NHS
Ipswich and East Suffolk
Clinical Commissioning Group

Joint Strategic Needs Assessment (JSNA) Overview

Evidence for authorisation	Domain reference	Criteria Button Number	Signpost (eg, paragraph 3, section 6 on page 10 of document A)
Analysis of the health needs of constituent communities and groups is reflected in CCG integrated plan.	2.1.1 B	19	Pages 5 to 12. Table 1 links CCG Clinical Priorities to JSNA.
CCG has outline plans in place to communicate and engage with strategic partners and diverse groups and communities	2.1.1 C	20	Page 4, Para 3 CCG engagement with Health & Wellbeing Board and partners and Appendix 1 pg 13
CCG integrated plan aligns with JHWS and enables integrated commissioning depending on local time frames	2.1.2 C	23	Page 3 Para 2
Plans reflect JSNA, stakeholder engagement and evidence/date analysis	3.1.3 A	43	Pages 5 to 12 Table 1, page 4, para 3 Appendix One – Notes of HWS stakeholder event
Through involvement in JSNA and in the development of the JHWS, the CCG has identified opportunities to reduce inequalities	4.2.3 B	74	Page 3, Para 2 Health and Wellbeing vision and CCG clinical priorities and Table 1 page 5-12
CCG has collaborated in the refresh of JSNAs and in the development of the JHWS, depending on local time frame	5.2 B	92	Page 4 Para 3
Arrangements in place between LA and CCG specifying how public health advice to CCGs will be delivered	1.3 C	13	Appendix Two – Statement of Arrangements Public Health Directorate and CCG

Contents

Title:	**Joint Strategic Needs Assessment (JSNA) Overview**
Purpose:	To demonstrate how the JSNA informs priorities identified in Ipswich and East Suffolk CCG's Clinical Priorities.
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Acknowledgement	Thanks to Katie Johnson, Specialty Registrar in Public Health
Date:	10 October 2012

1. Background:

Joint Strategic Needs Assessment describes a process that identifies current and future health and wellbeing needs in light of existing services, and informs future service planning taking into account evidence of effectiveness.

The JSNA in Suffolk comprises a suite of resources including:

- The State of Suffolk Report 2011
- Annual Public Health Reports (latest published September 2012)
- Suffolk Health and Wellbeing Strategy (currently in draft form)
- The Pharmaceutical Needs Assessment (PNA)
- The Suffolk Observatory
- IES CCG Public Health Profiles[1]

All JSNA resources can be found at www.suffolkobservatory.info which is also accessible through the CCG's own website www.ipswichandeastsuffolkccg.nhs.uk.

2. Links between the JSNA, NHS Ipswich and East Suffolk CCG's Clinical Priorities and Suffolk Health and Wellbeing Strategy Priority Themes

The information within the JSNA has informed the development of the CCG's Clinical Priorities and Health and Wellbeing strategy. The links between the various components of the JSNA and Clinical Priorities document are outlined in table 1.

Health and Wellbeing Strategy	CCG Clinical Priorities
Vision; People in Suffolk live healthier, happier lives. We also want to narrow the differences in healthy life expectancy between those living in our most deprived communities and those who are more affluent through greater improvements in more disadvantaged communities.	***Vision;*** Long and healthy lives for everyone in Ipswich and East Suffolk By 'long and healthy lives' we mean people's physical and mental health and wellbeing. By everyone we mean children, young people and adults. We are committed to reducing the inequalities which individuals currently experience.

[1] The IES Public Health Profiles are part of a suite of resources which form the JSNA. Although part of the JSNA these profiles are intended for internal use because of the practice specific data they contain.

Priorities:	Priorities:
• Every child in Suffolk has the best start in life • Suffolk residents have access to a health environment and take responsibility for their own health and wellbeing • Older people in Suffolk have a good quality of life • People in Suffolk have opportunities to improve their mental health and wellbeing	• To improve health and educational attainment for children and young people • To improve outcomes for patients with diabetes to above national averages • To improve care for frail elderly individuals • To improve access to mental health services • To allow patients to die with dignity and compassion and choose their place of death • To improve the health of those most in need • To ensure high quality local services, where possible • To promote self-care

3. On-going development of the Joint Strategic Needs Assessment

NHS Ipswich and East Suffolk CCG is engaged in the refresh of the JSNA through the Health and Wellbeing Board and its sub-groups. The CCG will help to define the objectives and priorities for research and analysis and to contribute the suite of resources through the sub-group.

Future JSNA resources will draw on:

quantitative data, including:

- the 2011 Census which we expect to be published from November 2012 to March 2013
- detailed health assessments, currently including children and housing

qualitative resources including**:**

- notes of patient and public engagement events held by the CCG;
- notes of Health and Wellbeing Board engagement events. The draft notes of the event held on 28th September are provided as an example, at **Appendix One.**

4. Statement of Arrangements with Public Health

The CCG has a Statement of Arrangements with Public Health, specifying how public health advice will be delivered to the CCG. This was reviewed and approved by the CCG governing body at its meeting on 17th July 2012 and is provided at **Appendix Two**. The arrangement has been actively implemented since that date through the provision of information and advice relating to development of our clinical priorities, identification of metrics to inform winter planning programmes and Vitamin D pathway analysis.

TABLE 1: Links between IES CCG Clinical Priorities and the Suffolk JSNA	
CCG Priority	**Links with JSNA**
To improve health and educational attainment for children and young people.	**State of Suffolk Report, 2011: Part A: A Sustainable Suffolk, 'Sustainable population growth?' and Part B 'Being Healthy and Living Well in Suffolk, under the themes of Early Years, Childhood and Adolescence (pp 58-75) and Families and Working Life (pp 76-80)** The importance of early years and addressing underachievement were two of the key themes in the State of Suffolk Report, 2011. Some of the key issues identified within are outlined below: • Most districts have seen a modest increase in the number of births each year since 2001 but Ipswich has seen a 40% increase in births from 1,336 to 1,900 which could have implications for schools if all these children grow up in the town. • Relative to the rest of the country, Suffolk has a similar level of infant mortality and lower rates of low birth weight and teenage conceptions. However, the rate of teenage conceptions in the Gipping ward, Ipswich is significantly higher than the national average. • Good quality childcare for pre-school children promotes social, emotional and mental development as well as providing support for working parents. • Suffolk pupils perform less well than their peers nationally at the end of primary and secondary education. • Children from poorer families and those with special education needs perform significantly less well, with boys and black and minority ethnic children also doing less well than their peers. • At age five 50**%** of five year olds are assessed as being school ready. At age eleven 68**%** of children reach the expected level of attainment at school. At 16 this figure is 54 %. • Children with special needs are more likely to be excluded than their peers compounding their difficulties in learning and achieving. • 1 in 6 children in Suffolk are living in poverty. Living in an area of deprivation is known to increase the likelihood of negative experiences, and as a consequence has a major impact on health and wellbeing. • Analysis of children who have been referred to social care shows that across all ages neglect is the primary reason recorded, with family dysfunction and family stress also significant factors. Where children are placed in care the stability of their placements can greatly assist in maintaining school attendance. Young people leaving care at 16 are more likely not to be in employment, education or training. • Suffolk has a higher proportion of young people not in education, employment or training (NEET) than the regional average and a lower proportion who progress to further education. • 22% of 16-19 year olds are estimated to have used some sort of drug in the last year, although only 53% are estimated to be regular drug users. • Children and young people with special education needs, those who regularly substance misuse, or who are looked after are more likely to have mental health needs too. • Improving Child and Adolescent Mental Health Services has been a focus for the Children's Trust in recent years in recognition of the rising demand for services. • Ensuring jobs are created to keep up with the rate of population growth offering a greater range of skilled roles and opportunities for advancement especially for young people.

