ITEM 5

Health and Wellbeing Board
North Yorkshire

NORTH YORKSHIRE COUNTY COUNCIL

NORTH YORKSHIRE HEALTH AND WELL-BEING BOARD

19 July 2013

Children's Trust Contributions to the North Yorkshire Health and Well-Being Strategy

1.0 PURPOSE OF REPORT

1.1 This report introduces a piece of work to map the contributions of the Children's Trust partners to the delivery of the North Yorkshire Health and Well-Being Strategy. It also introduces a national pledge to improve health outcomes for children and young people and a charter aimed at improving health outcomes for disabled children.

2.0 BACKGROUND

2.1 The Health and Well-Being Board has approved a Health and Well-Being Strategy for North Yorkshire. Partner agencies have been asked to demonstrate how their work supports this strategy. Section 3 of this report presents the work done to date to demonstrate the contribution of Children's Trust partners to the Health and Well Being Strategy.

2.2 This report also presents two further items related to the health and well being of children and young people. Section 4 of the report introduces the Department of Health's pledge to improve the health of children and young people and to reduce child deaths. Section 5 of the report introduces a Disabled Children's Charter for Health and Well Being Boards. At its meeting on 10 July the Children's Trust Board signed up to the national pledge and endorsed the Disabled Children's Charter for Health and Well-Being Boards. The Children's Trust Board also recommended that the North Yorkshire Health and Well-Being Board sign-up to both the national pledge and the disabled children's charter.

3.0 NORTH YORKSHIRE HEALTH AND WELL-BEING STRATEGY

3.1 In May 2013 the North Yorkshire Health and Well-Being Board formally approved the North Yorkshire Health and Well-Being Strategy, 2013-18. The strategy sets out the vision and objectives for improving health and well-being in North Yorkshire, by empowering people to live healthy active lives and reducing health inequalities across the county.

3.2 The strategy includes an explicit expectation that each partner organisation represented on the Health and Well-Being Board will develop its own plans to demonstrate how it can contribute towards the delivery of the Health and Well-Being Strategy. To support this, the strategy includes a 'strategic performance framework' organised around (i) challenges, (ii) priorities and areas for focus, (iii) success criteria, and (iv) local agency contributions.

3.3 In terms of local agency contributions, the NYCC Children and Young People's Service and health partners have worked together to identify existing and planned activities that support the health and well-being of children and young people. A key source of information for this exercise was the Children and Young People's Plan 2011-14, but material from other sources has also been used. These have been mapped against the priorities set out in the Health and Well-Being Strategy. The result is the document presented at Appendix 1.

3.4 Note that this is not a finalised piece of work, but the progress to date does demonstrate that there is a broad range of work in the children and young people sector that contributes to the delivery of the Health and Well Being Strategy.

4.0 HEALTH OUTCOMES FOR CHILDREN AND YOUNG PEOPLE: NATIONAL PLEDGE

4.1 In February 2013 the Department of Health published a new national pledge to improve the health of children and young people and to reduce child deaths. The pledge is part of the government's response to the Children and Young People's Health Outcomes Forum, whose report published in July 2012 set out a series of proposals for improving health and care provision and related services for children and young people.

4.2 The Department of Health is asking organisations who have the power to make a difference to sign up to the pledge alongside the government to improve the care that children and young people receive and reduce avoidable deaths. The pledge has five elements, as set out in the box below. The full pledge document is presented at Appendix 2:

> Our shared ambitions are that:
>
> 1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.
> 2. Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.
> 3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.
> 4. Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.
> 5. There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

4.3 The pledge is intended to support system-wide changes, nationally and locally. The intended impact is a series of improvements to the health outcomes of children and young people. Five particular outcomes are presented in the pledge document, as follows:

- reduce child deaths through evidence based public health measures and by providing the right care at the right time;

- prevent ill health for children and young people and improve their opportunities for better long-term health by supporting families to look after their children, when they need it, and helping children and young people and their families to prioritise healthy behaviour;
- improve the mental health of our children and young people by promoting resilience and mental wellbeing and providing early and effective evidence based treatment for those who need it;
- support and protect the most vulnerable by focusing on the social determinants of health and providing better support to the groups that have the worst health outcomes;
- provide better care for children and young people with long term conditions and disability and increase life expectancy of those with life limiting conditions.

4.4 The national pledge clearly aligns with the health and well-being priorities for children and young people in North Yorkshire as set out in the Children and Young People's Plan 2011-14 and in the Health and Well-Being Strategy. At its meeting on 10 July the Children's Trust Board signed-up to the pledge and recommended that the Health and Well-Being Board does so as well. By signing-up to the national pledge, the Health and Well-Being Board would demonstrate ongoing commitment to partnership working and system-wide change to deliver better health outcomes for children and young people.

