Torbay Strategic Partnership
Teaming up for Torbay's Tomorrow

Tuesday, 12 July 2011

A meeting of the **Shadow Health and Wellbeing Board** will be held on **Thursday, 21 July 2011**, commencing at **10.00 am**
The meeting will be held in the Board Room, Town Hall, Castle Circus, Torquay, TQ1 3DR

Agenda

Part 1

1. **Election of Chairman/woman**
To elect a Chairman/woman of the Shadow Health and Wellbeing Board for the 2011/2012 Municipal Year.

(a) Apologies and Changes in Membership

To receive any apologies, including notifications of any changes to the membership of the Board.

(b) Appointment of Vice-Chairman/woman

To consider appointing a Vice-Chairman/woman of the Shadow Health and Wellbeing Board for the ensuing Municipal Year.

2. **Introduction to Shadow Health and Wellbeing Board** (Pages 1 - 12)
To receive a presentation from Andrew Webster, National Director – Joint Commissioning from the Department of Health on the role of health and wellbeing boards.

3. **Indices of Multiple Deprivation** (Pages 13 - 34)
To note the attached report on the Indices of Multiple Deprivation.

(a) Joint Strategic Needs Assessment (Pages 35 - 60)

To note the attached report which provides an update on the Joint Strategic Needs Assessment (JSNA).

4. **Health and Wellbeing Strategy a Framework for Design to Delivery** (Pages 61 - 72)
To discuss the requirements of the Health and Wellbeing Strategy.

(a) Governance Structures (Pages 73 - 76)

To note the attached governance structures.

(b) User Engagement - the Role of HealthWatch

To consider the role of HealthWatch in respect of user engagement.

Part 2

5. Obesity - Informal Workshop Session (Pages 77 - 94)

6. Future Meetings and Items

The following issues will be discussed at the meetings below, these meetings will be held at 3.00 p.m. in the Town Hall, Torquay:

Thursday, 20 October 2011:

- Draft Health and Wellbeing Strategy.
- Pharmaceutical Needs Assessment.

Thursday, 15 March 2012:

- Statement on integration of health-related services and provision of health and social care services self-assessment (including feedback from LINk/HealthWatch).
- Agreement of next steps.

7. Background Papers (Pages 95 - 110)

Members of the Partnership

Councillor Chris Lewis	Torbay Council
Councillor Christine Scouler	Torbay Council
Councillor Mike Morey	Torbay Council
Anthony Farnsworth	Torbay Care Trust
Debbie Stark	Director of Public Health
Carol Tozer	Director of Children's Services
Caroline Taylor	Deputy Chief Executive Torbay Council
Clare Tanner	Torbay Council
Anne Mattock	Link
Sam Barrell	Baywide GP Commissioning Consortium
Kevin Muckian	Devon Local Pharmaceutical Committee

Observers

Councillor Alison Hernandez

Health and Well Being Board 21 July 2011

English Indices of Deprivation 2010

1. Background

1.1 The Indices are the Government's official measure of relative deprivation at a small level. The 2010 Index was published in March 2011 and based on data from 2008. The 2010 indices supersede the 2007 indices.

1.2 The Index is made up of 7 weighted domains making up the overall indices. It is weighted in favour of Income and Employment, with each domain weighted at 22.5%. Health and Education domains each make up 13.5% each, while Barriers to Housing, Crime and Living deprivation each make up 9.5% each of the overall indices.

1.3 Ranks provide the relative position based on the score with one being the most deprived.

1.4 The indices show Torbay's position relative to other areas. For example in three years time we may have improved, yet our relative position could stay the same or have worsened.

1.5 A paper is attached identifying key findings to enable board members to gain a further understanding of the issues and their relevance to the development of a Health and Well Being Strategy.

2. Summary of Key Findings for Torbay

- Torbay is within the top 20% most deprived local authority areas in England for the rank of average score and the rank of local concentration.
- The number of LSOAs across Torbay in the top 10% most deprived has increased over time from 4 in 2004, to 10 in 2007 and 12 in 2010.
- Numbers of areas in the top 10% most deprived in England has increased in Torbay, whilst conversely Torbay now has an area considered within the least 10% deprived in England. This could suggest a widening of the inequality gap across Torbay.
- Overall levels of relative deprivation have worsened in Torbay, with an estimated 21,000 (15%) residents living in areas considered in the top 10% most deprived in England, compared to an estimated 15,500 (11%) in 2007.

2.1 A focus for the Board will be to consider the potential impact for health and well being in Torbay and to develop both short and long term measures in response.

3. Recommendation(s)

3.1 That the Board use the findings along with other intelligence to inform the development of a Health and Well Being Strategy

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The English Indices of Deprivation 2010

Summary of findings for Torbay

This paper presents a brief overview of modelled deprivation in Torbay. The data is taken from the government's 2010 English Indices of Deprivation (http://www.communities.gov.uk). The paper presents some of the findings and illustrates the changing picture of relative deprivation over time.

Overview:

Torbay's relative position within the national model of deprivation shows a negative direction. This could be considered as a worrying trend for Torbay. Whilst there is no single local authority level measure favoured over another, if we consider the rank of local concentration (population weighted based on most deprived LSOAs containing 10% of population); Torbay's relative position has moved from 119 in 2004, to 75 in 2007 to 61 in 2010. Torbay's relative position has continued to be a worsening one, even after adjusting for the reduction in the number of local authority areas, from 354 to 326.

The number of geographies across England has remained constant over time at 32,482, with 89 areas in Torbay. These areas are called LSOAs, or Lower Super Output Areas. LSOAs are comparable geographies with a mean population of approximately 1,500.

Whilst the relative levels of deprivation have increased for Torbay, deprivation within Torbay shows noticeable variation. At town level both Torquay and Paignton could be perceived to show a worsening in relative deprivation between 2007 and 2010. However, levels in Brixham could be perceived as improving.

Key findings:

- Torbay is within the top 20% most deprived local authority areas in England for the rank of average score and the rank of local concentration.
- The number of LSOAs in Torbay in the top 10% most deprived has increased over time from 4 in 2004, to 10 in 2007 and 12 in 2010.
- Numbers of areas in the top 10% most deprived in England has increased in Torbay, whilst conversely Torbay now has an area considered within the least 10% deprived in England. This could suggest a widening of the inequality gap across Torbay.
- Overall levels of relative deprivation have worsened in Torbay, with an estimated 21,000 (15%) residents living in areas considered in the top 10% most deprived in England, compared to an estimated 15,500 (11%) in 2007.
- Some areas within Torbay have shown noticeable increases in levels of relative deprivation, Watcombe for example has seen a 10% increase in relative deprivation between 2007 and 2010.
- Croft Hall remains the practice drawing its registered patients from the most deprived communities.
- It appears that the populations in Torbay mostly living in areas in the top 10% most deprived in England are young families.
- 1 in 5 of Torbay's 20 to 29 population live in areas in the top 10% most deprived in England.

Summary of district level findings:

The summary measures at district level focus on different aspects of multiple deprivation in the area. No single summary measure is favoured over another, as there is no single best way of describing or comparing districts.

In all rankings throughout this paper, a rank of 1 indicates the most deprived in England.

Table 1: Ranking for Torbay with all authorities in …

Area & Year		Rank of Average Score	Rank of Average Rank	Rank of Extent	Rank of Local Concentra-tion	Rank of Income Scale	Rank of Employme-nt Scale	Total number of authorities
England	2010	61	49	82	61	97	99	326
	2007	71	57	89	75	93	94	354
	2004	94	89	113	119	95	94	
South West Authorities	2010	1	2	3	2	6	7	37
	2007	3	4	4	3	4	4	45
	2004	7	8	6	8	4	4	

Torbay's overall position as 61st most deprived local authority for the rank of average score and rank of local concentration places Torbay within the top 20% most deprived local authorities in England, between the 18th and 19th percentile. This position is, relatively, worse than that for 2007, even when considering the reduction in the denominator from 354 to 326 local authority areas. In 2007 Torbay was on the cusp of the top quartile most deprived between the 20th and 21st percentile.

Overview of the six summary measures:

Average score is the population weighted average of the combined scores for the SOAs in a district.

Average rank is the population weighted average of the combined ranks for the SOAs in a district.

Extent is the proportion of a district's population living in the most deprived SOAs in the country.

Local concentration is the population-weighted average of the ranks of a district's most deprived SOAs that contain exactly 10% of the district's population.

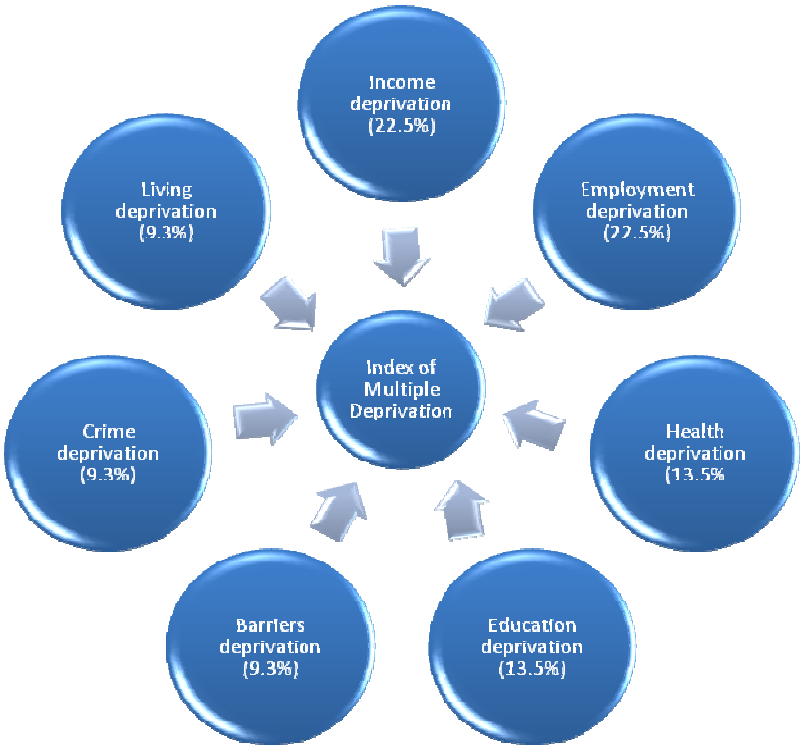
Income scale is the number of people who are income deprived.

Employment scale is the number of people who are employment deprived.

Small area deprivation

The Index of Multiple Deprivation is constructed from a weighted quantitative model. The model is weighted in favour of income and employment. Where the rationale is that without an income or employment, levels of deprivation will be higher. The weighted model is illustrated in figure 1 below, including the weightings per domain.

Figure 1: Construct of Index of Multiple Deprivation



Details of the indicators within each of these respective domains can be viewed in appendix B.

Each domain consists of a score which is then ranked. The scores for the Income Deprivation Domain and the Employment Deprivation Domain are rates. So, for example, if an LSOA scores 0.38 in the Income Deprivation Domain, this means that 38% of the LSOA's total population is income deprived. The same applies to the Employment Deprivation Domain where the rate refers to the percentage of the working age population that is employment deprived.

The scores for the remaining five domains are not rates. Within a domain, the higher the score, the more deprived a LSOA is, although because the distribution of the data has been modified, it is not possible to say how much more deprived one area is than another The IMD 2010 score is the combined sum of the weighted, exponentially transformed domain rank of the domain score. Again, the bigger the IMD 2010 score, the more deprived the LSOA. However, because of the transformations undertaken, it is not possible to say, for example, that an LSOA with a score of 40 is twice as deprived as an LSOA with a score of 20.

Over recent years the relative levels of deprivation within Torbay's population have shown a slight worsening, as can be seen in the Index of Multiple Deprivation columns below (table 2). The worsening levels of deprivation are most noticeable for the employment domain, where the number of LSOAs in the most deprived end of the spectrum has shown continued increase.

Table 2 (4 tables) presents the counts of LSOAs by deprivation decile. The tables also graphically present the numbers with a coloured bar (there is no meaning associated to the colour used), the larger the number the larger the bar. If the respective domain was evenly distributed across the population, we would expect to see '9' in each decile.

The least equal distribution compared to the national is the health domain, where on the distribution is centred on the 30+% to 40% most deprived.

The most evenly distributed domain is the crime domain, this shows a pattern of crime deprivation in line with the national perspective.

The picture of income deprivation affecting children shows pockets of acute deprivation, whilst the overall picture could be perceived as an improving picture. As the numbers in the most deprived increased, more noticeably the numbers in the least deprived increased in larger volume.

LSOAs are statistical building blocks, and not natural communities. It should also be noted that discrete pockets of severe deprivation may potentially be hidden at the population level.

Table 2: Distribution of LSOAs by decile of deprivation per domain – 'change over time'

Count of SOAs by decile	Index of Multiple Deprivation			Income deprivation			Employment deprivation		
	2004	2007	2010	2004	2007	2010	2004	2007	2010
Top 10%	4	10	12	6	6	6	7	12	13
10+% to 20%	8	4	4	8	10	13	17	15	20
20+% to 30%	16	24	23	25	22	24	20	23	19
30+% to 40%	22	18	12	16	21	11	22	11	13
40+% to 50%	12	8	12	14	12	15	11	18	11
50+% to 60%	11	15	14	11	9	11	6	3	9
60+% to 70%	9	5	6	6	6	6	4	6	4
70+% to 80%	4	4	4	1	2	2	2	1	0
80+% to 90%	3	1	1	2	1	1	0	0	0
90+% to 100%	0	0	1	0	0	0	0	0	0

Table 2 cont.

Count of SOAs by decile	Health deprivation			Education deprivation			Barriers to housing		
	2004	2007	2010	2004	2007	2010	2004	2007	2010
Top 10%	0	7	8	3	4	4	1	1	1
10+% to 20%	4	8	6	7	7	7	4	7	6
20+% to 30%	10	20	14	15	16	20	7	6	7
30+% to 40%	23	22	25	15	17	18	8	19	14
40+% to 50%	18	17	15	16	12	11	18	20	18
50+% to 60%	20	12	14	11	16	14	22	16	20
60+% to 70%	12	3	5	12	8	7	15	13	13
70+% to 80%	2	0	1	6	4	3	11	6	8
80+% to 90%	0	0	1	2	4	5	3	1	2
90+% to 100%	0	0	0	2	1	0	0	0	0

Table 2 cont.

Count of SOAs by decile	Crime deprivation			Living environment		
	2004	2007	2010	2004	2007	2010
Top 10%	4	7	9	19	17	16
10+% to 20%	4	10	8	12	18	16
20+% to 30%	3	6	8	13	12	14
30+% to 40%	7	12	9	12	11	9
40+% to 50%	9	12	10	4	7	9
50+% to 60%	10	11	7	5	7	6
60+% to 70%	17	5	6	8	7	7
70+% to 80%	9	13	12	5	2	3
80+% to 90%	13	10	10	6	7	4
90+% to 100%	13	3	10	5	1	5

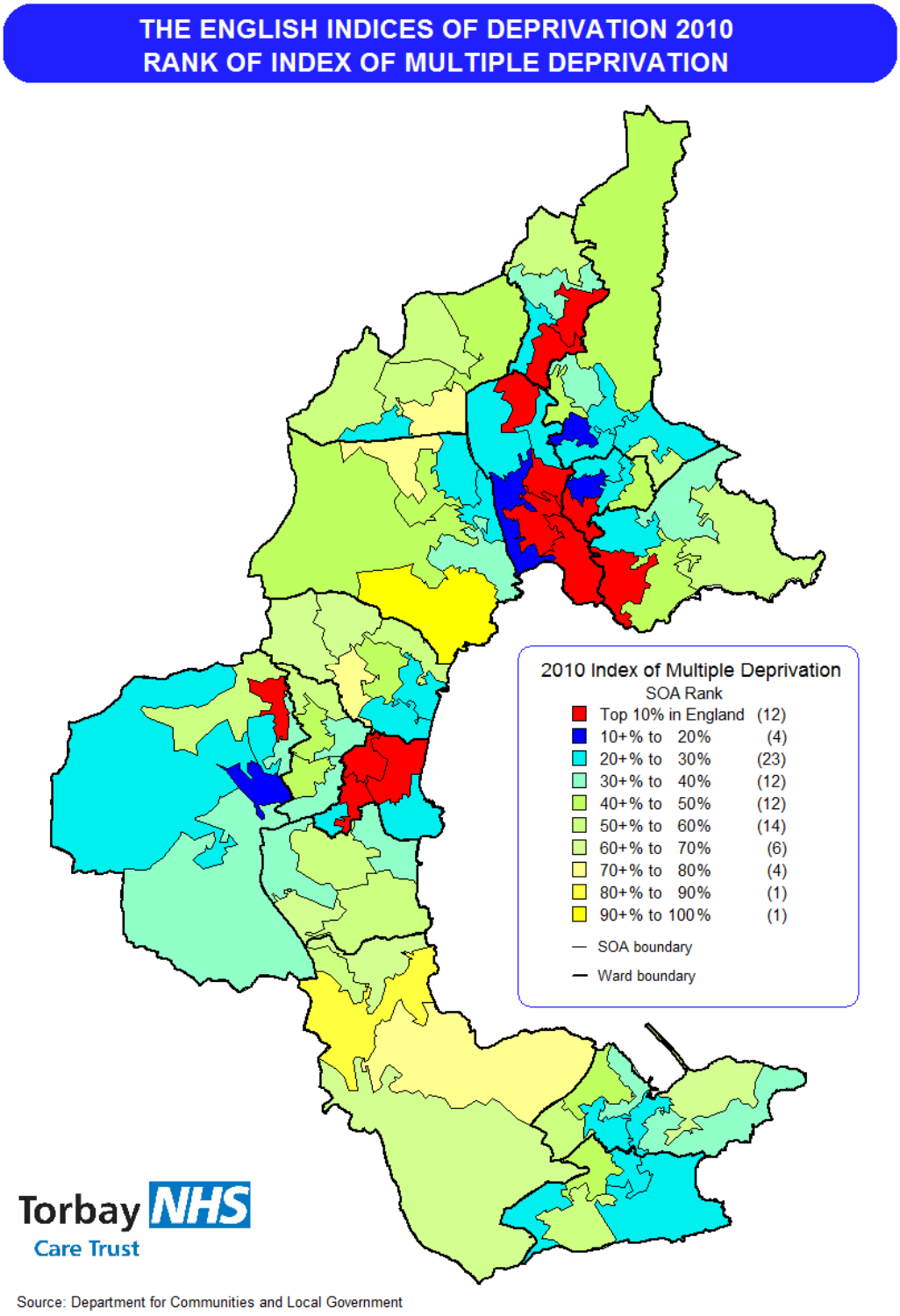
Table 2 cont.

Count of SOAs by decile	IDAC			IDAOP		
	2004	2007	2010	2004	2007	2010
Top 10%	5	2	7	4	5	3
10+% to 20%	9	10	8	16	12	13
20+% to 30%	15	19	18	13	16	16
30+% to 40%	20	17	12	15	11	13
40+% to 50%	19	23	19	11	17	19
50+% to 60%	11	9	8	10	12	9
60+% to 70%	6	5	10	11	10	11
70+% to 80%	4	3	4	3	2	1
80+% to 90%	0	1	3	4	2	3
90+% to 100%	0	0	0	2	2	1

Map 1 illustrates the geographical distribution of relative deprivation in Torbay for the Index of Multiple Deprivation. The small coloured areas are the LSOAs, where areas in red are areas considered within the top 10% most deprived in England.

Maps for the domains are presented in appendix A.

Map 1: 2010 Index of Multiple Deprivation



Source: Department for Communities and Local Government

Modelling deprivation at ward level was undertaken by attributing the average score to the each of the estimated population. The aggregated score then being divided by the total population provides the average score per ward. No confidence intervals are presented in this paper.

Table 3 shows the average score per ward for 2007 and 2010 (consistent methodology used to calculate), where the higher the score the higher the relative deprivation. The proportionate change is also presented. Watcombe shows a net (relative) position of being 10% worse in 2010 compared to 2007.

Table 3: Ward level findings

Ward	2007 Score	2010 Score	Change
Berry Head-with-Furzeham	22.6	22.1	-2.1%
Blatchcombe	29.2	30.5	4.7%
Churston-with-Galmpton	12.4	12.0	-3.1%
Clifton-with-Maidenway	22.1	21.3	-3.9%
Cockington-with-Chelston	19.1	18.7	-1.9%
Ellacombe	35.1	38.0	8.3%
Goodrington-with-Roselands	19.2	18.3	-4.7%
Preston	20.0	18.6	-7.0%
Roundham-with-Hyde	42.8	44.0	2.7%
Shiphay-with-the-Willows	16.4	17.6	7.5%
St Marychurch	25.6	25.9	1.0%
St Mary's-with-Summercombe	25.8	24.8	-4.0%
Tormohun	43.5	44.7	2.7%
Watcombe	32.8	36.2	10.1%
Wellswood	27.7	27.3	-1.6%
Torbay Resident	26.4	26.8	1.5%

There are areas in Torbay within the top 2% most deprived in England. For example, one LSOA in Roundham with Hyde is ranked as the 340th most deprived in England, just outside the top 1% most deprived in England. Table 4 summarises the most deprived LSOA per domain in Torbay and identifies the electoral ward and the relative position.

Table 4: Summary of most deprived LSOAs in Torbay

Deprivation domain	Most deprived rank		
	Rank	Top %	Ward
Index of Multiple Deprivation	446	1.4%	Ellacombe
Income deprivation domain	1,192	3.7%	Ellacombe
Employment deprivation domain	340	1.1%	Roundham with Hyde
Health deprivation and disability domain	1,149	3.5%	Roundham with Hyde
Education, skills and training deprivation domain	1,054	3.2%	Blatchcombe
Barriers to housing and services domain	1,742	5.4%	Blatchcombe
Crime domain	428	1.3%	Roundham with Hyde
Living environment deprivation domain	472	1.5%	Roundham with Hyde
Income deprivation affecting children	1,258	3.9%	Ellacombe
Income deprivation affecting older people	1,131	3.5%	Watcombe

GP practice deprivation scores have been calculated by attributing all registered persons within each practice, the IMD score for the area they live. This is based on postcode of residence and assumes a normal distribution of deprivation and patients per area. The cumulative score is then divided by the population of the practice to give an overall practice score. This is consistent with previous methodologies and allows comparisons of relative deprivation scores per practice in Torbay.

Table 5: Practice level findings

Name	2007 IMD Score	2010 IMD Score	2010 IMD Practice Rank	Change on 2007
Barton Surgery	29.4	31.0	5	5.4%
Bishops Place Surgery	30.6	31.3	4	2.3%
Brunel Medical Practice	25.3	25.8	11	2.2%
Chelston Hall	22.8	23.3	15	2.2%
Cherrybrook Medical Centre	15.4	15.0	20	-2.6%
Chilcote Surgery	27.8	28.9	7	4.1%
Compass House Medical Centre	21.0	20.3	19	-3.5%
Corner Place Surgery	26.4	26.3	10	-0.4%
Croft Hall Medical Practice	34.5	35.4	1	2.7%
Grosvenor Road Surgery	25.4	25.1	14	-1.1%
Mayfield Medical Centre	25.6	25.7	12	0.5%
Old Farm Surgery	26.7	27.5	8	3.0%
Old Mill Surgery	26.7	26.5	9	-0.9%
Parkhill Medical Practice	28.8	29.1	6	1.0%
Pembroke House	21.9	21.3	18	-2.5%
Shiphay Manor Surgery	30.4	32.1	2	5.5%
Southover Surgery	30.3	31.8	3	5.1%
St Luke's Medical Centre	22.8	22.6	17	-0.8%
The Greenswood Surgery	24.0	23.1	16	-3.7%
Withycombe Lodge Surgery	24.8	25.3	13	2.2%
Torbay Registered	26.2	26.6	-	1.5%
Approximate England Average	21.7	21.5	-	-

Levels of relative deprivation are highest for Croft Hall; this suggests that Croft draws their registered patients from the more deprived communities. Levels of relative deprivation for Croft have worsened between 2007 and 2010.

Relative levels for the practices in Brixham have all decreased. This does not mean they are more affluent, more that the relative levels of deprivation are worse in other areas.

Barton, Shiphay Manor and Southover have all seen an increase in terms of their patient's relative levels of deprivation between 2007 and 2010.

Understanding the population.

The population living in the areas of Torbay in the top 10% most deprived in England is illustrated in figure 2, and detailed further in table 6.

Figure 2 shows a clear younger structure living in the more deprived areas, when compared to the rest of Torbay's population structure.

Table 6 presents a breakdown of the population, and includes the proportion of that age group residing in the most deprived communities. For example, we can see that 20% (or 1 in 5) of the 20 to 24 population living area of Torbay in the top 10% most deprived in England.

