysis. This was agreed.

Who we are, what we do

Main provider of community healthcare across B&H and West Sussex.

Formed in October 2010 through the merger of

West Sussex Health
Healthcare closer to home

South Downs Health NHS
NHS Trust

4,400 staff: community & specialist nurses; doctors; therapists; healthcare assistants; support staff. Plus 500 volunteers.

Provide high quality medical, nursing and therapeutic care to more than **8,000 people a day**:
- With care and compassion.
- with quality our top priority.

Spent around £185m in 2012/13.

Our vision

Excellent care at the heart of the community.

We support people to:
• Plan for and manage changes in their health.
• Live healthier, more independent lives in their own homes.
• Avoid unnecessary visits to hospital.

The NHS nationally and locally needs to respond to rising demand (people living longer and needing more care, rising levels of ill-health).

Need to shift more care from the acute sector into the community.

We are the specialist community healthcare provider, so are a key part of the answer!

Becoming an NHS foundation trust is central to our future.

Where we work

90% of NHS care is provided **in the community** by GPs and by community health and care providers like us.

We care for our patients in a range of settings:

•Mainly in our patients' own homes.
•Our community hospitals, urgent treatment centre, minor injury units, child development centres and other locations.
•In care homes, GP surgeries and acute hospitals.

Across the age range, we care for some of the most vulnerable people**:**

•Our health visitors care for babies and young children.
•Our specialist doctors, nurses and therapists care for young people and adults with long-term conditions.
•Our multi-disciplinary community teams care for the frail elderly and people at the end of their lives.

About NHS FTs

About the consultation
•We will consult for 12 weeks: Mon, 10 June-Fri, 30 August.
•See our full or summary consultation documents.
•Or go to our website www.sussexcommunity.nhs.uk/ft

NHS FTs are
•Part of the NHS. Over half of all NHS services provided by NHS FTs.
•Work within framework of NHS Constitution, providing care that's free at the point of delivery.

Why are they different?
•Greater freedom from government control.
•More financial autonomy. Invest and improve services for patients.
•Greater scope to decide own future.
•Accountable in new ways to their communities and staff – through members & governors.

Why we want to be an FT

A stronger, more independent place at the heart of our community.

More freedom to set our own strategy for the long term.

News ways to be accountable to the people we serve – members & governors.

Play our full role in transforming local health & care system to better meet health and social care needs of local people from the resources available.

Government wants every NHS trust to become an NHSFT.

We believe we will be best placed to deliver **excellent care at the heart of the community** as an independent community NHSFT.

Members

Anyone aged 12 or above, and lives in West Sussex, Brighton & Hove or nearby. Our target is 5,000 public members – **please join us**.

All staff with a permanent contract of employment of more than 12 months automatically become a member. Staff are our greatest asset. **We want them to be passionate about FT.**

Members have a say in running the trust – and can vote for their governor
Can even stand for election to become a governor.

Members and governors

Are the heart of the NHS FT idea.

Become a member and have your say in how the trust is run and how services are provided to meet local needs.

Vote for a governor to represent your views.

Stand for election as a governor yourself!

Governors work with board of directors to help run trust.

Council of governors

Represents members' views.
Works with the board of directors, and holds board to account.
Influences how we develop and the services we provide.
We will have 20 members of our council of governors.
Elected governors form the majority.

PUBLIC GOVERNORS	**11**
Local council electoral areas(s)	Number
Adur District Council	1
Arun District Council	1
Brighton & Hove City Council	3
Chichester District Council	1
Crawley Borough Council	1
Horsham District Council	1
Mid Sussex District Council	1
Worthing Borough Council	1
Out of Area	1

STAFF GOVERNORS	**4**
Doctors & Dentists	1
Nurses	1
Therapists, Allied Health Professionals & Health Care Assistants	1
Support Staff	1

APPOINTED GOVERNORS	**5**
Local councils: WSCC, B&H	2
Voluntary/Charity	1
CCGs	1
Trade Union/Staff Side	1

We welcome:

- Your questions.
- Your comments.
- Your support.

www.sussexcommunity.nhs.uk/ft
Tel: 01273 242096