5.0 DISABLED CHILDREN'S CHARTER FOR HEALTH AND WELL BEING BOARDS

5.1 Every Disabled Child Matters, a consortium of leading organisations in the disabled children sector, in partnership with The Children's Trust Tadworth, a specialist provider of services for disabled children, have developed a Disabled Children's Charter for Health and Well Being Boards. The purpose of the charter is to support Health and Well Being Boards to meet their responsibilities towards disabled children, young people and their families, including children and young people with special educational needs and health conditions.

5.2 The charter sets out seven commitments to improve the health outcomes of disabled children and young people and their families. Those Health and Well Being Boards that sign up to the charter agree to pursue these seven commitments and to provide evidence after one year to demonstrate the progress made towards each. The seven commitments are set out in the box below, and the charter itself is presented at Appendix 3:

The Health and Well Being Board will provide evidence that it:

1. Has detailed and accurate information on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs.
2. Engages directly with disabled children and young people, and their participation is embedded in the work of the Health and Well Being Board.
3. Engages directly with parent-carers of disabled children and young people, and their participation is embedded in the work of the Health and Well Being Board.
4. Sets clear strategic outcomes for partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account.
5. Promotes early intervention and support for smooth transitions between children and adult services for disabled children and young people.
6. Works with key partners to strengthen integration between health, social care and education services, and with services provided by wider partners.
7. Provides cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners.

5.3 By signing the charter, the Health and Well Being Board will demonstrate that it is committed to improving the quality of life and outcomes experienced by disabled children, young people and their families, including children and young people with special educational needs and health conditions. It will demonstrate a commitment to engage and work together in partnership with disabled children and young people and their families to improve universal and specialist services, and ensure they receive the support they need, when they need it. In short, it will demonstrate that the Board is committed to supporting disabled children and young people so that they can lead better lives.

5.4 It is worth noting that the Mandate from the government to the NHS Commissioning Board for the period 2013-2015 includes the following statement of intent:

> "One area where there is a particular need for improvement, working in partnership across different services, is in supporting children and young people with special educational needs or disabilities. The Board's objective is to ensure that they have access to the services identified in their agreed care plan, and that parents of children who could benefit have the option of a personal budget based on a single assessment across health, social care and education." ('the Mandate', paragraph 4.13, page 18.)

5.5 The Children's Trust is progressing a programme of improvement in services for disabled children, young people and their families. The Children and Young People's Plan 2011-14 includes a priority to develop integrated approaches with the NHS for assessment, decision-making and provision for children and young people with Special Educational Needs and Disabilities (SEND). This work is being delivered through the SEND Change and Integration Programme, led by a multi-agency steering group and reporting through the Children's Trust Board (which is a sub-group of the Health and Well-Being Board). The priority outcomes of this programme are as follows:

- Improved collaborative working between education, health and care services in the provision of services for children and young people and their families, including joint commissioning of services (such as provision for speech, language and communication needs)
- Better information for families and young adults with SEN, including publication of the 'local offer' of what help is available locally for children and young people and their families.
- One overall assessment and plan for children and young people with SEN: with integrated 'health education and care plans' introduced from September 2014.
- Greater choice and for children, young people and their parents in the help they need, with personal budgets available for education, health and care services.
- Smoother and more integrated transitions to adulthood

5.6 As set out in Appendix 1, the SEND Change and Integration Programme contributes towards the delivery of the Health and Well Being Strategy. Particular contributions include the work to support children and young people, especially those from vulnerable groups, and work to develop more integrated models of commissioning and service delivery. Signing-up to Disabled Children's Charter will not only demonstrate that the Health and Well-Being Board is committed to improving the quality of life and outcomes experienced by disabled children, young people and their families, it will also endorse the SEND Change and Integration Programme developed and delivered to date by Children's Trust partners and recognise the contribution of this work to delivery of the Health and Well-Being Strategy.

5.7 At its meeting on 10 July the Children's Trust Board endorsed the Disabled Children's Charter and recommended that the Health and Well-Being Board signs up to it.

6.0 RECOMMENDATIONS

6.1 That the Health and Well Being Board:

(i) Endorses the work done to map Children's Trust partner contributions to the delivery of the North Yorkshire Health and Well-Being Strategy.

(ii) Signs up to the national pledge to improve children and young people's health outcomes and reduce child deaths.