Figure 2: Population pyramid

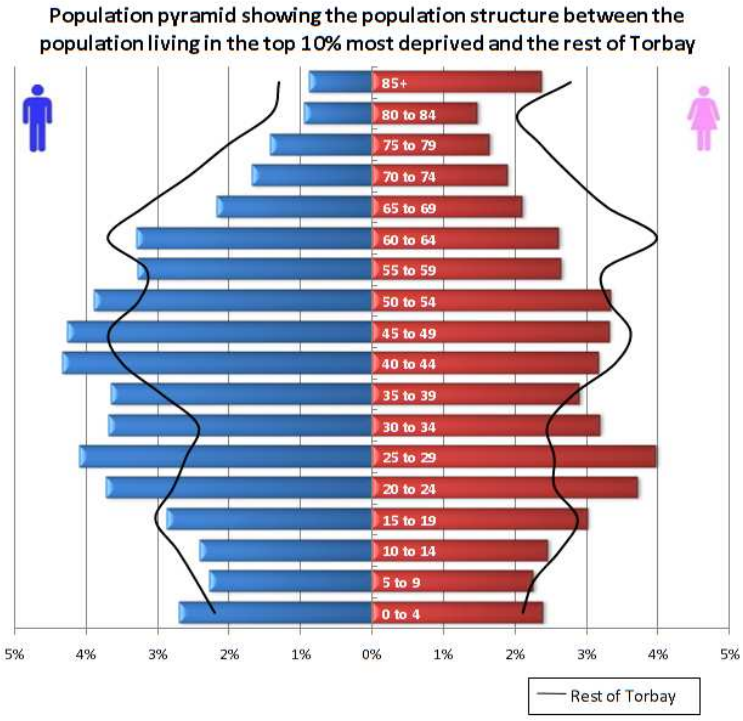
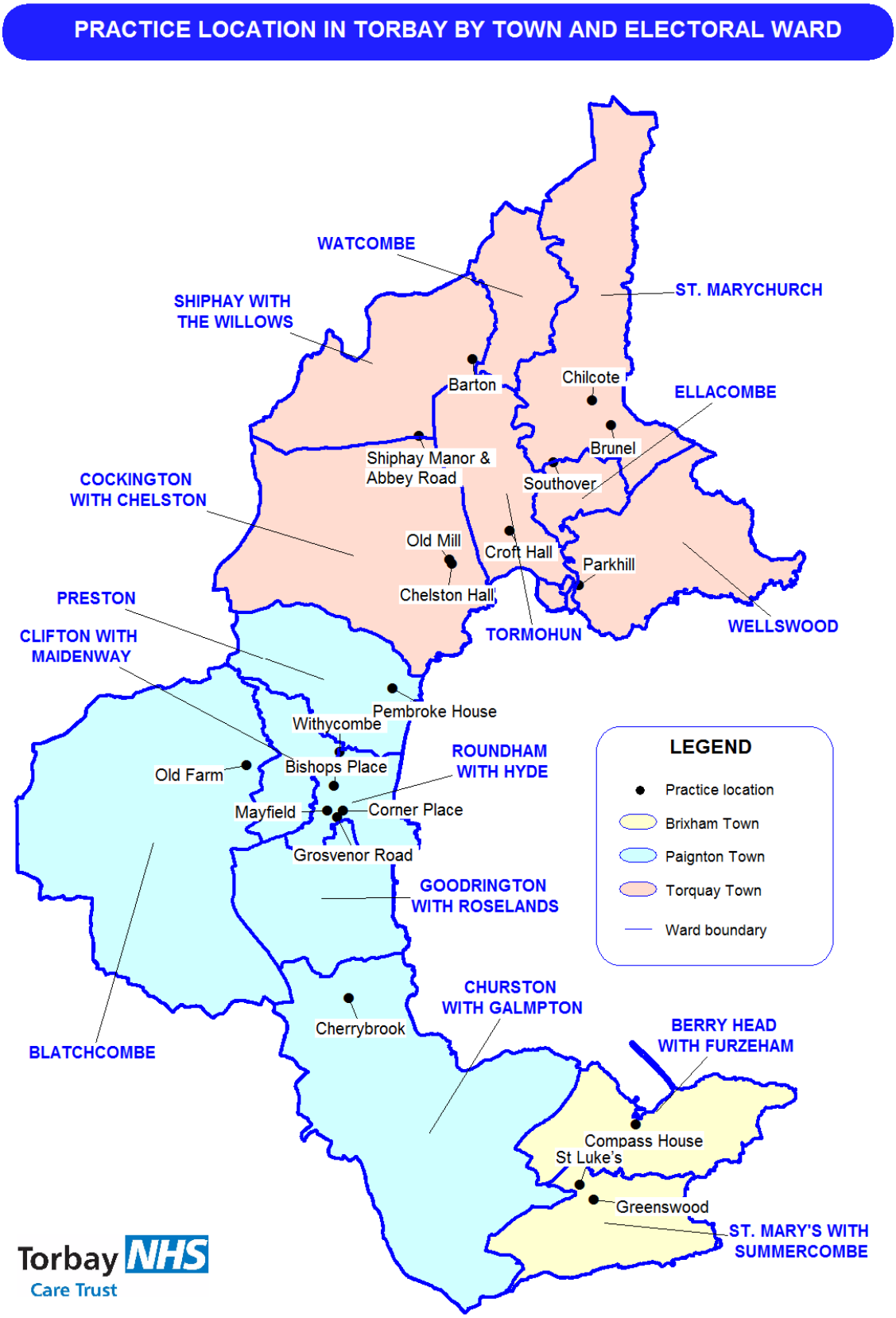


Table 6: Population structure

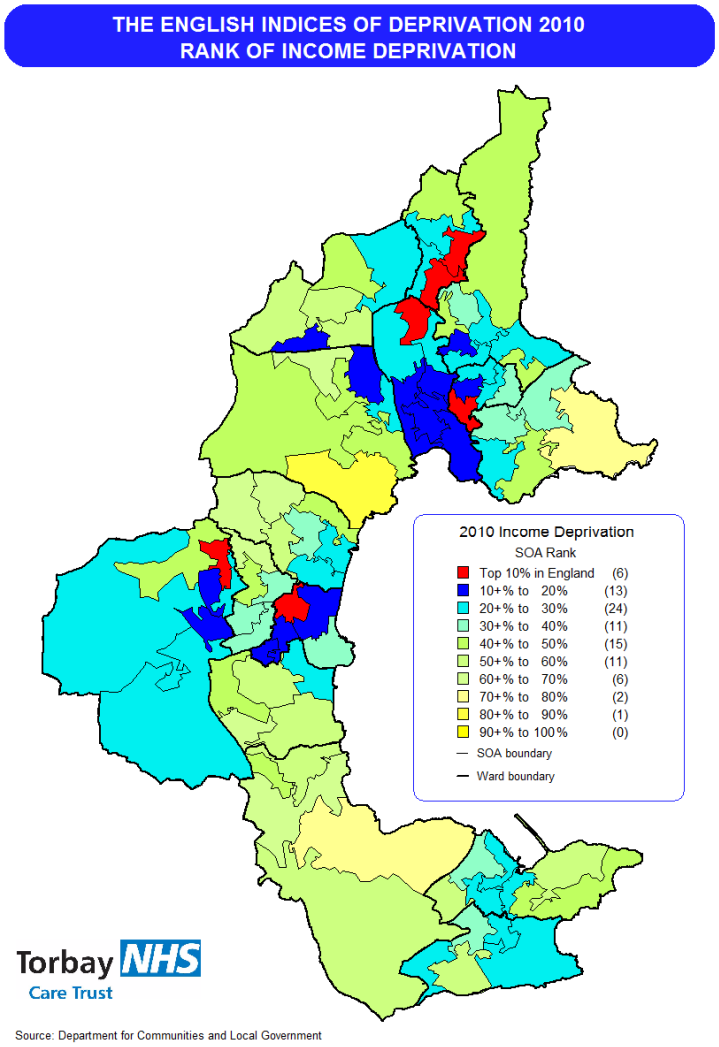
Population by quinary age banding and gender	Persons living in Top 10% most deprived in England			Rest of Torbay's population			Proportion of Torbay's residents living in Top 10% most deprived in England
	F	M	Total	F	M	Total	
0 to 4	500	550	1,050	2,500	2,650	5,150	16.9%
5 to 9	500	500	1,000	2,700	2,950	5,650	15.0%
10 to 14	500	500	1,000	3,150	3,250	6,400	13.5%
15 to 19	650	600	1,250	3,450	3,600	7,050	15.1%
20 to 24	800	800	1,600	3,050	3,350	6,400	20.0%
25 to 29	850	850	1,700	3,050	3,100	6,150	21.7%
30 to 34	650	750	1,400	2,950	2,900	5,850	19.3%
35 to 39	600	750	1,350	3,350	3,500	6,850	16.5%
40 to 44	650	900	1,550	4,050	4,200	8,250	15.8%
45 to 49	700	900	1,600	4,300	4,400	8,700	15.5%
50 to 54	700	800	1,500	3,950	3,900	7,850	16.0%
55 to 59	550	700	1,250	3,900	3,750	7,650	14.0%
60 to 64	550	700	1,250	4,750	4,400	9,150	12.0%
65 to 69	450	450	900	3,900	3,800	7,700	10.5%
70 to 74	400	450	850	3,350	3,050	6,400	11.7%
75 to 79	350	300	650	2,800	2,400	5,200	11.1%
80 to 84	300	200	500	2,450	1,700	4,150	10.8%
85+	500	200	700	3,300	1,550	4,850	12.6%
Total	**10,200**	**10,900**	**21,100**	**60,950**	**58,450**	**119,400**	**15.0%**

Source: 2010 Registered Patients list

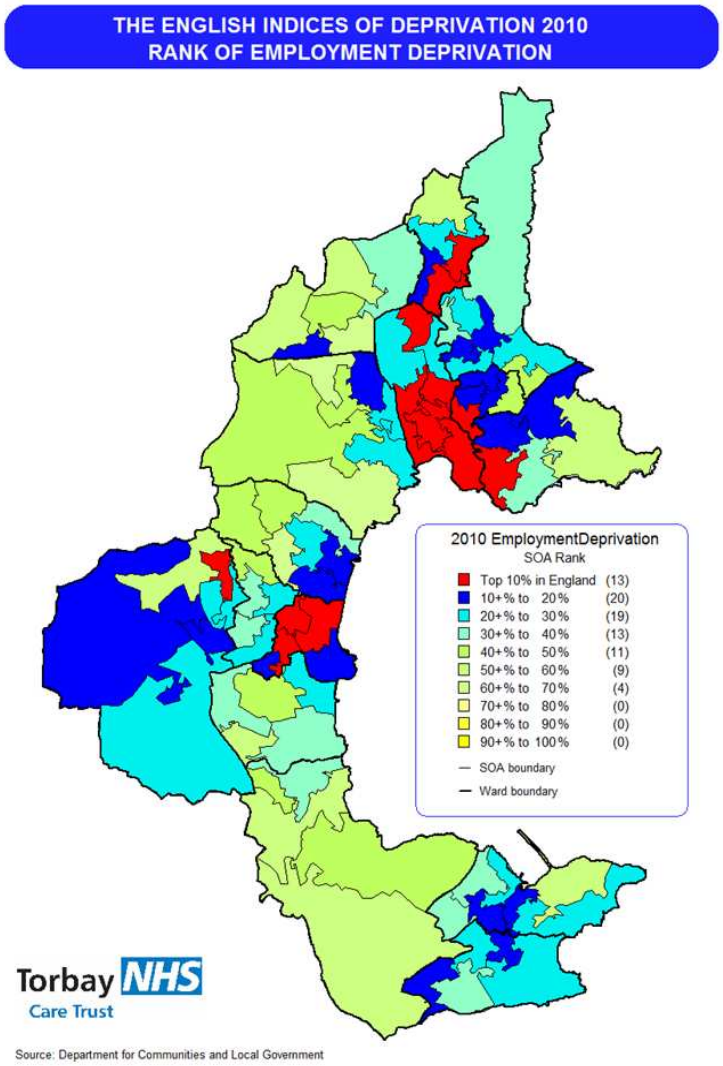
Map 2: Distribution of GP practices in Torbay by town and ward



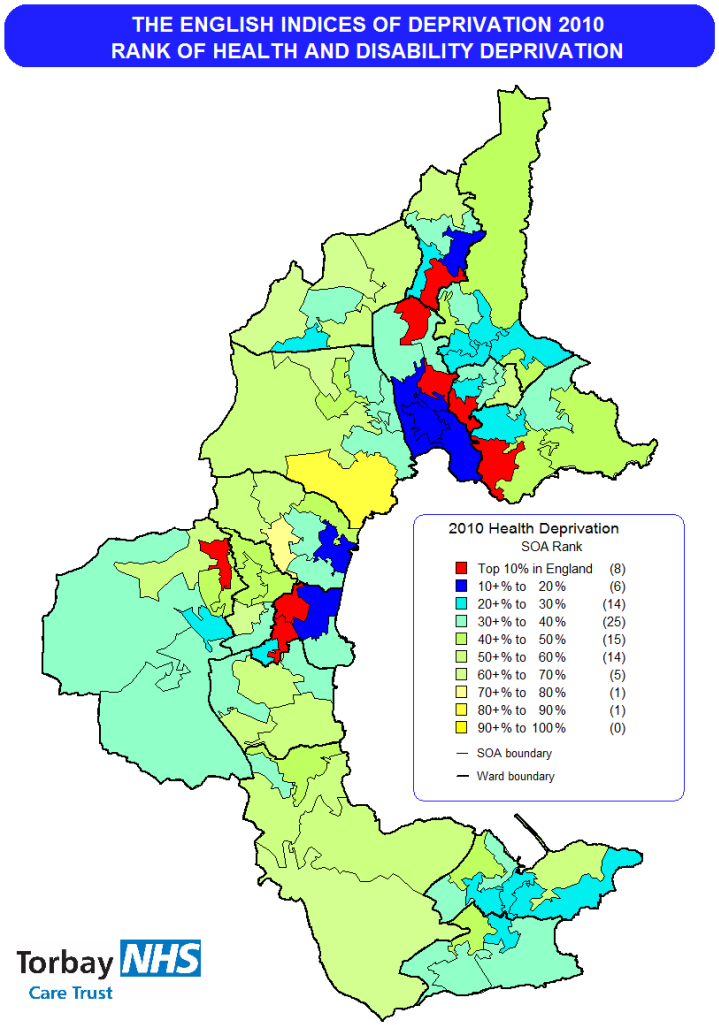
Appendix A - Map 3: 2010 Income deprivation



Map 4: 2010 Employment deprivation

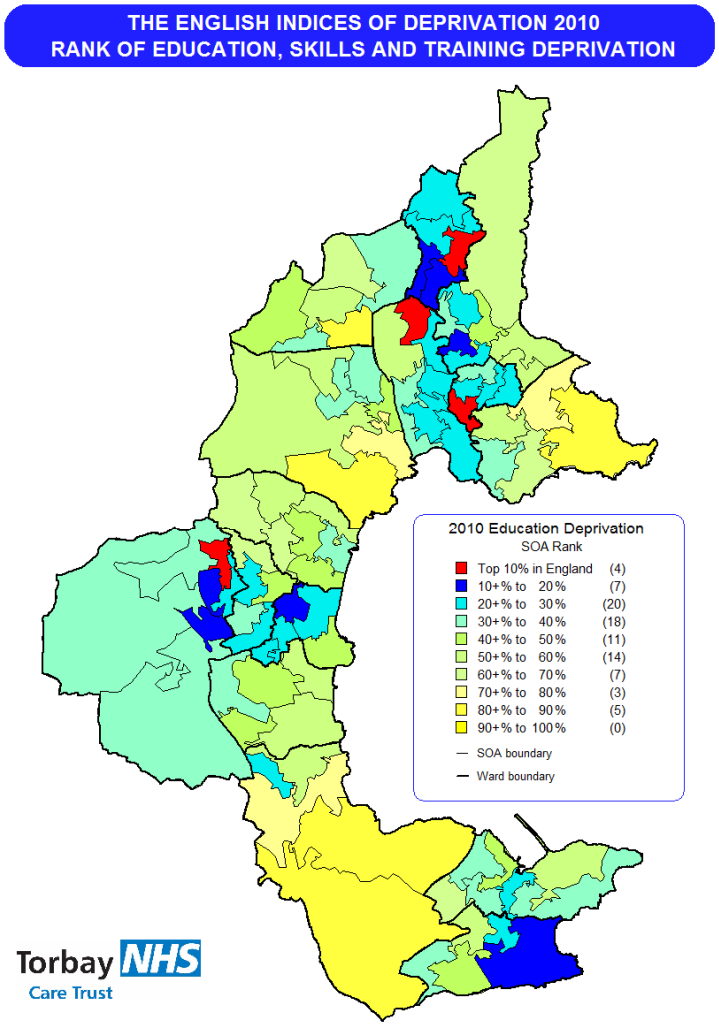


Map 5: 2010 Health and disability deprivation



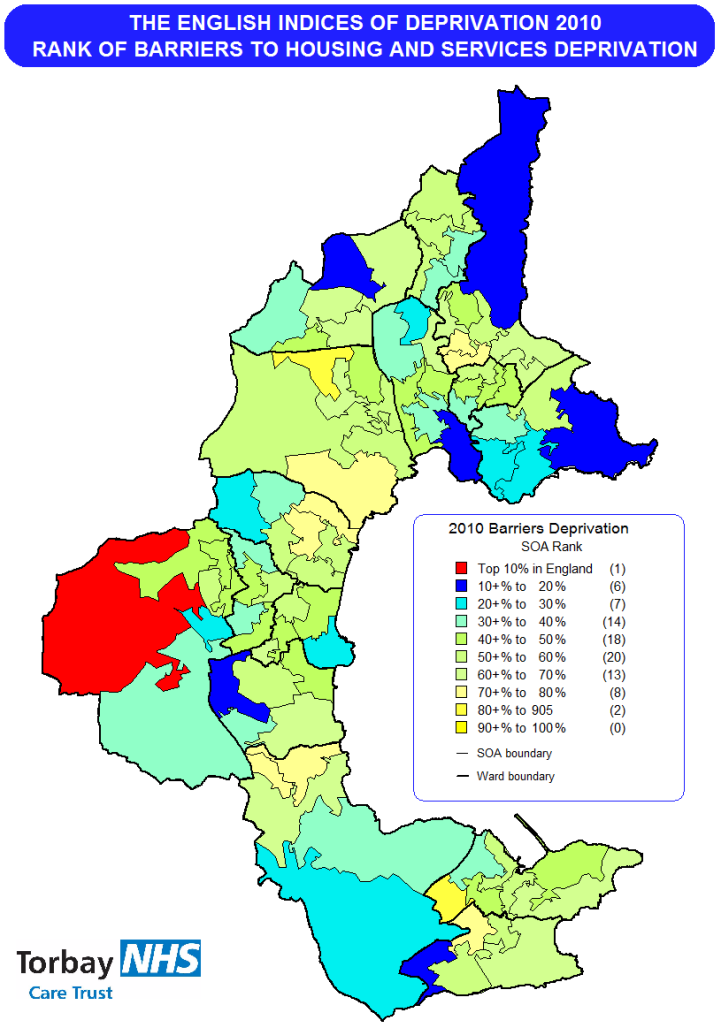
Source: Department for Communities and Local Government

Map 6: 2010 Education, skills and training deprivation



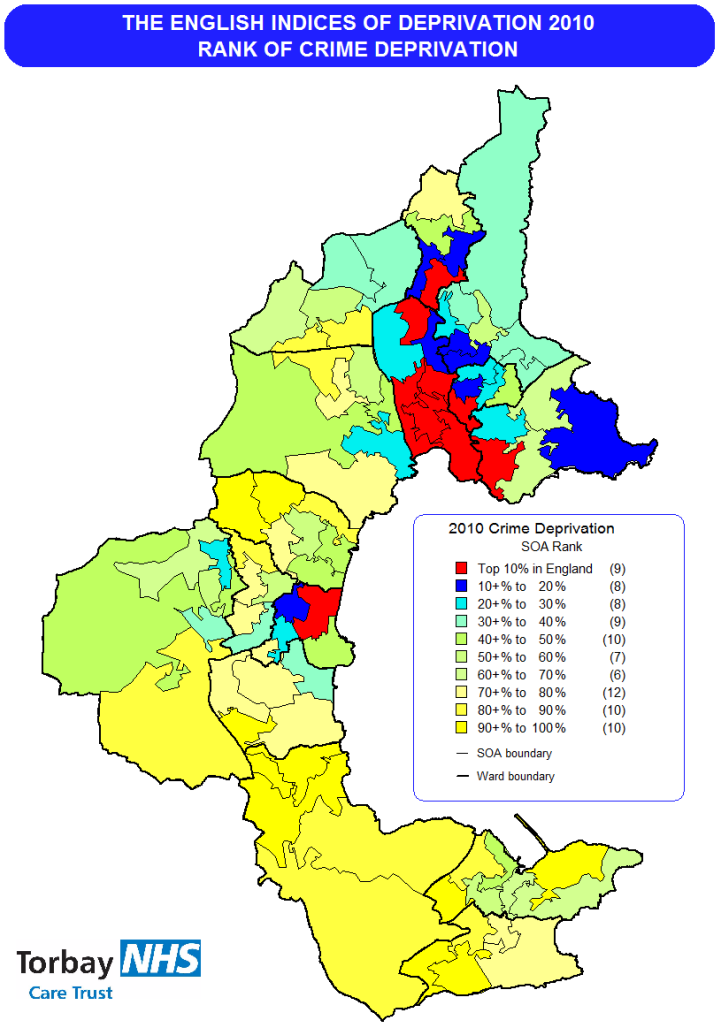
Source: Department for Communities and Local Government

Map 7: 2010 Barriers to housing and services deprivation



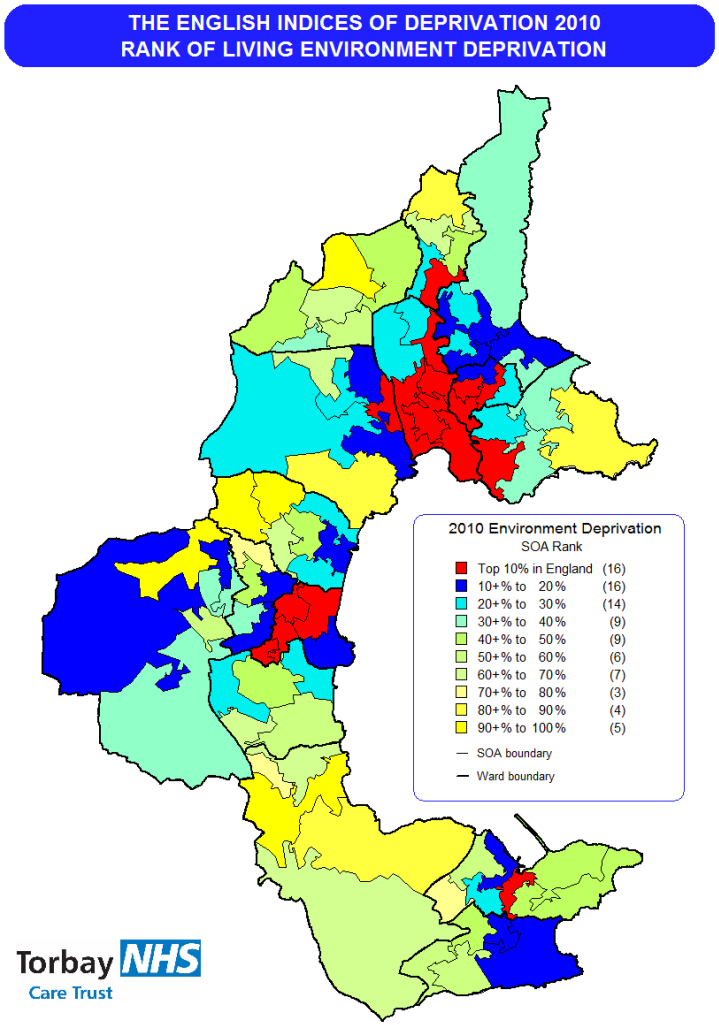
Source: Department for Communities and Local Government