	Annual Public Health report, 2012. Children: (pp11-33) School readiness; Children in Poverty; Pupil Absence and 16-18 year olds not in education, employment of training. • Only 52% of 5 year olds in Suffolk are described as being school ready. The percentage in Ipswich, at 43% is significantly lower than other districts. • Good quality childcare promotes social, emotional and mental development. • There are many adverse outcomes arising from living in poverty. Although child poverty is a different concept to wellbeing, poverty impedes wellbeing. • The proportion of children living in poverty in Ipswich at 22.1% is higher than the Suffolk (15.4%), East of England and England average (16.9%). • Poor attendance at school can be a cause or an effect of poor health and there is a clear link between poor attendance, living in poverty and educational attainment. The pupil absence rate in Ipswich is 6.2%, which is higher than Suffolk (5.8%) and the East of England (5.9%). • There is a need for a more person centred approach to ensuring young people get the most appropriate advice and support around the critical time of leaving school. **Suffolk Health and Wellbeing Strategy: Priority one: Ensuring every child in Suffolk has the best start in life** The focus of this priority is on: o Early intervention and prevention o School readiness o Educational attainment o Troubled families o Promoting a family focus across the work of all agencies **The Pharmaceutical Needs Assessment: Section 4.6 local vision and strategy.** Strategic goal 3 is to reduce inequalities in health within and between our communities with a key focus on marginalised communities, disadvantaged children and young people and prison health
To improve outcomes for patients with diabetes to above national averages.	**Annual Public Health report, 2012. Children: Excess weight in 4-5 and 10-11 year olds (pp22-23). Adults Ill health (pp50-57): Recorded diabetes.** • Deprivation is strongly associated with factors linked to diabetes including poor diet, lower levels of physical activity and obesity. The Ipswich area contains the most deprived lower layer Super Output Areas in NHS Suffolk (**IES CCG Public Health profiles**). • The report notes the importance of preventing the disease where possible, in particular by reducing obesity. • With respect to diabetes, Suffolk spends a disproportionately high amount on hospital care and a low amount on community based care. • Work is underway to see how people with diabetes can be supported closer to where they live.

	Suffolk Health and Wellbeing Strategy: Priority two: Suffolk residents have access to a healthy environment and take responsibility for their own health and wellbeing; Priority three: Older people in Suffolk have a good quality of life. • It is estimated that in Suffolk there will be an additional 11,000 people with diabetes by 2031 **The Pharmaceutical Needs Assessment: Section 4.6 local vision and strategy.** • The PNA supports existing contractors improving access for people with disabilities. • The PNA recognises diabetes as a priority in respect to advance services (Section 7.3 access). • Section 7.3 notes the significantly higher prevalence of diabetes in Black Caribbean, Indian, Pakistani and Bangladeshi populations.
To improve care for frail elderly individuals.	**State of Suffolk Report, 2011, Part A: A Sustainable Suffolk, 'Sustainable population growth?' (12-14); Part B 'Being Healthy and Living Well in Suffolk under the theme of Retirement and old age (pp 81- 86).** • The 2009 age structure shows that compared to England, Suffolk has more people aged over 60, particularly in the 60-65 age category, the fastest growing category. There are variations across the county with Ipswich being most like the English average and coastal and rural areas having a higher proportion of older people. • Higher numbers of older people are located in the rural parts of the County raising sustainability concerns for policies that encourage people to stay in their own homes for as long as possible, the implications for time and travel for care workers • People over 65 accounted for 61% of all unplanned hospital admissions in Suffolk in 2009, and 60% of the total cost of hospital admissions. • Falls represent the most frequent and serious type of injury for anyone over the age of 65 years. 50% of people over 80 years will fall every year (Department of Health, 2001): for Suffolk this could amount to over 7,000 people. • Hospital admission rates with any diagnosis of falls are higher in Ipswich Borough than any other district of Suffolk. • Hospital admission rates for falls increase with age. In Suffolk, the rates for persons aged 65-74 years, 75-84 years and 85 years and over were respectively over two times, over nine times and over thirty times the rate for persons aged under 65 years. • Frail older people have stated that they value a home close to amenities, family and friends and access to transport to reduce isolation especially in winter evenings and bad weather. • In 2009/10 there were 8,612 supported housing units available for various groups of vulnerable and marginalised adults. Older people represented 79% (6,268) of this uptake, the highest identified need coming from the frail elderly and older people with mental health and dementia problems. There is a surplus of sheltered housing but shortage of very sheltered and specialist high end services. • A joint project between NHS Suffolk and Suffolk County Council is examining preventative approaches to delaying the tipping point into frailty through building health and wellbeing capital; reducing risks; helping people cope with significant events and creating a strong, secure and safe environment. **Annual Public Health Report, 2012. Adults Ill health (pp50-57): Falls injuries and hip fractures in the over 65's.** • The rate of emergency hospital admissions for fall injuries in the over 65s in Suffolk was 404 admissions per 100,000 population, a total of 4,550 admissions. This rate was lower than the East of England (425) and England (500) rates.

	• The rate of emergency hospital admissions due to fractured neck of femur among 65s and over in Suffolk was 432 admissions per 100,000 population or 886 admissions. This was similar to the rate for the East of England (444) and England (452). • Better management of long term conditions may reduce excess winter deaths. **Suffolk Health and Wellbeing Strategy: Priority 3: Older people in Suffolk have a good quality of life.** • Falls and associated injuries are a leading cause of morbidity and mortality in older people. There is strong evidence that falls prevention services, such as exercise programmes focusing on improving strength and balance training, are effective and cost-effective and enable older people to remain independent longer. **The Pharmaceutical Needs Assessment: Section 4.6 local vision and strategy.** • Strategic objective 2 is to improve the health and sense of well being for all people in Suffolk. With a key focus on helping people be well, feel well and stay well, ensuring that if they become ill they have care of the highest possible clinical quality. • The PNA includes a priority to determine how medication errors in care homes for older people can be reduced. • Section 7.4 enhanced services recognises that NHS Suffolk has a significant number of elderly residents and that support may be needed to ensure that they can access their medicines and remain healthy for as long as possible. **IES Public Health Profiles, 2012:** • The age distribution of the East Suffolk population includes a lower proportion of children and young people (up to age 44 years) and a higher proportion of middle-aged and elderly people compared with NHS Suffolk overall and with England and is projected to increase by 16-32% between 2008 and 2031. The projected population growth will be accompanied by substantial ageing of the population.
To improve access to mental health services	**State of Suffolk Report, 2011: Part B 'Being Healthy and Living Well in Suffolk' How healthy are Suffolk people? (pp44-45); Early Years, Childhood and Adolescence (pp 58-75); Families and Working Life (pp 76-80) and Retirement and Old Age (pp 81- 86).** • The rate of suicide and undetermined injury in Suffolk has increased over the last 3 years and is now higher than the England average. • Depression is one of the most common chronic health conditions experienced by Suffolk residents. 13.4% of residents, or 64,989 people experienced depression in 2009. • Improving Child and Adolescent Mental Health Services has been a focus for the Children's Trust in recent years in recognition of the rising demand for services. **Annual Public Health Report, 2012. Adults Mental Health (pp58-63).** • Over half the people who die by suicide each year will have self harmed in the past. The rate of hospital admissions following self harm in Suffolk is lower than the UK rate. • Stable, settled accommodation linked to supportive social care may improve outcomes for adults with mental health problems. • There is a clear link between deprivation and mortality rates for self harm.