(iii) Signs up to the Disabled Children's Charter for Health and Well-Being Boards

PETE DWYER
Corporate Director, Children and Young People's Service

Report prepared by David O'Brien, CYPS Performance and Outcomes Manager

Health and Wellbeing Board
North Yorkshire

NORTH YORKSHIRE HEALTH AND WELLBEING BOARD

July 2013

Health and Wellbeing Commissioning Intentions in respect of the Joint Health and Wellbeing Strategy

NHS Scarborough and Ryedale Clinical Commissioning Group

1. Purpose

This paper presents the commissioning intentions of Scarborough and Ryedale Clinical Commissioning Group (SR CCG) in support of the North Yorkshire Joint Health and Wellbeing Strategy 2013-2018.

2. Background

2.1 The Health and Wellbeing Board produced its Health and Wellbeing Strategy for 2013-18. SR CCG Governing Body, in its Shadow form, was involved in the development of this strategy.

2.2 Through the Authorisation process, the CCG was required to demonstrate that its commissioning plans responded to the Joint Strategic Needs Assessment (JSNA) and that the plans demonstrate commitment to the local Health and Wellbeing Strategy.

2.3 The SR CCG response to the Health and Wellbeing Strategy demonstrates our commitment to it and the table attached details specific work that underpins the strategic objectives of the CCG and the Health and Wellbeing Strategy.

3. Recommendations

The Board is asked to note:

a. The intention of SR CCG to contribute to the overall health and wellbeing strategy

b. The work in place to underpin delivery of the success criteria outlined in the Health and Wellbeing Strategy.

Author: Simon Cox, Chief Officer, Scarborough and Ryedale CCG
Contact Details: simoncox1@nhs.net

Strategic Performance Framework emerging from the North Yorkshire Joint Health and Wellbeing Strategy SR CCG Commissioning Intentions

The following outlines some of the ways we will know the strategy has improved the Health and Wellbeing of people in North Yorkshire. It is intended that the framework is used as the starting point to develop with partners an agreed range of indicators to show how SR CCG commissioning plans will seek to make an impact on the challenges and priorities contained in the strategy.

Challenges	Priorities and areas for focus	What will success look like?	How SRCCG will locally contribute to success. Plans for 2013/14
Rurality Rurality leads to challenges in delivering services efficiently in remote rural areas. Access to services can be a challenge for some communities, service providers need to think creatively about rural solutions thus reducing further the need for transport. The isolation people can experience from living in rural locations can impact on their emotional wellbeing and mental health. Lack of readily available community support and services can reduce vulnerable people's opportunities to live safely in their own homes. Our rurality also means we have many opportunities within our countryside to improve the health and well-being of our community.	Healthy and sustainable communities. Emotional health and wellbeing. Social isolation and its impact on mental and wider aspects of people's health. Create opportunities to support, expand and grow the contribution people can make in developing safer, supportive communities. Improving the availability of more affordable housing that is appropriate to people's needs. Maximising opportunities for local economic and job development, including the continued development of a more sustainable transport system. Development of a North Yorkshire & York Local Nature Partnership Strategy which sets out how we will conserve and enhance our natural assets and utilise them to maximum effect to enhance the health and well-being of our communities.	Improved access to services for people in rural areas for example by enabling more local communities to manage their own support systems. Improved rural employment opportunities. Improved access to leisure activities for people in rural areas. Improved availability of appropriate and affordable housing. A reduction in the number of socially isolated vulnerable people. Improved communications (e.g. broadband) infrastructure for both business and private premises. The work of the North Yorkshire & York Local Nature Partnership will provide increased access to natural areas for outdoor recreation and conservation volunteering opportunities allowing people to be healthy and play an active role in maintaining our areas of natural beauty.	1. Continued exploration of the potential benefits of assistive technology, including supporting the implementation of the remote monitoring Enhanced Service in 2013-14. 2. Implementing Expert Consulting to reduce the number of unnecessary visits to hospital
An Ageing population Over the next 10 years and beyond, we will continue to see a substantial	Healthy and sustainable communities. People with long-term conditions.	A reduction in the number of socially isolated vulnerable people and the development of local strategies to	1. Joint commissioning of the 'Home from Hospital' scheme with NYCC to support vulnerable elderly