Map 8: 2010 Crime deprivation



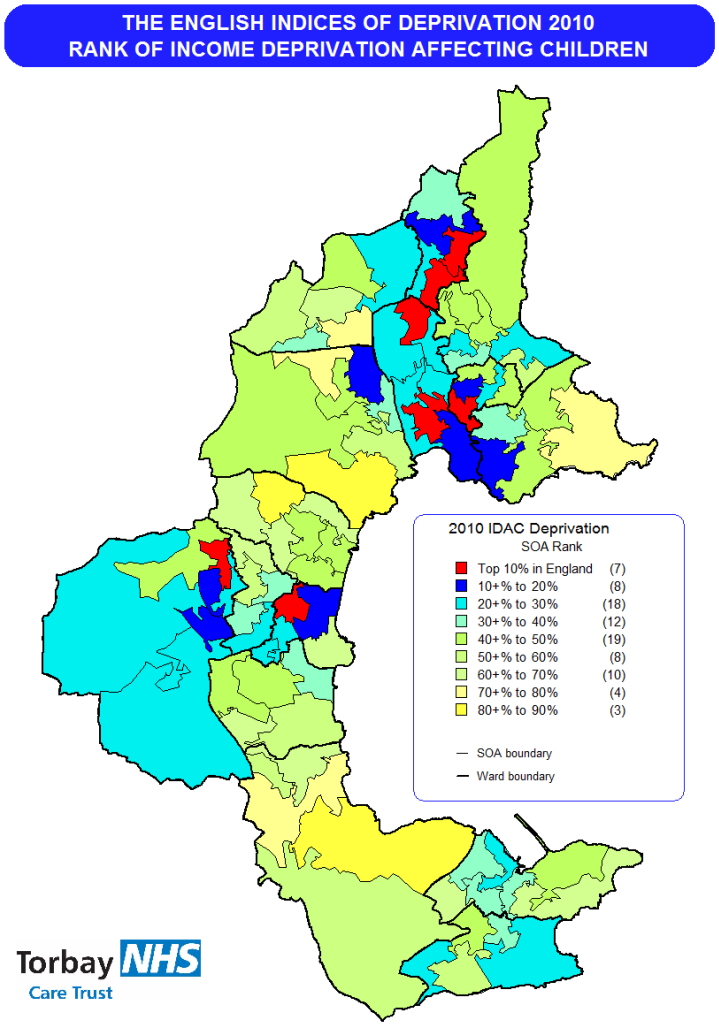
Source: Department for Communities and Local Government

Map 9: 2010 Living environment deprivation



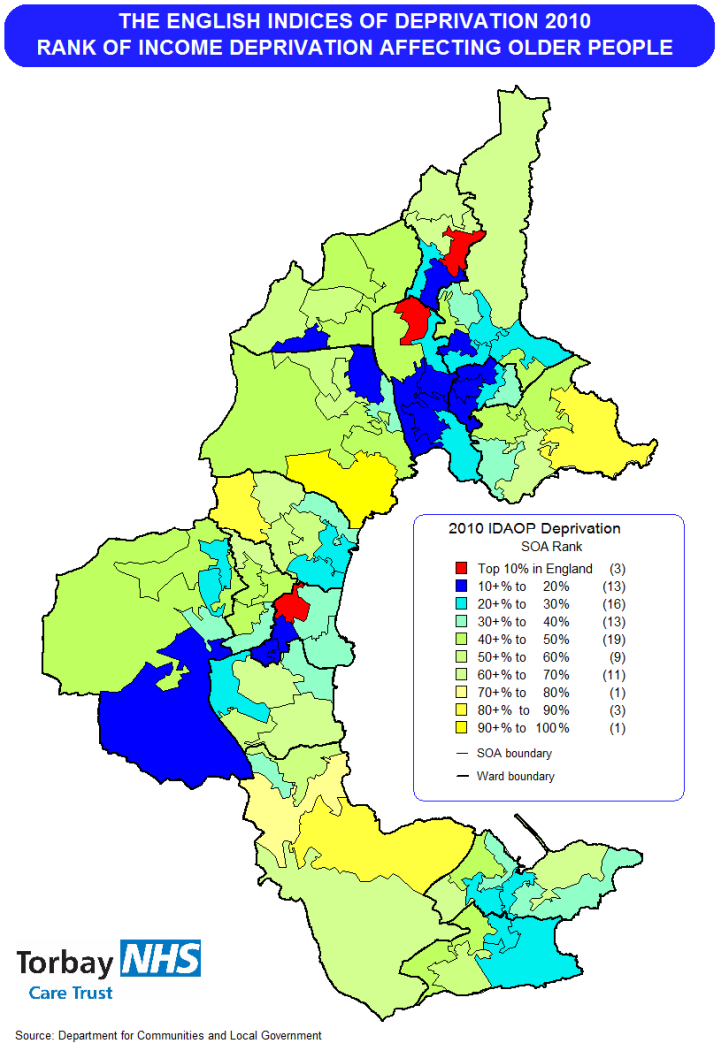
Source: Department for Communities and Local Government

Map 10: 2010 Income deprivation affecting children



Source: Department for Communities and Local Government

Map 11: 2010 Income deprivation affecting older people



Source: Department for Communities and Local Government

Appendix B

Income Deprivation Domain

This domain measures the proportion of the population in an area that live in income deprived families. The definition of income deprivation adopted here includes both families that are out-of-work and families that are in work but who have low earnings (and who satisfy the respective means tests).

The indicators

A combined count of income deprived individuals per Lower layer Super Output Area (LSOA) is calculated by summing the following five indicators:

• Adults and children in Income Support families. August 2008

• Adults and children in income-based Jobseeker's Allowance families. August 2008

• Adults and children in Pension Credit (Guarantee) families

• Adults and children in Child Tax Credit families (who are not claiming Income Support, income-based Jobseeker's Allowance or Pension Credit) whose equivalised income (excluding housing benefits) is below 60% of the median before housing costs

• Asylum seekers in England in receipt of subsistence support, accommodation support, or both.

The combined count of income deprived individuals per LSOA forms the numerator of an income deprivation rate which is expressed as a proportion of the total LSOA population.

Employment Deprivation Domain

This domain measures employment deprivation conceptualised as involuntary exclusion of the working age population from the world of work. The employment deprived are defined as those who would like to work but are unable to do so through unemployment, sickness or disability.

The indicators

A combined count of employment deprived individuals per LSOA is calculated by summing the following seven indicators:

• Claimants of Jobseeker's Allowance (both contribution-based and income based), women aged 18-59 and men aged 18-64. Quarterly average for 2008

• Claimants of Incapacity Benefit aged 18-59/64. Quarterly average for 2008

• Claimants of Severe Disablement Allowance aged 18-59/64. Quarterly average for 2008

• Claimants of Employment and Support Allowance aged 18-59/64 (those with a contribution-based element). Quarterly average for 2008

• Participants in New Deal for 18-24s who are not claiming Jobseeker's Allowance. Quarterly average for 2008

• Participants in New Deal for 25+ who are not claiming Jobseeker's Allowance. Quarterly average for 2008

• Participants in New Deal for Lone Parents aged 18 and over (after initial interview). Quarterly average for 2008

The combined count of employment deprived individuals per LSOA forms the numerator of an employment deprivation rate which is expressed as a proportion of the working age population (women aged 18-59 and men aged 18-64) in the LSOA.

Health Deprivation and Disability Domain

This domain measures premature death and the impairment of quality of life by poor health. It considers both physical and mental health. The domain measures morbidity, disability and premature mortality but not aspects of behaviour or environment that may be predictive of future health deprivation.

The indicators

• Years of Potential Life Lost: An age and sex standardised measure of premature death. 2004/08

• Comparative Illness and Disability Ratio: An age and sex standardised morbidity/ disability ratio. 2008

• Acute morbidity: An age and sex standardised rate of emergency admission to hospital. 2006/08

• Mood and anxiety disorders: The rate of adults suffering from mood and anxiety disorders. 2005/08

The indicators within the domain were standardised by ranking and transforming to a normal distribution.

Education, Skills and Training deprivation Domain

This domain captures the extent of deprivation in education, skills and training in an area. The indicators fall into two sub-domains: one relating to children and young people and one relating to adult skills. These two sub-domains are designed to reflect the 'flow' and 'stock' of educational disadvantage within an area respectively. That is, the 'children and young people' sub-domain measures the attainment of qualifications and associated measures ('flow'), while the 'skills' sub-domain measures the lack of qualifications in the resident working age adult population ('stock').

The indicators

Sub-domain: Children and Young People

• Key Stage 2 attainment: The average points score of pupils taking English, maths and science Key Stage 2 exams.

• Key Stage 3 attainment: The average points score of pupils taking English, maths and science Key Stage 3 exams.

• Key Stage 4 attainment: The average capped points score of pupils taking Key Stage 4 (GCSE or equivalent) exams.

• Secondary school absence: The proportion of authorised and unauthorised absences from secondary school.

• Staying on in education post 16: The proportion of young people not staying on in school or non-advanced education above age 16.

• Entry to higher education: The proportion of young people aged under 21 not entering higher education.

Sub-domain: Skills

• Adult skills: The proportion of working age adults aged 25-54 with no or low qualifications.

Barriers to Housing and Services Domain

This domain measures the physical and financial accessibility of housing and key local services. The indicators fall into two sub-domains: 'geographical barriers', which relate to the physical proximity of local services, and 'wider barriers' which includes issues relating to access to housing such as affordability.

The indicators

Sub-domain: Wider Barriers

• Household overcrowding: The proportion of all households in an LSOA which are judged to have insufficient space to meet the household's needs.

• Homelessness: The rate of acceptances for housing assistance under the homelessness provisions of housing legislation.

• Housing affordability: The difficulty of access to owner-occupation, expressed as a proportion of households aged under 35 whose income means that they are unable to afford to enter owner occupation.

Sub-domain: Geographical Barriers

• Road distance to a GP surgery: A measure of the mean distance to the closest GP surgery for people living in the LSOA.

• Road distance to a food shop: A measure of the mean distance to the closest supermarket or general store for people living in the LSOA.

• Road distance to a primary school: A measure of the mean distance to the closest primary school for people living in the LSOA.

• Road distance to a Post Office: A measure of the mean distance to the closest post office or sub post office for people living in the LSOA.

Crime Domain

Crime is an important feature of deprivation that has major effects on individuals and communities. The purpose of this domain is to measure the rate of recorded crime for four major crime types – violence, burglary, theft and criminal damage – representing the risk of personal and material victimisation at a small area level.

The indicators

• Violence: The rate of violence (19 recorded crime types) per 1000 at-risk population.

• Burglary: The rate of burglary (4 recorded crime types) per 1000 at-risk properties.

• Theft: The rate of theft (5 recorded crime types) per 1000 at-risk population.

• Criminal damage: The rate of criminal damage (11 recorded crime types) per 1000 at-risk population.

Living Environment Deprivation Domain

This domain measures the quality of individuals' immediate surroundings both within and outside the home. The indicators fall into two sub-domains: the 'indoors' living environment, which measures the quality of housing, and the 'outdoors' living environment which contains two measures relating to air quality and road traffic accidents.

The indicators

Sub-domain: The 'indoors' living environment

• Housing in poor condition: The proportion of social and private homes that fail to meet the decent homes standard.

• Houses without central heating: The proportion of houses that do not have central heating.

Sub-domain: The 'outdoors' living environment

• Air quality: A measure of air quality based on emissions rates for four pollutants.

• Road traffic accidents: A measure of road traffic accidents involving injury to pedestrians and cyclists among the resident and workplace population.

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Health and Well Being Board 21 July 2011

Joint Strategic Needs Assessment (JSNA)

1. Background

1.1 The Local Government and Public Involvement in Health Act (2007) require Primary Care Trusts and Local Authorities to produce a Joint Strategic Needs Assessment (JSNA) of the health and well-being of their local community.

1.2 As PCTs become abolished, it is anticipated that JSNA will be undertaken by local authorities and GP consortia through the health and wellbeing board.

1.3 The purpose of JSNA is to support improvements to the health and wellbeing of the population by identifying need both over the short term (three to five years) and longer term (five to ten years). JSNA identifies “the big picture” in terms of the health and wellbeing needs and inequalities of a local population. It provides an evidence base for commissioners to commission services according to the needs of the population.

1.4 JSNA is currently proposed as the primary process for identifying needs and building a robust evidence base on which to base local commissioning plans for the Health and Wellbeing board.

1.5 JSNA is expected to be the consistent evidence base that informs the health and wellbeing strategy.

1.6 A JSNA is not a needs assessment of an individual, but a strategic overview of the local community need – either geographically such as local authority / ward or by setting such as GP practice.

1.7 JSNA provides an objective analysis of current and future needs, and includes a range of both quantitative and qualitative data, including user views and community engagement.

1.8 Attached is Torbay’s 2010 Joint Strategic Needs Assessment. The JSNA identifies 14 top level areas of interest, themed around the LSP community plan. It also includes discussion on using the supporting tools (identified below) and methodologies for identifying the areas of interest.

2. JSNA in Torbay

2.1 In Torbay, JSNA has evolved from an NHS / Local Authority centric assessment to a Local Strategic Partnership (LSP) assessment of population need. Incorporating information from LSP members not only benefits wider LSP members, but also recognises the wider determinants of health.

2.2 Torbay's approach to JSNA recognises the importance that all organisations (statutory, voluntary and community) have in improving the health and wellbeing of Torbay's population.

2.3 Recent JSNA's in Torbay have been delivered through the local intelligence network, i-bay, whilst being led by the Public Health Epidemiologist. Members include Torbay Council, South Devon College, Torbay Development Agency, Job Centre Plus, CVA Torbay, Devon and Somerset Fire and Rescue.

2.4 The approach to JSNA in Torbay for 2010 onwards has been to remove the 'static document dataset' and move to a dynamic and interactive dataset. The tools that support JSNA in Torbay are set out below.

- The **ward profile tool** gives a summary of 24 indicators per ward in Torbay. These indicators are consistent across all wards and illustrate the variation that exists.
- The **population tool** allows users to look at linear growth models for Torbay compared to wards and GP practices.
- The **ward dataset** provides an interactive dataset across the community plan themes and time.

2.5 Torbay's partnership approach to JSNA has been held up as good practice. Torbay's Public Health Epidemiologist, and key members of the Consultation and Research Team, participated in a series of national workshops exampling good practice and peer reviewing JSNA. The outcome is that Torbay's JSNA has been sited within the national toolkit guidance, and has also featured as a specific case study in best practice. Both have been published through the local government improvement and development unit.

3. Summary of key issues for Torbay

- Ageing population
- Economy
- Inequalities
- Child poverty
- Poor health outcomes and behaviours in certain areas

3.1 Greater detail on the areas of interest is given within the attached JSNA report.

4. Recommendation(s)

4.1 Board members note the current, 2010 JSNA for Torbay.

4.2 Members note Torbay's 2010 JSNA, including the interactive set of tools

4.3 A specific briefing session is arranged for members interested in learning more detail on the tools.

4.4 Members are invited to comment on the tools.

4.5 The development of predictive indicators for longer term commissioning is supported by members.

Contact Officer: Doug Haines
Representing: Public Health, Torbay
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Torbay's

2010 Joint Strategic Needs Assessment

Intelligence Torbay 'working in partnership'

CONTENTS

Foreword

I am delighted that, together with the Torbay Public Health team and i-Bay, we have taken JSNA forward and developed a set of tools that provides a comprehensive picture of the differences in need across the population of Torbay.

This third Joint Strategic Needs Assessment (JSNA) takes us to a new level in analysing and understanding the complex factors that will help us to improve the lives of local people and reduce current inequalities.

JSNA continues to be based on the Community Plan, drawn up by the Torbay Strategic Partnership (TSP), which outlines the Partnership's vision for Torbay over the next 20 years. The views of residents and representatives of the business, community and voluntary sectors all contributed to the Community Plan.

The vision is directed by four key themes; Pride in the Bay, Stronger Communities, Learning and Skills for the Future and, underpinning it all, the New Economy. With economic prosperity at the heart of the plan leading towards community prosperity.

There is a strong relationship between improved health and well-being and employment. Our combined focus is on boosting economic prosperity, consistent with a higher quality of life and better access to jobs, based on the promotion of our skills base and a 'can do' entrepreneurial culture that is open to new ideas and seeks out all investment opportunities.

The JSNA will provide a solid base from which we can tackle the challenges ahead and action a wide range of measures to improve our local community. It has never been more important that we meet these challenges together across the Torbay Strategic Partnership.

The current recession is biting in Torbay and affecting local people. Our collective resolve and efforts must be based on a creative, cohesive and concerted response. But it must start with an excellent overview of people's needs and circumstances. This JSNA provides us with the right information at exactly the right time.

Nick Bye

Chair of Torbay Strategic Partnership

I am very pleased to publish the third JSNA for Torbay. The evidence from previous JSNAs and other work have been used to refine the key priorities for the Torbay Strategic Partnership and highlight the areas of greatest concern.

In creating this third JSNA, we have built on the application of previous versions and taken into account suggestions from local commissioners on how to improve the tools available.

The JSNA for 2010 has three main areas of functionality:

1. An interactive set of tools which allows users to interrogate indicators by geographical ward or GP surgery. These are dynamic and will need to be regularly updated. Commissioners will be able to see not only where the hotspot areas for attention within Torbay are on any given indicator, but also be able to correlate issues of concern with other datasets.
2. Whilst interactive and up to date data is essential in a changing world, I am also aware that commissioners have welcomed the previous analysis highlighting the current position for their ward or GP surgery for the statistically significant indicators for Torbay. This analysis is provided using the information currently available and is intended to highlight for commissioners areas for further attention.
3. Finally, Torbay Strategic Partnership (TSP) needs to see a summary analysis of current issues for the whole of Torbay. In presenting this analysis, I have acknowledged that some priorities have already been agreed in previous work. Some are nationally given, e.g. CO2 emissions, some have been highlighted in previous local analysis and remain an issue, e.g. the demographic bias, some are high risk or high cost, e.g. supporting the most vulnerable children and some have been identified through community feedback, e.g. Place Survey. These are illustrated by the 'Top level area of interest' in the following report.

As described above, the high level analysis for TSP reflects and summarises existing issues. This provides a baseline for the development of future priorities whilst taking into account previous work. The summary of statistically significant indicators for Torbay allows commissioners to identify areas for further analysis at a lower level and this analysis can be undertaken using the interactive tools.

The tools to support JSNA are discussed and exampled in detail in the appendices, and can be accessed online at: http://www.torbaycaretrust.nhs.uk/pages/publichealth.aspx

I would like take this opportunity to thank the i-bay network for their continued hard work in bringing together partnership information in a way that will be of benefit to the population of Torbay.

Debbie Stark

Director of Public Health, Torbay

INTRODUCTION

Background

The Local Government and Public Involvement in Health Act (2007) requires Primary Care Trusts (PCTs) and Local Authorities to produce a Joint Strategic Needs Assessment (JSNA) of the health and well-being of their local community. The needs assessment is a systematic method for reviewing the health and well-being needs of a population, leading to a review of commissioning priorities that will improve the health and well-being outcomes and reduce inequalities.

The purpose of JSNA is to improve the health and wellbeing of the population by identifying need both over the short term (three to five years) and longer term (five to ten years). JSNA identifies "the big picture" in terms of the health and wellbeing needs and inequalities of a local population. It provides an evidence base for commissioners to commission services according to the needs of the population.

A JSNA is not a needs assessment of an individual, but a strategic overview of the local community need – either geographically such as local authority / ward or by setting such as GP practice.

The JSNA allows local partners to identify common priorities (for particular groups, services, wards or GP practice) from key findings and to determine an evidence-based approach on how best to work together to meet those needs - whether through joint commissioning, joint provision or other approaches - and measure by achievement of joint targets (Community Plan).

A JSNA will:

- Provide an evidence base to aid better decision-making.
- Support the delivery of better health and well-being outcomes for the local community.
- Inform the next stages of the commissioning cycle.
- Underpin the Community Plan and the choice of local outcomes and targets, as well as local commissioning plans.
- Send signals to existing and potential providers of services about potential service change.
- Define achievable improvements in health and well-being outcomes for the local community.

In Torbay, JSNA has evolved from an NHS / Local Authority centric assessment to a Local Strategic Partnership (LSP) assessment of population need. Incorporating information from LSP members not only benefits wider LSP members, but also recognises the wider determinants of health. Torbay's approach to JSNA recognises the importance that all organisations (statutory, voluntary and community) have in improving the health and wellbeing of Torbay's population.

Structure

The JSNA structure is based around the LSPs Community Plan; 'together we can make a brighter bay'. The Community Plan, developed by the LSP on behalf of Torbay resident's, sets out ambitions for the next 20 years.

> *"The plan aims to unlock Torbay's potential and drive forward economic prosperity to give us prosperous communities with a higher quality of life and improved access to jobs."*

The approach to JSNA in Torbay from 2010 is to remove the 'static document dataset' and move to a dynamic and interactive dataset. The interactive dataset is exampled and discussed in further detail below in the methodology section, and also in the appendices of this report.

This new approach to JSNA in Torbay represents a positive step forward in meeting the intelligence needs of LSP members, enabling a better understanding of the needs and challenges within the population. Torbay's approach to JSNA has evolved over time, and will continue to evolve as more partners bring their ideas to JSNA.

This report presents a set of 14 broad 'areas of interest'. These 14 areas of interest represent an overview for the LSP to consider, and not a comprehensive or exhaustive list of all areas of interest.

Under each of the Community Plan themes (figure 1), there are a series of 'areas of interest', along with an additional section on demography. Accompanying the areas of interest are examples of what this means for Torbay.

Figure 1: Community Plan themes:

Figure 2: Area of interest setting matrix:

Methodology of selecting areas of interest

In determining the broad areas of interest, a matrix framework has been applied (figure 2) following a review of strategies and assessments across the LSP, supported by the JSNA interactive tools.

The 14 areas of interest have been derived from an approach that could loosely be described as a 'meta-analysis' following a systematic approach in reviewing the available local strategies and assessments.

Consideration has been given to nationally agreed and existing targets for Torbay for example to reduce the level of CO^2 emissions in Torbay, local needs identified through the JSNA interactive tools

for example the ageing demographic, high risk high cost priorities for example supporting the most vulnerable in society, and the local community views for example the results from public perception surveys.

Methodology of selecting indicators for profiles

The matrix framework shown in figure 2 has been further applied to identify a series of indicators. These indicators, 24 in total, are contained within the ward and GP profiles. The profiles provide a summary of the challenges for Torbay and highlight the inequalities that exist within Torbay. Further discussion on the presentation and content of the profiles is given in appendix 1.

Interpretation of JSNA dataset

The broad areas of interest are supported by a set of interactive tools. These interactive tools have been designed to allow interrogation by setting or area based data within Torbay, by either GP practice or electoral ward. The tools also allow comparison with a single indicator over time.

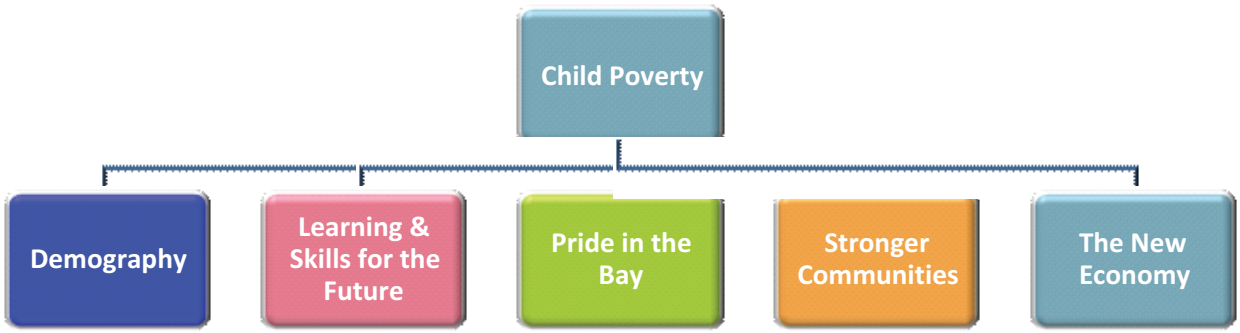
Presenting data in this fashion allows users to investigate relationships between topics. That could be over time or seeking out to identify a sensible relationship between indicators.

For example, if we consider Child Poverty. Formally defined as 'The proportion of children living in families in receipt of out of work benefits or in receipt of tax credits where their reported income is less than 60 per cent of median income'. Using the tools we can investigate an area based relationship between Child Poverty and other indicators within other themes of the community plan, along with the changing picture of child poverty over time.

Child poverty can therefore be looked at alongside demography indicators, including deprivation, and as we would expect there is a relationship. Within the context of child poverty and health, we can observe a strong relationship between child poverty and mothers that smoke during pregnancy. That is we can observe that areas with higher levels of child poverty, also experience a higher proportion of mothers that smoke during pregnancy.

