NORTH YORKSHIRE SHADOW HEALTH AND WELLBEING BOARD

DATE: Wednesday 30 May 2012

Developing a Health and Wellbeing Strategy (HWBS) for North Yorkshire

1. Purpose:

This paper outlines the suggested approach to the development of North Yorkshire's (NY's) Joint Health and Wellbeing Strategy (JHWBS) following the completion of the Joint Strategic Needs Assessment (JSNA) which will support the development of the Joint Strategy.

Background:

2.1 At the heart of the Health and Wellbeing Board's role in joining up commissioning across health and social care is the development of a JSNA and JHWBS. The Strategy is intended to have an influence on commissioning and on the integration of local health and care services so that health and wellbeing is improved. Ensuring the Strategy is developed in a way which exercises this influence will be one of the fundamental challenges for the Board.

2.2 Experience of previous partnerships suggests that strategies can be relatively straight-forward to write and publish but much harder to bring to life. Early informal discussions with partners have suggested that the 'how' of developing a strategy is in many ways more important than the 'what' – the end product.

2.3 This paper therefore sets down an approach which does not aim to impose priorities or task a few people to write a plan; rather it aims to start a dialogue and process that collectively builds a strategy providing a common set of priorities and ways of working - which ensures it will not gather dust on our respective office shelves.

3. Context:

3.1 We are not starting from a blank sheet in NY, and there are a number of issues we need to be mindful of when it comes to developing a Health and Wellbeing Strategy. These include:-

3.1.1 We have completed the JSNA supplemented by a considerable body of other population and user data and information at a pan-North Yorkshire / District Council (DC) and Clinical Commissioning Group (CCG) level. This has been presented on today's agenda as an earlier item.

3.1.2 Partners in the Health and Wellbeing agenda have existing plans, strategies and objectives which are currently driving commissioning priorities and spend, plus the CCGs are developing their own vision and development plans.

3.1.3 There are clear national expectations and policy drivers which will influence priorities.

3.1.4 There is major organisational change in the National Health Service (NHS), and management capacity is stretched.

3.1.5 Any approach to developing a HWBS needs to facilitate change – not hamper it.

4. Areas for consideration in developing the Health and Wellbeing Strategy:

4.1 The Health and Wellbeing Board would expect to be able to answer the below questions:-

- 4.1.1 What is the context for North Yorkshire and its communities? (economic, social and financial) (Known by all and captured in the Independent Review).
- 4.1.2 What principles and or values are we using to decide priorities? (to be agreed).
- 4.1.3 What are the top commissioning priorities for improving and sustaining the health and wellbeing of residents in across North Yorkshire and by CCG area?
- 4.1.4 What do North Yorkshire people think about our priorities?
- 4.1.5 What are the top commissioning priorities for improving and sustaining the health and Wellbeing of our communities?
- 4.1.6 What actions – collectively and as individual organisations – will partners in the Health and Wellbeing Board need to take during 2012 /2013 / 2014 to address these identified priorities?
- 4.1.7 How will we collectively and individually account for our actions?

4.2 The answers to these questions would essentially be the Board's 'strategy', the elements of which are then reviewed and refined each year.

4.3 In response to question 4 above on the views of the community on the priorities the health and Wellbeing Board; you will have noted Section 3 of the JSNA sought the views of community groups at the 7 District engagement events and a pan North Yorkshire JSNA event, where delegates were given the opportunity to suggest ways that decisions should be made about how priorities are identified. This is again presented at Appendix 1.

4.4 The JHWS is intended both to provide a basis for holding to account the partners represented on the Health and Wellbeing Board, as well as ensuring the Board engages with, and presents an account of, its work and priorities to the wider community. This dual purpose means that it is written for two audiences: a) for the membership of the Health and Wellbeing Board itself and b) for the wider population. As such, it is important that it is clear and memorable rather than providing great detail: detailed material specifically on implementing the improvements set out is better presented in the subsidiary plans. Thus, the overall length should be strictly limited, with the detailed plans referenced.

4.5 North Yorkshire's JSNA sets out the need and the JSNA highlights 10 key messages in its Executive Summary for the Health and Wellbeing Board to consider. The Health and Wellbeing Board has already indicated it cannot hope to address all needs and therefore the JHWS will have to focus on a much smaller number of key priorities. The degree of concentrated effort required suggests that we should be aiming for about 3 or 4. A corollary of this is that there are some key messages from the JSNA that will not make the cut as priorities to be addressed through the JHWS. This does not mean that existing programmes of work would be abandoned; it is possible that they will benefit from some of the ways in which the partnership is strengthened through the JHWS.

4.6 However, they will not benefit from the same high-level focus as those issues selected as JHWS priorities.

4.7 All the key issues identified in the JSNA are, by definition, important. The key criterion for selecting some of them as JHWS priorities is what value they will add. Questions that might be asked are:-

- 4.7.1 Is it an area of work where there are shared responsibilities?
- 4.7.2 How important is partnership working in addressing the issue?
- 4.7.3 How effectively are existing arrangements dealing with the issue?
- 4.7.4 How likely are efforts to have a positive impact?
- 4.7.5 What difference can the Health and Wellbeing Board make on this issue?