increase in the elderly population, and in the prevalence of age related conditions including obesity, diabetes, stroke and dementia and other long-term conditions. There is a huge challenge to find new ways of adequately meeting the resulting care and support needs of much higher numbers of very elderly people in the County.	Emotional health and wellbeing. People living with deprivation. Social isolation and its impact on mental and wider aspects of people's health. Create opportunities to support, expand and grow the contribution people can make in developing safer, supportive communities. Ensure services are rapidly developed, placing emphasis on integrated interventions which reduce unnecessary hospital admissions for people with long-term conditions and give improved outcomes. Improving the availability of more affordable housing that is appropriate to people's needs.	tackle this issue. The number of people living in poor quality or inappropriate housing is reduced. Reduction in the number of people living in fuel poverty. Increase in the number of people volunteering to help support their local community. Increase in the number of people being helped by the voluntary sector. More children, young people and other vulnerable groups are kept safe and protected from harm. Improved support for people with LTCs: reduction in the number of emergency hospital admissions. Improved knowledge and understanding of the assets available from within local communities by both health and social care agencies and communities themselves. More services being developed and provided in partnership.	people returning to their own accommodation. 2. Funding Care Home link nurses, provided by the local Hospice, to work with care homes to improve patient support, education and decision-making with the view of reducing avoidable inpatient admissions and A&E attendances. 3. Targeted work in Respiratory Medicine to support patient to self-manage their own care (for example roll-out of 'COPD and me') 4. Systematic review of patients on Heart Failure registers to optimize medication and management.
Deprivation and wider determinates of health The health of people within North Yorkshire is generally good compared to other parts of England. However, there is a gap in life expectancy between the least and most deprived communities across North Yorkshire of around 6.3 years for men and 4.6 years for women. Within some districts, the gap is nearly 10 years. Across the life course, deprivation can affect people at every life stage, including	Ill Health Prevention. Healthy and sustainable communities. Children and young people. Emotional health and wellbeing. People living with deprivation. Make a concerted multi-agency approach to identify and develop integrated solutions for children and families who are vulnerable to poverty, have high and complex needs or are in challenging	Reduction in the number of people living in fuel poverty. Investment and services are provided to communities and people in the most need of health and social care. All public agencies have the reduction of health inequalities embedded in their decision making processes. More children and young people are helped to make positive choices for personal responsibility. Increase in the overall employment rate and reduction in unemployment rate.	1. Joint commissioning of health trainer programme to focus on most deprived wards of SRCCG. 2. Targeted work on reducing smoking in pregnancy. 3. Maximizing referral into smoking cessation at the point of elective hospital referral. 4. Targeted work on reducing hospitalization in under 19s with asthma, diabetes and epilepsy

child poverty, inequitable educational attainment, fuel poverty and social isolation.	situations. Social isolation and its impact on mental and wider aspects of people's health. Create opportunities to support, expand and grow the contribution people can make in developing safer, supportive communities. Health, social care and other organisations should develop their knowledge of what community assets exist in their area and how they can be better used and developed. Improving the availability of more affordable housing that is appropriate to people's needs. Maximising opportunities for local economic and job development, including the continued development of a more sustainable transport system to meet the social and economic needs of local communities and safeguard the environment.	Reduction in the number and proportions of children living in poverty. More children, young people and other vulnerable groups are kept safe and protected from harm. Reduction in the gap in life expectancy between different areas of the county. Reduction in the variations in educational attainment believed to result from family circumstances. The proportion of children and young people not in education, employment, or training (NEET) is reduced. Maximising the opportunities afforded by greater access to broadband across our county. Support and encourage the development of social enterprise approaches to community support and the maintenance of our natural assets. Lead partner agencies to ensure their contracts support at least a minimum wage standard and encourage access to employment by vulnerable people through such approaches as innovation funds and contracting for outcomes. Enabling the provision of more affordable homes. Maintaining and improving existing housing stock. Improving access to housing services. Reduction in the rate of adult and young people homelessness.	
Financial pressures	Integrated commissioning maximising the use of the public purse. Integrated service provision which	The health and social care economy delivering good quality timely support within a financially balanced system.	1. Continuing the implementation of the local service improvement plan through the SWR Integrated