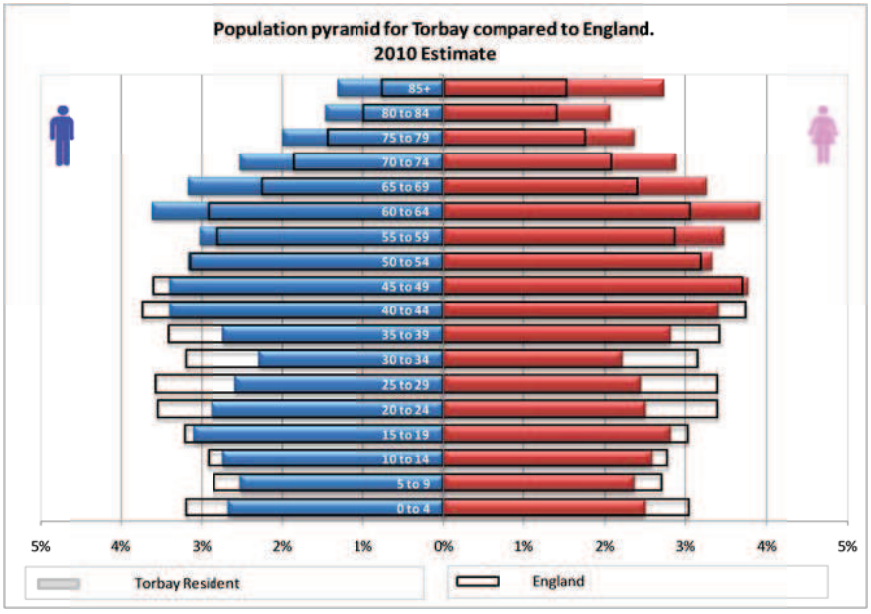
This approach is illustrated in figure 3, and is intended to facilitate a deeper understanding of the needs and challenges within the population.

Figure 3: example of how to compare datasets by Community plan theme.



Further detail on the interactive tools is given in appendix 2.

Torbay's position as a seaside community continues to prove popular as a retirement destination. This popularity is illustrated in the following population pyramid, where Torbay's population structure is shown with the solid bars, compared to the England structure with the hollow bars. Torbay's population structure is very much dominated by the higher proportion of older people and the noticeably lower proportion of younger adults aged 20 to 39.



Source: 2010 Sub National Population Projections, Office for National Statistics. Population pyramid taken from Torbay's JSNA population tool.

With this older person bias in the population, Torbay has a noticeably higher average age when compared to the national average. In 2010, Torbay's average age is estimated to be 4.7 years older than the national, this difference is expected to grow to just over 5 years by 2020.

As Torbay's population ages, the proportionate workforce within the bay to support the retirement age population is expected to decrease. This means that for every person of retirement age, there are expected to be fewer people of working age. In 2010, there are 2.1 working age people in Torbay for every person of retirement age; this is expected to decrease to 1.7 people of working age per person of retirement age by 2020. This is noticeably lower than the national average.

The Ratio within the following table, is the ratio between the working age population and the retirement age population, and is based on current working age parameters (16 to 59 females, 16 to 64 males).

Area	2010		2015		2020		2025	
	Average age	Ratio	Average age	Ratio	Average age	Ratio	Average age	Ratio
Torbay	44.1	2.1	44.8	1.9	45.6	1.7	46.4	1.6
England	39.4	3.2	39.9	3.0	40.5	2.8	41.4	2.6

Source: 2010 Sub National Population Projections. Office for National Statistics.

Despite Torbay's position as a seaside community, there are pockets of severe deprivation. These pockets, shown in red in the below map, have a direct link with communities with poorer educational attainment, poorer socioeconomic status, lower earnings and the lowest life expectancy. A partnership approach to reducing deprivation in these communities will have positive impacts, not only on the individuals in the communities but also on the services commissioned and provided within these communities.

Levels of modelled socio economic deprivation for Torbay have deteriorated over the last 10 years. From just outside the top quartile most deprived local authorities in 2001 and 2004 to well within the top quartile most deprived in 2007, this trend of worsening deprivation is expected to continue when the updated 2010 Index of multiple deprivation is published (expected autumn 2010).

There is an overwhelming amount of evidence that links economic prosperity and population socio economic outcomes, evidenced recently in the Marmot review[1].

Stimulating the local economy of Torbay, such as, removal of infrastructure isolation would have a direct positive outcome on the population's health and wellbeing, along with reducing the level of inequalities that exist within the population and offering effective cost savings across public sector agencies.

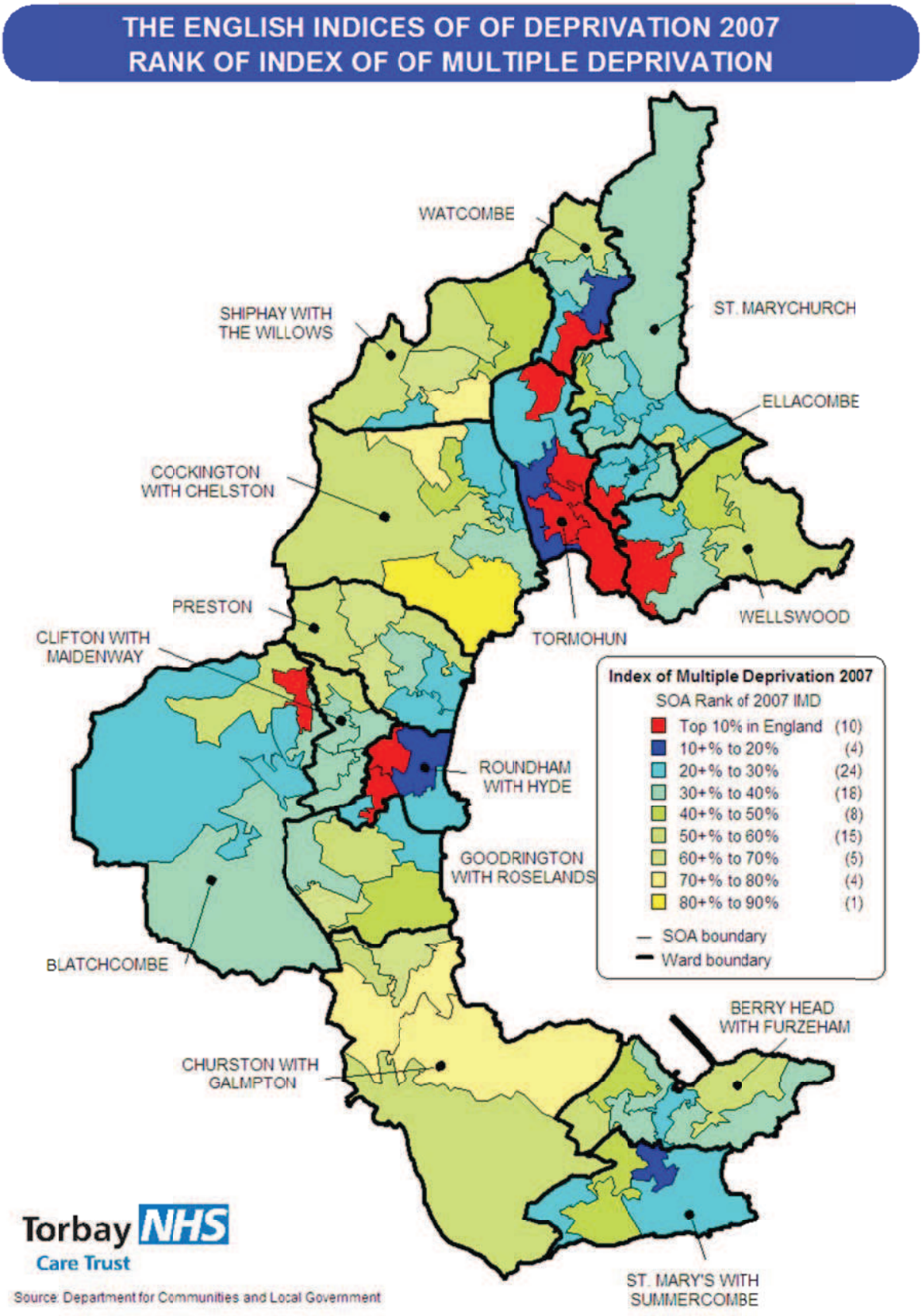
Health inequalities, and in particular poorer outcomes for poorer communities, have been well evidenced in recent years. From the 2004 Choosing Health White Paper[2], to Fair Society, Healthier Lives (The Marmot Review[1]) 2010 and more recently the Coalition Government State of the nation report: poverty, worklessness and welfare dependency in the UK[3]. All of these papers highlight inequalities and aspirations to build a fairer society. Inequalities in the population have a detrimental impact on public sector expenditure, with the tax payer disproportionately spending more in areas of greatest need. Evening out the playing field by removing, or significantly reducing inequalities would be to the benefit of society in general.

Within Torbay there are multiple inequalities and worsening levels of relative modelled deprivation. For example, the gap in life expectancy between the more affluent and most deprived communities in Torbay remains at over 7 years. The gap between the poorest neighbourhoods dying 7 years earlier than the richest represents a gap that exists in other key outcomes along the life course, and is indicative of the gap in inequalities within Torbay.

Demographic areas of interest and potential consequences:

Top level areas of interest	What this means for Torbay
Plan for the ageing population. *Identified through the JSNA*	The average age of the Torbay population is higher than the national. This is expected to increase over the coming years.
Reduce the gap between the most and least deprived in our community. *Identified through the JSNA and Marmot review*	Life expectancy at birth is higher in Torbay than the national. However, there are noticeable variations within Torbay.

Deprivation map of Torbay with associated electoral wards. Areas in red are amongst the top 10% most deprived areas in England. The English Indices of Multiple Deprivation are due for update in late 2010.



Through the 'Pride in the Bay' theme in the Community Plan we are aiming for a cleaner and greener Torbay.

Together we can:

- Create and maintain quality environments that are clean, safe and pleasant.
- Improve the quality and quantity of culture on offer in Torbay.
- Make it easier to get around Torbay.
- Be proud to provide high quality services to visitors and residents.

The environment in which we live is directly related to the health and well-being outcomes of those that live in those communities. Enabling communities to become healthy and sustainable places to live is fundamental in the reduction of inequalities.

The communities we live in affect our physical and mental health and well-being (Marmot[1]). The characteristics of the communities, through the built environment, do not always enable communities to undertake healthy behaviours.

Understanding the preventative agenda, where prevention is preferred to cure, is important in understanding the impact Pride in the Bay has on services further along the life course.

Key findings:

- Torbay has achieved a great deal in continued reductions around the levels of CO2. Figures from the Department of Energy & Climate Change show Torbay had the second lowest level of emissions per capita in the region in 2008, at 5.0 tonnes per head, this compared to 7.8 regionally and 8.0 nationally.
- The local perception around being able to influence decisions in the local area is amongst the lowest in England, 4th lowest out of 352 local authority areas.

Areas of interest and what this means for Torbay

Top level areas of interest	What this means for Torbay
Multi agency commitment to reducing the level of CO2 emissions in Torbay. *Identified through the 'Climate change strategy for Torbay'*	Levels of CO2 emissions are relatively low in Torbay, however reducing emissions further continues to be a national priority.
Improving the infrastructure and connectivity of Torbay with the rest of the country. *Identified through the 'Local Transport Plan'*	Torbay's position as an almost isolated community within a peninsular not only impacts on the economy, but also population health.
Building social capital through allowing communities to make the local decisions. *Identified through 'Putting People at the centre of decision making'*	Shifting the balance of power in local decision making to the communities of Torbay supports the governments drive for 'Big Society'.

Through the 'Learning and Skills for the Future' theme in the Community Plan we are aiming for better education, better skills and better prospects for current and future generations in Torbay.

Together we can:

- Ensure every child and young person in Torbay is supported and helped to achieve the best outcomes they can.
- Ensure every child and young person in Torbay lives in safety and good health, is well educated, enjoys their childhood and contributes positively to community life.
- Support families to care for their children.
- Make a positive difference to children and families in Torbay.

Giving every child the best start in life, not only in supporting the child and family in early health related services, but also in their journey through the educational system, is important to reducing health inequalities through the rest of their life course.

A disproportionate focus on achieving specific outcomes within the educational system would be ineffective if the support is not given in the early developmental years (Marmot[1]). Investing in early years is crucial to breaking the cycle of inequalities and reducing the gap between the least and most advantaged.

A key document setting out distinct priorities for children and families in Torbay is the 2010/13 Torbay Children and Young People's plan. The Torbay Children Trust has a very simple vision that guides all of its work, 'everyone working together to ensure the best outcomes for now and for the future for all our children and young people'.

The children's and young people's plan for Torbay contains a series of priorities. These priorities, listed below, set out the priorities for the children's trust over the coming three years.

- Raise attainment at all stages of education
- Improve attendance and behaviour at education settings
- Ensure all children and young people are protected from abuse and neglect and feel safe and supported in their families and communities
- Increase participation and positive activities
- Reduce the number of teenagers becoming pregnant
- Reduce the number of children and young people living in poverty
- Reduce the use of alcohol and substance misuse

Some of these priorities are identified within the top levels of interest, in this and other community plan sections.

A Multi-Agency Safeguarding Hub (MASH) is being developed in Torbay with Devon and Cornwall Police, Children's Services, Torbay Care Trust and South Devon Healthcare Foundation Trust with

other partners. Where MASH partners work together to provide detailed knowledge and analysis to ensure all safeguarding activity and intervention is timely, proportionate and necessary.

Key findings:

- Communities performing poorly in foundation stage profile, show poor performance through the key stages.
- The level of qualification attainment in Torbay's workforce has increased over recent years, with fewer people in the workforce without any qualifications.

Areas of interest and what this means for Torbay

Top level areas of interest	What this means for Torbay
Invest in early years. *Identified through the 'Children and Young Peoples Plan' and the 'Marmot Review'*	Improving the health and wellbeing at the start of the life course has been evidenced by Marmot as reducing generational inequalities.
Support the most vulnerable children and young people in the bay. *Identified through the 'Children and Young Peoples Plan'*	There is a social and political responsibility to provide a safe environment for all children in Torbay, enabling them to grow, develop and reach their full potential.
Develop the workforce skill set to suit the needs of the business community. *Identified through the 'Economic Strategy' and the 'Employment and skills board'*	Successful and sustainable economic growth in Torbay will depend on increasing the demand for higher level skills to support the workforce.

THE NEW ECONOMY

Through the 'New Economy' theme in the Community Plan we are aiming for a thriving and more prosperous Torbay.

Together we can:

- Improve the leisure economy and what we have to offer visitors.
- Increase value and improve economic performance of key sectors.
- Encourage appropriate diversification of the economic base.
- Provide business and infrastructure support for economic growth.
- Develop skills and learning opportunities.
- Support our communities to achieve a higher quality of life.

Without a thriving local economy Torbay will experience a significant widening of inequalities. Where those in good employment experience a more positive impact on health, compared to the unemployed who experience negative and poorer health outcomes.

Torbay's low wage and benefit dependent economy is linked to poorer health outcomes of residents. Those who are disadvantaged from good employment are more likely to experience poor health. Patterns of employment in Torbay are closely linked to inequalities, where areas of most disadvantage suffer the highest levels of unemployment and the greatest barriers to address.

Key findings:

- Torbay's overall economic performance, measured by Gross Value Added, is the lowest in the region at £12,506 per head of working age population. This is well below the regional (£18,235) and national (£20,458) averages.
- Torbay suffers from a limited and low wage economy. An economy dependent on the public sector employment leaves Torbay vulnerable to large scale public sector cuts.

Areas of interest and what this means for Torbay

Top level areas of interest	What this means for Torbay
Reduce the number of children living in poverty. *Identified through the 'Children and Young Peoples Plan', 'Economic Strategy', Marmot Review and the Field report*	The levels of child poverty in Torbay are higher than the national average. Preventing Torbay's poorer children becoming poor adults themselves is a collective responsibility.
Reduce the number of people dependent on benefits. *Identified through the 'Economic Strategy' and the 'Employment and skills board'*	Benefit claimant levels and worklessness are particularly high in Torbay, with distinct variations in claimant levels by area.
Improve the economic resilience, competitiveness and productivity of Torbay. *Identified through the 'Economic Strategy' and the 'Employment and skills board'*	A large dependence on public sector employment leaves employees in Torbay vulnerable to government cuts.

STRONGER COMMUNITES

Through the 'Stronger Communities' theme in the Community Plan we are aiming for a safer and healthier Torbay.

Together we can:

- Create a safe place to live, work and visit.
- Have access to good quality housing and support education, training and employment.
- Live in healthier communities and have happy, independent and healthy lives.
- Develop our own communities and treat each other with respect and consideration.
- Value the contribution that older people can make to the economy and life in Torbay.

To some extent there is a causal relationship between the three community plan themes of pride in the bay, learning and skills for the future and the new economy with stronger communities. In essence if the priorities associated with these three themes are addressed, the longer term effect would be that of a healthier and safer community.

The gap in life expectancy in Torbay between the least and most disadvantaged communities is approximately 8 years, for both males and females in 2007-09. This gap has widened slightly in recent years from just less than 7.5 years in 2006-08, although it is too early to see if this is a trend.

Key findings:

- Mortality considered amenable to healthcare in Torbay is significantly higher than the regional average, but in line with the national.
- Alcohol contributes significantly towards Torbay's night time economy. Alcohol also contributes towards localised violent assaults and increases the burden on the health care system through alcohol related hospital admission.

Areas of interest and what this means for Torbay

Top level areas of interest	What this means for Torbay
Close the gap in mortality between the most and least advantaged communities. *Identified through the 'Liberating the NHS'*	There is a noticeable gap in the rates of mortality between communities in Torbay. Where the more deprived communities die earlier than the least deprived.
Develop sustainable neighbourhoods. *Identified through 'The Future of Housing in Torbay'*	The level of poor housing and households living in fuel poverty is an issue in Torbay. There is also a deficit of affordable housing in the Bay; with over 5,500 households on the housing waiting list.
Building a safer Torbay together. *Identified through 'Devon and Cornwall police, Local Policing Plan' and Safer Communities Torbay*	Overall, Torbay is a relatively safe place to live, levels of crime were below the national average but violent crime was similar to the national average. There are distinct variations by area within Torbay.

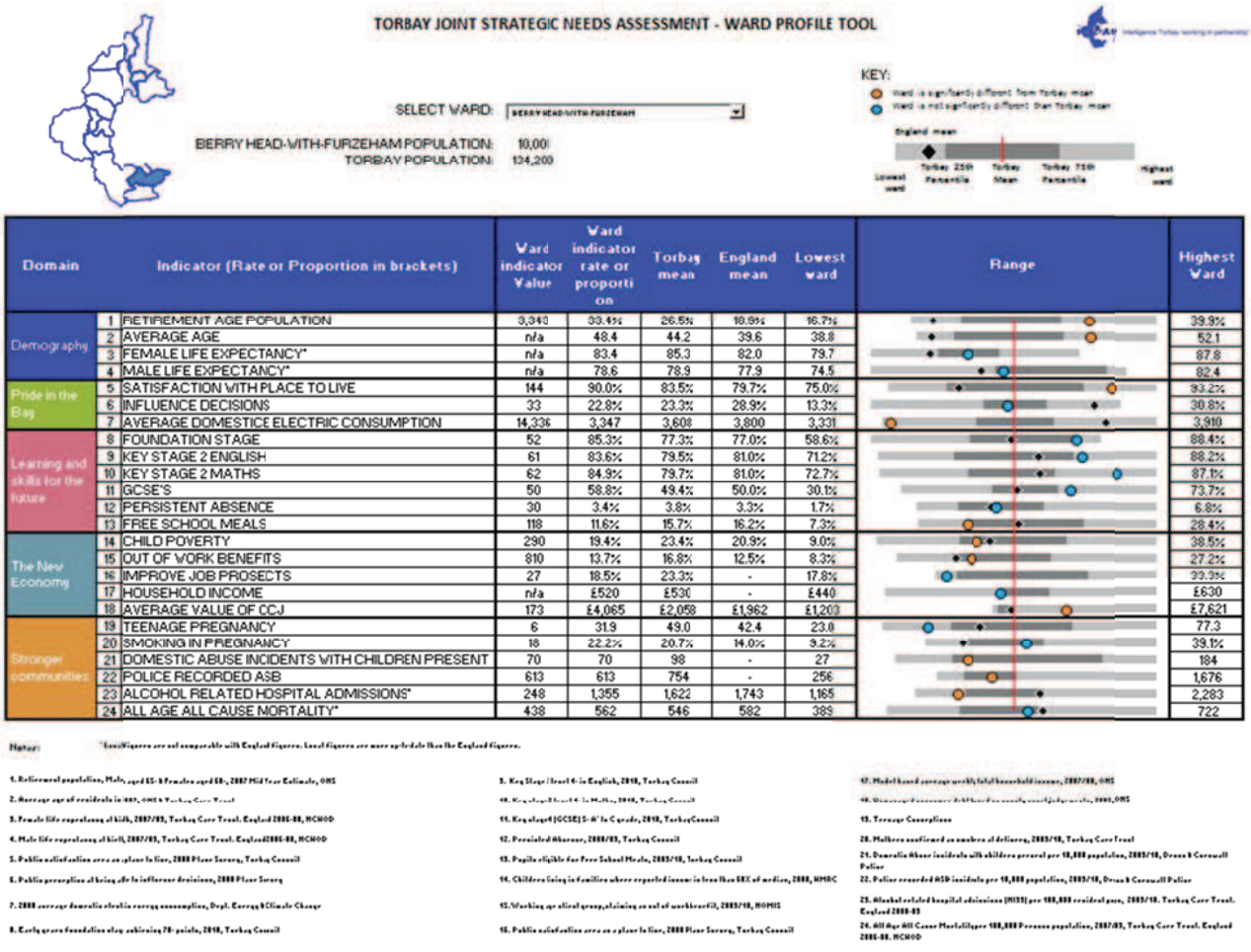
Appendix 1: Summary Profiles

The profile tools provide a framework to compare indicators against the Torbay and England average, where possible. Users of the profiles can select the geographical area of interest, or GP practice of interest. In doing this users are then able to look at the key indicators to identify challenges within that population.

Modelling is underway to estimate some of the wider social challenges by GP practice in the Bay. For example, the levels of child poverty by practice.

The data is presented in both tabula and graphical format, as shown below. This allows users a quick visual reference on the area of interest and also allows users to extrapolate the numbers where applicable.

The graph highlights indicators as either statistically significantly different, or not, to the Torbay average.



Domain		Indicator (Rate or Proportion in brackets)	Ward indicator Value	Ward indicator rate or proportion	Torbay mean	England mean	Lowest ward	Range	Highest Ward
Demography	1	RETIREMENT AGE POPULATION	3,340	33.4%	26.5%	18.9%	16.7%		39.9%
	2	AVERAGE AGE	n/a	48.4	44.2	39.6	38.8		52.1
	3	FEMALE LIFE EXPECTANCY*	n/a	83.4	85.3	82.0	79.7		87.8
	4	MALE LIFE EXPECTANCY*	n/a	78.6	78.9	77.9	74.5		82.4
Pride in the Bay	5	SATISFACTION WITH PLACE TO LIVE	144	90.0%	83.5%	79.7%	75.0%		93.2%
	6	INFLUENCE DECISIONS	33	22.8%	23.3%	28.9%	13.3%		30.8%
	7	AVERAGE DOMESTIC ELECTRIC CONSUMPTION	14,336	3,347	3,608	3,800	3,331		3,919
Learning and skills for the future	8	FOUNDATION STAGE	52	85.3%	77.3%	77.0%	58.6%		88.4%
	9	KEY STAGE 2 ENGLISH	61	83.6%	79.5%	81.0%	71.2%		88.2%
	10	KEY STAGE 2 MATHS	62	84.9%	79.7%	81.0%	72.7%		87.1%
	11	GCSE'S	50	58.8%	49.4%	50.0%	30.1%		73.7%
	12	PERSISTENT ABSENCE	30	3.4%	3.8%	3.3%	1.7%		6.8%
	13	FREE SCHOOL MEALS	118	11.6%	15.7%	16.2%	7.3%		28.4%
The New Economy	14	CHILD POVERTY	290	19.4%	23.4%	20.9%	9.0%		38.5%
	15	OUT OF WORK BENEFITS	810	13.7%	16.8%	12.5%	8.3%		27.2%
	16	IMPROVE JOB PROSECTS	27	18.5%	23.3%	-	17.8%		39.9%
	17	HOUSEHOLD INCOME	n/a	£520	£530	-	£440		£630
	18	AVERAGE VALUE OF CCJ	173	£4,065	£2,058	£1,962	£1,203		£7,621
Stronger communities	19	TEENAGE PREGNANCY	6	31.9	49.0	42.4	23.0		77.3
	20	SMOKING IN PREGNANCY	18	22.2%	20.7%	14.0%	9.2%		39.1%
	21	DOMESTIC ABUSE INCIDENTS WITH CHILDREN PRESENT	70	70	98	-	27		184
	22	POLICE RECORDED ASB	613	613	754	-	256		1,676
	23	ALCOHOL RELATED HOSPITAL ADMISSIONS*	248	1,355	1,622	1,743	1,165		2,283
	24	ALL AGE ALL CAUSE MORTALITY*	438	562	546	582	389		722

The indicators have been selected using data from the JSNA interactive tools, where consideration has been given to the matrix discussed in the introduction. This has however been constrained by the availability of information below the Torbay level, allowing the variations between areas to be highlighted.