	Suffolk Health and Wellbeing Strategy: Priority 4: People in Suffolk have the opportunity to improve their mental health and wellbeing. • The priority includes a particular focus on the provision of high quality services that are equally accessible for all. **The Pharmaceutical Needs Assessment: Section 4.6 local vision and strategy.** • Strategic objective 2 is to improve the health and sense of well being for all people in Suffolk. With a key focus on helping people be well, feel well and stay well, ensuring that if they become ill they have care of the highest possible clinical quality. • Strategic goal 3 is to reduce inequalities in health within and between our communities with a key focus on marginalised communities, disadvantaged children and young people and prison health. • The PNA support existing contractors in improving access for people with disabilities. • Section 7.4 – Access identifies that support may be needed to ensure that older people can access their medicines and remain healthy for as long as possible.
To allow patients to die with dignity and compassion and choose their place of death	**State of Suffolk Report, 2011: Introduction: Why is Health and Wellbeing Important? (pp4-12)** • The 2009 age structure shows that compared to England, Suffolk has more people aged over 60, particularly in the 60-65 age category, the fastest growing category. **Suffolk Health and Wellbeing Strategy: Priority 3: Older people in Suffolk have a good quality of life.** **The Pharmaceutical Needs Assessment: Section 7.4 local health needs** • Recognizes the need for people of all ages to have appropriate and timely access to medicines at the end of life.
To improve the health of those most in need	**State of Suffolk Report, 2011: The theme of health inequalities runs throughout the report.** • Inequalities exist between different groups and geographical areas in Suffolk. In 2005-09 life expectancy among males living in the most deprived parts of Suffolk was on average 5.3 years less than males living in the least deprived areas. The gap for females was 4.4 years. • The gap in disability free life expectancy is even greater with men living in the most deprived areas expected to live 8.3 years less in good health compared to those in the most affluent areas and a 7.6 year gap for women. • Many surveys show that there is in general lower awareness of health-related issues within Black and Minority Ethnic and deprived communities and we know that these communities often experience poorer health. • Cardiovascular disease is the biggest contributor to inequalities in life expectancy between those living in the most and least deprived areas in Suffolk. • Inequalities in premature death due to Coronary Heart Disease are getting wider. • In 2009/10 there were 8,612 supported housing units available for various groups of vulnerable and marginalised adults. The highest identified need comes from the frail elderly and older people with mental health and dementia problems. There is a shortage of accommodation for marginalised young people aged 16-25 years old and a very significant shortage for people with disabilities.

- With respect to disabled people, many of the issues which impact on their sense of wellbeing mirror those of the population as a whole including the need for accessible transport; signposting to information about relevant events and benefits; appropriate housing and work opportunities. However, specific issues which are especially pertinent to disabled people include ensuring that places and services are truly accessible.
- 80% of carers report that caring has damaged their own health. Carers are less likely to seek help from their GP for their own health needs.
- The Family Networks project works with high demand families on behalf of a number of agencies to help families turn their lives around.
- Ensuring jobs are created to keep up with the rate of population growth offering a greater range of skilled roles and opportunities for advancement especially for young people.

Annual Public Health Report 2012: The theme of health inequities runs throughout the Annual Public Health Report 2012 which is structured around the Public Health Outcomes Framework for England.

- Homelessness is associated with severe poverty, adverse health education and social outcomes and statutory homeless households contain some the most vulnerable and needy members of our community.
- Tackling fuel poverty has multiple benefits.
- Tackling the substantial and widening burden of death and ill health due to CVD in disadvantaged communities is a major challenge for Suffolk.
- Sustained action is required to reduce smoking prevalence in the most deprived communities.

Suffolk Health and Wellbeing Strategy:
Addressing the differences in healthy life expectancy between those living in our communities is part of the vision for this strategy. Tackling health inequities is a theme that runs throughout this draft document which has cross cutting principles of equity, accessibility, integration, effectiveness and sustainability.

The Pharmaceutical Needs Assessment: Section 4.6 local vision and strategy.
- Strategic objective 2 is to improve the health and sense of well being for all people in Suffolk. With a key focus on helping people be well, feel well and stay well, ensuring that if they become ill they have care of the highest possible clinical quality.
- Strategic goal 3 is to reduce inequalities in health within and between our communities with a key focus on marginalised communities, disadvantaged children and young people and prison health
- The PNA supports continuing to run community pharmacy health promotion campaigns targeted towards health improvement priority areas identified in localities.
- Section 7.3 sets out priorities for improving access.

IES Public Health Profiles, 2012: Executive summary.
- The Ipswich area includes the most deprived parts of NHS Suffolk which are located in the western, central and southern parts of Ipswich Borough. Most of the general practices in Ipswich are among the most deprived practices in NHS Suffolk with four practices having more than 60% of their population living in the most deprived areas in NHS Suffolk.

To ensure high quality local services, where possible	The delivery of high quality local services is essential to meet the needs of the Suffolk population as identified within the JSNA. **The Pharmaceutical Needs Assessment: Section 4.6 local vision and strategy.** • Strategic goal 1 is to improve the overall experience of healthcare services for all people in Suffolk with a key focus on access, safety and clinical quality. • Strategic objective 2 is to improve the health and sense of well being for all people in Suffolk. With a key focus on helping people be well, feel well and stay well, ensuring that if they become ill they have care of the highest possible clinical quality. • Strategic goal 3 is to reduce inequalities in health within and between our communities with a key focus on marginalised communities, disadvantaged children and young people and prison health • Strategic objective 4 is to Increase joint working between NHS organisations, partners and other sectors across Suffolk for improved joint planning and better integration of services • Section 7.3 sets out priorities for improving access.
To promote self care	**State of Suffolk Report, 2011: State of Suffolk Report, 2011: Part A: A Sustainable Suffolk, 'Sustainable population growth?' and Part B 'Being Healthy and Living Well in Suffolk' How healthy are Suffolk people? (pp44-45); Early Years, Childhood and Adolescence (pp 58-75); Families and Working Life (pp 76-80) and Retirement and Old Age (pp 81- 86).** • People of Suffolk are unlikely to reach retirement without developing a long term disability/condition. 97,000 people in Suffolk or 16.6% of the adult population report having a limiting long term illness/disability which affects their daily living. • 23% of the 18,000 social care customers in Suffolk are under 65. For the majority of this group the key challenge is to regain or maintain independence through innovative support leading to greater participation in learning, work or leisure. • The most common chronic health conditions experienced by the Suffolk population include high blood pressure (13.7% or 84,332 people), depression (13.4% or 64,989), asthma (6.5% or 40,004), diabetes (5% or 24,470) and Coronary Heart Disease (3.7% or 22,754). • Positive social and community networks support positive health and wellbeing. • Physical activity and access to universal services are important to health and the promotion of self care. • Ensuring that the housing stock meets the needs of the changing population profile, with older people living alone is a key priority. • Preservation and enhancement of the natural environment contributes to make Suffolk a good place to live and helps support a high quality of life, facilitating outdoor exercise and healthy living. **Annual Public Health report 2012. Adults: Successful completion of drug treatment (p47)** • A crucial element of long term recovery from drug dependence is engagement with mutual aid groups.