4.8 There is also an important emotional and ethical aspect to securing a shared commitment. The Board cannot expect the JHWS to bring about change in its priority areas unless the members of the Health and Wellbeing Board are passionate about achieving such change and are able to convey that passion within their own agencies. Within North Yorkshire, the process of agreeing a shared 'vision' for the Health and Wellbeing Board is crucial to identifying the shared values that can drive forward implementation of the JHWS.

4.9 Health inequalities were identified early on as a key important area that the Health and Wellbeing Strategy would need to cover. The JSNA Steering Group therefore decided to use the evidence in 'Fair Society, Healthy Lives – The Marmot Review'[1] around reducing health inequalities to present the findings of the JSNA.

4.10 The Marmot Review looks at how local and national government should tackle health inequalities and evidenced how tackling the social determinants of health can reduce health inequalities. Whilst acknowledging that chronic disease management is very important in reducing health inequalities, Marmot describes how more systematic work is needed in medium-term interventions like lifestyle behaviour change, and long-term interventions on the wider determinants of health. Marmot describes 6 domains to reduce health inequalities and improve health:-

4.10.1 Give every child the best start in life;
4.10.2 Enable all children, young people and adults to maximise their capabilities and have control over their lives;
4.10.3 Create fair employment and good work for all;
4.10.4 Ensure a healthy standard of living for all;
4.10.5 Create and develop healthy and sustainable places and communities;
4.10.6 Strengthen the role and impact of ill health prevention.

4.9 Marmot also makes it clear that in order to reduce inequalities and improve health, actions must be proportionate to the degree of disadvantage and hence applied in some degree to al people, rather than applied to the most disadvantaged. He calls this "proportionate universalism".

5. Conclusion:

5.1 The development of a Health and Wellbeing Strategy for North Yorkshire will be an important test of the effectiveness and impact of the Board. The approach set out in this paper aims to recognise that the Board is not starting from scratch, but working in an environment where partners already have commissioning priorities. The way the Board collectively builds up the elements of the strategy, and how it uses this transition year to build and foster sound working relationships, will be nearly as important as the content. The Board will recognise that all areas of need high-lighted by the JSNA will need to be tackled but also acknowledge that it will have to prioritise the issues. In doing so it needs to take account of both the Big Issues presented by the community and the prioritisation frameworks proposed by communities. Finally the Board will note that the work of Marmot suggests that the determinants of Health inequalities will need to be addressed on all fronts.

6. Next Steps:

6.1 If the Board agrees this overall approach the proposal is that there is a 5 step approach to developing the Strategy (JHWS). This includes:-

6.1.1 Using part of the next HWB Boards' Workshop to prioritise potential areas that the Strategy should focus on based on the Marmot domains and using evidence in the JSNA;
6.1.2 Then in the light of this steer and in order to take forward the drafting of the strategy, it is proposed that a task group should be established to take responsibility of the preparation of the JHWS. It is recommended that this group should be led by the Director of Public Health or their representative. Core membership of the group to include representatives of the CCG, the Director of Health & Adult Social Services

[1] Fair Society, Healthy Lives. Available at http://www.marmotreview.org/

and the Director of Children's Services), with the Cluster, as the forerunner of the NHS Commissioning Board, being invited to nominate a representative. There should also be a representative from District Council's, the Voluntary Sector and HealthWatch.

6.1.3 The HWB Board and partner Boards to take an initial view of the draft strategy;

6.1.4 Views are sought from the community before finalising the JHWS.

6.1.5 Final Draft comes back to the Board for sign off.

7. Recommendation:

7.1 The Board is asked to agree the overall approach as set out in Sections 4 & 5 of this paper and the proposed next steps in Section 6.

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Appendix 1: Extract from JSNA Document on developing the HAWS – Community View

Section 3: Using the JSNA to develop a Health and Wellbeing Strategy:

The outputs from the JSNA will be used to inform the development of the Health and Wellbeing Strategy. The Health and Wellbeing Strategy is about ensuring commissioning of services leading to improved health and wellbeing. It needs to compliment the work which is ongoing around implementing the North Yorkshire Review - which is looking at how to make best use of resources within the North Yorkshire health economy.

The Health and Wellbeing Strategy will also need to take into account the NHS Outcomes Framework, the Public Health Outcomes Framework and the Social Care Outcomes Framework.

Suggested criteria for prioritisation from engagement events:

At the seven District engagement events, delegates were given the opportunity to suggest ways that decisions should be made about how priorities are identified. Delegates were asked how they made decisions about how they spend their household budget. They were then asked to apply similar thinking and derive criteria or rules for prioritising. At each plenary session, the individual criteria developed on each table were shared and discussed with the whole room, and the following criteria was produced:

Thirsk

- Statutory – keep within the law.
- Innovative creative return on investment.
- Transparency – explain decision.
- Individual responsibility and accountability.
- Maximising impact on communities and individuals.
- Ethics – open decision making; options and consequences.
- Equity and fairness.
- Political aspects of development.