Appendix 2: Torbay's move to a new model for JSNA

Torbay's JSNA model is centred on a series of interactive tools based on the community plan themes. These are supplemented with additional tools around demography including population projections.

The NHS white paper, Equity and excellence: Liberating the NHS, places commissioning responsibility for improving the health and wellbeing of the population jointly with GP consortia and local authorities. This perspective is reflected in JSNA with the inclusion of practice based data, where applicable.

This JSNA forms a tiered model to JSNA for commissioners across all public service agencies, providing them with the evidence needed to agree and shape service delivery across Torbay. It should be possible to import sections of this report or interrogation of the tools into funding applications, strategies and reports.

The tools are intended to be dynamic in allowing partners to update when applicable, ensuring that users access up-to-date information. The JSNA tools will represent a set of strategic intelligence tools and not a performance repository. They will however be informed by the emerging proposals in the consultation paper Liberating the NHS, Transparency in Outcomes and other emerging white papers and changes in policy.

Tools:

- Projected needs tool — In development
- Population projection tool — (exampled below)
- JSNA Data tool — (exampled below)

The projected needs tool is designed to represent straight line growth based on present data. For example, if hospital admissions are currently X in year 2010, given the expected population change we would expect to see Y admissions in year 2010+Z.

This tool will be a mixture of being able to enter data into a set of defined parameters, or by selecting themes of interest. For example, an individual practice may wish to know how many patients to expect on a specific register in 5 years' time. The practice could enter the data and derive an estimate. To improve the estimate, the data input options would allow quinary age bandings by gender, and the output supplied with appropriate confidence intervals around the estimate. A second example would allow a commissioner to take current use of a service and predict forwards into the future using expected population variations.

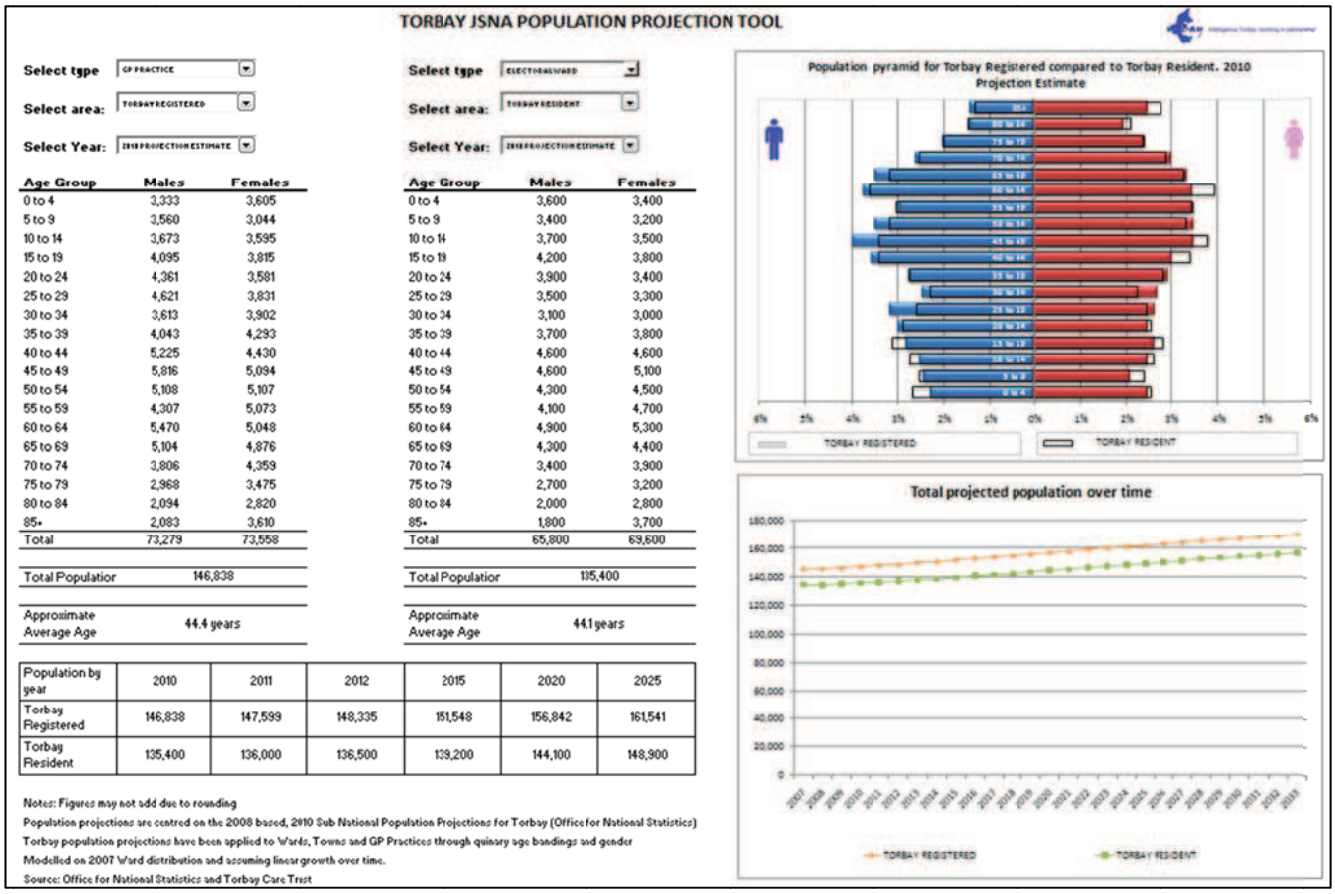
This tool is expected to be ready by early 2011. Other projection tools are being developed nationally and will be added when available.

Overall, the tools have been designed to allow a quick and intuitive analysis through a series of drop down boxes. This includes a series of self-generating notes and includes notes on how to interpret the data

Population projection tool

This tool gives flexibility for users to choose an area or setting by year of interest between 2007 and 2033. Users are able to select local wards, towns or GP practices and compare them with either the same area / setting at two different points in time, or compare different areas / settings.

The example given below is a comparison between resident and registered populations in 2010. Data is output in the quinary age banded gender table with totals and estimate average age at that year. Selection of settings / areas by year generates a comparison population pyramid and a chart showing the estimated population growth over time for the two areas / settings.



TORBAY JSNA POPULATION PROJECTION TOOL

Select type: GP PRACTICE
Select area: TORBAY REGISTERED
Select Year: 2010 PROJECTION ESTIMATE

Age Group	Males	Females
0 to 4	3,333	3,605
5 to 9	3,560	3,044
10 to 14	3,673	3,595
15 to 19	4,095	3,815
20 to 24	4,361	3,581
25 to 29	4,621	3,831
30 to 34	3,613	3,902
35 to 39	4,043	4,293
40 to 44	5,225	4,430
45 to 49	5,816	5,094
50 to 54	5,108	5,107
55 to 59	4,307	5,073
60 to 64	5,470	5,048
65 to 69	5,104	4,876
70 to 74	3,806	4,359
75 to 79	2,968	3,475
80 to 84	2,094	2,820
85+	2,083	3,610
Total	73,279	73,558

Total Population	146,838
Approximate Average Age	44.4 years

Select type: ELECTORAL WARD
Select area: TORBAY RESIDENT
Select Year: 2010 PROJECTION ESTIMATE

Age Group	Males	Females
0 to 4	3,600	3,400
5 to 9	3,400	3,200
10 to 14	3,700	3,500
15 to 19	4,200	3,800
20 to 24	3,900	3,400
25 to 29	3,500	3,300
30 to 34	3,100	3,000
35 to 39	3,700	3,800
40 to 44	4,600	4,600
45 to 49	4,600	5,100
50 to 54	4,300	4,500
55 to 59	4,100	4,700
60 to 64	4,900	5,300
65 to 69	4,300	4,400
70 to 74	3,400	3,900
75 to 79	2,700	3,200
80 to 84	2,000	2,800
85+	1,800	3,700
Total	65,800	69,600

Total Population	135,400
Approximate Average Age	44.1 years

Population by year	2010	2011	2012	2015	2020	2025
Torbay Registered	146,838	147,599	148,335	151,548	156,842	161,541
Torbay Resident	135,400	136,000	136,500	139,200	144,100	148,900

Notes: Figures may not add due to rounding
Population projections are centred on the 2008 based, 2010 Sub National Population Projections for Torbay (Office for National Statistics)
Torbay population projections have been applied to Wards, Towns and GP Practices through quinary age bandings and gender
Modelled on 2007 Ward distribution and assuming linear growth over time.
Source: Office for National Statistics and Torbay Care Trust

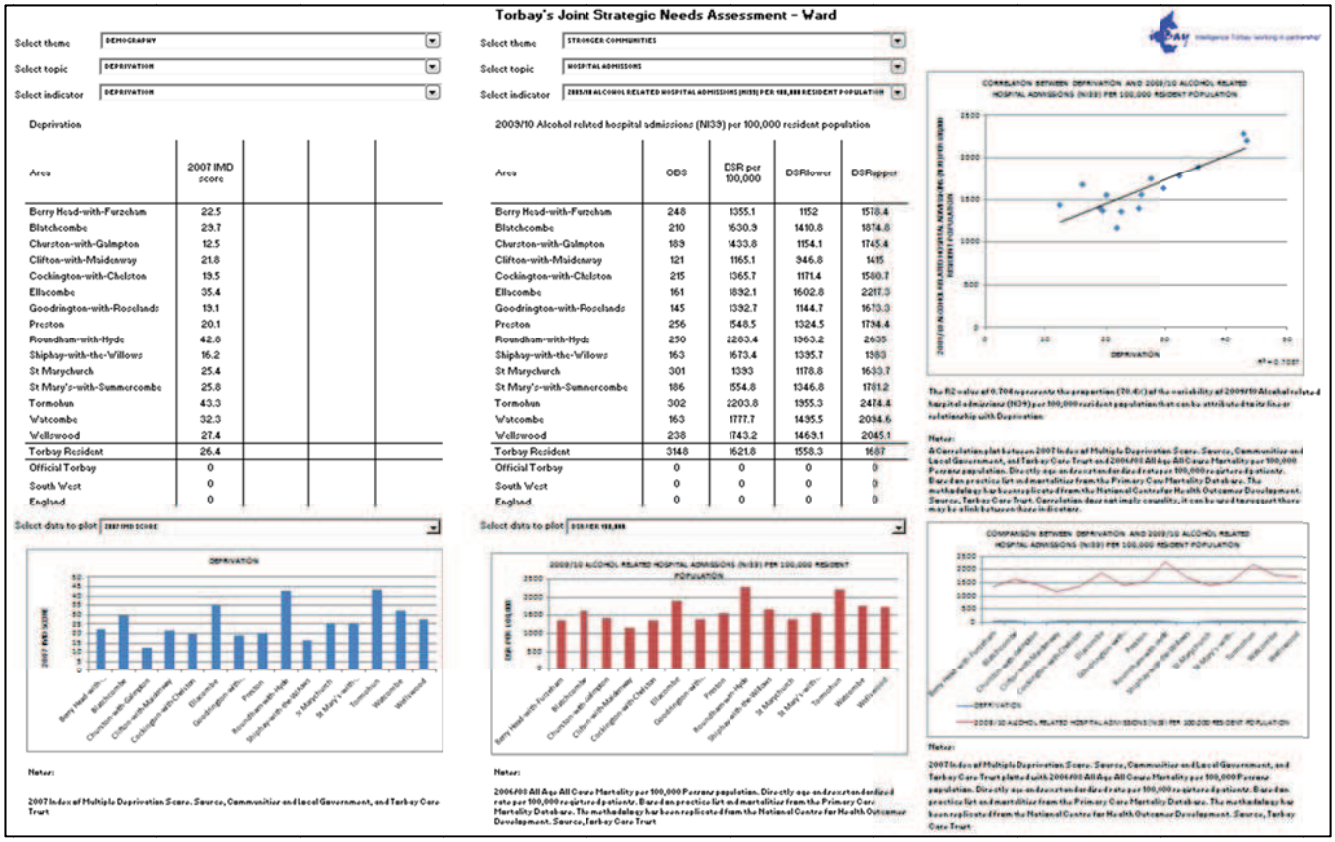
JSNA data tool

This tool allows users to interrogate various datasets under the community plan themes, along with additional intelligence on demography.

Information has been presented by setting or area (GP practice or ward) where possible and applicable. Through a series of drop down boxes, users can quickly look at a single topic, or compare two indicators to investigate any sensible relationships.

The example below presents ward data for deprivation and alcohol related hospital admissions. The data is presented in tabula format, with graphs per dataset presented below the tables. Users can also view a scatter plot illustrating area based relationships (these relationships do not imply causality). In this example, we can see a strong positive relationship. That is our more deprived communities tend to show higher levels of alcohol related hospital admissions.

Finally, there is a chart that shows the two datasets against each other, in this example the scale of the deprivation does not lend itself well to the directly age standardised rate of hospital admissions.



Appendix 3: Reference and contribution

References:

1. Fair Society, healthy Lives. The Marmot Review. University College London, Feb 2010

2. Choosing Health, Making healthier choices easier. Department of Health, Nov 2004

3. State of the nation report: poverty, worklessness and welfare dependency in the UK. Cabinet Office, May 2010

Supporting documents:

Climate change strategy for Torbay 2008-2013	Torbay Council
Community Plan, Together we can make a brighter Bay 2010-2013	Torbay Strategic Partnership
Fair Society, healthier Lives 2010	The Marmot Review
Liberating the NHS, Transparency in outcomes	Department for Health
Local Policing Plan 2010-2013	Devon and Cornwall Police
Local Transport Plan 2006-2011	Torbay Strategic Partnership
Putting People at the centre of decision making	Torbay Strategic Partnership
Setting up an Employment and Skills Board for Torbay and South Devon 2009-2010	
Strategic Assessment for Safer Communities Torbay, 2010-2011	Safer Communities Torbay
The Foundation Years: preventing poor children becoming poor adults	Field Report
The future of housing in Torbay, 2008-2011	Torbay Strategic Partnership
Torbay Children and Young People's Plan 2010-2013	Torbay Children's Trust
Torbay Economic Strategy 2010-2015, Accepting the Challenge	Torbay Development Agency
Torbay Local Economic Assessment, Interim Assessment July 2010	Torbay Development Agency

i-bay

Torbay's local intelligence network, i-bay, was set established in 2008 to deliver the 2008 JSNA. Following the success of the 2008 JSNA the network has delivered several partnership pieces of work.

Contributors from the i-bay network to the 2010 JSNA:

Name	Organisation
Alli Grant	Torbay Council
Bernard Page	Torbay Council
Claire Truscott	Torbay Council
Dan Hallam	South Devon College
Dave Church	Devon and Somerset Fire and Rescue
Debbie Passmore	Torbay Development Agency
Doug Haines	Torbay Care Trust
Ges Hughes	Torbay Council
Ian Poole	Torbay Council
Ian Tyson	Torbay Care Trust
Jo Beer	Torbay Council
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Torbay NHS Care Trust

Title:	**Health & Wellbeing Strategy A Framework for Design to Delivery**		
Report to:	Health & Wellbeing Board		
Directorate/Department:			
Prepared By:	Siobhan Grady Doug Haines	Contributors:	
Date Prepared:		Date of Meeting:	21st July 2011

Summary of Report:

This report provides the Board with a proposed framework for the structure to the Health & Wellbeing Strategy to be developed around the following themes

The current strategy document has been drafted and framed around current published documentation. It offers an initial draft framework for the structure and identify the elements for which further information is sought.
A draft strategy will be completed for submission to the September meeting of the Board.

Recommendations:

The Board is asked to consider and agree to the proposed themes.

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HEALTH AND WELL BEING STRATEGY

2011 – 2013

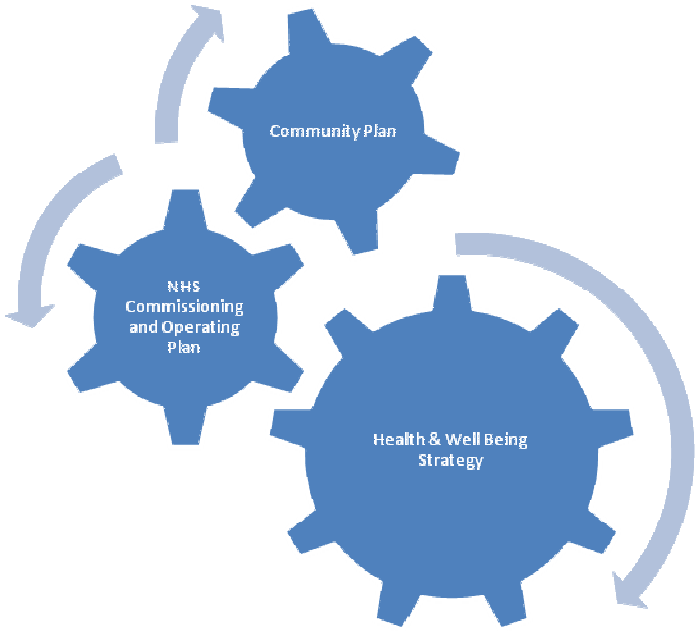
(A Framework for Design to Delivery)

FORWARD

Chair of Health and Well Being Board

A strategy that will enable communities to reduce inequalities and experience good health and wellbeing throughout life needs to take account of the wider determinants and mirror the cross government framework.

To include statement / diagram outline linkages with other strategies



1.0 POLICY CONTEXT

The Coalition Government has set out major reform within the Local Government and National Health Service. A vast number of literature has been published; equity and excellence: liberating the NHS[1], healthy live healthy people[2], no health without mental health[3] and the health and social care bill 2011.[4] These papers set the backdrop for change, including a new Public health System which will focus on improving the health of the poorest fastest and transformational change to the way that services are commissioned and increasing local democratic legitimacy.

The health and social care bill makes proposals to strengthen the partnership working across health and local authorities, underpinned by local democracy. This will see the establishment of Health and Well Being Boards providing the opportunity for a more integrated approach at a local level to deliver better health and wellbeing outcomes, better quality of care and better value.

2.0 HEALTH AND WELL BEING BOARDS

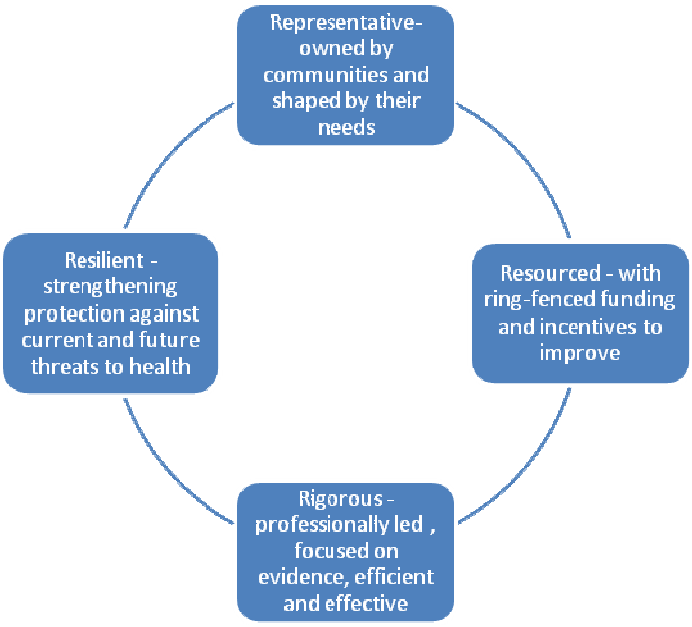
Previous papers discussing the development a Torbay of Health and Wellbeing Board has already been discussed and presented with options locally, 'Report Number TSP/3/11'. In summary the Government proposals have set out the proposed role and function of the Health and Well Being Board:

- To assess the needs of the local population and lead the statutory joint strategic needs assessment.
    - Including the undertaking of the Pharmaceutical Needs Assessment.
- To promote integration and partnership working between the health, social care, public health and other local services.
- Promote collaboration on local commissioning plans, including supporting joint commissioning and pooled budget arrangements where each party so wishes.
- To undertake a scrutiny role in relation to major service changes and priorities.

Membership of the health and wellbeing board, outside a core membership list, will be discretionary at a local level. The core membership, as proposed in liberating the NHS: legislative framework and next steps[6], include GP consortia, the director of adult social services, the director of children's services, the director of public health, an elected member and a local health watch. The local preference is to continue with an extended membership as follows:

3.0 INFLUENCING POLICY AND DESIGN

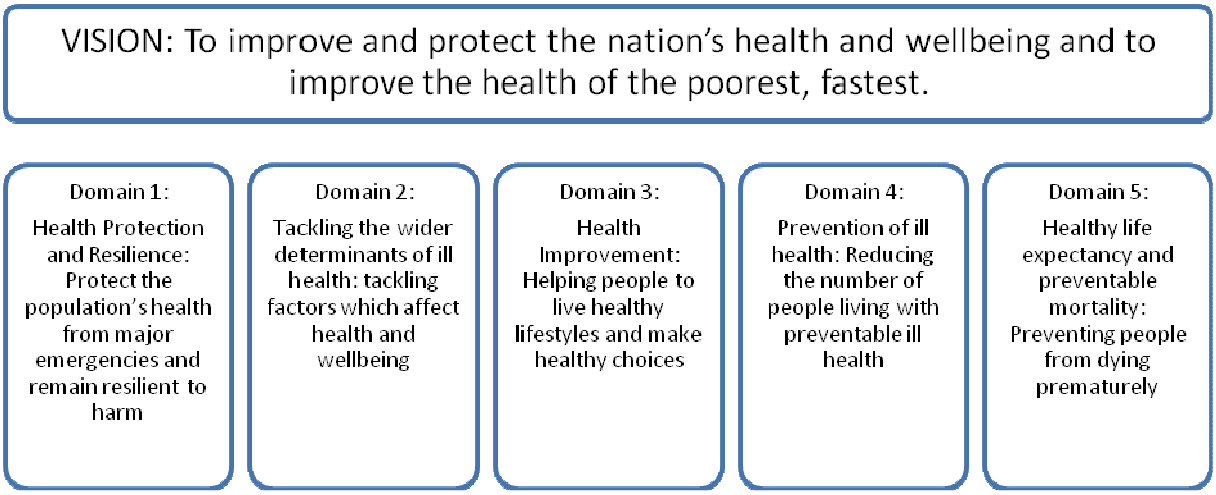
3.1 The White paper 'Healthy Lives, Healthy People: Our Strategy for Public Health in England' sets out the future for public health. It adopts a life course framework for tackling the wider social determinants of health. In addition to the establishment of a new body, Public Health England, as part of the Department of Health it clearly places public health responsibilities back to local government with a stated ring fenced budget to ensure that local government and local communities are central to improve health and wellbeing of their populations and tackling inequalities. This new approach to Public Health set out in the White Paper is illustrated below:



Source: Healthy Lives, healthy People

A new Outcomes Framework for public health at national and local levels is proposed. It will be evidence driven, taking account of the different needs of different communities and supportive of delivering health and well being strategies. Figure 2 illustrates the proposed Public Health Outcomes Framework which is set out across five domains

Figure 2: Public Health Outcomes Framework



3.2 The Health and Social Care Outcomes and Accountability Framework plays a significant role in shaping the priorities for the local population together with evidence from the joint strategic needs assessment.

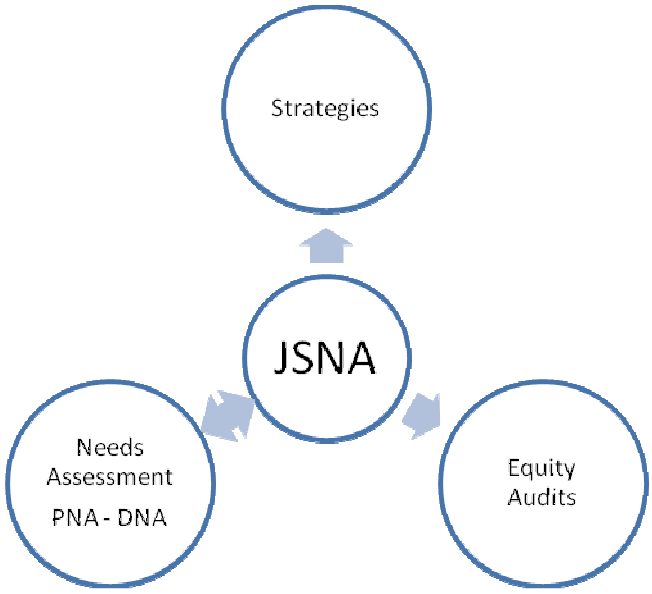
Figure 3. Health & Social Care Outcomes and Accountability Framework

3.3 The level of spend already within the Bay is considered a shrinking purse. The current £? NHS combined with LA £? provides a basis on which to plan and commission less not more. The challenge will be to manage the increasing expectation and levels of need from our residents balanced against the .....