	reduces duplication and adds value to people's care pathways. Better support and management of long term-conditions which maximises the use of life enhancing technologies. A better balance between investment in acute support and community focussed early intervention and prevention strategies.	Evidence that there is a sustainable balanced investment in: • early interventions aimed at reducing the need for statutory intervention; • a robust integrated rapid short term response system geared to quickly return people to an acceptable level of health and well-being; and • A financial sustainable acute care response geared to returning people to their appropriate community setting.	Care Delivery Board, with agreed actions supporting delivery of organizational efficiency programmes. 2. Partnership integration work: Integrated Care Board, jointly funded project support working across Health and social care, piloting integrated care teams. 3. Working to ensure that where appropriate care is provided outside an acute hospital setting, where appropriate. 4. Bringing Health and Social Care commissioning together under the Vulnerable Adults and Children Commissioning Unit (VACCU).
Killer diseases Circulatory disease (including heart disease and stroke) and cancers account for the greatest proportion of deaths within North Yorkshire. Cancers are the most common cause of death under the age of 75 years. There are particular challenges for certain conditions due to increasing age (e.g. dementia and stroke) or change in projected prevalence (e.g. obesity and diabetes). Across all age groups, there is a need to establish joined-up care pathways making best use of community	Ill Health Prevention. Children and young people. People living with deprivation. Create opportunities to support, expand and grow the contribution people can make in developing safer, supportive communities. Ensure services are rapidly developed placing emphasis on integrated interventions which reduce unnecessary hospital admissions for people with long-term conditions and give improved outcomes. Encourage positive lifestyle behaviour changes.	Reduction in the instances of "killer" diseases. Improvements in life expectancy for people with chronic/LTC. Reduction in emergency admissions for people with LTC. Increase in the number of people of all ages choosing to adopt healthier lifestyles (reduced smoking, alcohol consumption, lower obesity, etc.).	1. Agreed Stroke improvement plan to establish a fully accredited acute stroke service for the CCG locality by the end of 2013. 2. Establishment of community stroke therapy services resourced through joint Health and Social care funding. 3. Targeted work on reducing smoking in pregnancy. 4. Maximizing referral into smoking cessation at the point of elective hospital referral. 5. Review of GP practice use of the Cancer two- week wait system to support

support.			earlier identification and referral of potential cancer patients into diagnosis and treatment. 6. Joint work with Public Health and acute providers to target reducing the levels of smoking in pregnancy.
Emotional and mental wellbeing Emotional and mental wellbeing is important across all age groups. Mental health is not just the absence of mental disorder. It is defined as a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Physical health and mental health are strongly linked. Dealing with pain or a long-term condition can impact on one's mental health and sense of wellbeing. People with persistent mental health problems often have a long-term physical complaint. Some communities and those who are lonely and isolated are at increased risk of mental ill-health. So the challenge in North Yorkshire is to give attention to develop sustainable, cohesive and connected communities; have safe places for children to engage in positive activities; reduce crime and anti-social behaviour; support more people to reduce their dependencies on substance misuse and tackle domestic violence as all	Develop the culture within our North Yorkshire communities to enable everyone to aspire to a positive sense of emotional health well-being. In partnership to help people to better understand the connection between mental health and physical health and promote improvement through our public health agenda work. Shifting the focus of service provision to one where the performance focus is on the numbers of people who have recovered and the number of people positively reporting on their experience of care and support. Partners collectively agreeing a joint strategy addressing domestic violence. Develop and test innovative approaches to reducing loneliness and isolation.	More people have better mental health. More people with mental illness or who are substance dependent will recover. People with mental health needs will have improved physical health. More people have a positive experience of care and support. Fewer people suffer avoidable harm. Fewer people experience stigma and discrimination. More local investment in schemes with a focus on reducing isolation and loneliness can demonstrate evidence of improved outcomes for people. People who use services say that those services have made them feel safe and secure. An increase in the number of people who feel they have more control over their service as a result of receiving self-directed support. People in contact with secondary mental health services have improved opportunities to access paid employment. People with mental illness have equal opportunity to live independently in settled accommodation with or without	1. Developing a dementia collaborative with partner agencies including the main Mental Health care providers and the local voluntary sector services. 2. Developing comprehensive access to CAMHS out of hours as well as in hours. 3. Proactively engaging with patients and the public through the Practice Patient Engagement groups and in partnership with bodies such as Healthwatch. 4. Enhancing access to Mental Health crisis response and liaison psychiatry. 5. Joint work with Scarborough Borough Council and Scarborough Citizens Advice Bureau to support patients on long term benefit. 6. Reviewing current autism/ADHD service in under 19s and re-designing pathways to meet demand

having their part to play in improving emotional health and well-being		support. People of all ages know they have a safe haven to go to if they feel under threat. People who use services and their carers find it easy to find information about services.	

Health and Wellbeing Board
North Yorkshire

NORTH YORKSHIRE HEALTH AND WELLBEING BOARD

July 2013

Health and Wellbeing Commissioning Intentions in respect of the Joint Health and Wellbeing Strategy

Airedale Wharfedale & Craven Clinical Commissioning Group

1. Purpose

This paper presents the commissioning intentions of Airedale Wharfedale & Craven (AWC) Clinical Commissioning Group in support of the North Yorkshire Joint Health and Wellbeing Strategy 2013-2018.

