ITEM NO: 6

	Health Select Committee 5th June 2007 **Report from the Director of Policy & Regeneration**

Brent's Health and Wellbeing Strategy

1.0 Summary

1.1 The Council is working with Brent teaching Primary Care Trust to jointly develop a Health and Wellbeing Strategy (the Strategy) for our community. The Strategy will prioritise the health and wellbeing needs of our community over the next 15 years and plan how we are going to meet these needs.

2.0 Recommendations

2.1 That the committee comment on the proposed aims, vision and objectives of the strategy and its development process, as outlined in this report.

2.2 That members consider how to respond to the development of this strategy in relation to the committee's work programme for 2007/8.

3.0 Context

Why do we need a Health and Wellbeing Strategy?

3.1 Reducing inequalities and improving the health and wellbeing of the community is a long standing government priority, recently articulated in the white paper *Our Health, Our Care, Our Say* (2006). This paper outlines a vision of moving services towards prevention and providing users with greater choice and control over the services they receive. This concept is reinforced in the recent Department of Health (DoH) consultation document *Commissioning Framework for Health & Well-being*. One of the few statutory duties outlined in this paper is for local authorities to work with their PCT to produce a Joint Strategic Needs Assessment (JSNA) for their community. The JSNA (or what will be our Health and Wellbeing Strategy) will then be used to inform other strategic planning documents such as the Local Area Agreement (LAA),

Sustainable Communities Strategy, and the Children and Young People's Plan.

3.2 The purpose of the JSNA is to analyse the current and future health and well-being needs of your population and strategically plan for future service provision and joint commissioning arrangements. This analysis should not be solely focused on illness but include lifestyle behaviours and the wider determinants of health such as employment and education. The JSNA should also focus on disadvantaged neighbourhoods and groups of people in the community who are at high risk of future illness or disability and have the lowest levels of well-being.

3.3 Brent is a culturally diverse borough with high concentrations of black and minority ethnic groups in a small number of wards. Our 2004 IMD ranks us 81st out of 354 boroughs in the country and therefore in the 25% most deprived local authorities in the country. With our life expectancy gap increasing between the best and worst wards in Brent, there is a real need in Brent to jointly plan for the health and wellbeing needs of our community.

What is the process for developing the Strategy?

3.4 The strategy is steered though the Health and Social Care Partnership Board which is a sub group of the Local Strategic Partnership. The Board is comprised of Directors from the Council and PCT. The strategy is progressed through the Health and Wellbeing Strategy Working Group which is also comprised of senior representatives from each organisation. Updates on progress with the Strategy will be provided to the Health Select Committee.

3.5 The DoH consultation paper indicates that local areas should have a Strategy in place by April 2008. The working group has already made substantial progress on developing the Strategy and we are on track to meeting this deadline.

3.6 The following table lists the key actions which are currently being progressed by the working group over the coming year:

Key Actions	Timeframes
Establish evidence base – health and wellbeing profile of Brent	In Progress, ongoing
Identify aim, vision, objectives and priority outcomes	In Progress – July 2007
Collate service provision data	In Progress – June 2007
Incorporate consultation with community, patients and users through range of processes	July 2007
Analysis	July – Sep 2007
Identify actions and develop action plan	Sep – Oct 2007
Write draft strategy	Nov 2007– Jan 2008
Approve strategy – LSP	Feb – Mar 2008

Aims and priorities

3.7 The proposed strategic direction for the Strategy has been structured along four main levels:

Aim → Vision → Objectives → Priority Outcomes

3.8 The **aim** of the Strategy is to narrow the gap in life expectancy at birth between the lowest and highest fifth of Brent wards by 2017.

3.9 Our **vision** is to improve the health and well-being of all Brent residents, with a particular focus on vulnerable communities. We will:

- Reduce health inequalities,
- Increase social inclusion
- Secure longer, healthy lives for Brent's residents.

3.10 We will achieve our vision through redirecting resources, where possible and using sound evidence, from expensive interventions in acute care into prevention based activities. We will develop and implement a coherent strategy to improve Community Well being. This approach will focus resources towards improving the behaviours which influence health and wellbeing and tackling the broader factors which determine health and wellbeing.

3.11 The Strategy will be implemented under 4 objectives, which are:

- Redirect resources to prevention
- Reduce the health conditions with the highest rates
- Improve health and wellbeing behaviours
- Improve factors that influence health and wellbeing

3.12 Priority outcomes will fall under each of these objectives. A proposed list of outcomes is provided at **Appendix (A)**. It is intended that this list be prioritised to further focus the strategy. As the Strategy has a 15 year time period, it is intended that only a few outcomes be targeted for achievement in the first couple of years.

Target Population

3.13 The Strategy will a focus on the following vulnerable communities. All groups will be screened for equity of provision to BME communities.

- Older people
- Children and young people
- People with mental health needs
- People with disabilities
- Carers
- People with Long Term Conditions
- People experiencing domestic violence
- Refugees and asylum seekers
- Homeless people
- People who misuse substances
- Offenders

Health and Wellbeing Profile

3.14 To understand the needs of our community a health and wellbeing profile of Brent was developed as an evidence base for the strategy. This provided a picture of what inequalities are affecting Brent, who is most disadvantaged and what areas are most affected.

3.15 Inequalities in health and well being arise as a combination of differences in the demographic characteristics of a population such as gender, age, ethnicity and the consequence of inequities in opportunities in life including unequal access to education, employment and housing. When developing the profile, our focus was therefore broader than just the illnesses and conditions affecting people but also included the wider determinants of health.

3.16 In general Brent was found to be performing well against many of the primary measures of health inequalities such as life expectancy and mortality and is either equal to or better then both the England and London averages. Despite good performance at a borough level there are significant discrepancies in health and wellbeing outcomes at the ward level, primarily to the south of the borough, and for particular groups within our community.

3.17 Key health inequalities which emerged from the profile were:

- The gap in average life expectancy for men at birth between the lowest and highest wards has increased to 11 years. Four wards in particular are below the England average: Harlesden, Kensal Green, Mapesbury and Stonebridge.
- Some of the most deprived wards in the South of the borough also have a higher mortality rate, particularly for CHD and cancer. CHD for people aged 75 years or below is particularly higher then the England average in Harlesden, Stonebridge and Wembley Central wards.
- High predicted levels of people with diabetes, primarily due to Brent's large BME population, with people from the Indian sub-continent being most at risk. Wembley and Kingsbury localities have the highest levels.
- Brent has one of the highest TB rates in the country, over double the London rate, and the numbers are increasing. TB also disproportionately affects the migrant population.
- Brent's teenage pregnancy figures continue to decrease but we are still above the England average. Rates are significantly higher in wards to the south of the borough.
- High and increasing numbers of HIV and sexually transmitted infections, particularly affecting BME community and men.
- High levels of tooth decay in children.
- High rates of Sickle Cell and Thalassaemia, particularly affecting Asian and Mediterranean community.

3.18 Brent does not appear to be performing significantly worse then the national average on many of the lifestyle behaviours that significantly impact upon health such as smoking, diet and physical activity. Despite this, predicted levels across the country and within the borough are high and well above desirable levels and significant improvements are still needed.

Next Steps

The next key steps in the development of the health strategy are:

- Analyse services provision across the borough and identifying gaps.
- Incorporate consultation with community, patients and users

3.19 Members will be presented with a full draft version of the strategy in February 2008 (as outlined above).This committee will receive reports back on the progress and development of the strategy, as appropriate, throughout the year.

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