Suffolk Health and Wellbeing Strategy: Priority two: Suffolk residents have access to a healthy environment and take responsibility for their own health and wellbeing.

- Improving health-related behaviour is likely to reduce demand on health and social care in the long term and evidence based treatment of conditions such as cancer, coronary heart disease, diabetes and stroke can contribute to healthier life expectancy.

The Pharmaceutical Needs Assessment: Section 4.6 local vision and strategy.

- The PNA Encourages pharmacies and pharmacists to become eligible to deliver Medicines Use Reviews (MURs) and will direct these to priority areas and to people who are having difficulties taking their medicines appropriately.
- The PNA will support people with long term conditions through improved medicines management.

Appendix 1

Summary Outcomes of the Suffolk Health and Wellbeing Strategy Stakeholder Event 28th September 2012

Background

As Suffolk's Health and Wellbeing Board we are responsible for developing a strategy which will take us through the next decade, and, as a key part of that strategy development, we wished to test out what we have developed so far with a range of key stakeholders. As such we had a stakeholder event where over 150 people attended. The following summary provides you with an overview and key outcomes from the day to which we hope there will be further contributions and will provide us with a basis on which we can develop and grow together as a focus for our collective efforts rather than something dry and irrelevant to our day to day lives.

''Our aim is that people in Suffolk live healthier, happier lives and that we see the differences in healthy life expectancy between those living in our communities decrease.''

Health and Wellbeing priorities for Suffolk

Through this strategy, the Suffolk Health and Wellbeing Board want to ensure that those in Suffolk live long, healthy and fulfilling lives. We will know that we have been successful over the next decade by measuring:

- Increased healthy life expectancy
- A reduction in the differences between communities in life expectancy and healthy life expectancy.

We have agreed on four priority areas, chosen using information from the Joint Strategic Needs Assessment (JSNA) and evidence that shows action in these areas will help us attain our long term aims. These are:

- ✓ *Every child in Suffolk has the best start in life*
- ✓ *Suffolk residents have access to a healthy environment and take responsibility for their own health and wellbeing*
- ✓ *Older people in Suffolk age well and have a good quality of life*
- ✓ *People in Suffolk have the opportunity to improve their mental health and wellbeing*

What is health and wellbeing?

Health and wellbeing encompasses a person's life experience and includes a sense of physical, mental and social wellbeing. Through working jointly across health, local government and wider communities, we can make a real difference in improving the health and wellbeing opportunities for all those in Suffolk.

Health and Wellbeing in Suffolk

The Suffolk population experiences some of the highest life expectancy in England, with a girl born today expected to live 84 years and a boy 80 years.

However, we also need to focus on quality of life and minimise the impact of long term illnesses and disability.
Economic disadvantage affects our health and wellbeing throughout our lives. Premature mortality (deaths under the age of 75) is greater in deprived areas and the two main causes are cancers (44%) and cardiovascular disease (26%). People in our affluent areas live longer than those in poorer areas and we want to decrease the 12 year gap between the electoral wards with the highest and lowest life expectancy in Suffolk.

Introduction and objectives for the day

The leader of Suffolk County Councils and Chair of the Health and Wellbeing Board Councillor Mark Bee opened the day reminding us of the objectives of the day which were:

- To share the emerging strategy and the developments of the Health and Wellbeing Board thus far
- To agree the areas of focus for early priority delivery within the strategy
- To agree how to communicate, engage and develop with a wider range of stakeholders and the public

He highlighted the opportunity we had today having such a rich and representative group of people to influence this extremely important strategy and talked about the progress that had been made so far by the shadow board which would become a statutory body from April 2013.

An overview of the emerging strategy

Tessa Lindfield then gave an overview of the strategy development so far indicating some of the key factors which have informed the priorities and areas of focus that we all need to work together on if we are to make a difference to the outcomes given the current indicators and predicted changes to the population profile.

Round Table Sessions

These sessions were the 'meat' of the day providing us with a structured process to explore the four priority areas through the following questions:

1. Are there any additional areas for action which we need to address?
2. What areas of action should we initially focus on?
3. How will we measure and demonstrate our impact?

Each session had a short introduction from a Board member who provided their perspective and some challenging thoughts/questions for us to consider and stimulate our debate.

Session 1 – Giving young people a better start

Introduced by Cllr Graham Newman portfolio Lead for Children and Young people's services

Graham provided a very compelling overview as to why it is important that we focus on giving every child a better start in life, as that will be a lifelong investment, and, in particular, the need to focus on education in every way. Graham then introduced a short clip showing how family support in children's centres can really make a difference at a very early stage to the wellbeing of whole families.

The key emerging themes from our discussion were:

- **Integration** of services, agencies, plans, resources, early intervention and prevention strategies, structures and investment plans.

- **Education** on health and wellbeing at all levels and ages, embed into school curriculum behaviours and messages e.g. road safety, PHSE, positive mental health, further education programmes as well as primary and secondary schools who need to be part of this process and were missing on this day.

- **Community** led initiatives, with voluntary agencies, working with communities on local projects which enable whole family development and support early recognition, positive mental and physical wellbeing. ''*It could be reward based e.g. Healthiest Village / Children get vouchers for points – like 'London 2012' - competition for the name.''*

- **Safeguarding** to prevent greater harm in risk groups:
  - Domestic violence (also Children's Trust priority)
  - Young carers
  - Looked after children
  - Troubled teenagers
  - Those struggling with mental health.
  - Troubled families
  - Maternity and prenatal – early identification of those at risk.

- **Focus on Family** and **early intervention and prevention** not just children as children thrive best in well functioning families who need support as early as possible in easily accessible non threatening ways

- **Engage children and young people** in the strategy development; make it relevant, accessible and part of their world

- **Healthy lifestyles –** life skills in schools – shopping, seasonal foods, cooking**,** sport in schools and free/subsidised access to clubs etc in holidays (tennis, swimming, leisure centres).

- **Young adults and parents –** promote positive image and opportunities for teenagers in towns and villages, and focussed help/support groups peer networks and role models for young parents

- **Focus on mental Health**:
    - Of the 150,000 children in Suffolk aged 0-17 research shows that:
        - 15 % of children aged 0-17 will have mild, early stage mental health problems.
        - 7% of the same population will experience moderate to severe mental health problems.
        - 1.85% will experience severe to complex mental health problems.
        - 0.075 % will experience very serious persistent problems. (Source of data: Norfolk and Suffolk NHS Foundation Trust.)

- **Demonstrate our impact**
    - Initially by uptake of services then, school readiness leading to attainment levels; with some assessment of inequality measures across these
    - Asking all organisations to demonstrate how they are contributing to priorities
    - Develop case studies models to demonstrate impacts.

Round Table Session 2 – Improving our mental health

Introduced by Dr Mark Shenton GP Chair, Ipswich & East Suffolk CCG, and member of the Health and Wellbeing Board

Mark reminded us to consider how common mental health issues are and how important our mental health is in all aspects of our wellbeing with the need for a holistic approach. He then showed a short clip of one person's story demonstrating what a difference a holistic approach can make when it centres on what a person can do rather than them being dismissed and defined by their mental health problems.

The key emerging messages from our discussions were:

- **Community:** Better referral by Housing officers, teachers, Police.

- **Education:**
    - Addressing the stigmatisation and education from school area about mental health (PHSE).
    - Self care and education programmes need to be developed.