2. Background

2.1 The Health and Wellbeing Board produced its Health and Wellbeing Strategy for 2013-18. AWC CCG Governing Body, in its Shadow form, was involved in the development of this strategy.

2.2 Through the Authorisation process, the CCG was required to demonstrate that its commissioning plans responded to the Joint Strategic Needs Assessment (JSNA) and that the plans demonstrate commitment to the local Health and Wellbeing Strategy.

2.3 The AWC CCG response to the Health and Wellbeing Strategy demonstrates our commitment to it and the table attached details specific work that underpins the strategic objectives of the CCG and the Health and Wellbeing Strategy.

3. Recommendations

The Board is asked to note:

a. The intention of AWC CCG to contribute to the overall health and wellbeing strategy

b. The work in place to underpin delivery of the success criteria outlined in the Health and Wellbeing Strategy.

Author: Dr Colin Renwick, Chair

Strategic Performance Framework emerging from the North Yorkshire Joint Health and Wellbeing Strategy AWC CCG Commissioning Intentions

The following outlines some of the ways we will know the strategy has improved the Health and Wellbeing of people in North Yorkshire. It is intended that the framework is used as the starting point to develop with partners an agreed range of indicators to show how AWC CCG commissioning plans will seek to make an impact on the challenges and priorities contained in the strategy.

Challenges	Priorities and areas for focus	What will success look like?	How AWC CCG will locally contribute to success. Plans for 2013/14
Rurality Rurality leads to challenges in delivering services efficiently in remote rural areas. Access to services can be a challenge for some communities, service providers need to think creatively about rural solutions thus reducing further the need for transport. The isolation people can experience from living in rural locations can impact on their emotional wellbeing and mental health. Lack of readily available community support and services can reduce vulnerable people's opportunities to live safely in their own homes. Our rurality also means we have many opportunities within our	• Healthy and sustainable communities. • Emotional health and wellbeing. • Social isolation and its impact on mental and wider aspects of people's health. • Create opportunities to support, expand and grow the contribution people can make in developing safer, supportive communities. • Improving the availability of more affordable housing that is appropriate to peoples needs. • Maximising opportunities for local economic and job development, including the continued development of a more sustainable transport system. • Development of a North Yorkshire & York Local Nature	• Improved access to services for people in rural areas for example by enabling more local communities to manage their own support systems. • Improved rural employment opportunities. • Improved access to leisure activities for people in rural areas. • Improved availability of appropriate and affordable housing. • A reduction in the number of socially isolated vulnerable people. • Improved communications (e.g. broadband) infrastructure for both business and private premises. • The work of the North Yorkshire & York Local Nature Partnership will provide increased access to	Expansion of telehealth services in patients homes throughout the Craven area to support self management. This includes the focus on reducing follow up appointments by 30% through the utilisation of technology Expand use of tele medicine and care planning in care homes including local authority homes to support management and reduce need for conveyance to hospital (reduce A&E and admissions by 12%) Expansion of the Craven Collaborative Care Team (multi-disciplinary and multi-organisations team) and increase the number of beds

countryside to improve the health and well-being of our community.	Partnership Strategy which sets out how we will conserve and enhance our natural assets and utilise them to maximum effect to enhance the health and well-being of our communities.	natural areas for outdoor recreation and conservation volunteering opportunities allowing people to be healthy and play an active role in maintaining our areas of natural beauty.	in Castleberg Hospital ensuring that patients can be treated closer to home. Increase utilisation of e-consultation to prevent people having to travel into hospital for appointments Community based model of dementia care for patients and their carers Incentivise Yorkshire Ambulance Service to improve response time in Craven and provide static defibrillators and first responders in this rural area Work with HDFT to improve response time and delivery of equipment supplies to support people to stay at home in Craven rural area
An Ageing Population Over the next 10 years and beyond, we will continue to see a substantial increase in the elderly population, and in the prevalence of age-related conditions including obesity, diabetes, stroke and dementia and other long-term	• Healthy and sustainable communities. • People with long-term conditions. • Emotional health and wellbeing. • People living with deprivation.	• A reduction in the number of socially isolated vulnerable people and the development of local strategies to tackle this issue. • The number of people living in poor quality or inappropriate housing is reduced.	The transformation of integrated care for adults is a key priority for the CCG and work includes as follows: - Specific delivery boards and groups focused on this agenda using a multi-disciplinary approach to