Figure 4. Resource Matrix

4.0 DELIVERING THE JSNA

Joint Strategic Needs Assessment (JSNA) provides the principle evidence base for the Health and Wellbeing Strategy as well as central to other needs assessments, strategies and equity audits.



The Torbay approach to JSNA recognises the importance that all organisations (statutory, voluntary and community) have in improving the health and wellbeing of Torbay's population and defines this within a local context, setting realistic expectations and flexibility in aligning the PNA (Pharmaceutical Needs Assessments) and DNA (Dental Needs Assessments) with the model.

JSNA is led by Public Health within the Local Authority as part of the local intelligence network, iBAY which was established in 2008 with membership from a number of partner agencies. The potential for wider participation within the intelligence network continues to be explored in particular .....

5.0 DEVELOPING A SUSTAINABLE HEALTH AND WELLBEING STRATEGY

This Health and Wellbeing Strategy is based around an integrated approach which reflects the collective responsibility of communities, the local authority and partners in improving and protecting health. Along with objective needs identified from within the JSNA; priorities identified from people in the community ('what matters the most') under the direction of the Health and Wellbeing Board we can jointly create opportunities by maximising resources and minimising duplication.

Physical and psychological health and wellbeing is an essential foundation for a prosperous and flourishing society. [(13)] It enables individual and families to contribute fully to their communities, and underpins higher levels of motivation, aspiration and achievement. It improves the efficiency and productivity of the labour force – critical to ensuring economic recovery. Poor health and wellbeing also costs a great deal through medical and social care costs, reduced productivity in the workplace, increased incapacity benefits, and many other calls on public services and community support. Our most deprived communities experience the poorest health and wellbeing, so systematically targeted approaches on the geographical areas and population groups at greatest need is crucial in reducing inequalities. The strategy is structured around the following cross sector framework

5.1 TACKLING HEALTH INEQUALITIES

A 'First and Most' approach to address tobacco use; physical inactivity, excess alcohol consumption, poor diet and mental health within our communities.

Four behavioural risk factors – tobacco use, physical inactivity, excess alcohol consumption and poor diet – are the biggest behavioural contributors to preventable disease. These 'top four' are responsible for 42% of deaths from leading causes and approximately 31% of all disability adjusted life years *World Health Organization, The European Health Report, 2005). Tackling behavioural risk factors through health promotion is often seen as an issue among younger, predominantly healthier people, however, behavioural factors are also major risk factors in the onset and relapse of, and premature mortality from, long-term conditions such as diabetes, cardiac disease and respiratory disease, and for increase disability from musculoskeletal conditions and mental ill health. There is also strong evidence that reducing behavioural risk factors in older people significantly increase both quality and length of life, irrespective of any pre-existing long term condition. 'No Health without Mental Health ' (DH, 2011) Government strategy provides focus and evidence that improving mental health and wellbeing significantly reduces physical (as well as psychological) ill health. Mental health is a gap in the current JSNA.

5.2 EMPOWERING LOCAL COMMUNITIES

'Big Society' requires a strong 3rd sector and effective community organising infrastructure and a strategic approach to community engagement.

5.3 GIVING EVERY CHILD THE BEST START IN LIFE

CYPP - priorities

5.4 MAKING IT WORK TO PAY

5.5 DESIGNING COMMUNITIES FOR ACTIVE AGING AND SUSTAINABILITY

Increase health expectancy and an improved quality of life and reduction in disability for people with long-term conditions

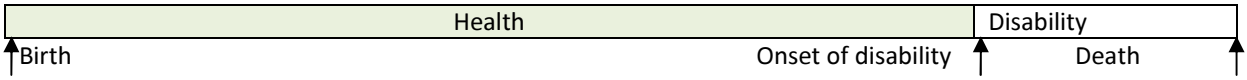
With an ageing population, it is critical that we have a strong focus on improving health and wellbeing in older people. Torbay expects to have 50% of its population aged 50 or above by 2020. Our population structure is already older than the national average and this is predicted to become even more acute which is likely to place additional demands on public services. The Torbay active aging strategy sets out the 'call for action' over the next 3 years.

There has been much debate about the age at which people are classified as 'old' but most people would recognise that as people age, they are likely to require some support to keep active and well both physically and socially.

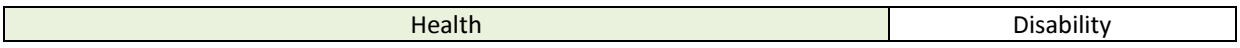
Prioritisation of investment in medical technology and treatments has been a contributing factor to increases in the overall life expectancy. Whilst some progress has been made with this we find that those people living longer are living with a disability. Therefore there needs to be a shift in intervention to increase both disability-free life expectancy and overall life expectancy with a clear focus on prevention and self management.

Improving health expectancy: policy options

Representation of current average life expectancy – a substantial portion of lives, particularly in disadvantaged groups, spend in ill health



Impact of many current health interventions – increase overall life expectancy by increasing life lived with disability



'Ideal' health interventions – increase disability-free life expectancy and overall life expectancy

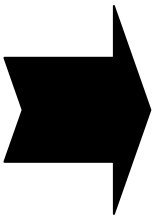
Many important healthcare interventions increase life years lived with disability, and achieve the outcome represented by the second bar above. However, many interventions that cost less and are most cost-effective increase disability-free life expectancy, yet are not routinely implemented. For example, increasing physical activity improves mental health and wellbeing, reduces rates of heart

disease and cancer, reduced the likelihood of developing diabetes in those at risk, reduces deterioration and supports fulfilled lives in people with many established long-term conditions and disabilities, and improves mobility, quality of life and life expectancy in older people.

5.6 WORKING COLLABORATIVELY WITH BUSINESS AND VOLUNTARY SECTOR

6.0 IN SUMMARY

Given the scale of the challenge set before us in addressing the inequalities that exist across the Bay the support to communities to help build a sustainable health and well being system will require transformation and challenge to the way of thinking and expectations. For example.

From	Health and social care as institution led services		To	Health and social care as part of the community
From	Curative and fixing medical care		To	Early intervention and preventative care
From	Sickness		To	Health and well being
From	Sustainability as an add on		To	Integration in culture, practice and training
From	Nobody's business		To	Everyone's business
From	Single indicators and out of date measurements		To	Multiple score card information with Outcomes

Source: Route Map for Sustainable Health

Therefore, investment in prevention is considered paramount and all sectors work more closely together to provide appropriate care. This means housing, educations, support to early years and community networks provide a fully integrated health and well being system. For instance, vulnerable people receive integrated health funds to insulate their homes better. This minimises ill health during winter, reduces hospital emissions and enables savings and a better standard of living. (local example?)

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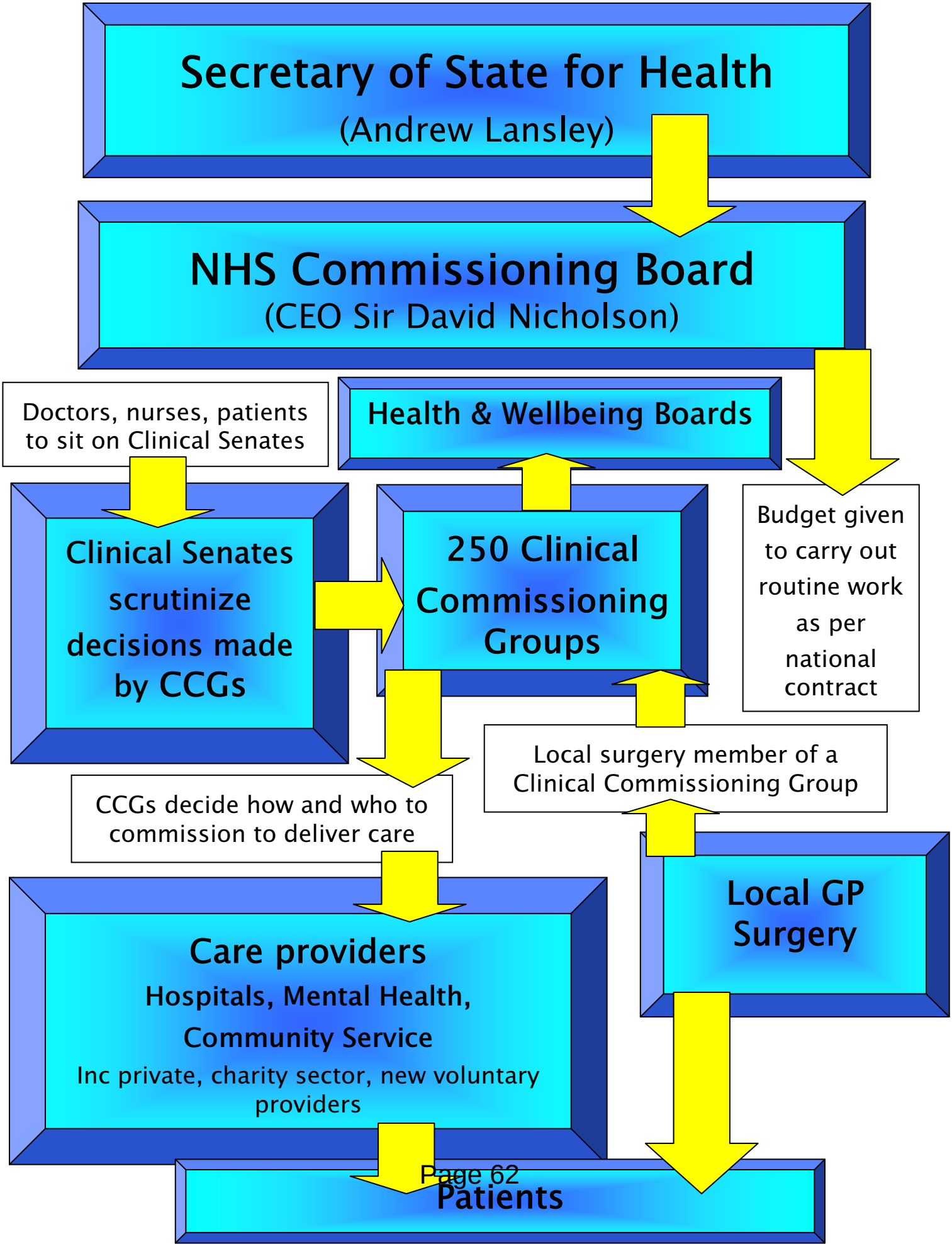
14.

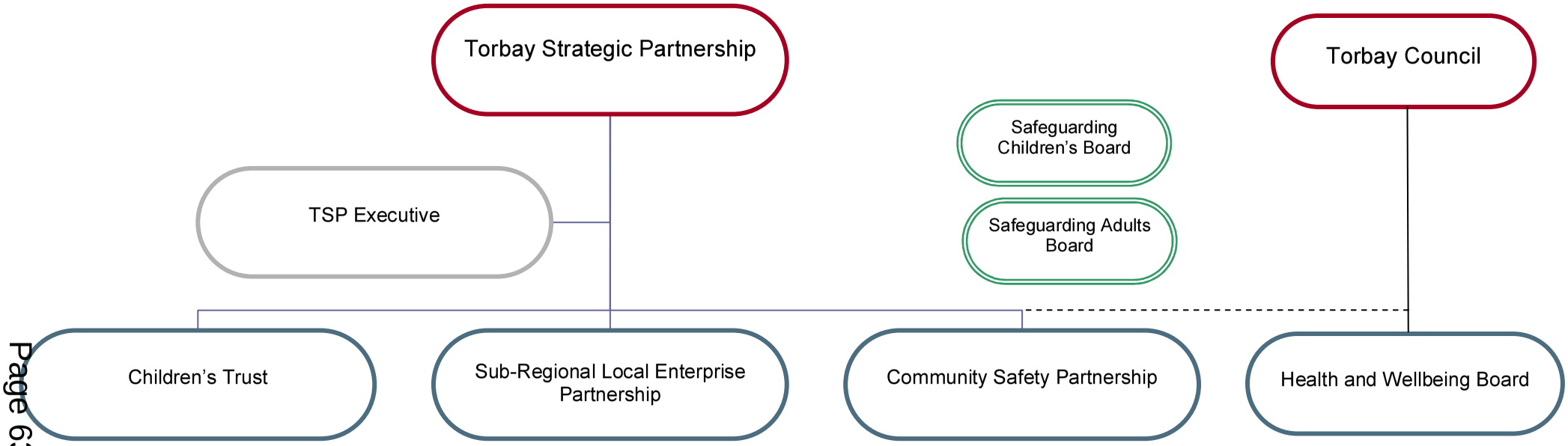
Current structure of the NHS

Currently Primary Care Trusts (PCTs) decide how best to spend health service budget in their area, commissioning local providers such as hospitals, dentists, community services, mental health and GPs to deliver local healthcare services

New NHS structure



Commissioning Structure for Torbay 2011/12



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OBESITY

HEALTHY WEIGHT, HEALTHY LIVES

BRIEFING PAPER

RECOMMENDATIONS

Prior to the issue of specific NICE guidance aimed at addressing obesity in local communities, the Health & Well Being Board is asked to consider the following:

1. Levels of obesity in Torbay reflecting on the national picture and the rates continuing to rise.
2. The wider strain and cost to the wider economy.
3. What makes Torbay an obesogenic environment and how can we address this?
4. Increase active travel opportunities e.g. park & ride facilities, cycling routes
5. Ensure health impact assessments are routinely incorporated in to all planning process's
6. Promote the availability of current services, including training opportunities and public programmes

JULY 2011

1.0 PURPOSE

To provide the Health and Well Being board with a background paper on the issue of obesity both as a national Public Health concern but one which locally also poses an increasing burden on resources in terms of capacity as well as financial.

Obesity is a preventable condition which has a far reaching detrimental impact on the individual's health; life expectancy; social and behavioural wellbeing.

Obesity is estimated to reduce life expectancy by between 3 and 14 years and is a health inequality issue.

People need to eat a healthy diet and maintain an active lifestyle through exercise. All organisations can contribute to the opportunities for the local population to do so. In particular, local authorities can take the strategic decisions which make it easier for people to make healthy choices.

The National Institute for Health and Clinical Excellence (NICE) is developing guidance for Public Health, 'Obesity: working with local communities', which will consider how local policy and decision makers can work with different communities to reverse the obesogenic tendencies associated with contemporary living. It will cover access to food, transport, education, planning and media as well as opportunities for physical health.

This guidance will be presented to the Board in the near future but this paper seeks to give members a chance to consider how Council decisions could positively address the rising tide of obesity in Torbay.

The health and wellbeing board are asked to drive, support and increase the profile of the multi pronged action needed to be taken across Torbay Care Trust Public Health Team, Torbay Local Authority (including environmental health, education and transport and planning), private organisations and within local communities.

2.0 DEFINITION

The World Health Organisation (WHO) defines obesity and overweight as 'abnormal or excessive fat accumulation that presents a risk to health.' Body mass index (BMI) is routinely used to measure overweight and obesity. BMI is weight (kg) divided by height squared (m^2). A BMI of 25-30 is generally described as overweight, 30+ is obese.

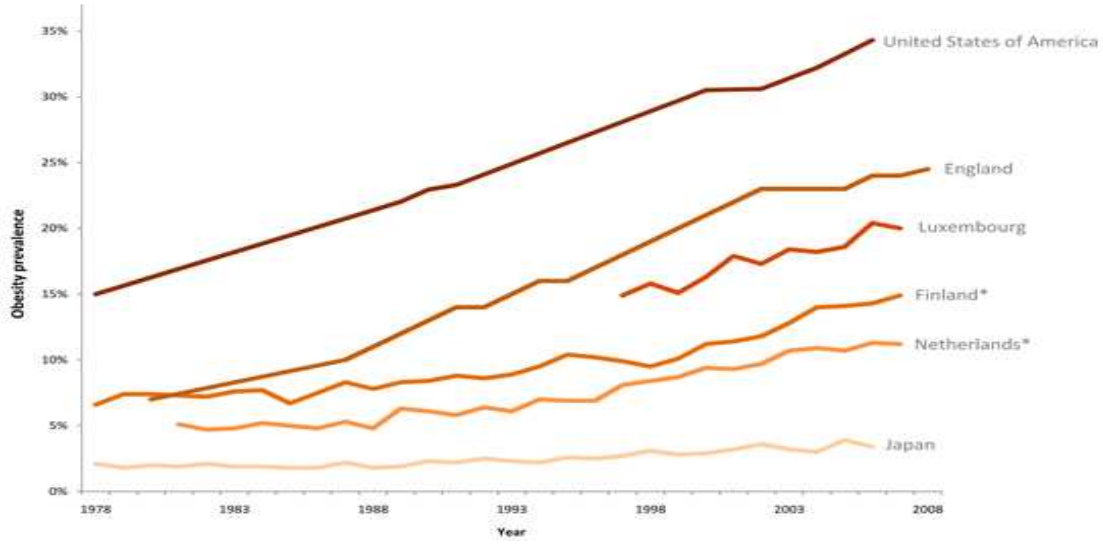
It is more complex to measure BMI in children and adolescents than it is in adults since BMI changes naturally with age and differs between boys and girls. Therefore, children's weight in the UK is assessed by reference to BMI percentile charts (comparable to growth charts). A high BMI for age is termed 'obesity'; a slightly lower BMI for age is defined as 'overweight.'

Although waist circumference is a more simple proxy measure which is now used to classify adults as obese or overweight, various systematic reviews (NICE 2006 and ISG 2003) have concluded that there is insufficient evidence to recommend this should replace the BMI for children and young people.

3.0 PREVALENCE

The prevalence of obesity in England has more than doubled in the last twenty five years. Although this recent increase in the prevalence of obesity has been seen in virtually every country in the world, the rate of increase in England has been particularly high (see Figure 1).

Figure 1: Trends in adult prevalence of obesity (BMI ≥30kg/m2) – percentage of the adult population assessed as obese in a selection of countries



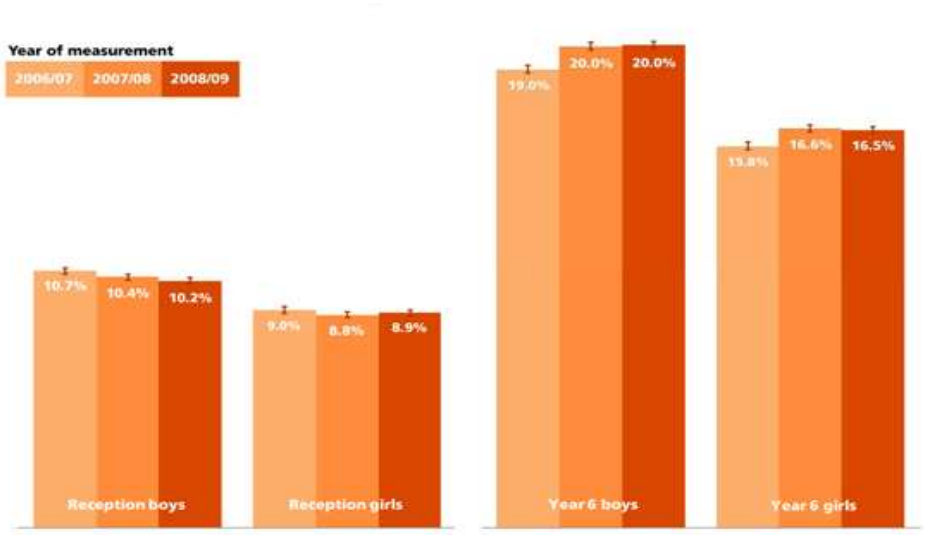
The rapid increase in the prevalence of overweight and obesity has resulted in the proportion of adults in England with a healthy BMI (18.5-24.9) decreasing between 1993 and 2008 from 41.0% to 32.5% among men, and 49.5% to 41.1% among women. In England, currently 24.5% of adults (aged 16 years and over) are obese (HSE 2008).

By 2050 the prevalence of obesity is predicted to affect 60% of adult men, 50% of adult women and 25% of children (Foresight 2007).

The prevalence of obesity and overweight changes with age. Prevalence of overweight and obesity are lowest in the 16-24 years age group and generally higher in the older age groups among both men and women. (HSE 2008)

Among children 10.2% of boys and 8.9% of girls in Reception year (aged 4-5 years) and 20.0% of boys and 16.5% of girls in Year 6 (aged 10-11 years) are also classified as obese according to the British 1990 population monitoring definition of obesity (≥95th centile) (NCMP 2008/09) (Figure 2).

Figure 2: Prevalence of obesity (with 95% confidence limits) by year of measurement, school year, and sex (National Child Measurement Programme)

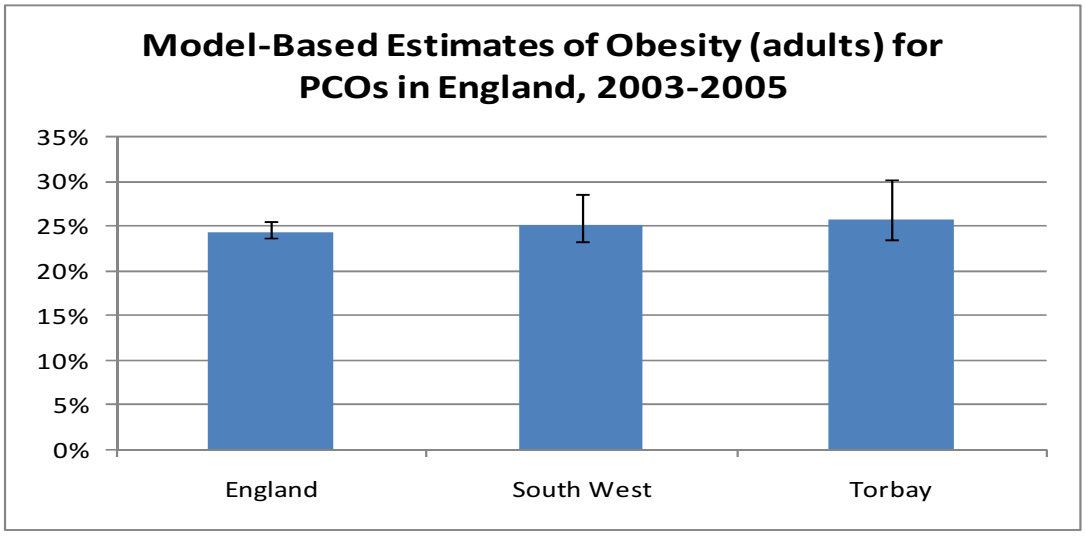


Information from the Health Survey for England shows an increasing trend in child obesity prevalence between 1995 and 2004. Particularly among older children, there is evidence of a slowing down the increase in the rate of child obesity since 2004.