    - **Integration**:
    - There is demand for greater inter-agency collaboration as well as integrated services which would aid continuity. E.g., CAMHs do not

need to be the only point of call for young people and older people and dementia services.

- VASP network useful communication tool – aware of local networks, support groups etc and better signposting and awareness of services available especially VCS e.g. information points in GP surgeries.

- **Early interventions**: Talking therapies and review of thresholds to enable early intervention.

- **Mental Health in young people**:

- Issues for children and young people related to mental health link across a number of key themes and demonstrate the importance of this area of work:
  - Poverty/Domestic violence/Mental Health issues in parent / carers.
  - 13 years is too late, need greater emphasis on CAMH's and support in YOI's.
  - In order to prevent children and young people becoming acute and needing tier 3+4 services, there need to be improved understanding within universal services about mental health issues that affect children and young people.
  - School Management of MH.
  - Suggest the utopia would be for all school staff to be trained and youth workers, school nurses, health visitors etc.
  - MH services going into school and raising awareness about MH issues (reducing stigma) – raising awareness of MH at early age.
  - Tackle bullying – social media. Support young people to develop self esteem.
  - Value of role models e.g. celebrities that say have had problems and how they dealt with it.
  - Schools to develop more low key counselling, mentoring services to prevent stigma and frightening people, particularly young people.

- **Mental Health in the workplace**:

- Educate employers and business communities. Start with our own agencies. Do we support employment of people with mental health difficulties?
- Healthy workplace programmes to encourage business to promote good Mental Health and support those with Mental Health issues (educate small businesses).
- Employment point of contact, various agencies – SHAW trust, MIND etc.

- **Tackle stigmatisation**.

- De-medicalisation of mental health – medicine not the sole prescription.

- Reduce emergency admissions and improve support post discharge from hospital with timely access to a health supporter.
- Need to enable more people to be treated in primary care.
- Prevent isolation of families trying to support and cope with helping someone with MH with actions to promote volunteering easy access to services and empowering people to help themselves and self refer.
- Raise awareness of HWB issues in all front line services e.g. Police, criminal justice system, primary mental health workers, school nurses etc as a 1st point of contact and support to the professionals.

- **Demonstrate our impact through**:
  - Reduction in prescribed medication.
  - Reduction of people off work with stress or other rises in sickness absence change in pattern of workplace absence.
  - Improved wellbeing and reduction of depression, GP referrals/admissions and suicides
  - Increased normalisation and integration into wider community activities, leisure, employment and associated change in attitudes of

Round Table Session 3 – Building a healthier lifestyle and environment

Introduced by Councillor Mary Neale District Council Member of the Health and Wellbeing Board

Mary gave a presentation which highlighted the range of areas and initiatives currently being supported through District and borough councils within Suffolk, enabling people to live healthier lives, increase activity, live and work in a better environment and reduce smoking, alcohol consumption, obesity and other lifestyle related factors.

The key emerging themes from our discussion were:

- **Review and increase early interventions which work** such as smoking cessation and diet/obesity management e.g. 69% of smokers don't want to smoke
- **Build on community assets e.g.:**
  - Schools as community 'hubs'.
  - Using community to promote health. Make public aware of what is happening in their communities
  - Community leaders / champions recognition scheme.
  - More clubs/community activity – adult sports / equipment in parks. Facilitating and improving leisure access
  - Work with voluntary orgs who support health and wellbeing priorities e.g. NCT and Breast Feeding – make all work places breast feeding friendly and follow the Unicef Baby Friendly Initiative (BFI)

- **Focus on alcohol**
  - Greater damage than drugs.

- Banning high strength alcohol.
- Convey message to young people about risks of alcohol and substance abuse.
- Alcohol misuse amongst young people - actions relating to licenses for alcohol relate to MH and young people.
- An early look at alcohol volumes of consumption and risk taking behaviour - smoking and alcohol – root causes.
- Alcohol is a huge problem in society for all ages and has big impact on families and community – Change cultural acceptance of alcohol misuse.

Focus on healthy lifestyle:

- Fun, easy, popular – make activities all of these things. E.g. free swimming/gym passes, pedometers for kids
- Focus on children and young people and intergenerational activities – for smoking, physical activity – get them to influence parents and support clubs and competitions for children and parents
- 'Buddy' system to encourage people to take up physical activity – build up people's confidence.
- Integrated strategies for smoking and alcohol reduction with all other areas trying to address this problem such as the community safety partnership and smoking in pregnancy.
- Ask people why they choose unhealthy choices – don't just lecture them. Family interventions – particularly for healthy eating

Promote and protect 'Green Spaces':

- Is access to green space and promotion of physical activity a big enough priority in local development frameworks?
- Town district/borough parish and Suffolk County Council need to work together to efficiently use the green space available and how they can use it to promote physical activity.
- Need to ensure green spaces are clean, safe and litter free.
- Use 'natural resources' not just focus on sports facilities.

Review policy areas to ensure not counterproductive e.g.

- Make it easier for small and voluntary organisations to bid
- Licensing authorities need to be more firm.
- Issues that if people volunteer to improve employment prospects they are penalised with their benefits.
- Recognise the role technology can play
- Emphasis on good planning with awareness of creating healthy environments.

- **Focus on improving transport where we can make a difference within the resources we have:**
  - Big issue – rural county – transport hubs.
  - Planning in relation to walking and cycling routes – which are safe and people feel safe.
  - Access to services – health and leisure.

- **Demonstrate our impact through:**

- Alcohol:
  - Reduction in alcohol related crime/health problems.
  - Minimum prices – strong lager/cider.
  - Ban super strength alcohol – 'Suffolk is low strength county.'
  - Surveys of alcohol use
  - L/T improvements in consumption of units and associated health indicators.
  - Fewer admissions of people to hospital due to alcohol.
- Reduction in obesity / uptake in physical activity.
- Number of employers signed up to initiative to promote health and wellbeing.
- Other healthy behaviour measures seem clearly monitored.
- Reduction in medication bill for anti-depressants.
- Try to utilise some of the physical activity data to develop a local indicator.
- Make more use of measures from other areas e.g. fear of crime, social cohesiveness.
- Travel surveys and work/school.
- Employers demonstrating % of workforce using sustainable transports.
- Reduced congestion.
- More joined up priorities/reporting.
- Environmental audits.
- Board to look at planning policies (LDF) Local Development Framework. Need to make sure we have homes that meet specific needs in Suffolk. Houses for life – too many people have to leave electric wheelchairs outside.
- Gaps narrowed between the deprivations outliers (so not 12yrs difference in life expectancy.)
- School attainment.
- Measure places to exercise, store bikes safely.
- Increase in breast feeding prevalence

Market Place

During lunch we had the opportunity to 'have our say' recorded and made into a short DVD which we heard later in the day and to visit the 'market place of various stalls. We tasted some lovely healthy food and were made aware of the range of providers already working within Suffolk.

Round table session 4 - Ageing well

Introduced by Councillor Colin Noble we firstly experienced what it is like to do some chair based exercises currently provided for older people but could easily be introduced in workplaces as a way of increasing energy and improving circulation in sedentary jobs. Graham then provided us with an overview of some of the key areas we need to be focussed on in planning for the impact of the huge demographic changes which we in Suffolk will be experiencing and the consequences in terms of demand and increases in long term conditions, dementia etc unless we start to change the way we age. He then showed us a very moving film relaying different people's stories and what measures we can put into place which may seem quite small and simple but which have a transformative effect on people's lives.