Richmond

- Access to services – transport, appointment times
- Need for more customer focus
- Prevention – including housing, physical fitness, etc
- Local data plus local assets -> solutions
- Partnership working
- Whole person – Person centred approach. More generic approach
- Lifestyle education – all ages, but start early
- Communication
- Deprivation

Skipton

- Critical services
- Accessibility
- Communication
- Optimise level of choice
- Best practice
- Affordability
- Whole life impact
- Prevention - Spend now to save later

Malton

- Prevention – invest now to save later
- Need not want
- Need for long term planning
- Service provision dependent on lifestyle change ??
- Probability of good outcome
- Cost benefit analysis

Selby

- Based on need
- Impact. Good return for investment
- Greatest good versus vulnerable. conundrum
- Prevention. Cost more later.
- Invest in skills to achieve outcomes
- Sources of income
- Smart working - partnership
- Budget management – avoid duplication
- Education around services available (to professionals and community)
- Costs may be cheaper to individual than state
- Essential services need to be cost effective
- Increase market place and mechanism to pay
- Contingency planning

Harrogate

- Statistics, data, evidence of need
- Accountability
- Ethics
- Affordability
- Prevention versus acute care (anticipatory), including mental health
- Ageing population
- Sustainability
- Reducing health inequalities
- Holistic/creative decisions/solutions (working with partners)
- Quality (needs to be adequate, appropriate, accessible)
- Community engagement and part of the solution (including family networks)

Scarborough

- Return on investment;
- Prevention – do now rather than pay more tomorrow;
- Cost effectiveness (difficult to measure down the line);
- Long term view – looking to future needs;
- Must dos (legislation);
- Cooperation;
- Health needs of the community;
- Target for maximum effect;
- Accountability Political;
- Vested interests;
- Effectiveness – does what its meant;
- to do / don't tolerate waste;
- In context of assets in the community;
- Clear information;
- Transparency.

Using the outputs from each workshop, the following collated criteria were tested out at the final engagement event:

Is this non-discretionary?
Is this something that is a 'must do' – ie, is there a statutory obligation to provide the service and / or programme? If not – then use the following criteria:-

1. **Maximise Health and Wellbeing gain:**
   Health gain refers to the magnitude of effect. This will be affected by the numbers of people affected by the condition or issue and also whether the magnitude of the effect of any intervention or service. Though an intervention or service maybe effective the additional gains in terms of quantity and quality of life can be marginal over and above existing interventions or services.

2. **Reduce Inequalities:**
   Ensure that any intervention and / or service provision doesn't widen inequalities - and preferably reduces the inequalities gap.

3. **Cost effectiveness:**
   Cost effectiveness refers to the cost per outcome from services / interventions. An intervention or programme that has a higher cost with the same outcomes as another should not be used.

4. **Investing in Health and Wellbeing for the future:**
   Does the intervention or programme lead to better outcomes in the future?

5. **Affordability:**
   The treatment / intervention must be affordable within the context of the budget as whole. The opportunity to cost other treatments / services must be considered when deciding on funding (ie, identify what the funding could also have been spent on).

6. **Accessibility:**
   Any treatment or service provision needs to be accessible to all who might benefit. Accessibility may be influenced by means of access to a treatment / service / location, and perception of the service or clinical or awareness of the service.

Finally, all decisions should be made in an ethical and transparent manner.

Delegates were asked to give a relative score to each of the six criteria if the first criteria was given an arbitrary score of 10. Therefore if delegates thought that criteria 2 was more important than criteria 1 they would score it higher, and conversely score less if they thought it was less important.

In total 66 people completed the exercise. The following weightings were derived based on the total number of scores given:
1 Maximise health and wellbeing gain 12.7%
2 *Reduce inequalities* 12.8%
3 Cost effectiveness 18.8%
4 Investing in health and wellbeing for the future 19.9%
5 Affordability 18.5%
6 Accessibility 17.3%

Therefore 'investing in Health and Wellbeing for the future' was seen to be the most important criteria.

However, when the individual's ranking of the criteria was taken into account (ie, if the highest scoring criteria was given a rank of 1, and the second highest scoring criteria was given a rank of 2 for each individual response), then 'investing in Health and Wellbeing for the future' came out as the most important again - but equal to 'accessibility'.

Ranking:
1. Maximise Health and Wellbeing gain - 5
2. Reduce inequalities - 6
3. Cost effectiveness - 4
4. Investing in Health and Wellbeing for the future - 1
5. Affordability - 3
6. Accessibility 1

It should be noted that these are not absolute weightings are should only be used as an indication as to what delegates on the day perceived to be more important.