4.0 PREVALENCE IN TORBAY

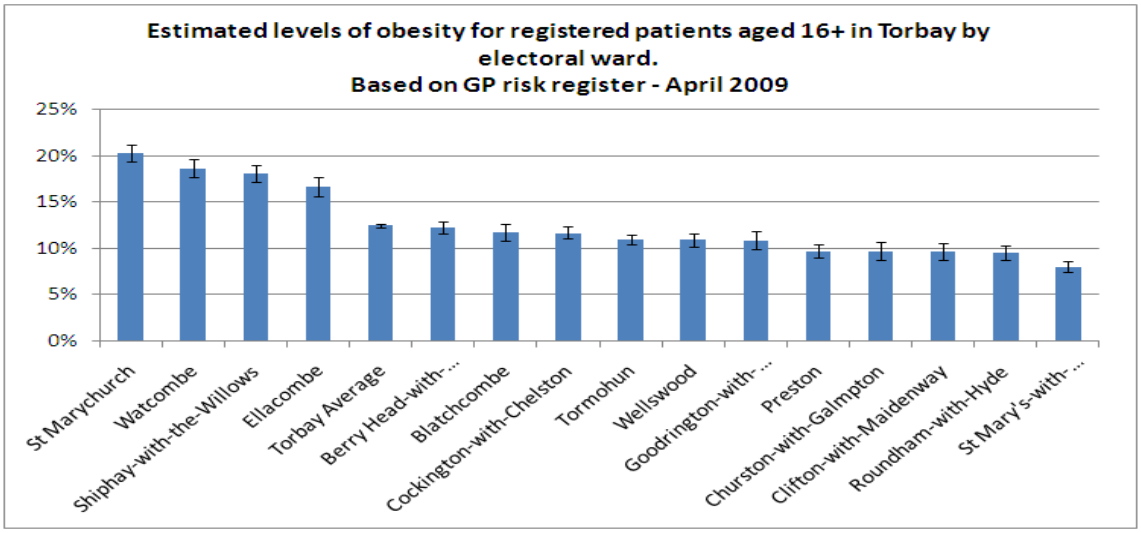
4.1 Adults - Locally it is estimated that 25% of adults are obese. (Health Surveys for England 2003 to 2005)

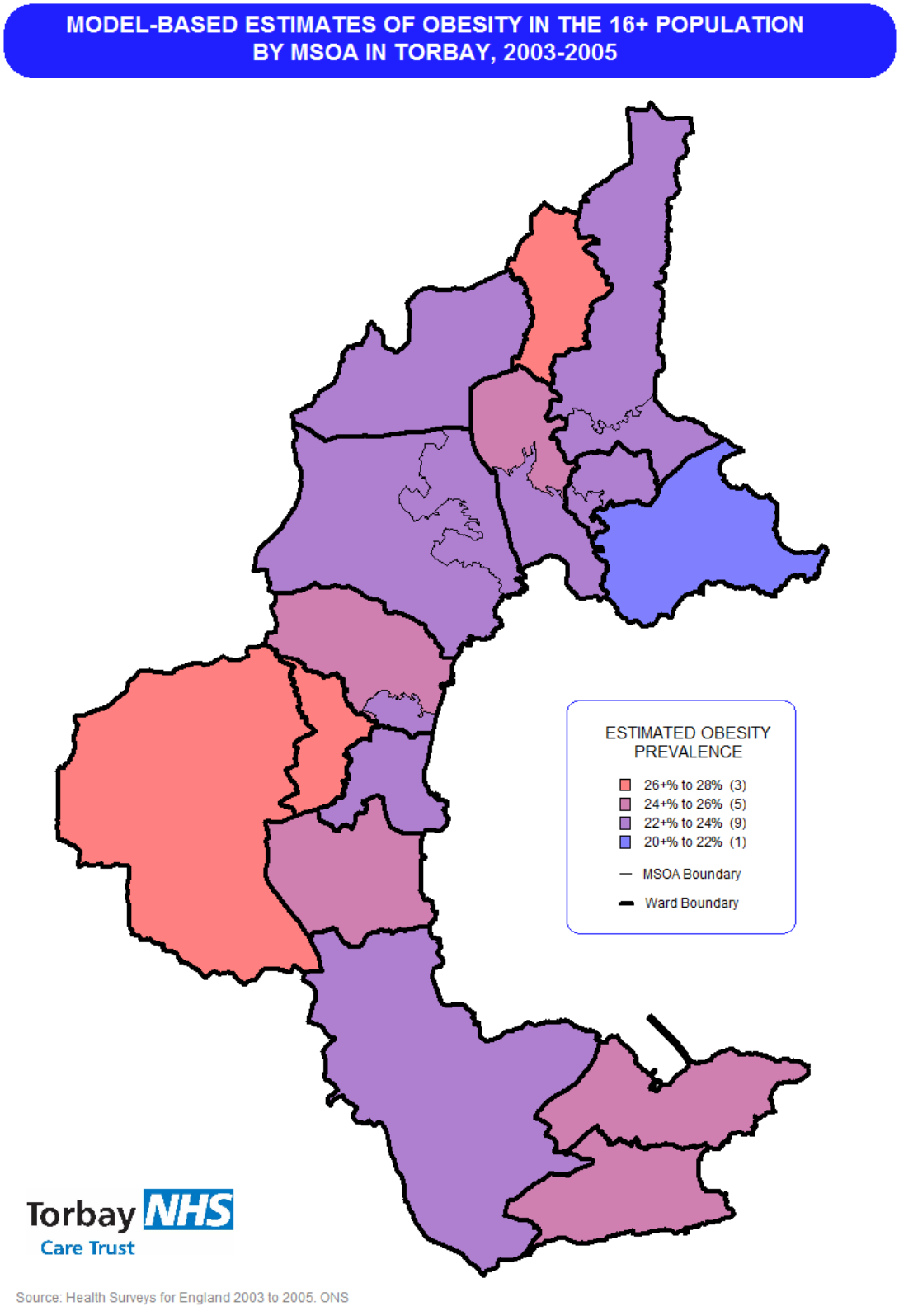
Figure 3:



The JSNA data using primary care information estimates the figure to be ~19% of adults to be obese. However there is selection bias in the results as three practices did not return data and GPs do not have measurement details for the whole population, only those attending the surgery therefore it is more likely to be in line with the higher estimate of 25% .

Figure 4: Estimated levels of Obesity for registered patients.


Estimated levels of obesity for registered patients aged 16+ in Torbay by electoral ward.
Based on GP risk register - April 2009
25%
20%
15%
10%
5%
0%
St Marychurch
Watcombe
Shiphay-with-the-Willows
Ellacombe
Torbay Average
Berry Head-with-...
Blatchcombe
Cockington-with-Chelston
Tormohun
Wellswood
Goodrington-with-...
Preston
Churston-with-Galmpton
Clifton-with-Maidenway
Roundham-with-Hyde
St Mary's-with-...



4.2 **Children** – Good participation rates within the childhood measurement programme has provided data which shows continuing high levels of obesity among primary school age children. 8.9% of reception children in 2009 are obese and 17.4% of year 6 children are obese.

Figure 5: Prevalence of obese children in Reception

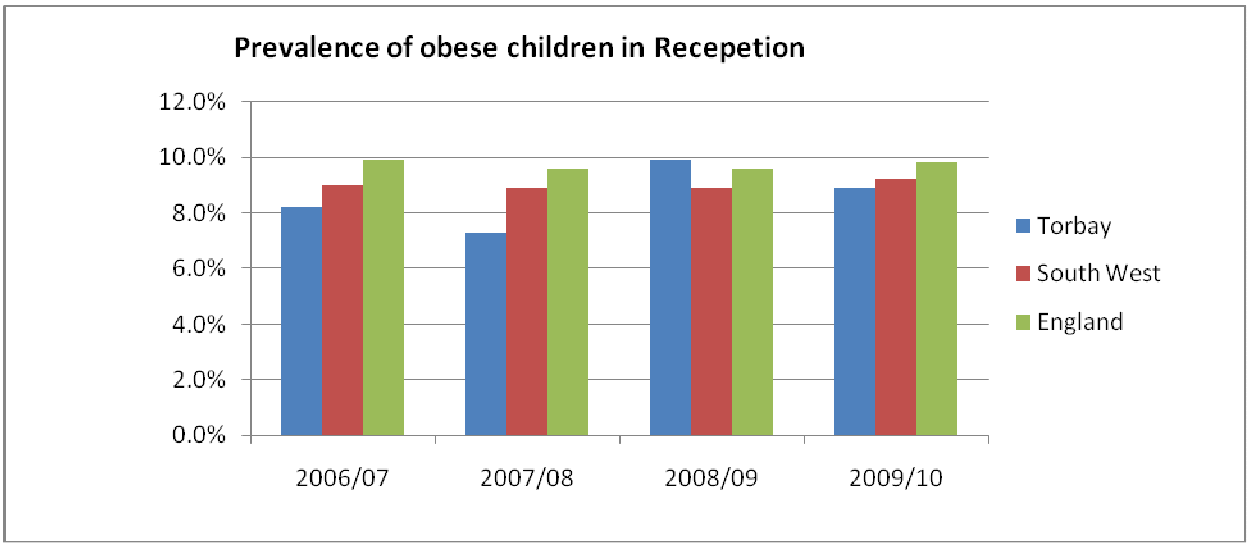
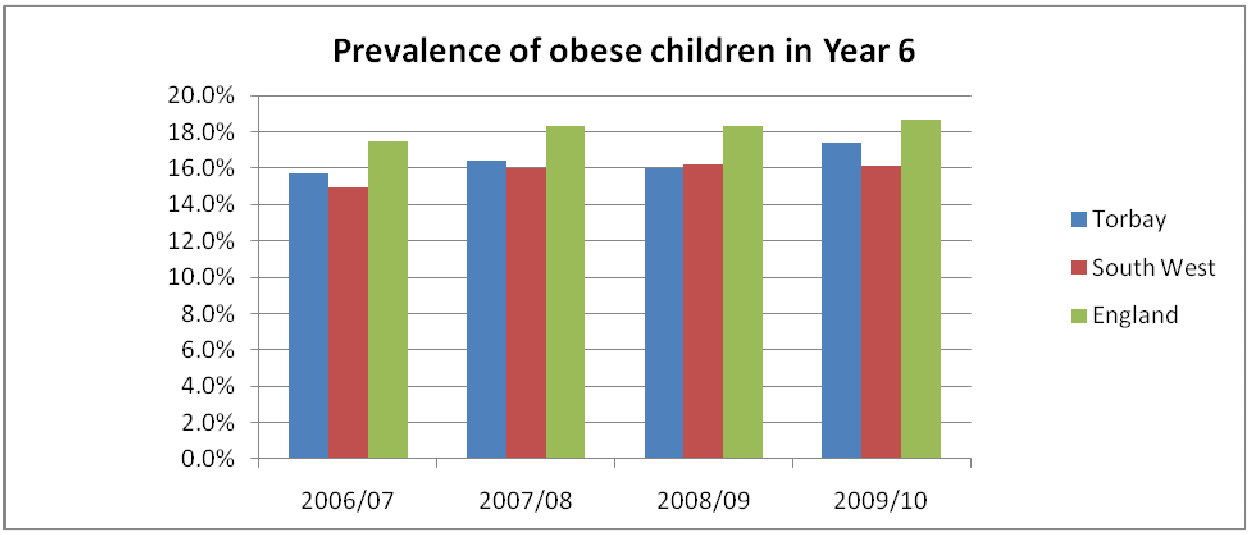
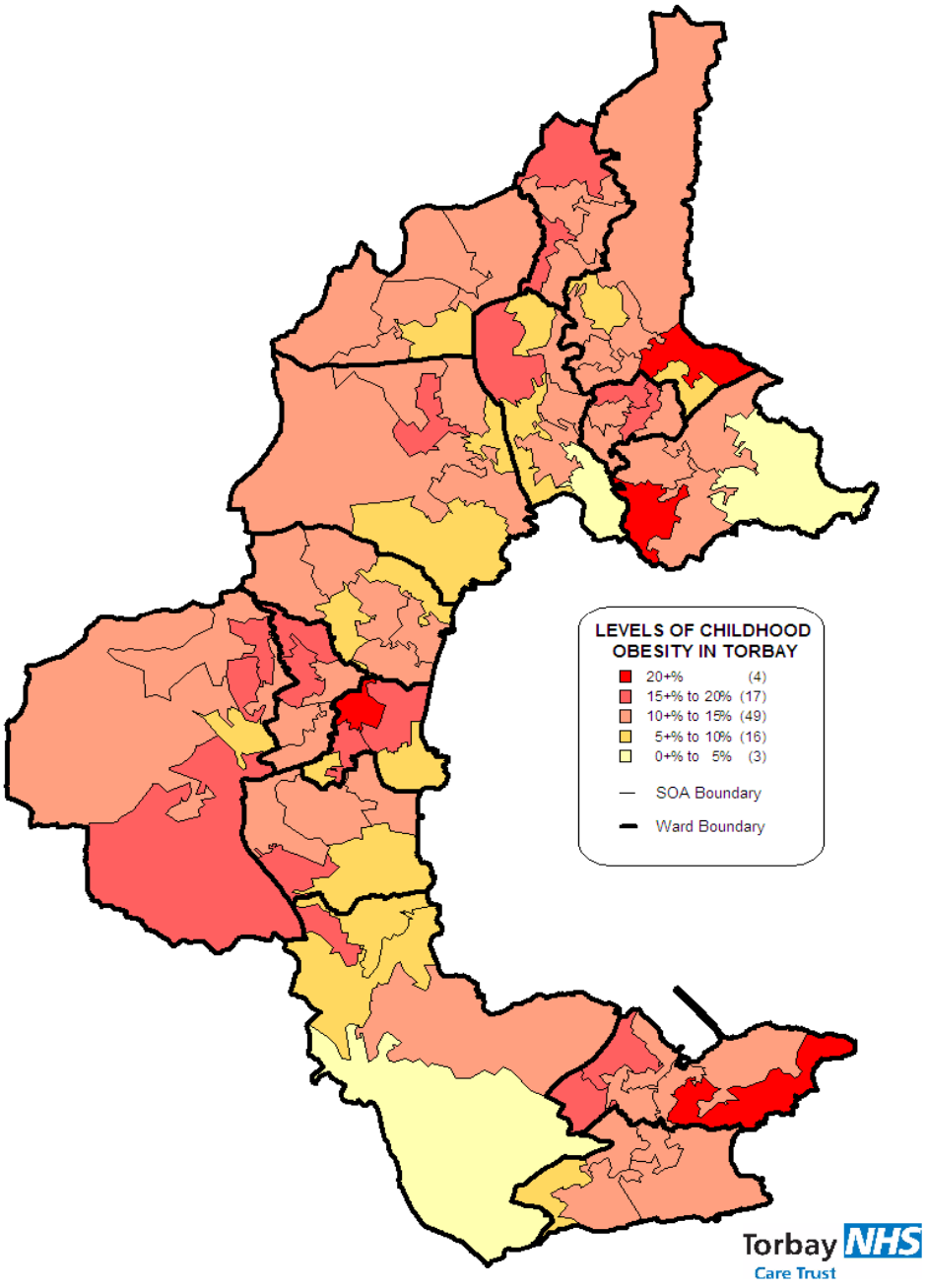


Figure 6: Prevalence of obese children in Year 6



AVERAGE LEVELS OF CHILDHOOD OBESITY IN TORBAY FOR BOTH RECEPTION YEAR AND YEAR 6 PUPILS FROM 2005/06 TO 2008/09



5.0 WHO IS AT GREATEST RISK

The prevalence of obesity and overweight changes with age; social class and deprivation; parental BMI and ethnicity. Prevalence of overweight and obesity are lowest in the 16-24 years age group and generally higher in the older age groups among both men and women. Obesity prevalence has increased across almost all social classes however the gap between the highest and lowest social class has widened for both sexes. (HSE 2008).

Other high risk groups include recent weight reducers; ex smokers; individuals with physical or learning difficulties; women post pregnancy and individuals with mental health problems.

6.0 OBESITY AND HEALTH

6.1 Adults - Obesity in adults is known to lead to both chronic and severe medical problems.

It reduces life expectancy by an average of nine years (more years in smokers), greatly increases the risk of heart disease, cancer, type 2 diabetes and high blood pressure. Around 8% of annual deaths in Europe (at least one in 13) have been attributed to overweight and obesity. (Appendix 1: Health Risks of Adult Obesity)

6.2 Children - Obesity in childhood and adolescence similarly has a range of serious adverse health consequences, both in the short term (for the obese child) and long term (for the adult who was obese as a child). Once established, obesity is notoriously difficult to treat, so prevention and early intervention are very important.

It is estimated that high blood lipids are present in at least one quarter of obese adolescents and conditions not previously seen in children, such as fatty liver disease and type 2 diabetes (Reilly 2009). Childhood obesity has also been linked to a range of negative consequences and social inequalities including impaired psychological health, poor quality of life, low self esteem and poor educational outcomes (Reilly 2009). (Appendix 2: Health Risks of Childhood Obesity)

7.0 COST OF OBESITY

The cost to the UK economy of overweight and obesity was estimated at £15.8 billion per year in 2007, including £4.2 billion in costs to the NHS. In economic terms, NHS costs attributable to overweight and obesity are projected to double to £10billion per year by 2050, while the wider cost to society and business are estimated to reach £49.9 billion per year at today's prices (Butland et al 2007).

The estimated annual costs of diseases relating to overweight and obesity in Torbay is in the region of £42.4 million, increasing to £47.1 million in 2015.

	Estimated annual costs to NHS of diseases related to overweight and obesity £ million			**Estimated annual costs to NHS of diseases related to overweight and obesity £ million**		
	2007	**2010**	**2015**	**2007**	**2010**	**2015**
Torbay Care Trust	42.4	44	47.1	22	23.8	27.4

SOURCE: Healthy Weight, Healthy Lives: A toolkit for developing local strategies (2008)

Bariatric surgery, a generic term for weight loss surgery has increased in recent years from around 470 in 2003/04 to over 6,500 in 2009/10. This is NHS commissioned and does not include the unknown level of activity carried out by the private sector. During 2008/09 29 Torbay patients had NHS commissioned surgery at a total cost £163,051. Costs for drugs treating obesity in 2008/09 was £99,917.

The three most commonly performed bariatric surgery procedures in the UK are adjustable gastric banding, gastric bypass and sleeve gastrectomy. Bariatric surgery is recommended as a treatment option when all appropriate non-surgical measures have been unsuccessful for adults with morbid obesity. Its use is not generally recommended with children and adolescents.

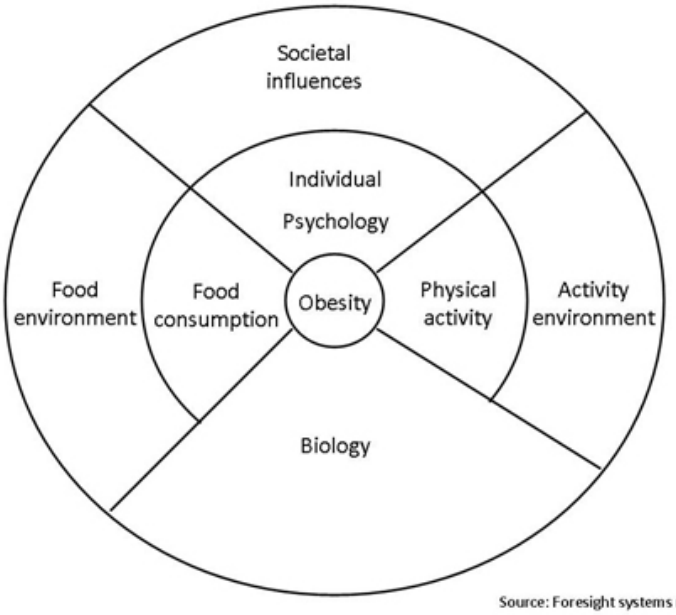
Bariatric surgery is more effective in achieving weight loss than non-surgical management and weight loss is more likely to be maintained in the longer term. However, adverse events are more common following surgery, and vary from one procedure to another.

8.0 CAUSES OF OBESITY

For obesity to develop, the number of calories consumed by an individual must exceed the number of calories utilised over a period of months and years.

However there are many complex behavioural and societal factors that combine to contribute to the causes of obesity. The Foresight report (2007) referred to a "complex web of societal and biological factors that have, in recent decades, exposed our inherent human vulnerability to weight gain". The report presented an obesity system map with energy balance at its centre. Around this, over 100 variables directly or indirectly influence energy balance (Figure 7). For simplicity the Foresight map has been divided into 7 cross-cutting predominant themes .

Figure 7: Foresight Systems Map 2007



Source: Foresight systems map, 2007

9.0 DEALING WITH THE ISSUE

The distinction between prevention and treatment is important. Once weight is gained and overweight obesity established, it is difficult to reverse. A number of NICE guidance has been published which looks at the links between obesity and built environment; Promoting physical activity and workplace guidance; Promoting physical activity for children and young people.

Treatment – while treatments are generally thought to be of limited effectiveness, as people may find it difficult to maintain weight loss, a modest weight loss by 5 to 10% of initial weight is said to reduce the risk of developing type 2 diabetes, improve blood pressure and reduce total cholesterol. Therefore treatment alongside prevention to support people to avoid weight gain is essential.

Locally the NHS is treating and providing intervention services to address issues of overweight and obesity through the following programmes.

Figure 8. Local models of Provision

Level 3 + Bariatric Surgery – a new level 3 service is currently being commissioned. The service will offer pre obesity surgery service for those people being considered for bariatric surgery following NICE criteria. Level 4 Obesity surgery is last resort after all other options have been explored. The new level 3 service will offer intensive support to patients within their local setting, including a structured education and supervised physical activity programme. Clinician, dietitian and psychologist involvement will ensure a high quality service that can provide tailored weight management support within the community.

Level 2 Weight Management programmes – structured weight management programmes delivered in the community have been developed across agencies to ensure the multi disciplinary approach needed in tackling the complex range of issues individuals deal with in relation to their weight.

Change 4 Life adult weight management programme is an 11 week community based course led by Dietician and lifestyle support workers offering support and advice with weight loss. This programme is offered to people aged over 18 years who have a BMI between 25 and 42.

Weight reduction and Exercise Programme – pilot scheme initially among the Torquay North cluster of GP practices has since been rolled out to accept referrals from all GP practices in the Bay. This programme is offered to patients with a BMI >30 but with no co-morbidities and lasts 26 weeks. It combines weight reduction which is monitored by the Practice Nurse, together with a tailored fitness/exercise weekly programme with a personal trainer.

Private Providers – Weight watchers, Slimming World, Rosemary Conley. Independent groups run throughout the bay.

Community Fitness Team delivers free or discounted physical activity programmes which includes one to one advice; GP exercise referral; pedometer loans, Bay walks; Exercise group for carers, Cardiac rehabilitation, balance and strength exercises for the prevention of falls.

MEND - programme is a community, family based 10 week programme for overweight and obese children aged between 7-13 years and their families. We are currently delivering our 8th MEND programme within the bay and now looking at adapting the model to meet the needs of the family and flexibility in order to achieve better retention rates balanced against outcome measure of weight loss.

Prevention programmes within schools and communities – there are a range of strategies that aim to prevent the development of overweight in normal-weight individuals and the progression of overweight to obesity in those who are already overweight.

Provide information and enhancing skills – community cooking skills; website; pharmacy public health campaigns; Pedometer loan scheme; type 2 diabetes group education, Fit 4 School booklet distributed by schools to all reception age children, Junior Life Skills Healthy Eating scenario reaches all year 6 pupils.

Enhanced services and support – walk to school; cost to access sports facilities; education programmes for carers including exercise and nutrition; Be HiP (healthy in Pregnancy) programme

Modifying access, barriers and opportunities – parks and recreational facilities; cycle paths;

Changing the consequences of key behaviours – 5 a day; Change4life; Bay Walks;

Modifying policies and broader systems – school meals; Schools Sports Partnership; Licensing of fast food premises; transport planning, planning developments to include health impact assessments.

Training

Obesity Brief Intervention Training is now routinely available for all healthcare professionals and key community work force. Training for both childhood and adult obesity are currently available.

Cook 4 Life Facilitator Training is currently available, for key community staff.

9.0 HOW CAN WE HELP PEOPLE TO BE A HEALTHY WEIGHT?

Whilst the health service can treat the symptoms of obesity and provide interventions to address unhealthy lifestyle behaviours, Local Authorities can take steps to prevent their environments from being obesogenic.

An obesogenic environment is one which discourages physical activity and makes it easy to access foods high in fats and sugar. The National Obesity Observatory provides a number of publications including systematic evidence reviews which shows the environment has an effect on people's dietary habits and participation in physical activity, which in turn affects their health. In order to identify where this may be a problem and to develop appropriate interventions, local areas need to investigate elements of the physical environment that relate to physical activity and diet. The impact on dietary behaviour such as food purchasing and consumption, and physical activity behaviour such as mode of travel to work. These can include:

- Accessibility: for example, travel time to a healthy food outlet; opening hours of a healthy food outlet; distance to shops and work; cost of healthy food; cost of physical activity facility; and distance to a green space or park.
- Availability: for example, types of food outlet available in a local area; availability and quality of green space; and availability of good quality food in a local area.
- Perceptions: for example, perceptions of safety in parks, food provided in food outlets and cost of healthy foods.

The observatory also provides insights into the knowledge and attitudes people hold that prevents them living a healthy life.

Obesity is a major public health concern both nationally and locally, for which there are no easy or short-term solutions. In order to meet this challenge, it is important that local responsibility for the health of our community is shared between the agencies that make up the Health and Well Being Board as well as the community itself. Action to be taken .....

Promoting a healthy weight through their role in shaping how cities, towns and villages are developed and built.

- **Ensure planning applications for new developments always prioritise the need for people (including those whose mobility is impaired) to be physically active as a routine part of their daily life.**
- **Ensure pedestrians, cyclists and users of other modes of transport that involve physical activity are given the highest priority when developing or maintaining streets and roads.**

Plan and provide a comprehensive network of routes for walking, cycling and using other modes of transport involving physical activity.