The key emerging themes from our discussion were:

- **A strong and early focus on dementia is essential:**
  - Early signs need to be spotted by wider range of community and old people networks; people scared off by stigma of dementia.
  - Raise awareness and reassess type of care to help people stay in community.
  - Numbers increasing but services are not meeting needs for patient and families.
  - 'Choice' should not become confusing for families, take away or hinder their control.

- **Integration of planning, commissioning and delivery is essential:**
  - Joint training programme/awareness-raising of what services are available for front line service providers e.g. Housing officers, police, trading standards. Networks are key to improving outcomes for this and all other priorities.
  - One form/file for a patient/person and actions should focus on the whole person and integrating MH. Don't focus on disease and not person.
  - HWB should apply its muscle to holding MH, social care, NHS teams to account and ensuring they are working in a truly integrated way, promoting common management.
  - Don't need sub groups to be talking shops. Use existing networks to deliver -

- Informing or equipping front line staff with information about wellbeing services awareness of where people can be referred to and signposting.
- Needs far more clarity on NPNs and SLBs and how these help older people – why are district councils not included?
- Look for cross cutting opportunities between the themes of the strategy.
- Pooled budgets.
- Widen the remit of neighbourhood partnership networks to include: district/town/parish council officers.
- Single IT systems.
- Families able to access from a distance the information (also about how information is shared) – the culture.

- **Access and quality of care homes**:
- Difference in quality of care in homes.
- Funding issues for care homes – having to sell homes means some stay at home when they would prefer not to.
- Choice.

- **Reduce Isolation amongst old people:**
- Community based ways of reading older people.
- Enabling old people to access IT (intergenerational opportunity). E.g. Skype - way of accessing social network if can't physically get out
- Dying well – worries including being alone etc..
- Faith groups important socially – network/support.
- Self help – managing self care.
- Social prescribing – vital to work out how e.g. volunteers, warm handovers etc.
- Motivation to keep healthy and active.
- We **want** to age well. No-one volunteers to be dependent.
- Issue of under reporting of crime by old people because of fear of being put in home.
- Public transport (some villagers very isolated with limited bus services and cannot easily access services).
- Health visitors' for older people to give them the time they need and 'social prescribing and a phone line to seek information and support
- We support the mobilization of local community assets to help tackle isolation for old people as volunteers and to reduce social isolation.

- **Impact on carers** - Awareness/identification indicators of age related conditions. What are the signs to look out for – promote self awareness and awareness for people who care for others.

- **Retirement Planning** - Encourage employers to introduce phased retirement. Link this with introducing people who are seeking work.

- **Asset based approach with communities:**
- Living wills.
- Voluntary sector hotline – get a directory of services
- Attitudes to older people need to change - look at different cultural awareness - services by older people for older people.
- Build and not re-invent.

- **Demonstrate our impact by:**
- Sampling – MORI etc.
- Health watch/Age UK Assess.
- Helpline/Support system take-up.
- Spend on high level care.
- People living longer with less morbidity and less repeated illnesses with fewer hospital admissions/ shorter periods of hospitalisation and multiple admissions for the elderly
- Reduction in Suffolk of people needing residential care.
- Healthier life spans.
- More older people volunteering.
- Decrease in deprivation / inequality.
- More families/individuals having the end of life they wanted.
- Personal feedback from service users.
- Identify key outcomes and related performance indicators.
- Working with Old People to co-produce any outcomes and progress framework. -not simple to measure opinion/ Quality of life/ Connectedness or Happiness.
- Net promoter scores – would you recommend this County as a place to live?

The following thoughts about the strategy as a whole were also noted from the round table discussions:

- Map on Suffolk Observatory and communication links to social networks etc.
- Accept soft of targets – be brave enough to be outcome based. Let the people set the outcomes.
- Sell the vision – engage public momentum and enthusiasm of Olympics.
- Stop the stuff that isn't working.
- The Strategy needs to be communicated in easy to understand ways.
- Explain what Health and Wellbeing Board is to public and what they can do to be involved. There needs to be more awareness.

- Make sure every meeting ends in an action which is then implemented with published progress
- Use Healthwatch - HWB Board ←→Healthwatch ←→Empowered public/patients.
- Use Districts/borough councils more as councillors have a great knowledge of the public and what they want and need.

Voting on our priorities

We then had an opportunity to vote on the priorities and the key areas for action which had already been identified. It was stressed that this in no way reflected the areas that had been identified today and nor was this a binding process, rather an opportunity to gain some measure of what the views were within this group as a part of an ongoing process of development. The following results were noted:

Giving children a better start:

1. Services for adults should be family focussed to take into account the needs of the child
2. Support parents to improve their own circumstances
3. Provide a range of interventions and opportunities
4. Support children's health development

Improving mental health:

1. Ensure mental health is everyone's business
2. Holistic, seamless mental health provision
3. Meant Health services to bring together all elements of wellbeing
4. Support all people over 13 along a whole life pathway

Aging well:

1. Integrated approach to health and social care
2. Promotion of healthy lifestyles and other initiatives which help age well and prevent ill health
3. Whole system shift to personalisation, prevention and asset based approach
4. Multi-agency action to tackling, stroke, heart disease, cancer and dementia

Building a healthier lifestyle and environment:

1. Create an environment where it is easy to make healthy choices
2. Increase access to physical activity
3. Increase access to suitable housing
4. Decrease excessive use of alcohol

Communication and engagement with our communities and stakeholders – *led by Deborah Cadman Chief executive of Suffolk County council*

Deborah helped us to reflect on the day thus far and not only the scale and scope of the challenge but the massive amount of progress already going on. She challenged us to maintain the energy in the room and to ensure that we took equal responsibility for generating the leadership, commitment and involvement with all of our stakeholders and communities so as this took hold in Suffolk with a change in culture which sees the agencies as enablers rather than the source of all solutions.

In Conclusion

We then received considered thoughts from 5 of our board members on the key messages that they would be raking away from the day and back to the Board with a final conclusion from Mark Bee who identified the forward plan for further developing the strategy before it is finalised early in 2013.
Some key things to reflect on are quoted as follows:
"For me personally, perhaps the most poignant part of the whole day was the film clip we saw of Peter, Ahmed and Betty coping with situations which faced them in their later years. For me that so starkly portrayed the situation facing many older people, and which may face each of us in the future as we all get older. This is why we must redouble our efforts to connect with them and keep them active and socialising – by engaging advocacy, voluntary and community activities and organisations"

"We talked a lot on our table about how we could evangelise the well-being message. Here in this room I think everybody is signed up to this agenda – mindful of the savings we've all got to make, getting best value out every penny we've got. But if we all *convinced* someone else this week about the importance of this agenda, and they all went on to tell someone else the next week, and so on, how long would it take to get the message well and truly embedded throughout Suffolk. A year? Who knows. But we need to make every contact count"

"We also acknowledged that much of what we needed to achieve was very aligned to our own behaviours at a quite basic personal level. What is it that makes us decide to go swimming every week to pursue a more active life style? Or cut down on inappropriate food because we're piling on the pounds? What drives us to take up smoking or ratchet up our drinking – when we have so much evidence that to do so is bad for us?" Connecting with our public in a more meaningful way to change behaviours means we all have to think about the culture we create, with the need to start with putting our own houses in order re: being mental health and breast feeding friendly, healthy places to live and work and demonstrating healthy active behaviours.