conditions. There is a huge challenge to find new ways of adequately meeting the resulting care and support needs of much higher numbers of very elderly people in the County.	• Social isolation and its impact on mental and wider aspects of people's health. • Create opportunities to support, expand and grow the contribution people can make in developing safer, supportive communities. • Ensure services are rapidly developed, placing emphasis on integrated interventions which reduce unnecessary hospital admissions for people with long-term conditions and give improved outcomes. • Improving the availability of more affordable housing that is appropriate to peoples needs.	• Reduction in the number of people living in fuel poverty. • Increase in the number of people volunteering to help support their local community. • Increase in the number of people being helped by the voluntary sector. • More children, young people and other vulnerable groups are kept safe and protected from harm. • Improved support for people with LTCs: reduction in the number of emergency hospital admissions. • Improved knowledge and understanding of the assets available from within local communities by both health and social care agencies and communities themselves. • More services being developed and provided in partnership.	health and social care - Integrated community teams - Roll out of technology to assess patients with high levels of needs and co-morbidities to ensure pro-active case management and reduce hospital admissions Development of multi-disciplinary teams for dementia/cognitive impairment patients and their carers Ongoing work with nursing homes to develop good practice in medicines management to reduce attendances/unplanned admissions Review diabetes, community nursing, tissue viability, neurology, stroke and cardiology services to inform service improvement and commissioning decisions in 2014/15 Move towards harmonisation of specialist community nursing service provision across all CCG localities,

			particular gaps in Craven
Deprivation and wider determinates of health The health of people within North Yorkshire is generally good compared to other parts of England. However, there is a gap in life expectancy between the least and most deprived communities across North Yorkshire of around 6.3 years for men and 4.6 years for women. Within some districts, the gap is nearly 10 years. Across the life course, deprivation can affect people at every life stage, including child poverty, inequitable educational attainment, fuel poverty and social isolation.	• Ill Health Prevention. • Healthy and sustainable communities. • Children and young people. • Emotional health and wellbeing. • People living with deprivation. • Make a concerted multi-agency approach to identify and develop integrated solutions for children and families who are vulnerable to poverty, have high and complex needs or are in challenging situations. • Social isolation and its impact on mental and wider aspects of people's health. • Create opportunities to support, expand and grow the contribution people can make in developing safer, supportive communities. Health, social care and other organisations should develop their knowledge of what community assets exist in their area and how they can be better used and developed. • Improving the availability of more affordable housing that is appropriate to people's needs.	• Reduction in the number of people living in fuel poverty. • Investment and services are provided to communities and people in the most need of health and social care. • All public agencies have the reduction of health inequalities embedded in their decision making processes. • More children and young people are helped to make positive choices for personal responsibility. • Increase in the overall employment rate and reduction in unemployment rate. • Reduction in the number and proportions of children living in poverty. • More children, young people and other vulnerable groups are kept safe and protected from harm. • Reduction in the gap in life expectancy between different areas of the county. • Reduction in the variations in educational attainment believed to result from family circumstances. • The proportion of children and	Warm homes health partnership work which supported vulnerable people over the winter period. Wheezy child pathway currently being rolled out in the Craven area following successful implementation in Airedale and Wharfedale. Ongoing work with schools on the Injury Minimisation Programme

	• Maximising opportunities for local economic and job development, including the continued development of a more sustainable transport system to meet the social and economic needs of local communities and safeguard the environment.	young people not in education, employment, or training (NEET) is reduced. • Maximising the opportunities afforded by greater access to broadband across our county. • Support and encourage the development of social enterprise approaches to community support. And the maintenance of our natural assets. • Lead partner agencies to ensure their contracts support at least a minimum wage standard and encourage access to employment by vulnerable people through such approaches as innovation funds and contracting for outcomes. • Enabling the provision of more affordable homes. • Maintaining and improving existing housing stock. • Improving access to housing services. • Reduction in the rate of adult and young people homelessness.	
Financial pressures The challenge in a period of budget constraints is to find creative, innovative and efficient solutions to address needs of an increasing and in particular an ageing population. A conclusion	Integrated commissioning maximising the use of the public purse. Integrated service provision which reduces duplication and adds value to people's care pathways.	The health and social care economy delivering good quality timely support within a financially balanced system. Evidence that there is a sustainable balanced investment in:	Transformational change board and the transformation and integration group enable commissioners and providers to work in partnership in delivering the health and social care agenda.