- **Ensure public open spaces and public paths can be reached on foot**
- **Urban walkability scores.**
- **Provision of pavements.**

Promoting healthy workplaces. Opportunistic physical activity advice for staff accessing occupational health services; Provision of drop-in weight management services for all staff

Role in the management, maintenance and development of open/green space facilitating and encouraging physical activity by the local and wider community

Promoting physical activity for children and young people

- **the importance of consultation with children and young people and how to set about it**
- **planning and providing spaces, facilities and opportunities particularly with new school builds**
- **training people to run programmes and activities such as youth workers**
- **how to promote physically active travel such as cycling and walking to school.**
- **Children: healthy growth and healthy weight – for example, as many mothers as possible**
- **breastfeeding up to 6 months – promoting 'baby friendly' venues in town.**
- **Promoting healthier food choices – for example, less consumption of high-fat, high-sugar and high-salt foods in school food contracts**
- **Building physical activity into our lives – for example, reduced car use and more outdoor play**
- **Creating incentives for better health – for example, more workplaces that promote healthy eating and activity**
- **Personalised support for overweight and obese individuals – for example, everyone able to access appropriate advice and information on healthy weight.**

10.0 RECOMMENDATIONS

Prior to the issue of specific NICE guidance aimed at addressing obesity in local communities, the H&WB is asked to consider the following:

1. Levels of obesity in Torbay reflecting on the national picture and the rates continuing to rise.
2. The wider strain and cost to the wider economy.
3. What makes Torbay an obesogenic environment and how can we address this?
4. Increase active travel opportunities e.g. park & ride facilities, cycling routes
5. Ensure health impact assessments are routinely incorporated in to all planning process's
6. Promote the availability of current services, including training opportunities and public programmes

APPENDIX 1 – IMPACT OF OBESITY (ADULTS)

Musculoskeletal system

- Raised body weight puts strain on the body's joints, especially the knees, increasing the risk of osteoarthritis (degeneration of cartilage and underlying bone within a joint).
- There is also an increased risk of low back pain.

Circulatory system

- Raised BMI increases the risk of hypertension (high blood pressure), which is itself a risk factor for coronary heart disease and stroke and can contribute to other conditions such as renal failure.
- The risk of coronary heart disease (including heart attacks and heart failure) and stroke are both substantially increased.
- Risks of deep vein thrombosis and pulmonary embolism are also increased.

Metabolic and endocrine systems

- The risk of Type 2 diabetes is substantially raised: it has been estimated that excess body fat underlies almost two-thirds of cases of diabetes in men and three quarters of cases in women. Diabetes currently affects nearly 200 million people worldwide and International Diabeted Federation predict that this will increase to over 330 million by 2025, with a massive burden in developing countries. Worldwide, the number of people with diabetes has tripled since 1985.
- There is a greater risk of dyslipidemia (for example, high total cholesterol or high levels of triglycerides), which also contributes to the risk of circulatory disease by speeding up atherosclerosis (fatty changes to the linings of the arteries).
- Metabolic syndrome is a combination of disorders including high blood glucose, high blood pressure and high cholesterol and triglyderide levels. It is more common in obese individuals and is associated with significant risks of coronary heart disease and Type 2 diabetes.

Cancers

- The risk of several cancers is higher in obese people, including endometrial, breast and colon cancers.

Reproductive and urological problems

- Obesity is associated with greater risk of stress incontinence in women.
- Obese women are at greater risk of menstrual abnormalities, polycystic ovarian syndrome and infertility.
- Obese men are at higher risk of erectile dysfunction.
- Maternal obesity is associated with health risks for both the mother and the child during and after pregnancy. Click here for more information on maternal obesity

Respiratory problems

- Overweight and obese people are at increased risk of sleep apnoea (interruptions to breathing while asleep) and other respiratory problems such as asthma.

Gastrointestinal and liver disease

Obesity is associated with:

- Increased risk of non-alcoholic fatty liver disease.
- Increased risk of gastro-oesophageal reflux.
- Increased risk of gall stones.

Psychological and social problems

- Overweight and obese people may suffer from stress, low self-esteem, social disadvantage, depression

APPENDIX 2 – IMPACT OF OBESITY (CHILDREN)

Mental health

- The emotional and psychological effects of being overweight are often seen as the most immediate and most serious by children themselves. They include teasing and discrimination by peers; low self-esteem; anxiety and depression. In one study, severely obese children rated their quality of life as low as children with cancer on chemotherapy (Schwimmer et al 2003). Obese children may also suffer disturbed sleep and fatigue.

Physical health

- Overweight and obese children are more likely to become obese adults, and have a higher risk of morbidity, disability and premature mortality in adulthood. Although many of the most serious consequences may not become apparent until adulthood, the effects of obesity – for example, raised blood pressure, fatty changes to the arterial linings and hormonal and chemical changes such as raised cholesterol and metabolic syndrome; type 2 diabetes – can be identified in obese children and adolescents.

Other health risks of childhood obesity include early puberty, eating disorders such as anorexia and bulimia, skin infections, and asthma and other respiratory problems. Some musculoskeletal disorders are also more common, including slipped capital femoral epiphysis (SCFE) and tibia vara (Blount disease)

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SHADOW HEALTH AND WELLBEING BOARD FOR TORBAY

Background Information Pack

Terms of Reference

- To develop the Joint Strategic Needs Assessment, draft Health and Wellbeing Strategy and Pharmaceutical Needs Assessment
- To provide a statement on the integration of health-related services and the provision of health and social care services in Torbay
- To participate in the early implementer network for Health and Wellbeing Boards

Membership

Member	
Councillor	Christine Scouler
Councillor	Chris Lewis
Councillor	Mike Morey
Councillor	To be confirmed (Lib Dem)
Director of Adult Social Services	Anthony Farnsworth
Director of Children's Services	Carol Tozer
Director of Public Health	Debbie Stark
Chair (or representative) of Torbay Local Involvement Network (LINk)	Anne Mattock
Chair (or representative) of Baywide GP Commissioning Consortium	Sam Barrell
Representative of Devon Local Pharmaceutical Committee	Kevin Muckian
Chief Executive (Torbay Council)	Elizabeth Raikes
Deputy Chief Executive (Torbay Council)	Caroline Taylor

Structure and Accountability

The relationships between Torbay Council, the Torbay Strategic Partnership and the Health and Wellbeing Board are shown in the structure chart on the next page.

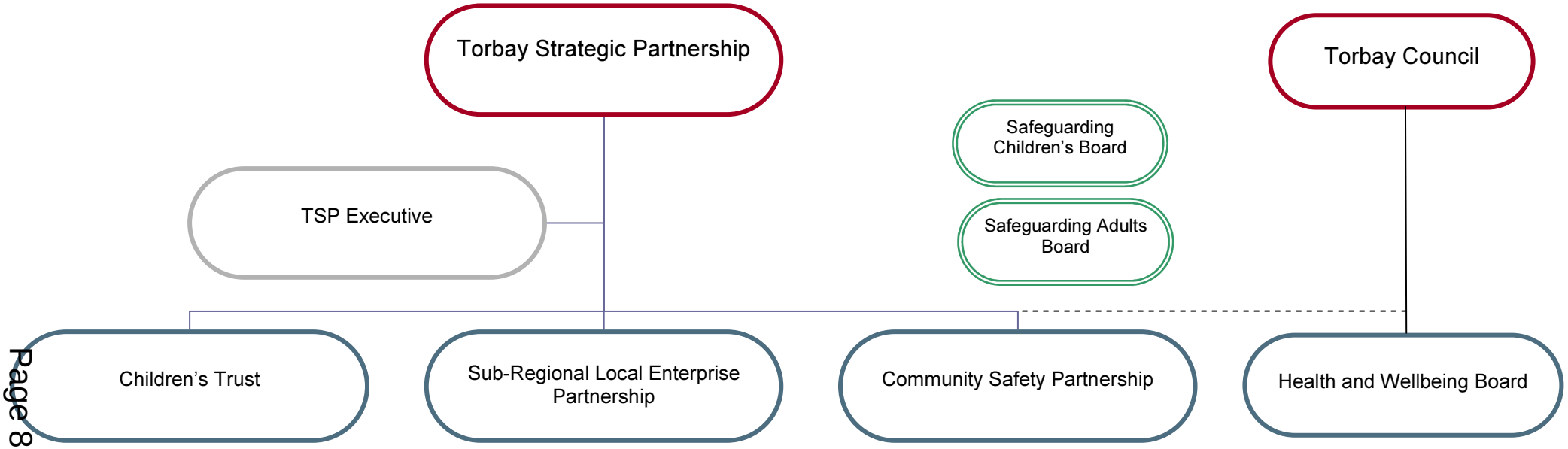
Reporting lines for the Shadow Health and Wellbeing Board will be flexible during its first year of operation ensuring that there is buy-in from both the Council and the Torbay Strategic Partnership. As a non-decision making body, these will not need to be formalised during this year which will enable the Council to take full account of emerging legislation, regulations and guidance.

In terms of accountability, the Overview and Scrutiny Board will continue to be able to hold the Torbay Strategic Partnership and its partner organisations to account and this will be extended to the Shadow Health and Wellbeing Board. In practice, this will mean members of the Board having sight of agendas and minutes from both partnerships, being able to review or scrutinise any issues of concern and attending meetings as observers.

Early Implementer Network

Details of the Early Implementer Network, of which Torbay is a member, are set out on the third page of this note.

Commissioning Structure for Torbay 2011/2012



Sent via email

Caroline Taylor
Deputy Chief Executive
Torbay Council
Town Hall, Castle Circus
Torquay
Devon, TQ1 3DR

10 March 2011

Dear Ms Taylor

Further to my letter of 27 January, I am writing to thank you for responding to our invitation and to confirm that you are now part of the early implementers' network. This letter sets out what being part of the early implementer network means and how we can support you.

How will the network work?

The early implementers' network will be a learning network. Subject to parliamentary approval, each council will be responsible for establishing a health and wellbeing board from April 2013. There is an expectation that each council will establish a health and wellbeing board in shadow form by April 2012. The purpose of the network is to support councils to prepare for this new role, working with Local Government Group, Solace, ADASS, ADCS and the public health community, along with SHAs. We have agreed that the best way to do this is through the development networks bringing together key partners at a local level to learn together how best to establish health and wellbeing boards. This approach is designed to offer three levels of support;

- **Sharing learning and information** - via the web and an interactive web forum hosted by LGID;
- **Building connections** – signposting you to other early implementers areas with similar interests; and
- **Practical support** - through workshops, facilitated discussions, peer support and challenge and disseminating learning products.

This activity will take place at a national, regional and local level, according to the needs of all partners and in order to achieve maximum impact. This role will of course need to evolve in response to our understanding of key challenges through 2011/12 and as we move to shadow running in 2012/13.

Focus of the network

Developing health and wellbeing boards, the public health system, GP consortia, local HealthWatch and wider partnership arrangements provide a real opportunity to ensure that agencies act together to meet the needs of local people in a coordinated and coherent way. In our early discussions to date, early implementers have identified the following key themes as an initial focus for activity;

- **Setting a new direction while continuing to deliver services through the transition –** ensuring the reforms achieve improved outcomes and integrated working, while managing the risk of losing relationships, talent and capacity during transition.
- **Relationships and knowledge –** focusing on building new relationships, particularly between GP consortia and councils. This includes building understanding of how partner organisations function and transfer knowledge.
- **Accountability and transparency –** making a success of governance arrangements and complex accountabilities, while improving transparency and accountability to local people.
- **Boundaries and levels –** managing the complexities of operating where GP consortia and councils are not co-terminus, and where county and district councils need to work together.

In designing the learning network the key is to capture the learning which emerges and to share it across the network. There are a number of approaches that early implementers may want to take;

- National & regional conferences
- Action Learning Sets
- Issue focussed workshops
- Regional and Sub-regional networks
- Virtual networks & Web-based discussions

Nationally the DH will work to establish the learning network with early implementers, other Government Departments and LGID. We will also set up some focussed national work on core overarching issues such as the development of JSNAs and joint health and wellbeing strategies, implementation of local HealthWatch and the role of elected Members.

As a next step we want to know what all members of the early implementers learning network would want to support their work locally in addition to the work which will be required at a national level. Therefore DH staff will make contact with each council over the next two weeks to discuss how to build the learning network.

As part of this, we will be particularly interested to know whether you think we have identified the right areas of focus, and whether the offer to empower the learning network I have described is the right one. We will then write to you again about the next steps.

The leadership team for this work is lead by Andrew Larter, working alongside DH teams in the regions and SHAs, supporting discussions and sharing learning between local areas. The lead contacts for this in your region are Lynne Dean and Richard Gleave, working closely with the Regional Director of Public Health, Gabriel Scally, and the Director of Commissioning Development, John Bewick.

I know that Sir Ian Carruthers wrote to all Chief Executives in the South West last month to seek views on how the NHS can work best with local authorities in the coming months, particularly on the development of health and wellbeing boards. Many of you will have been involved in the event on February 18 to take this forward.

Accessing learning

We've created an online channel to support you at www.dh.gov.uk/healthandcare. Through this you'll be able to access a directory and map of early implementers, identifying who else is working on similar issues. You can see some vox pops of places talking about what they hope to achieve through health and wellbeing boards at http://healthandcare.dh.gov.uk/category/local-government/ . We are also working with LGID to set up a community of practice for you to discuss issues and work collaboratively.

Links to GP pathfinders

We will bring together the learning and communications for early implementers with GP pathfinders through www.dh.gov.uk/healthandcare and other joint communications. A map of GP pathfinders to date is available at http://healthandcare.dh.gov.uk/721/ .

Links to HealthWatch

I wrote to all Local Authorities with Joan Saddler, National Director for Public and Patient Affairs, earlier this week, describing our approach to supporting learning on HealthWatch and inviting Pathfinder proposals. We will also link this work closely to the early implementers for health and wellbeing boards.

Promoting the network

We are delighted by the level of response to our invitation to join the early implementer's network, and it's likely that Ministers will be talking about this in the press over the coming week. If you have plans to talk about your local work in the press, our communications lead Amy Key would love to hear from you, and to offer any support you might need.

Action

In order to arrange the early discussion about how this might work, please contact Andrew Larter on andrew.larter@dh.gsi.gov.uk.

The team here in DH look forward very much to working with you to take this forward.

Yours sincerely

David Behan CBE
Director General
Social Care, Local Government and Care Partnerships
Department of Health

Useful contacts

National

Andrew Larter
Deputy Director
020 7972 4401
Andrew.larter@dh.gsi.gov.uk

Kathy Wilson
Local Government Policy Lead
020 7972 4200
Kathy.wilson@dh.gsi.gov.uk

Amy Key
Communications lead
Amy.key@dh.gsi.gov.uk

Regional

Deputy Regional Director for Social Care and Partnerships;
Lynne Dean
Lynne.dean@dh.gsi.gov.uk
0117 900 3528

Richard Gleave
Richard.gleave@southwest.nhs.uk

Regional Director of Public Health;
Gabriel Scally
Gabriel.scally@southwest.nhs.uk

Director of Commissioning Development, John Bewick
John.bewick@southwest.nhs.uk

To:
Chief Executives of local authorities 31 March 2011

Dear colleague,

It is excellent news that all sixteen upper tier local authorities in the South West have expressed interest in becoming part of the early implementer network for Health and Wellbeing Boards. Most of you will have received a letter from David Behan welcoming you to the programme – the local authorities who expressed interest early in process were already engaged and so may not have received this letter.

Following up the discussions at the regional event on Health and Wellbeing Boards on the 18th February, we have been talking to the Department of Health team and agreed that it would be helpful to explore whether additional opportunities to support the national network could be developed at a regional or sub-regional levels within the South West.

This letter is seeking your views on this and suggesting that an initial meeting of the local leads on Health and Wellbeing Boards is held to explore this.

The letter from David Behan outlined the network approach which is designed to offer three types of support:

- **Sharing learning and information** - via the web and an interactive web forum hosted by LGID;
- **Building connections** – signposting you to other early implementers areas with similar interests; and
- **Practical support** - through workshops, facilitated discussions, peer support and challenge and disseminating learning products

DH wants to encourage local, sub-regional and regional work to complement the national programme. With all localities in the South West being part of the national network, there are excellent opportunities to work together across the region and develop additional support and opportunities for sharing learning.

We attach a short paper to stimulate this discussion which describes some possible principles of engagement and next steps for early implementers in the South West. Also attached is a template to collect views about specific ideas and priorities for support - and to volunteer to run or contribute to particular events.

It would be helpful if you could respond to lynne.dean@dh.gsi.gov.uk by April 15th on:

a) Whether you would like there to be an exploratory meeting about South West network(s) and, if you are supportive, your nominations. We know some areas have identified a local government lead and a health lead

to work together. We have reserved 10 May 2011 for this meeting and would probably hold it in the Taunton area.

b) Your ideas on what support network(s) in the South West might provide, ideally through the attached table.

We look forward to hearing back from you.

With best wishes

Yours sincerely

Lynne Dean
Deputy Director of Social Care
Department of Health

Richard Gleave
Director of Programme Implementation
NHS South West

CC:
Gabriel Scally, Regional Director of Public Health
PCT Chief Executives
Directors of Public Health
Andrew Larter, Deputy Director for Local Government
Health and Wellbeing Board Leads

Discussion paper about potential network activity in the South West

Potential principles

Network activity across the South West could be informed by some core principles and, to stimulate a discussion locally, some initial thoughts are as follows:

- Decision making about the way that individual Health and Wellbeing boards will operate will be made locally and there is no requirement for a common model. Individual communities need will look at what they already have in place and decide how to implement the requirements in the legislation.
- Success for the new boards will be based upon the initial work to create the framework within which the board will operate. These include good relationships, trust between partners, a common purpose and a focus on delivery of improvement in shared outcomes.
- Sharing information/research/insight/best practice, will support local reflection on the way forward and potentially save time and money
- Any support work needs to be designed to meet the changing landscape given the Health Bill is still before Parliament and there are local elections in some parts of the region.
- The NHS "intermediate tier" is changing. Work in 2011-12 between South West Local Authority Chief Executives, the Department of Health South West and the Strategic Health Authority may help create mechanisms that support local work especially in bringing together key elements of the wider transition programme, to help the interface of Health and Wellbeing Boards with the wider change process.

Sharing information, ideas and suggestions between localities

The attached table provides a mechanism to collect initial thoughts which can be shared and discussed. This could form the basis for discussion at an initial meetings of local leads for Health and Wellbeing Boards.

The first two columns are based on work nationally about the creation of Health and Wellbeing Boards while other columns are for localities to complete about what they want to focus on locally and what regional or sub-regional networks might support. Please add to the national columns if you have specific ideas on key issues for the Department of Health and its national partners.

The final column is seeking suggestions about the sorts of activities that you might want to be arranged. These might include:

- Network meetings
- Joint events for H&W Board leads with other stakeholders, such as Public Health England, Local Health Watch leads, GP pathfinders and emerging GP Commissioning Consortia.

- Sub regional events
- Scenario planning /testing events
- Regional master classes
- Sharing information electronically using a networking tool such as Huddle
- Meetings to explore specific areas of work for Health and Wellbeing Boards, such as children's services and Joint Health and Wellbeing Strategies.

We would like your thoughts and suggestions about what would be useful, and it would be helpful if people were able to volunteer to run or contribute to particular events.

Please can you return to lynne.dean@dh.gsi.gov.uk by 15 April.

From the Rt Hon Andrew Lansley CBE MP
Secretary of State for Health

DH Department of Health

Baroness Eaton DBE DL
Local Government House
Smith Square
London
SW1P 3HZ

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

20 JUN 2011

Dear Margaret,

Last week, the NHS Future Forum made its report to the Prime Minister, Deputy Prime Minister and me. We accept all of their core recommendations. Today, we have published a more detailed response, and you will find this on the Department's website.

I would like to take this opportunity to thank you for your contribution to the listening exercise. Many of your suggestions resonated strongly with both the NHS Future Forum and the Government and helped to shape the overall direction of the subsequent changes to the legislation.

I hope you feel satisfied that we have paid particular attention to the Local Government Group's concerns around strengthening health and wellbeing boards, integrated commissioning, and a focus on delivering improved outcomes through locally determined solutions.

In your letter of 11th April, you proposed strengthening the relationship between clinical commissioning groups and the health and wellbeing board. The changes to the Bill seek to establish balanced, reciprocal and mutual local partnership arrangements, which are stronger than the previous provisions. The revised clauses in the Bill will make clear that health and wellbeing boards should be involved throughout the process as clinical commissioning groups develop their commissioning plans, and this will be in addition to the existing duty to co-operate with the health and wellbeing board. There will also be a stronger expectation, set out in statutory guidance, for the plans to be in line with the health and wellbeing strategy. Though they will not have a veto, health and wellbeing boards will have a clear right to refer plans back to the group or to the NHS Commissioning Board for further consideration.

Consortia will have a requirement, if challenged, to publicly explain and justify significant variance between commissioning plans and the joint strategy, and health and wellbeing boards will have a formal role in authorising clinical commissioning groups and in their annual assessment. Furthermore, we agreed with your view that healthcare decisions can be reinforced by the involvement of communities and citizens who can identify and act upon local health needs and concerns. You will no doubt be pleased to note that health and wellbeing boards will also be subject to a new duty to involve patients and the public when developing the joint strategic needs assessment and the joint health and wellbeing strategy.

Part of the strengthening of the role of Health and Wellbeing Boards was also due to your concerns around integrated commissioning. On this front, health and wellbeing boards will have a stronger role in promoting joint commissioning and integrated provision across health and social care. We will make clear that health and wellbeing boards are not just about assessments and strategies. They can be the vehicle for "lead commissioning" for particular services, for example learning disabilities – with the NHS commissioners able to delegate responsibilities to the health and wellbeing boards. This way, not only can they support better integration on the commissioner side, they can also promote more integrated provision for patients and care users – joining up social care, public health and NHS services.

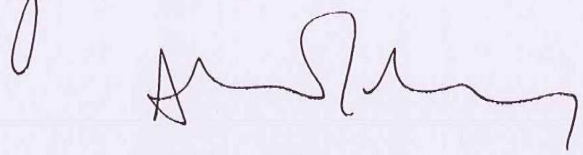
I know that you have also raised concerns about co-terminosity between clinical commissioning groups and local authorities. In response to those concerns, clinical commissioning groups seeking establishment on the basis of boundaries that would cross local authority boundaries, will be expected to demonstrate to the NHS Commissioning Board a clear rationale in terms of benefit to patients – for example, to reflect local patient flows, or to enable groups to take on practices where, overall, this would secure a better service for patients – and provide a clear account of how they would expect better integration between health and social care services to be achieved. The NHS Commissioning Board will need to agree proposed boundaries as part of the establishment process. Before establishing any clinical commissioning group, the Board will be required to seek the views of emerging health and wellbeing boards. Health and wellbeing boards may choose to object. The Board will always have to satisfy itself that any such objections have been taken properly into account.

DH Department of Health

In your letter, you also asked a series of questions about Public Health England, and its relationship with local authorities. As you know, we will be shortly publishing a consultation response on this subject, and we hope that will address your concerns.

I hope you will continue to lend your support to the reforms, and I thank you once again for your constructive contributions to the Listening Exercise and Future Forum Report. I look forward to continuing to work with you.

Yours ever,



ANDREW LANSLEY CBE

Just a brief update on the announcement of funding support for the early implementer H&W Board programme..... this is money which will be committed nationally to support the programme and will not be available direct to LAs. (see email below) We can discuss with John Wilderspin at our July meeting how this will be used.

Lynne Dean
Deputy Regional Director, Social Care, Local Government and Care Partnerships
Department of Health
2 Rivergate
Temple Quay
Bristol BS1 6EH

Mobile 07917 210508
Office contact 0117 900 3528
----- Forwarded by Lynne Dean/OIS/DOH on 01/07/2011 09:26 -----

Dear Colleagues

SoS announced £1m to support development of Health and Wellbeing Boards in his speech at the LGA conference today. This is the funding we have secured to support the national early implementer learning network that John (Wilderspin) and Andrew (Larter) have been discussing with you, including learning sets, developing the JSNA and joint health and wellbeing strategy guidance, comms and knowledge management to share learning, products to disseminate best practice and development support for elected members.

The funding **is not** designed to go out to individual local authorities, as I know a few people have asked.

We'll be talking to you at your July meetings further at the July RDsPH and DRD meetings respectively about next steps with this work, and of course how it can best complement and draw upon the work that you're leading at regional level.

There is a brief article about the funding on the DH website
http://healthandcare.dh.gov.uk/1m-to-support-health-and-wellbeing-boards/

Best wishes

Kathy

Kathy Smethurst (nee Wilson)
Local Government Policy Lead
Local Government and Regional Policy Branch
Department of Health

Local Government and Regional Policy
114 Wellington House
020 7972 4200
GTN: 7396 24200

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