"I came in this morning thinking the key skills we need to harness are communication and education, with a family focus and I think I'm probably going home still thinking they are the two key skills. I'm very disappointed we've not had any representation in the room from the education sector. This

is not about me trying to reclaim old ground for the county council around running schools, it is simply that we have to bring schools with us on the well-being journey and start the education as early as we can with our children. We have to maintain a Suffolk family of schools – be they free schools, academies or maintained schools – if we are to secure our aims. On communication I know we have the wherewithal to harness social marketing and other techniques… we can't just keep on saying to people "don't do this, that or the other" because they're not listening anymore. We've got to get more media savvy to make this work"

"I was worried about the common line of questioning on our priority areas – *How will we measure and demonstrate our impact* – I'm not sure we'll see impact in a year, maybe not three years – but we ought to be seeing big change within the decade. How will we know… perhaps as you walk down your supermarket aisle, passing fellow shoppers – and remember one in seven of them will probably be someone with a caring responsibility – will they be smiling? Will they look at ease? And let's not change the plan before we've had time to see the results"

"And finally, may I just re-quote my good friend at Suffolk Family Carers – Jacquie Martin – when she said "We don't want another talking shop". Ladies and gentleman, haven't some of us been here before, under the old Local Area Agreement exercise three or four years ago? We knew nearly all of this stuff then, but we frittered away the opportunity. Let's not do that again – given the budgetary pressures we're all under, and the coming together of health & wellbeing professionals in a way not seen before we must use the assets we have and work with our communities to help them to help themselves if we are to make any sustainable change for the future. We cannot so it for them."

The day was facilitated by Janice Steed who can be contacted at janice@steedconsulting.co.uk

Appendix Two

Statement of Arrangements between local authority and CCG for public health advice

Evidence for authorisation	Domain reference	Criteria Button Number	Signpost (eg, paragraph 3, section 6 on page 10 of document A)
Arrangements in place between LA and CCG specifying how public health advice to CCGs will be delivered	1.3	13	This document

Public Health Directorate- Ipswich and East Suffolk CCG Statement of Arrangements- 2012/13

Purpose

The purpose of this document is to establish a framework for the working relationship between the NHS Suffolk Public Health Directorate and Ipswich and East Suffolk Clinical Commissioning Group (CCG) for the transition year 2012/13. The arrangements will be reviewed and further developed during the year with a view to developing and agreeing a definitive Memorandum of Understanding (MOU) for 2013/14. The document focuses on the provision of public health advice to NHS commissioning. The working arrangements in relation to the health improvement and health protection functions of public health will be developed during the year.

Context

Since 1974 specialist public health staff, based in the NHS, have delivered the three core public health responsibilities on behalf of the NHS and local communities:

- Health improvement e.g. lifestyle factors and wider determinants of health
- Health protection e.g. immunisation, screening and the response to major incidents
- Population healthcare - public health advice to health services commissioning

With the implementation of the Health and Social Care Act 2012, responsibility for strategic planning and commissioning of NHS services will transfer to the NHS Commissioning Board and to Clinical Commissioning Groups (CCGs). It is the DH policy intention that local arrangements will be in place to ensure that CCGs have access to PH advice from PH teams based in local authorities to support NHS commissioning.

Public Health Advice to NHS Commissioning

The Health and Social Care Act establishes CCGs as the main commissioners of local health services with a duty to continuously improve the effectiveness, safety and quality of services. Health and wellbeing boards will provide local strategic and collaborative leadership in the reformed health system. Health and wellbeing boards will have responsibility for undertaking the Joint Strategic Needs Assessment (JSNA) and developing the joint health and wellbeing strategy which will be used to inform CCG commissioning plans.

From 1 April 2013 when the public health function transfers to local government, local authorities will have a new duty to provide a 'core service of specialist public health expertise and advice to NHS commissioners'. It is the DH's policy intention to make it a mandatory requirement for local authorities to provide this service to CCGs with the DPH responsible for its delivery. The draft DH guidance includes examples of the proposed content of public health advice together with examples of expected outputs (Appendix 1). Further definitive DH guidance is anticipated during 2012/13 which will inform the development of the MOU for 2013/14.

The contribution that public health professionals will be able to make to both local authorities and CCGs includes the following skills and expertise:

- Structured ways of doing needs assessment
- Finding, assessing and applying evidence of what works
- Understanding the interaction and collective impact of complex variables and modelling the potential impact of different options for service redesign
- Strengthening prevention to avoid downstream spend across service areas
- Assistance with prioritisation to help manage the conflict between individual wants and needs and the best use of resources for the whole population
- Advice about the most appropriate targeting of services and interventions to those groups at greatest need
- Support for public consultation
- Evaluation of the success of service redesign

The key public health skills required to support the successful commissioning of health care services include:

- Assessing health needs of populations and how they can be best met using evidence-based interventions
- Supporting commissioners in developing evidence-based care pathways, service specifications and quality indicators
- Providing a legitimate context for setting priorities using 'comparative effectiveness' approaches and public engagement
- Supporting the evaluation of commissioned services.

Public Health Advice to NHS Commissioning in Suffolk 2012/13

The statutory role of the Director of Public Health (DPH) will transfer to the Local Authority (Suffolk County Council) in April 2013. The DPH and public health team are currently co-located in Suffolk County Council accommodation but remain NHS employees. Public health specialist staff currently provide a range of support for NHS commissioning functions. NHS employed public health staff will continue to provide a skilled multi-disciplinary public health workforce to the CCG and increasingly to appropriate Local Authority functions. The purpose of this document is to set out the working relationship between the NHS Suffolk Public Health Directorate and Ipswich and East Suffolk Clinical Commissioning Group (CCG) for the transition year 2012/13.

This document establishes a framework for the working arrangements and sets out the expectations for both the NHSS Public Health Directorate and the CCG in 2012/13. The priorities/work programme of the of the members of the Public Health directorate providing public health advice to the CCG will be agreed by the DPH and CCG Chief Operating Officer.

NHSS Public Health Directorate will:

- Provide specialist public health advice to the CCG and will work with them to refocus activity within the available capacity to support immediate priorities
- Ensure that the public health advice will be delivered by consultants and other specialists from the Public Health Directorate supported as appropriate by other members of the team including public health information analysts, Knowledge Services and public health trainees.
- Provide public health capacity to support commissioning in line with draft DH guidance- approximately 40% of the public health specialist team, 1 wte per 270,000 population. This equates to approximately 2.3 wtes for NHS Suffolk.
- Provide specialist public health advice in accordance with the DH Factsheet *Public health advice to NHS commissioners* and other DH guidance (current draft DH guidance based on the stages of the commissioning cycle included at Appendix 1).
- Identify a named Consultant in Public Health to act as the principal link between Ipswich and East Suffolk CCG and the Public Health Directorate.
- Identify a named Health Improvement contact to provide monitoring information and advice regarding the Healthy Ambitions QIPP Plan.
- Ensure that the linked consultant is available to be based for part of the week (to be agreed) with the CCG and will act as the principal point of contact between the CCG and the public health team.
- Support the CCG in developing evidence-based care pathways in agreed priority areas, including needs assessment, inclusion of prevention, reviewing the evidence of effectiveness and predictive modelling of effects. Provide public health advice in the development of service specifications and quality indicators to improve patient outcomes.
- Ensure that identifying and reducing health inequalities are prioritised in the commissioning of services.
- Provide public health advice on the design of monitoring and evaluation frameworks.
- Support the CCG in interpreting and understanding data on clinical variations in both primary and secondary care.
- Provide specialist technical reports and support in relation to Individual Funding Requests (IFRs).