of the Independent Review of Health Services in North Yorkshire and York, published in 2011 was that we must deliver services within our means and place greater emphasis on prevention and support in communities, thus reducing the need for acute care. Our response to these challenges must be planned in the context of the resources available. People in North Yorkshire have high expectations of the quality and availability of health services. However the national criteria used to allocate NHS spending has resulted in North Yorkshire receiving less money per resident compared with many other areas, despite problems associated in particular with its rurality. The challenge for us as a community is to manage our expectations and find cost effective creative efficient solutions within the resources we have.	Better support and management of long term-conditions which maximises the use of life enhancing technologies. A better balance between investment in acute support and community focussed early intervention and prevention strategies.	• early interventions aimed at reducing the need for statutory intervention; • a robust integrated rapid short term response system geared to quickly return people to an acceptable level of health and well-being; and • A financial sustainable acute care response geared to returning people to their appropriate community setting.	Bid for 'Pioneer' status – national support for integration of health and social care and system redesign Expansion of telehealth services in patients homes and in residential/nursing homes throughout the Craven area. This includes the focus on reducing follow up appointments by 30% through the utilisation of technology 25% of day case procedures will be undertaken in an outpatient or community setting Enhanced Recovery Programme focused on reducing length of stay in hospital by 20%
Killer diseases Circulatory disease (including heart disease and stroke) and cancers account for the greatest proportion of deaths within North Yorkshire. Cancers are the most common cause of death under	• Ill Health Prevention. • Children and young people. • People living with deprivation. • Create opportunities to support, expand and grow the	• Reduction in the instances of "killer" diseases. • Improvements in life expectancy for people with chronic/LTC. • Reduction in emergency admissions for people with LTC.	Reduce emergency admissions by 30% through transforming community services, this includes both long term conditions and paediatric admissions

the age of 75 years. There are particular challenges for certain conditions due to increasing age (e.g. dementia and stroke) or change in projected prevalence (e.g. obesity and diabetes). Across all age groups, there is a need to establish joined-up care pathways making best use of community support.	contribution people can make in developing safer, supportive communities. • Ensure services are rapidly developed placing emphasis on integrated interventions which reduce unnecessary hospital admissions for people with long-term conditions and give improved outcomes. • Encourage positive lifestyle behaviour changes.	• Increase in the number of people of all ages choosing to adopt healthier lifestyles (reduced smoking, alcohol consumption, lower obesity, etc).	Develop ambulatory care pathways and alternative community services to reduce emergency admissions Weight watchers on prescription
Emotional and mental wellbeing Emotional and mental wellbeing is important across all age groups. Mental health is not just the absence of mental disorder. It is defined as a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Physical health and mental health are strongly linked. Dealing with pain or a long-term condition can impact on one's mental health and sense of wellbeing. People with persistent mental health problems often have a long-term physical complaint. Some communities and those who are	• Develop the culture within our North Yorkshire communities to enable everyone to aspire to a positive sense of emotional health well-being. • In partnership to help people to better understand the connection between mental health and physical health and promote improvement through our public health agenda work. • Shifting the focus of service provision to one where the performance focus is on the numbers of people who have recovered and the number of people positively reporting on their experience of care and support. • Partners collectively agreeing a joint strategy addressing domestic violence.	• More people have better mental health. • More people with mental illness or who are substance dependent will recover. • People with mental health needs will have improved physical health. • More people have a positive experience of care and support. • Fewer people suffer avoidable harm. • Fewer people experience stigma and discrimination. • More local investment in schemes with a focus on reducing isolation and loneliness can demonstrate evidence of improved outcomes for people. • People who use services say that those services have made them feel safe and secure.	Development of multi-disciplinary teams for dementia/cognitive impairment patients and their carers Investment in psychological therapies to improve access to services and reduce wait times, including additional counselling services in Craven Investment in alcohol specialist nursing teams Increased investment in support for carers as part of Craven Collaborative Care Team

lonely and isolated are at increased risk of mental ill-health. So the challenge in North Yorkshire is to give attention to develop sustainable, cohesive and connected communities; have safe places for children to engage in positive activities; reduce crime and anti-social behaviour; support more people to reduce their dependencies on substance misuse and tackle domestic violence as all having their part to play in improving emotional health and well-being	• Develop and test innovative approaches to reducing loneliness and isolation.	• An increase in the number of people who feel they have more control over their service as a result of receiving self directed support. • People in contact with secondary mental health services have improved opportunities to access paid employment. • People with mental illness have equal opportunity to live independently in settled accommodation with or without support. • People of all ages know they have a safe haven to go to if they feel under threat. • People who use services and their carers find it easy to find information about services.	