- Support the CCG in the achievement of the indicators in the NHS Outcomes Framework for Domain One - preventing people from dying prematurely.
- Work with the CCG to ensure that the Suffolk Joint Strategic Needs Assessment (State of Suffolk) identifies, and is relevant to, the needs of the population of Ipswich and East Suffolk CCG. This will be based on the use of the CCG Public Health profiles produced in March 2012.
- Provide public health support to the CCG to ensure that the needs of the CCG are incorporated into the Suffolk Health and Wellbeing Strategy.
- Provide public health st,.Jpport to the CCG to translate the JSNA (State of Suffolk) and HWB Strategy into commissioning plans/intentions relevant to the population including identification of priorities.

NHS Ipswich and East Suffolk CCG will:

- Consider how to incorporate specialist public health advice into corporate decision making in order that public health skills and expertise can inform key commissioning decisions. This may include the link public health consultant attending corporate meetings e.g. CCG Board or Clinical Executive meetings.
- Support a process to review the transition arrangements in 2012/13 and develop and agree a definitive Memorandum of Understanding for 2013/14.
- Contribute to the production of the Suffolk JSNA (State of Suffolk) and Health and Wellbeing Strategy.
- Continue to support contract management and performance in relation to screening and health improvement contracts.
- Continue to provide patient safety and clinical quality advice and support in relation to public health commissioned programmes.

Governance and quality assurance

All members of the public health team responsible for delivery of this function will be accountable to the DPH. The DPH will ensure that an appropriately skilled public health workforce will be maintained and supported to allow delivery of the technical and leadership skills required of the function. This will include:

- Ensuring that the current planned wte resource available to support this function is not reduced without discussion and agreement with the CCG
- Ensuring that all public health consultants will be fully qualified with the FPH and be subject to all existing NHS clinical governance rules, including those for continued professional development

Developing arrangements post April 2013

Current draft DH guidance recommends that the transition year, 2012/13, is used to develop appropriate arrangements post April 2013. This will be informed by anticipated further definitive DH guidance issued to accompany regulations on local authority mandatory functions which will come into force in April 2013.

Issues that have already been identified and will require discussion and inclusion in the MOU for 2013/14 include:

- Working arrangements between the public health directorate and the CCG in relation to health improvement and health protection
- Identification of the reciprocal arrangements for CCG support to the SCC public health function. This may include support in relation to contract management, clinical quality/governance, development of Local Enhanced Service (LES) agreements, and management of public health elements of the prescribing budget.

It is anticipated that further issues for discussion and inclusion in the MOU for 2013/14 will also be identified during the year.

Signatures

Tessa Lindfield	Director of Public Health, NHS Suffolk and Suffolk County Council
Date	17.07.2012
Julian Herbert	Accountable Officer (Designate), Ipswich and East Suffolk CCG
Date	11/7/12

Appendix 1 -Core Specialist Healthcare Public Health Advice Service to Clinical Commissioning Groups.·
Extracted from draft DH guidance March 2012.

WORKING DRAFT FOR DISCUSSION

[SUBJECT TO PARLIAMENT]

The Core Specialist Healthcare Public Health Advice Service to Clinical Commissioning Groups

Stages in the Commissioning Cycle	Core Specialist Healthcare Public Health Service	Examples of Outputs
Strategic Planning -Assessing needs	Using and interpreting data to assess the population's health, this may include – Supporting CCGs to make inputs to the Joint Strategic Needs Assessment and to use it in their commissioning plans. - Development and interpretation of neighbourhood/locality/practice health profiles, in collaboration with CCGs and local authorities - Providing specialist public health input to the development, analysis and interpretation of health related data sets including the determinants of health, monitoring of patterns of disease and mortality -Health needs assessments (HNA) for particular conditions/disease groups – including use of epidemiological skills to assess the range of interventions from primary/secondary prevention through to specialised clinical procedures.	 JSNA and joint health and wellbeing strategy with clear links to CCG commissioning plans Neighbourhood/locality /practice health profiles, with commissioning recommendations Clinical commissioners supported to use health related datasets to inform commissioning HNA for condition/disease group with intervention / commissioning recommendations
-Reviewing Service Provision	- Identifying vulnerable populations, marginalised groups and local health inequalities and advising on commissioning to meet their health needs. Gee-demographics profiling to identify association between need and utilisation and outcomes for defined target population groups, including the protected population characteristics covered by the Equality Duty	Vulnerable and target populations clearly identified; PH recommendations on commissioning to meet health needs and address inequalities.

Stages in the Commissioning Cycle	Core Specialist Healthcare Public Health Service	Examples of Outputs
	-- Support to CCGs on interpreting and understanding data on clinical variation in both primary and secondary care. Includes PH support to discussions with primary and secondary care clinicians if requested - PH support and advice to CCGs on appropriate service review methodology	PH recommendations on reducing inappropriate variation PH advice as appropriate
- Deciding Priorities	-Applying health economics and a population perspective, including programme budgeting, to provide a legitimate context and technical evidence-base for the setting of priorities -Advising CCGs on prioritisation processes - governance and best practice. -Work with CCGs to identify areas for disinvestment and enable the relative value of competing demands to be assessed - Critically appraising the evidence to support development of clinical prioritisation policies for both populations and individuals -Horizon scanning: identifying likely impact of new NICE guidance, new drugs/technologies in development and other innovations within the local health economy and assist with prioritisation	Review of programme budget data Review of local spend / outcome profile Agreed CCG prioritisation process Clear outputs from CCG prioritisation Clinical prioritisation policies based on appraised evidence for both populations and individuals. PH advice to clinical commissioners on likely impacts of new technologies and innovations

Stages in the Commissioning Cycle	Core Specialist Healthcare Public Health Service	Examples of Outputs
Procuring Services -Designing Shape and structure of supply Planning capacity and managing demand	Taking into account the particular characteristics of a specified population - Providing specialist PH advise on the effectiveness of interventions, including clinical and cost-effectiveness (for both commissioning and de-commissioning) -Providing **PH** specialist advice on appropriate service review methodology -Providing PH specialist advice on medicines management - Providing specialist input to the development of evidence-based care pathways, service specifications and quality indicators to improve patient outcomes -PH advice on modelling of the contribution that interventions make to defined outcomes for locally designed and populated care pathways and current and future health needs	 **PH** Advice on focussing commissioning on effective/cost effective services PH advice to medicines management eg ensuring appropriate prescribing policies **PH** advice on development of care pathways/ specifications/ quality indicators **PH** advice on relevant aspects of modelling/capacity planning.
Monitoring and evaluation -Supporting patient choice -Managing performance -Seeking public and patient views	-PH advice on the design of monitoring and evaluation frameworks, and establishing and evaluating indicators and benchmarks to map service performance	Clear monitoring and evaluation framework for new intervention/service PH recommendations to improve quality, outcomes and best use of resources
	-Providing the necessary skills and knowledge, and population relevant health service intelligence to carry out Health Equity Audits and to advise on Health Impact Assessment and meeting the public sector equality duty	Health equity audits. PH advice on Health Impact Assessments and meeting the public sector equality duty.
	-Interpreting service data outputs, including clinical outputs	PH advice on use of service data outputs.